CHRISTUS St. Vincent Regional Medical Center:

Realizing the Common Good in Santa Fe, NM

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Part I: Introduction

CHRISTUS St. Vincent Regional Medical Center is a 200-bed, comprehensive, acute care hospital located in Santa Fe, New Mexico. Founded in 1865 by Archbishop Jean Baptiste Lamy and the Sisters of Charity of Cincinnati, St. Vincent functioned as a Catholic hospital for slightly more than a century. In 1978 the Sisters of Charity transferred the hospital's ownership to an independent, community-based board of trustees, under whose sole auspices it was managed until 2008, when it partnered with CHRISTUS Health, a Texas-based Catholic health care system. Throughout these changes in ownership and management, St. Vincent has maintained its mission of serving the common good by enhancing the health and well-being of the residents of Santa Fe and the surrounding region—with a particular emphasis on meeting the health care needs of the poor and most vulnerable.[1]

The following essay constitutes a case study of St. Vincent's contribution to the common good of Santa Fe and northern New Mexico throughout its 150-year history. Detailed attention is given to St. Vincent's work in community health since 2010. In many ways, these efforts anticipate and surpass the requirements of the Patient Protection and Affordable Care Act of 2010, which mandated that all tax-exempt hospitals triennially assess community health needs and annually report progress on initiatives addressing those needs. In fact, as we intend to show,

[1] See https://www.christushealth.org/st-vincent/about

St. Vincent's community health undertakings offer a model for understanding how institutions can wisely and effectively serve the common good.

Our study highlights three features of St. Vincent's efforts. First, they *continue the hospital's historical dedication* to the health of Santa Fe, with an emphasis upon the poor and vulnerable. This dedication is a legacy of the sisters who managed St. Vincent for roughly the first century of its existence, one that continues to animate the hospital. The second part of the essay narrates the story of St. Vincent, from its origins in 1865 to its partnership with CHRISTUS Health in 2008. This section highlights two influential figures in St. Vincent's past: Sr. Blandina Segale and Sr. Joaquin Bitler. The essay's third and fourth parts examine the work of Kathy Armijo Etre, who assumed leadership for St. Vincent's community health initiatives in 2010.

Kathy's work draws attention to a second feature of St. Vincent's efforts to serve the common good, namely its creation of innovative *internal* and *external* structures to better promote the health of the local population. *Internally*, a special committee of the Board of Directors ensures community health strategies are robust and impactful, while a dedicated community health department implements these strategies. *Externally*, St. Vincent has created multiple collaborative partnerships. Many partnerships ensure the delivery and coordination of required health services. One emerging collaboration helps to coordinate funding in the community, to ensure adequate financial resources for organizations addressing critical gaps in clinical service or the socio-economic factors that influence health outcomes. Such collaborations are vital: Because the health of a population is a function of multiple determinants – for example, medical care, health behaviors, the physical environment, and socio-economic influences – a range of institutions is needed and effective cooperation between them is required in order to make progress against goals for enhanced community health.

Third and finally, St. Vincent's programs are notable for their *effectiveness*, especially with at-risk populations. Of particular interest is St. Vincent's High Utilizer Group Services (HUGS) program, which aids people with complex social needs and health problems, including behavioral health diagnoses. The HUGS program has been recognized as a best practice by both CHRISTUS Health and a national professional organization, specifically for its effectiveness in catalyzing health improvements and enhancing the quality of life for program participants.

Part II: The History of St. Vincent's

Archbishop Lamy and the Sisters of Charity (Cincinnati)

St. Vincent Hospital, the first in the New Mexico territory, was established in 1865 by that city's famed Archbishop, Jean Baptiste Lamy.[2] Purchase of the necessary land was made possible by a $3000 bequest from one of Lamy's priests, Fr. Etienne Avel, who had died under tragic circumstances.[3] The small hospital was originally staffed by four Sisters of Charity from Cincinnati, two of whom had served as nurses in the Civil War: Srs. Vincent O'Keefe, Theodosia Farn, Pauline Leo, and Catherine Mallon. The four women had endured a grueling twelve day journey by rail, boat, and stagecoach from the Sisters of Charity motherhouse in Ohio.[4] The weekly *New Mexican* advertised their arrival in its October 13 (1865) edition:

> A small body of Sisters of Charity having arrived in this city design opening a Hospital for the sick and infirm. The Institution will be located in the former residence of the Right Rev. Bishop Lamy. The house is exceedingly commodious, with garden and

[2] Lamy, who served as Archbishop from 1851-1888, is the real-life model for Archbishop Jean Marie Latour in Willa Cather's highly regarded *Death Comes for the Archbishop* (New York: Alfred Knopf, 1927), a semi-fictional novel about Lamy/Latour's efforts to establish a Catholic diocese in the New Mexico territory.
[3] Fr. Avel died after drinking poisoned wine during Mass, a fate intended not for him but an assistant priest who failed to show up that day. See Graña, *Charity's Sister: The Story of Sister Mary Joaquin Bitler, SC*, 14.
[4] Sr. Blandina Segale recounts the narrative of this adventure heard first hand from Sr. Catherine. See Segale, *At the End of the Santa Fe Trail*, 84-88.

> grounds of very great beauty. The number of poor persons they will be able to take care of depends upon the liberality and benevolence of the people of this city and Territory. Attached to the establishment will be several excellent rooms for the reception of sick boarders. They will receive the constant attention of trained and experienced nurses, with every comfort and convenience possible in this country. The rate of board will be reasonable. For particulars apply to Sister Servant Mary Vincent.[5]

With their arrival, and the formal opening of St. Vincent, a more than 150 year-long relationship between the Sisters of Charity, St. Vincent Hospital, and the city of Santa Fe and its surrounding region had begun.

The relationship was, from the start, informed by a desire to serve the common good. To this extent—and only to this extent—the founding of St. Vincent followed a pattern similar to that of most private hospitals being built in the United States (and its territories) in the latter half of nineteenth century. In fact, as Charles Rosenberg writes of that period, so unquestioned was the commitment to the common good as the constitutive purpose of these institutions that it is difficult to consider them as truly "private."

The trustees of voluntary hospitals thought of themselves as serving the community, not as running a private enterprise. It was no narrow legal authority they exerted, but a more general stewardship, justified by the responsibilities appropriate to their class and demanded by the common good.[6]

In the case of St. Vincent's, of course, the "trustees" were none other than the Archbishop himself and, very soon, the Sisters of Charity. These are not minor differences, for as Rosenberg

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[5] Segale, *At the End of the Santa Fe Trail,* 289n.9.

