



# ENCOURAGING PHYSICIAN LEADERSHIP

**C**atholic healthcare systems are beginning to see their affiliated physician communities as sources of leadership for their own particular organizations and the ministry as a whole. Increasingly, such organizations are encouraging potential physician leaders to assume both formal and informal roles.

Such encouragement includes, on one hand, formal instruction in business skills and management techniques, and, on the other, informal cultural exchanges in which physicians and nonphysicians meet and discuss each other's roles and responsibilities.

Two key factors are driving this trend. First, Catholic healthcare organizations, traditionally directed by men and women religious, are today increasingly led by laypeople. Second, many physicians, regardless of their religious affiliation, share the values of service, respect, and dignity that underpin the ministry's mission. Such physicians are, moreover, often in a position to direct the integration of operations and resource management and of hospitals and physicians necessary for integrated delivery network (IDN) performance.

## *Catholic Healthcare Systems Explore Balanced Relationships*

**BY WENDE L. FOX;  
P. TERRENCE  
O'ROURKE, MD;  
MICHAEL COLLINS, MD;  
& KATHRYN GOODING**

Some Catholic healthcare systems are being creative in their development of real partnerships with physicians. Some seek physician candidates for their top positions, whereas others embrace a physician-administrator team approach. Some systems are creating physician organizations that have physician-led boards and physician-filled senior administrative positions with real authority. Other Catholic systems are building IDNs in which the affiliated physician organization shares the results of both the network's successes and its failures. An example of the latter approach is a for-profit professional corporation in Tucson, AZ, 51 percent of which is owned by its employees, who are the primary care physicians of Carondelet Health Network. This and other models of shared risk have helped produce dramatic improvements in some physician organizations' performance.

### **SOME GENERAL PROBLEMS**

Despite such successes, some still ask whether IDNs and physician practices can be true partners. Some organizations have failed to give physician leaders real influence over the network's vision, processes, or outcomes. In other cases, highly touted "partnerships" have in fact limited the physicians' authority, and, as a result, their ability to effect real change and to share in its results. However, as systems and physician organizations become increasingly interdependent, their partnerships will of necessity need to become more genuine as well.

In creating genuine partnerships with physicians, Catholic and non-Catholic systems face similar challenges: trust issues; cultural differences between the independent practitioner (the physician) and the large organization (the hospital); and, most recently, an increasingly constrained economic environment in which many interests struggle to maintain their own slices of a shrinking pie.



*Ms. Fox is a director and Ms. Gooding is a senior associate in the Chicago office of APM Management Consultants. Dr. O'Rourke is board chairperson, Centura Health, Englewood, CO. Dr. Collins is president and CEO, Caritas Christi Health Care, Boston.*



Then too, few systems have found their efforts to integrate with a physician organization to be profitable when the latter's revenues and expenses were measured apart from those of the IDN as a whole. This is true primarily for two reasons:

- Compensation arrangements often include salary guarantees without productivity requirements. Such arrangements force the system, not the physicians, to bear drops in productivity or revenue per patient.

- Acquired physician practices often adopt hospital-oriented compensation and benefit plans for their employees, thereby increasing employee costs.

In addition, there are up-front costs involved in integrating a physician practice into any system. In recruiting senior staff, for example, most systems seek candidates who can smoothly fit acquired practices into the large panels needed to win and administer managed care contracts. Hiring talented people can be expensive. In the beginning, such costs are usually not offset by increased market share or other measures of success. They are part of the price a system must pay to become an IDN, and should be considered—like the cost of information systems—capital requirements.

#### PROBLEMS OF RELIGIOUS SPONSORSHIP

Catholic healthcare systems also face challenges related to their sponsorship by religious entities. For example, situations sometimes arise in which a system's leaders must negotiate with—and possibly defer to—their religious sponsor. Physicians may find this frustrating. But just as teaching physicians about business management can alleviate frustrations they may feel as members of a large and complex organization, educating them in canon law can ease frustrations deriving from religious traditions.