[6] Rosenberg, Charles. *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987):105.

himself observes, the impulse and prerogatives behind the founding of Catholic hospitals differed significantly from those of their secular, and even Protestant, counterparts in the rapidly growing cities of *post bellum* America.[7]

For one thing, Catholic hospitals were founded and operated under the auspices of religious orders, primarily women's orders like the Sisters of Charity, whose work was informed less by the sort of benevolent maternalism and generic commitment to the common good of which Rosenberg speaks, than by their distinctive history and charism, which typically involved the provision of either education or health care (often both) to the poorest and neediest. Many of these orders had been founded in the eighteenth and nineteenth centuries, but some (e.g., the Alexian Brothers) stretched back to the Middle Ages and even earlier. All of them ultimately understood their work as "extending the healing ministry of Jesus," to borrow a line from the mission statement of CHRISTUS Health, a system St. Vincent joined in 2008.

The "evangelical impulse" of the founding religious orders served to distinguish Catholic hospitals like St. Vincent in a second way from their secular and Protestant counterparts: their willingness to treat the "worthy" and the "unworthy" poor alike.[8] As Rosenberg writes, hospitals in nineteenth-century America tended to mirror the values and class distinctions of the larger society.[9] Among the most persistent of such distinctions was the one between the deserving and undeserving poor. The needs of the latter were largely provided—to put it generously—by the almshouse.[10] In fact, it was the overwhelming desire among the laboring classes to avoid the

[7] Rosenberg, *The Care of Strangers*, 111.
[8] On "evangelical impulse," see Kauffman, "Catholic Health Care in the United States: American Pluralism and Religious Meanings." *Christian Bioethics* Vol. 5, No. 1 (January 1999): 44-65.
[9] "Society reconstructed itself within the hospital, mirroring in microcosm those values and relationships that prevailed outside its small stage. Education, piety, genteel dress and diction brought appropriate respect; venereal disease, alcoholism, and low ethnic status brought a parallel disdain (Rosenberg, *The Care of Strangers*, 39-40).
[10] On the "almshouse experience," see Rothman, *The Discovery of the Asylum*, Chapter 8.

horrors of the almshouse, with all its attendant social stigma, that constituted one of the primary motivations for the mid-century hospital movement to begin with.[11]

The distinction between the worthy/unworthy poor is vividly displayed, to take but one example, in an 1866 report of the Hartford (Connecticut) Hospital, in which the trustees emphasize that the free care offered by their hospital was intended for

> . . . persons of temperate and industrious habits, who, from sickness or accident required care or attention, for which they are unable to pay; . . . We would not have this Hospital a receptacle for persons degraded with vice or intemperance, or a home for the hopeless pauper. It is a home for the honest mechanic and laborer, who by temporary disease or accident, is unable to support himself or family . . . . It is a home for respectable domestics who cannot be made comfortable in their attic chambers or receive necessary attention however well-disposed the family in which they reside.[12]

Demographics and geography alone would have prevented Lamy and the Sisters from indulging in such distinctions. In 1866 Santa Fe's population was slightly under 5,000, not including the native population. (Hartford's population at the time was approximately 30,000.) And the area under Lamy's jurisdiction was a massive 400,000 square miles. (All of Connecticut is less than 6,000 square miles.)

More importantly, prior to Lamy's arrival in 1851 there were effectively no formal institutions other than the Church itself, i.e., no schools, orphanages, hospitals, or even almshouses, dedicated to serving the basic needs of the residents—rich *or* poor—of the New Mexico territory.[13] Without such institutions, of course, it is difficult to speak meaningfully

[11] Cf. Rosenberg, *The Care of Strangers*,15-19.
[12] Rosenberg, *The Care of Strangers*,108; citing The Hartford Hospital *Annual Report* 1866, pp. 6-7.
[13] Graña, *Charity's Sister,* 14.

about the existence of a "common good." Thus, in establishing St. Vincent Hospital, and much else, Lamy and the Sisters of Charity may justly be said to be the first to have "realized" the common good in Santa Fe and its surrounding region. Many more would follow in their paths.

Sr. Blandina Segale, SC

Among the most vivid of them is Sr. Blandina Segale, who towards the end of her life published a trove of letters she had written to her sister Maria (also a Sister of Charity) recounting her adventures serving in the New Mexico Territory over a twenty-year time span, ten of which (1872-82) were in Santa Fe.[14] During her time in Santa Fe, Blandina addressed a variety of matters pressing on St. Vincent, perhaps none more important than the hospital's financial viability, a concern that would come to occupy many of her successors in the coming decades.

In order to maintain St. Vincent's ability to provide free care for the indigent, Blandina successfully solicited contributions both informally, through direct solicitation of miners and railroad workers (the railroad came to Santa Fe in 1880), as well as formally, through lobbying governing authorities and legislators for subsidies.[15] Again, it was a pattern that would be taken up by successive leaders at St. Vincent well into the following century, though perhaps never quite like Blandina. One episode in particular captures her "pioneering" spirit.

A recently elected County commissioner, a Democrat who had run on a platform promising to serve more of the community's needs, was resisting Blandina's request to increase the amount

[14] Segale, *At the End of the Santa Fe Trail*, 1-10. Sr. Blandina was born Rosa Maria Segale in 1850, in Cicagna, Genoa, which was then still part of the Kingdom of Sardinia. At the age of four she emigrated, with her family, to the United States, settling in Cincinnati. She entered the Sisters of Charity at the age of sixteen. In 1872, in answer to a longstanding desire of hers, she was sent to serve in the American southwest. She returned to Cincinnati in 1894 where she lived and worked until her death in 1941.

[15] In 1877 a relief bill was passed granting St. Vincent $400 per month to cover the costs of caring for the poor. Cf. Segale, *At the End of the Santa Fe Trail*, 142-44.

that the county would pay for the burial of the deceased poor, from $8 to $15. $8.00 was insufficient, Blandina argued. The Commissioner, adamant, encouraged Blandina to help him "economize," and instructed her to "bury [a recently deceased pauper] for what you have been receiving, $8.00." "I made answer," responded Blandina, "In fifteen minutes the corpse will be brought to your office. You can economize as you wish. Good-bye." The Commissioner relented.[16]

Another characteristic emerges from Blandina's letters that will also find an echo in the future annals of St. Vincent's: her clear-eyed dedication to serving the needs of all comers, especially the native population, but also the morally (and criminally) reprobate. Of the latter, much has been made of Blandina's relationship with William H. Bonney, "Billy the Kid," and his gang, who were then terrorizing the region. Having saved his life after a gunshot battle in Trinidad, Blandina (and the rest of the Sisters of Charity, easily recognizable in their habits) were never troubled by the outlaws again.[17]

As far as the natives were concerned, and by "natives" she means both the Indian tribes indigenous to the region (primarily Apache, but also Navajo and Comanche) as well as Mexicans, i.e., those who had chosen to stay in the newly annexed territory after the United States' defeat of Mexico in 1848, Blandina recognized that the westward expansion was a mixed blessing:

> Grave problems are ahead of us. . . . Progress is in sight—so is disaster to a certain portion of our native population. . . . The labor of our pioneer missionaries on our natives will be destroyed by money-making schemes. Deceit and dishonesty will rob the poor

[16] Segale, *At the End of the Santa Fe Trail*, 151-2.
[17] The American television series *Death Valley Days*, hosted by Ronald Reagan, aired an episode in 1966 based on Blandina's encounters with Billy the Kid, "The Fastest Nun in the West."
https://www.imdb.com/title/tt0556781/?ref_=ttfc_fc_tt

> natives of everything. . . . I saw this process take place in Trinidad, Colorado. Nothing too bad for the natives—nothing too good for the land grabbers. . . . Among my forebodings I foresee the disastrous effects on the spiritual life of our people.[18]

Blandina was even touched personally by this corruption. A speculator had been falsely advertising in the St. Louis newspapers that gold had been found, "in abundance," at "Sister Blandina's mine." (There was, of course, no such mine.) When the scam was brought to her attention, Blandina personally went to the mining camp and confronted the con-artist. In response to Blandina's withering criticism, all the overmatched prospector could muster was: "All right, Sister. You win."[19]

Sr. Joaquin Bitler, SC

As important (and colorful) as Sr. Blandina's story is for understanding the relationship between St. Vincent Hospital and the community of Santa Fe, that story, and her influence, pales in comparison to that of Sr. Mary Joaquin Bitler SC. Interestingly, Joaquin and Blandina shared similar life trajectories: both were of Italian heritage (Joaquin's mother, Teresa della Chiesa was a highly regarded mezzo-soprano, and her grandfather Giovanni had played oboe and clarinet at La Scala in Milan); both were raised in Ohio; and both entered the Sisters of Charity at a young age. Joaquin, born Gina Rita Bitler, became a postulant in 1943, aged 21.[20]

After her solemn profession, Joaquin was sent to Good Samaritan Hospital in Dayton, Ohio, where she trained as a nurse, receiving her R.N. in 1947 and licensure the following year. She was initially sent to St. Vincent in Santa Fe as Superintendent of Nursing but was soon called to

[18] Segale, *At the End of the Santa Fe Trail*, 135.
[19] Segale, *At the End of the Santa Fe Trail*, 156.
[20] Graña, *Charity's Sister,* 20-22.

Corwin Hospital in Pueblo, Colorado. However, after eight years there, she was sent back to St. Vincent's, only this time as the hospital's chief administrator. It was 1960, she was thirty-eight years old, and had never managed a hospital.

Much had changed, of course, both in Santa Fe and at St. Vincent, by the early 1960s. For one thing, a new hospital building had opened in 1952 (part of the surge of hospital construction in the United States following the passage of the Hill-Burton Act of 1946). The loan that the Sisters of Charity needed to build the new hospital was great, almost $2 million. Repaying this debt would prove to be a heavy burden on Joaquin. In addition, the community had grown uncertain about their sole hospital being Catholic. Some wanted the Sisters to remain; others argued for a "nonsectarian" county hospital.[21]

By the time Joaquin assumed her duties as administrator, the financial situation had become critical. As Mari Graña writes:

> The costs to cover the nonpaying indigents had escalated to fifteen percent per year, and the general occupancy rate was only fifty percent. The hospital wasn't breaking even. Given the grim situation, the Cincinnati Sisters were unable to make payments on their $2 million loan. . . . No capital improvements had been made, and in the fast pace of medical innovation, the life of much of the equipment had passed.[22]

Not surprisingly given these circumstances, some in the community were beginning to raise questions about the quality of care St. Vincent was providing, with some referring to the hospital as "St. Victim's."

The passage of Medicare and Medicaid in 1965 brought some relief, as did Joaquin's relentless lobbying for a quarter cent sales tax in Santa Fe County to help subsidize the cost of

[21] Graña, *Charity's Sister,* 25.
[22] Graña, *Charity's Sister,* 28.

indigent care, which passed successfully in 1968. However, by that point in time, Joaquin had formulated what to her was the only long-term solution to St. Vincent's fiscal woes, and to maintaining the hospital's historic mission of serving the people of Santa Fe, particularly the poor: turning control of the hospital over to a community board of directors.[23]

The plan was initiated in 1967, and included what by then had also become obvious: building a completely new, fully modernized hospital. The plan took a full ten years to realize, in part because of the economic uncertainties of the early 1970s, in part because of lingering ambivalence within the community over the necessity of a new hospital. However, the ambivalence was eventually overcome, and the finances approved by the city council, in 1973. A brand new hospital building, occupying a site on St. Michael's Drive, opened its doors in 1977.

While the outcome was considered a success, it was nonetheless a bittersweet ending for the more than century-old formal relationship between St. Vincent and the Sisters of Charity of Cincinnati, especially for some of the Sisters, nine of whom still worked in the hospital. Perhaps it was in this spirit that one Sister was prompted to describe the transfer of the hospital as a "gift" from the Sisters to the people of Santa Fe. Gift: it was a term more fitting than perhaps intended, for in many ways that is what St. Vincent had been from its beginnings.[24]

As for Sr. Joaquin, for her work in bringing the plan to a successful conclusion, she was presented with numerous awards and commendations from the Santa Fe community, which she took with her into a long but active retirement. As Graña summarizes, "the indefatigable nun had accomplished what she had set out to do."

> She had turned the ownership of the hospital over to a nonprofit community corporation, the first of this kind in New Mexico. She relieved the Sisters of Charity of their $2

[23] Graña, *Charity's Sister,* 35.
[24] Graña, *Charity's Sister,* 50.

> million debt, which would finally be paid when the Palace Avenue building [constructed in 1952] was sold. She orchestrated the construction of a massive new nondenominational hospital for Santa Fe, located on a site that would allow for future expansion.[25]

Community Hospital

St. Vincent remained a fully community-owned, non-profit hospital for the next thirty years. During these turbulent decades, which witnessed the acceleration of large-scale changes in the American health care system (e.g., the rise of managed care, HMOs, PPOs, etc.), the major challenge for St. Vincent was fending off take-over bids by larger, for-profit hospital systems, a challenge shared by virtually every independent, non-profit hospital across the United States at the time.[26]

In view of the very real threat these changes posed to St. Vincent's identity as a non-profit community hospital dedicated to serving the health care needs of the entire Santa Fe community—including the poor—the hospital's board of directors convened in extraordinary session during 2004 to discern the future of their institution. The board concluded that if St. Vincent was to survive, it would need to find a suitable partner. The only question was who that partner should be. In what, in retrospect, became a major turning point in the St. Vincent's history, the board identified a set of values they wanted in any partner organization.

[25] Graña *Charity's Sister,* 58-9.
[26] In an early (1980), and often-cited article on the phenomenon, Arnold Relman describes the emergence of what he terms a new and highly problematic "Medical-Industrial Complex," one more beholden to shareholders than the public good. See: "The New Medical-Industrial Complex," *New England Journal of Medicine,* Vol. 303, No. 17 (October 23, 1980): 963-970.

First, the organization would have to be non-profit. Second, it would have to be a true partner, that is, not controlling owner. Third, it would need to at least respect, if not outright share, the hospital's local identity. Fourth it would need to be, or be part of, a larger hospital/health care system. And finally, the partner would have to share St. Vincent's core values.

With these criteria in place, the hospital board initiated a formal search for a partner in 2006. An external consulting firm was retained to assist with the highly confidential search. One year later a prospective partner was identified in CHRISTUS Health, a Texas-based, non-profit Catholic health care system. Kathy Armijo Etre, a St. Vincent board member at the time, characterized discussions with CHRISTUS as open and honest. "We were able to ask them tough questions."[27] When queried about *their* interest in St. Vincent's, CHRISTUS executives consistently replied that St. Vincent was a "perfect fit" for their growing ministry, which, it is important to note, identified "special concern for the poor and underserved" among its core values.

Satisfied that CHRISTUS met the criteria identified in its 2004 retreat, the St. Vincent board approved the partnership and in 2008 an agreement between St. Vincent Community Hospital and CHRISTUS Health was formally executed. The partnership constitutes a unique relationship, at least as far as Catholic health care systems in the United States is concerned, for "CHRISTUS St. Vincent Regional Medical Center" is an institution *both* Catholic *and* community-based. From a cultural perspective, one might say that this had *always* been St. Vincent's identity. One suspects that neither Lamy nor Blandina would have objected to the description. Joaquin, who died in 2003, did not live to see the partnership with CHRISTUS, though her biographer suggests

[27] Kathy Armijo Etre, personal conversation, April, 2018.

that it was something of an "ironic twist" that St. Vincent would once again be identified as a Catholic hospital, given all that Joaquin had done to relinquish it to the citizens of Santa Fe. That CHRISTUS itself was formed in 1999 by a merger of two other Catholic health care systems, one of which was associated with the "Sisters of Charity" is mentioned as yet a further irony, though perhaps mistakenly so.[28]

Part III: Kathy Armijo Etre

The Catholic health ministry had changed considerably since the mid-1970s, when St. Vincent Hospital had ended its affiliation with the Sisters of Charity of Cincinnati. Most notably, as the number of woman religious dwindled, fewer sisters could be found working as administrators or nurses in Catholic hospitals. Some sisters continued to be active in governance roles, on boards of directors or sponsorship boards; however, by the time St. Vincent joined CHRISTUS Health in 2008, day to day leadership of Catholic health systems and hospitals had passed to the laity.[29] Thus, the challenge of preserving and strengthening St. Vincent's historical support for the common good – in particular, the health of the entire Santa Fe community, including its most vulnerable residents – fell to the lay men and women serving on the hospital's board and senior management team. Furthermore, the hospital faced a demanding environment, one marked by convoluted and dynamic regulations, falling reimbursement rates from insurance programs, the need for ongoing reinvestment in increasingly expensive medical technologies,

[28] Graña, *Charity's Sister,* 144. The "Sisters of Charity of the Incarnate Word" (San Antonio) operated the health care system that merged to form CHRISTUS in 1999. Despite their similar names, the two orders, Sisters of Charity of Cincinnati and the Sisters of Charity of the Incarnate Word do not belong to the same "Sisters of Charity" family of women's religious orders. The biographer, Graña, seems unaware of this fact. Interestingly enough, the Sisters of Charity of the Incarnate Word were beginning their ministry serving the educational and health care needs of Texan communities (Houston, Galveston, and San Antonio) at precisely the same time that the Sisters of Charity of Cincinnati were doing so in Santa Fe, i.e., 1865-66.

[29] See Barbara Mann Wall, "From Sisters in Habits to Men in Suits," in *American Catholic Hospitals: A Century of Changing Markets and Missions* (New Brunswick: Rutgers University Press, 2011): 1-22.

rising expectations from patients and employees, as well as complex challenges linked to the health of the local population. The remainder of the case study considers the women and men who succeeded Sr. Blandina and Sr. Joaquin as St. Vincent's leaders, and their efforts to continue the legacy of the Sisters of Charity under these circumstances. Specifically, it focuses upon one particular leader, Kathy Armijo Etre.

Kathy Armijo Etre was born in Albuquerque, New Mexico. When she was five years old, a job opportunity for her father prompted the family to move to Santa Fe. The city became the family's new home, and it was in Santa Fe that Kathy and her three sisters grew to adulthood.

While neither of Kathy's parents received a collegiate degree, both of them had taken college-level courses in business. They stressed the importance of education to their four daughters, and carefully managed their limited financial resources to ensure funds were available to provide all four with an undergraduate degree. One result of the family's focus on education was that Kathy enrolled at St. Michael's High School upon completing her primary education in the Santa Fe public schools. Like St. Vincent Hospital, St. Michael's founding stemmed from the initiative of Bishop Lamy. Dismayed by the lack of schools in frontier Santa Fe, Lamy had requested assistance from the Christian Brothers. In October of 1859, four members of the order arrived from France to address this challenge. Less than a month later, they opened the doors of St. Michael's to both boarding and day students.

Throughout her childhood and adolescence, Kathy had displayed concern for helping those in need. For example, during elementary school she would conduct fundraisers in her neighborhood to aid children suffering from muscular dystrophy. After graduating from St. Michael's, Kathy's interest in the welfare of the needy and marginalized led her to matriculate at New Mexico State University in the field of social work. After completing her undergraduate

degree, she pursued graduate studies at Boston College's School of Social Work, earning a Master of Social Work in 1982. Kathy eventually returned to Santa Fe in 1983, after working for a year with Big Sisters of Greater Boston.

Over the next twelve years, Kathy held positions in multiple New Mexico state agencies, including the Department of Human Services, the Department of Health, and the Department of Children, Youth, and Families. These experiences gave her a first-hand acquaintance with the needs of several vulnerable populations – at-risk children, adolescents, and elderly; persons with physical and mental disabilities; and individuals with AIDs. They also helped her gain a detailed understanding of public programs intended to serve these groups, as well as the state and federal systems through which the programs were financed.

In 1996, Kathy moved from the public sector to the private sector, accepting a role with Presbyterian Medical Services, a not-for-profit health system that served as the successor to the United Presbyterian Church's medical mission in the southwestern United States. Kathy's responsibilities engaged her directly in the challenges of health care administration. For example, she led efforts to gain accreditation from the Joint Commission for Accreditation of Health Care Organizations (JCAHO) for a statewide network of primary care clinics, mental health centers, home health agencies, and long-term care facilities. Her work at Presbyterian Medical Services also allowed her to continue working with at-risk populations: Kathy managed a Medicaid- and state-funded behavioral health program that served individuals through northern New Mexico, in addition to administering an $8 million program that provided low-income families with a comprehensive range of child and family services.

Upon leaving Presbyterian Medical Services in 2000, Kathy was contacted by a friend and former colleague who had taken an executive position at St. Vincent Hospital. The colleague,

who served as the hospital's vice president of strategic planning, discussed with her the state of St. Vincent's Board of Directors. Many board members had retired to Santa Fe after concluding successful careers elsewhere in the United States. These individuals brought needed expertise and a wide range of valuable skills to the governing body; however, they lacked a detailed understanding of the Santa Fe community, including the struggles and needs of residents at all social and economic levels. The colleague suggested that Kathy could bring precisely that knowledge to the group's deliberations, as a result of the decades she had spent living and working in Santa Fe and northern New Mexico. Her recent experience in health care administration also would prove valuable. Following their conversation, the colleague arranged for Kathy to speak with the board's chairman, a retired orthopedic surgeon. This meeting resulted in Kathy joining the board.

Kathy served on St. Vincent's Board of Directors throughout the next decade, participating in the decision to seek a partner for the hospital, as well as the process that led to the selection of CHRISTUS Health. It also was during this time that she undertook doctoral studies in human and organizational systems at Fielding Graduate University, completing her Ph.D. in 2009

By 2009 implementation of the agreement between St. Vincent Hospital and CHRISTUS Health was well underway. As part of the ongoing management of the facility, now known as CHRISTUS St. Vincent Regional Medical Center, its leaders continued to evaluate the hospital services in light of such factors as community need and affordability. In August of 2009, local mental health activists heard rumors that the hospital was looking to close its 11-bed inpatient psychiatric unit. They subsequently expressed their concerns about this potential cutback in a meeting with St. Vincent's chief executive officer, Alex Valdez. During the meeting, Valdez committed to keeping the unit open. However, he noted that on average the unit served only six

patients a night, and finances might lead the hospital to increasingly deliver its mental health services on an outpatient basis.

His exchange with the activists convinced Valdez that the organization needed to determine more precisely the types of mental health services needed in Santa Fe and northern New Mexico. Knowing Kathy's expertise in this area, Valdez asked her to lead the research. Both of them recognized the conflict of interest the assignment would create, given Kathy's membership on the board. However, steps were taken to mitigate this risk and, with the approval of the other board members, Kathy agreed to undertake the study.

The study identified eight major concerns related to care for those suffering with mental illness: Humane treatment and respect; crisis response; alcohol and drug abuse; child and adolescent behavioral health; systems of care; professional development for caregivers; service capacity; and public policy and health care reform. It also recommended ways to remedy deficiencies in each area. Overall, the study highlighted the need for greater collaboration and coordination throughout the care system.

One outcome of the study was unforeseen, at least by Kathy. At the hospital's 2009 Christmas party, Valdez asked Kathy if she would leave the Board of Directors and join his staff, to lead St. Vincent's community health efforts. Valdez suggested that the hospital had an opportunity to differentiate itself within the CHRISTUS Health system on the basis of excellence in community health. Accomplishing this would require a strong, knowledgeable leader, someone capable of directing efforts inside the hospital and connecting them to the work of external parties. In Valdez' eyes, Kathy was that leader.

Kathy agreed to consider Valdez' request. She saw great potential in the situation: It presented an opportunity to create an integrated system aimed at the health needs of the local

population. Her efforts would enjoy the CEO's support. Also, they would be aligned with the hospital's ethos: Almost 40 years after their departure, the commitment of the Sisters of Charity to serving all people, regardless of their ability to pay, remained an enduring part of St. Vincent's culture. However, Kathy had no illusions about the difficulty of tasks that would confront her in the role: It would entail forging relationships with people and groups that viewed CHRISTUS St. Vincent suspiciously or as "St. Victim's." It also would require her to work in an organization that was more focused upon performing medical procedures than establishing a system of care to address longstanding health challenges in the community.

After taking time for discernment, Kathy contacted Valdez to accept his offer. In early 2010, she resigned from the hospital's Board of Directors and assumed the position of Vice President – Community Health.

Part IV: Supporting the Health of the Community: Moving from Aspiration to Action

Laying the Foundation: Relationships, Structures, and Programs

As Kathy moved into her role, she made contact with public agencies and other local groups involved in community health. One important body was the Santa Fe County Health Policy and Planning Commission (HPPC). The HPPC made recommendations concerning the provision of health care services to the Board of County Commissioners and to the county's Department of Community Services. The HPPC also played a pivotal role in allocating public funds to health-related programs, whether they were administered by government bureaus or other organizations. HPPC members were selected by the County Commissioners. Both the Commissioners and the HPPC had been highly critical of St. Vincent through the years, and were mistrustful of the hospital and its leaders. Despite this, Kathy made a point of attending HPPC meetings. Her

presence heightened the hospital's visibility in this forum. It also gave her an opportunity to remind HPPC members and other attendees of St. Vincent's contributions to Santa Fe County.

Kathy learned that St. Vincent historically had funded not-for-profit groups whose services promoted health and wellness in the community – for example, free clinics, shelters, and organizations aiding addiction recovery. The hospital's relationships with these groups were important: Many had the potential to develop into vital partnerships through which needed clinical services could be delivered outside the hospital's walls (e.g., dental care), or partnerships that could help address behavioral and social factors that influenced health – for example, alcohol and drug abuse, domestic violence, housing, the availability of healthy food, access to education, the quality of the physical environment, etc. However, funding decisions had involved the HPPC. Thus, the hospital did not exercise full authority over how its grants were allocated. Also, Kathy discovered that the hospital's past practice had been to provide monies to these organizations in a manner that promoted neither ongoing collaboration nor accountability for outcomes. For example, some community groups that received funds from St. Vincent did not accept patients referred by the hospital. Also, St. Vincent's funds were provided largely without stipulations concerning the grantee's effectiveness or specification of the measures that would be used to assess its performance.

Kathy established new expectations for how the funding process would work in the future. It was made clear that funding decisions would be driven by St. Vincent, and they would be based on a group's willingness to sustain a partnership with the hospital. Among other things, this entailed accepting referrals from St. Vincent. It also entailed participating in future planning efforts intended to help the community as a whole coordinate its resources in light of identified health needs. In addition, Kathy worked with the grantees to place St. Vincent executives and

leaders on their governing boards. This provided the organizations with much needed knowledge and skills. It also gave St. Vincent "a seat at the table" as the community groups sought news ways to operate more effectively.

Kathy also set about creating a unit within the hospital dedicated to community health. Established in 2010, the new Department of Community Health inherited some hospital operations, as well as the personnel associated with them. For example, it took over responsibility for directing a fifteen-bed, residential Sobering Center. The Center was available 24 hours a day, seven days a week. It provided patients with detox services for three to seven days, while they sought referrals to longer-term treatment facilities or other recovery services. The department also managed a new service launched in 2010, the High Utilizer Group Services (HUGS) program.

HUGS was designed to serve people with complex needs. The program focused upon the top 25 utilizers of St. Vincent's emergency department who also had a behavioral health condition. Typically, such individuals struggled with multiple problems: Homelessness, long-term drug or alcohol abuse, isolation from family members, unemployment, and chronic physical maladies. Many of them also were well-known to law enforcement and emergency responders, due to encounters stemming from mental health crises and other behavioral problems. Kathy identified a group of counselors, case managers, and other staff who listened to these patients, identified what they required to lessen their dependence upon the emergency department, and then pioneered ways to connect them to needed services.

Over time, this experiment grew into a formal program. Three HUGS navigators linked participants to medical providers and to social services in the community, to ensure they received care and support that addressed their needs in a comprehensive manner. By re-integrating

participants into the community's system of care, HUGS enabled participants to improve their quality of life, reduce their utilization of St. Vincent's emergency department, and reduce public expenditures tied to their previous behavior. Two years after its inception, the HUGS program was awarded the CHRISTUS Health Touchstone Award for Community Benefit, signifying its recognition as a best practice within the system.

In 2011 the CHRISTUS St. Vincent Board of Directors established a board committee dedicated to community health. The committee was put in place to signal the board's interest in community health, and to help sustain the governing board's focus on related issues. The committee's membership included a majority of the board members, and its responsibilities encompassed oversight for activities in multiple areas. These included the identification of community health needs; the establishment of community health priorities for the hospital; approval of plans addressing those priorities; and administration of the hospital's charity policy. In addition, the committee oversaw the community benefit funding process, which included the funding of local community groups.[30]

Certain provisions of the Patient Protection and Affordable Care Act (ACA) that addressed community health came into effect in 2012. They reinforced Kathy's work, as well as the work of the Board Committee of Health and Wellness. Passed in March 2010, the ACA emphasized the duty of tax-exempt hospitals like St. Vincent to enhance the health of the communities they served, and to demonstrate their impact in an evidence-based manner. Starting in 2012, the ACA required tax-exempt hospitals to conduct a community needs health assessment (CHNA) every three years. The CHNA report had to describe the prioritized health needs of the community, as well as the data and methods used to identify those needs. As a follow-up, each hospital was

[30] CHRISTUS St. Vincent Regional Medical Center. *Transforming Health, Strengthening Our Community: CHRISTUS St. Vincent 2017-2019 Community Health Needs Assessment* (2016): 9-10.

required to develop a community health implementation plan (CHIP). The CHIP report identified the strategies the hospital would use to address the most critical of the prioritized needs, as well as the means through the needs would be met, e.g., resources that would be committed resources and planned collaborations. The ACA also required the governing body of each tax-exempt hospital to approve the CHIP. Finally, the community benefits provided by the hospital through these and other efforts were to be reported to the Internal Revenue Service on its Form 990 filing.

Tax-exempt hospitals in the United States long had been required to provide benefits to the communities in which they were located – for example, free or discounted medical care, subsidized clinics for the indigent, education for aspiring health professionals, and medical research. However, some members of the U.S. Congress, concerned about growing federal deficits, questioned the extent to which not-for-profit health care institutions actually provided these benefits, and whether they justified tax immunity for these institutions.[31] The provisions of the ACA that dealt with community benefit and community health were in part a response to such concerns. In the eyes of St. Vincent's administrative leaders, the hospital's community health efforts continued the legacy bequeathed to them by the Sisters of Charity, who from their arrival in 1865 had sought to respond generously to the needs of the residents of Santa Fe and surrounding towns. The ACA's requirements provided regulatory legitimation for Kathy's plans to strengthen these efforts, as well as the board's new responsibilities in this area.

The Department of Community Health ultimately assumed responsibility for coordinating the triennial CHNA, developing a CHIP in response to the findings, and then administering the implementation strategies identified in the CHIP. In addition, it managed the distribution of

[31] Shaeffer, Pamela. "Assessing and Evaluating Community Benefit." *Health Progress* (Nov.-Dec. 2014): 54.

funds to community groups. Operating under Kathy's leadership, the department worked closely with the Board Committee of Health and Wellness on these matters.

Expanding Collaborations: The 2013 CHNA

In 2011 Kathy's efforts to engage with local governmental officials began to bear fruit, as she developing a working partnership with Rachel O'Connor, the director of Santa Fe County's Department of Community Services. Community Services included a division that promoted access to health care and preventative health services for all County residents, including those who lacked the means to pay. Like Kathy, Rachel had an extensive background in human service administration. As the two conversed, they discovered they shared common perspectives on many issues. Chief among these was a deep-seated belief that the hospital, governmental agencies, and local not-for-profit organizations needed to improve their coordination if health challenges facing Santa Fe were to be successfully addressed.

Santa Fe County had not performed a health needs assessment in 12 years. Thus, as St. Vincent prepared to perform its first CHNA, Kathy and Rachel discussed the possibility of collaborating. They eventually agreed that St. Vincent and Santa Fe Country would jointly conduct a CHNA during 2012 and 2013, pooling their resources and sharing expenses. The resulting report, "Santa Fe County in 2013: A Community Health Profile," featured both the seal of Santa Fe County and the logo of CHRISTUS St. Vincent Regional Medical Center on its front cover.

The 2013 CHNA emphasized quantitative data: It summarized the state of health within Santa Fe County through a broad range of indicators and metrics. The information on which the assessment was based was drawn largely from the New Mexico Department of Health's

databases. St. Vincent used the report to identify strategies to enhance community health over the next three years. The hospital's 2013-16 CHIP established initiatives in thirteen areas. The hospital undertook some of these initiatives on its own; others were addressed in cooperation with not-for-profit organizations in the community, with St. Vincent providing in-kind or financial support.

St. Vincent also used the 2013 CHNA to guide the allocation of its community benefit funds. For their part, not-for-profit community groups seeking funds used the CHNA to demonstrate how their proposals aligned with documented health needs in the county. St. Vincent awarded over $1 million each year through this process. In light of the 2013 CHNA and the 2013-16 CHIP, priority was given to funding groups whose efforts sought to eliminate gaps in the local care system and organizations addressing the social determinants of health.

Work on the issues identified in the CHNA yielded many positive outcomes. Yet perhaps the most important result was the enhanced cooperation and coordination that followed in the assessment's wake:

> The 2013 CHNA has promoted an on-going, "living" process of continuously assessing the health needs of our population…The collaboration that began through the 2013 CHNA led to three years of effective coordination throughout the community. Collaboration between Santa Fe County, [CHRISTUS St. Vincent], SVHSupport, the City of Santa Fe, Santa Fe Community Foundation, Department of Health, local non-profit health and social service providers, the Federally Qualified Health Centers, Brindle Foundation, pediatricians, health and social service providers and then community

> stakeholders has been ongoing and has resulted in program planning and strategy development to address the most pressing of our community's health challenges.[32]

Expanding Dialogue and Tightening Coordination: The 2017 CHNA

Work on the 2017 CHNA commenced in the Department of Community Health during the autumn of 2015. Unlike St. Vincent, Santa Fe County officials did not need another assessment to be performed so soon. Consequently, St. Vincent served as sole leader of the 2017 assessment process.

St. Vincent had refined its approach to community health in the years since the 2013 CHNA. The modified approach employed a life-stage model. In this model

> the lifespan is broken down into six distinct categories. These groupings facilitate a more focused and in-depth understanding of the barriers to health experienced within each age group. The lifespan categories targeted are: maternal and early childhood, school-age children and adolescents, adult behavioral health, adult physical health, women and seniors. Although the CHNA considers each lifespan category separately, we acknowledge the strong linkages across stages and know that what happens in one stage of life often impacts or determines what will happen in the next. [33]

By highlighting health problems that occurred throughout the human life cycle, the life-stage model encouraged the organization to consider the needs of multiple populations and discouraged it from trading off one group's needs against those of another. The model prompted the organization to become more strategic by seeking interventions that would improve health across each and every lifespan category.

[32] CHRISTUS St. Vincent Regional Medical Center, *Transforming Health*, 10-11.
[33] CHRISTUS St. Vincent Regional Medical Center, *Transforming Health*, 4.

The refined approach also placed even greater emphasis on the social determinants of health. This resulted from the "systems of care" philosophy on which the approach was grounded. This philosophy recognized that no single organization could effectively address all the factors that influence health, given their number and variety. Systems of care and service were needed to ensure all health determinants would be attended to, including socio-economic conditions. Constructing these systems required organizations to partner with one another, to build a network of entities and providers capable of delivering effective, comprehensive care.

Like the 2013 CHNA, the 2017 CHNA incorporated extensive quantitative data. The data focused on eighteen health indicators deemed most critical for the community, based on the 2013 findings and other information. Under Kathy's leadership, the collection of *qualitative* information was greatly enlarged in 2017. This turned the assessment process into a conversation among a wide range of individuals and groups about the state of health in Santa Fe. Individual interviews were conducted with medical practitioners and other professionals with expertise on specific health concerns. Five focus groups also were conducted at different locations throughout Santa Fe, including a Catholic parish. The focus groups enabled a wide range of voices to be included in the assessment – for example, the voices of city and county government officials, representatives of law enforcement and the public schools, members of the area's Spanish-speaking immigrant population, military veterans, adult and adolescent students, and providers working to prevent substance abuse.

While work on the 2017 CHNA was underway, collaborations fostered by the 2103 assessment continued. For example, in 2015 and 2016 St. Vincent brought together a number of organizations in Santa Fe that funded not-for-profits, to explore whether they might coordinate their gifts:

> This impetus for the group is the need to fully leverage public and foundation funding to non-profits, to plan together, to avoid duplication of funding, and to align funding. While early in the organizing, there is a shared interest in working together. To the extent that the effort works, we will be taking a big picture look at funding of services for given population groups community-wide and together create greater community impact. In joining together, resource allocation can be more fully leveraged to address the needs of special populations. It is due to the effectiveness of collaboration of leaders in our community that this is possible.[34]

Representatives from St. Vincent, SVHSupport, Santa Fe County, the Santa Fe Community Foundation, the Brindle Foundation, and the Thornburg Foundation participated in these meetings. While the discussions did not lead immediately to action, they helped participants recognized the advantages coordinated funding offered to the community at large.

The 2017 CHNA was approved by St. Vincent's Board of Directors in June of 2016, and the 2017-2019 CHIP was approved three months later. The CHIP was notable for three reasons. First, the report identified three "super priorities" for the hospital's efforts: Adult behavioral health, care for senior citizens, and domestic violence.[35] These priorities were selected in collaboration with the City of Santa Fe, Santa Fe County, the Santa Fe Community Foundation, the hospital's Board Health and Wellness Committee, and local experts in community health.[36] The super priorities represented the areas of greatest need in the community. Second, the CHIP identified two strategies for each super priority.[37] The first strategy articulated what St. Vincent

[34] CHRISTUS St. Vincent Regional Medical Center, *Transforming Health*, 10.
[35] CHRISTUS St. Vincent Regional Medical Center. *2017-2019 Community Health Implementation Plan* (2016): 14.
[36] CHRISTUS St. Vincent Regional Medical Center, *2017-2019 Implementation Plan*, 14.
[37] CHRISTUS St. Vincent Regional Medical Center, *2017-2019 Implementation Plan*, 2.

would do *internally* to address the super priority, e.g., improving its focus on the priority, enhancing related hospital processes, etc. The second strategy articulated efforts that would be pursued *in the community* to address the super priority, e.g., expanding collaborations, identifying potential funding sources for new efforts, etc. This dual approach ensured that St. Vincent would pursue each super priority from both an internal and external perspective, seeking to enhance the hospital's effectiveness while also helping create an effective system of care in the broader community. Finally, the CHIP identified four efforts from the 2013-2106 CHIP that would continue. There efforts addressed a wide range of lifespan categories.[38]

Throughout 2016 and 2017, St. Vincent undertook work targeting the three super priorities. In March of 2017, the Association for Community Health Improvement, the leading U.S. organization for community health professionals, named Kathy the first-ever recipient of its "Spirit of Community" Community Champion Award. The award recognized Kathy's creativity in building programs like HUGS and forming partnerships that benefitted vulnerable populations. And as 2017 drew to a close, St. Vincent's work to enhance the coordination of funding for local not-for-profits yielded positive results: Participants in earlier discussions agreed to make their 2018 funding decisions in consultation with one another, to better leverage these donations in light of the community's documented health needs.

Throughout its history, the leaders of St. Vincent had sought to "realize" the common good in widely varying contexts. In case of Bishop Lamy and the founding Sisters of Charity, doing so entailed establishing a hospital to serve the basic needs of all residents of frontier Santa Fe; with Sr. Blandina, it entailed sustaining St. Vincent's ability to serve all comers in the midst of the chaotic conditions frequently created by the nation's westward expansion; in the case of

[38] CHRISTUS St. Vincent Regional Medical Center, *2017-2019 Implementation Plan*, 13-14.

Sr. Joaquin, it entailed securing a stable basis for the hospital's continued existence, and the continuation of its historic mission to the poor, by placing it under community control. In the opening decade of the 21st century, "realizing" the common good required Kathy and other hospital leaders to forge collaborations with a wide range of partners within Santa Fe, to mobilize resources and channel them toward the development of a system of care capable of addressing the community's most pressing health needs. In sum, these efforts highlight that the common good is not attained or achieved by following a rote formula. Rather, leaders must discern a path forward for their institution in light of both its mission and the specific realities they confront, to shape conditions inside and outside the organization in a way that will increasingly secure the good of each and every person in the community.

Part V: A Theological Postscript

Common Good, Institutions, and the Kingdom of God

We conclude our study of CHRISTUS St. Vincent's efforts to serve the common good of Santa Fe with some brief observations of a theological nature. Such observations are doubly warranted, first by St. Vincent's longstanding, and in the present context highly unique identity as *both* Catholic *and* community hospital; and second, by the imperative to put some much-needed flesh on the concept of the "common good" in its relationship to *institutions*, such as St. Vincent, through whose work it is "realized." Accordingly, it might be helpful to think of these observations as contributing to a "theology of institutions."[39]

[39] The broad outlines of such a theology may be found in Richard Gaillardetz' short essay, "Theology of Institutions," in Charles Bouchard, ed. *Incarnate Grace: Perspectives on the Ministry of Catholic Health Care* (St. Louis: Catholic Health Association of the United States, 2017): 251-267.

The common good, as usually defined—particularly in Catholic contexts—is the "sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily."[40] The *Catechism of the Catholic Church* elaborates on this definition by noting that there are three "essential elements" of the common good: respect for individuals; the social well-being and development of the group; and peace, which is the fruit of a justly ordered society.[41] The papal social encyclical tradition, to say nothing of an enormous theological literature, adds yet further conceptual detail, the most important of which, for the purposes of this essay, is the necessarily *institutional* dimension through which the common good is pursued. Organizations, and not just individuals, are essential if the common good, human flourishing, is to be served. As Pope Benedict XVI puts it in his 2009 encyclical letter *Caritas in Veritate:*

> To take a stand for the common good is on the one hand to be solicitous for, and on the other hand to avail oneself of, that *complex of institutions* that give structure to the life of society, juridically, civilly, politically and culturally, making it the *pólis*, or "city".[42]

Benedict goes on to speak of this "organizational" commitment to and pursuit of the common good in terms of love, that is, as the "institutional path" of charity, which, he writes, should not be considered inferior to the individual path. On the contrary, the institutional path is "no less excellent and effective than the kind of charity which encounters the neighbor directly, outside the institutional mediation of the *pólis.*[43]

[40] *Catechism of the Catholic Church*, no. 1906, citing Pope John XXIII, *Mater et Magistra* (1961), no. 65, and Vatican Council II, *Gaudium et Spes* (1965), no. 26.
[41] *Catechism of the Catholic Church*, nos. 1907, 1908, 1909.
[42] *Caritas in Veritate*, no. 7 (emphasis added).
[43] *Caritas in Veritate*, no. 7.

The larger and more complex a society becomes, of course, the more necessary this "institutional path" will be, not only in order to serve the common good but, in a more fundamental sense, to "realize" it in the first place. We borrow the term "realize" from the U.S. Bishops' document *The Ethical and Religious Directives for Catholic Health Care* (5th ed.) which refers to the common good as being "*realized* when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals."[44] The Bishops' employment of the term, perhaps unintentionally, allows a significant theological dimension of the common good, and consequently of civic life, to come forward. How so?

First, "to realize" something can have both a cognitive and entitative meaning. Cognitively, to "realize" a specific fact or going-on is to become aware of it, perhaps for the first time. On this sense of the term, institutions are necessary to help us realize, that is, become aware of, the common good. Institutions, in other words, may disclose or reveal the common good. In fact, it has been one of the chief burdens of this study to show how the work of St. Vincent over the past 150 years has been more than just "contributing" to the common good. It has been revealing it. And to that extent it has also been "making it real," to draw on the second or entitative meaning of the term 'realize.' We can now state more plainly, following Pope Benedict's lead (and before him St. Augustine of Hippo, d. 430 AD), that what St. Vincent as an institution has been making is nothing other than a *polis*, a city, in this case the city of "holy faith," Santa Fe itself. (Obviously, and importantly, St. Vincent has not been alone in this making.)

[44] USCCB, *Ethical and Religious Directives for Catholic Health Care Services*,5th edition, (Washington, DC.: USCCB Publishing): Part I, "Introduction."

Hospitals, Catholic or otherwise, have long been the sites where the common good is disclosed and civic life constructed. Or better yet: reconstructed. And here an important second theological move must be made. Institutions animated by charity, by love, will be particularly attentive to the sorts of social divisions that obscure the common good, that are destructive of authentic social life, and that thus constitute obstacles to human flourishing; in short, such institutions will be attentive to all those conditions that detract from the full health of the community. Bishop Lamy, Sr. Blandina, and even Sr. Joaquin, did not use the terms "social determinants of health," but it was to such that they conceived St. Vincent as an institutional response. And in conducting its "Community Health Needs Assessments" and implementation plans, what CHRISTUS St. Vincent Regional Medical Center has been doing today is, in effect, working to identify and then address (redress) those aspects of Santa Fe's communal life most in need of healing. In such detailed institutional work civic life is constantly made.

The work is in many respects about relationship-building, as we hope our narrative of Kathy Armijo Etre's efforts shows. But then what else is a city than a set of relationships between *cives,* citizens, animated by a shared vision of their life together? In the Christian tradition that vision is ultimately a transcendent one, a vision of a city, a Kingdom, of God, which is nevertheless "realized" here and now. The kingdom, to quote Pope John Paul II, "aims at transforming human relationships; it grows gradually as people slowly learn to love, forgive and serve one another."[45] One might even say that in founding St. Vincent, Archbishop Lamy and the Sisters of Charity brought the kingdom to Santa Fe. And still it comes.

[45] Pope John Paul II, *Redemptoris Missio* (1990): no. 15.

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