Some physicians are, moreover, under the misapprehension that Catholic healthcare organizations are “soft” compared to non-Catholic ones—that is, less sophisticated in terms of technology and business savvy. To counter this belief, Catholic-sponsored systems should be prepared to communicate the clinical and business successes of their organizations and affiliated physicians. Such information will help attract physicians with similar goals and ideals to Catholic organizations committed to collaborating with them.

Unfortunately, some physicians perceive a disparity between a particular Catholic-sponsored organization's professed commitment to community health and evidence of that commitment. If such a gap exists, the organization should see closing it as an opportunity to live its mission,

There are up-front costs involved in integrating a physician practice into any system.

thereby attracting—and keeping the allegiance of—like-minded physicians. One way Catholic organizations can close the gap is by, first, developing corporate “tithing” targets for charity work and, second, establishing performance measurements for executives to ensure that the targets are met.

Finally, as healthcare continues to shift from hospital to outpatient care, Catholic organizations must keep care aligned with mission. One model might be the electronic networks some IDNs now use to link doctors' offices with inpatient and laboratory services. Catholic organizations could possibly employ interactive technology to track patients as they are treated across the continuum in order to provide them with appropriate pastoral care. In any case, the traditional boundaries that separate medical practices from other healthcare services will continue to blur, and Catholic sys-

*Continued on page 47*



## PHYSICIAN LEADERSHIP


Continued from page 41

tems will have to develop new forms of ministry to meet new needs.

### CATHOLIC SYSTEMS' ADVANTAGE

But Catholic-sponsored systems have, along with special challenges, a major advantage: They are known to be values-based organizations that respect physicians' concerns. As one doctor has put it, "Sisters and physicians are natural partners because they believe in the same things—dignity, respect, and service." In a Catholic-sponsored organization, physicians feel more latitude to care for all patients regardless of their ability to pay. They know that the organization has the community's long-term interests at heart.

True partnerships between physician practices and healthcare organizations are the wave of the future. Built on relationships between physicians and institutional managers, these partnerships reflect an evolving care model that links business decisions to clinical outcomes. □

 For further information call Wendie L. Fox or Kathryn Gooding, 312-470-8600.

## PHYSICIAN FORUM PLANNED

The Catholic Health Association (CHA) recently brought together a group of physician leaders and asked them to recommend strategies for developing physician-system partnerships.

This fall CHA will convene a physician-directed educational forum based on those recommendations. It will provide opportunities for interaction among physician leaders. Sessions will also provide education on business and management in the context of the ministry, articulate the benefits of Catholic sponsorship, and disseminate management and ministry "best practices."

Additional information about the forum will appear in future issues of *Health Progress* and at [www.chausa.org](http://www.chausa.org).

## PARTNERSHIPS

Continued from page 43

mation systems, budgeting, and general management; valuation of practices and other physician enterprises; and specific guidance regarding the design of physician compensation programs.


**Medical Management** These services—designed to foster excellent clinical results in a cost-effective manner—include the refinement of precertification and referral management activities, utilization management, case management, disease management, and demand management initiatives.

**Physician Support** These are services that can be performed cost effectively in a central location without compromising the local nature of healthcare delivery. They include group purchasing and buying professional liability insurance, for example. Other shared services, such as physician leadership education, are being developed.

**Knowledge Management** These services—which also involve all the others described above—organize benchmark and other comparative information regarding network management, practice management, and medical management throughout DCNHS. The services include conducting ad hoc surveys, performing academic research, collecting comparative data, gathering industry news, and scheduling network forums.

### A SOLUTION TO TWO PROBLEMS

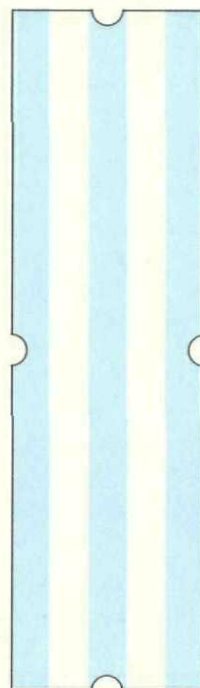
With the creation of PPC, DCNHS has simultaneously achieved two goals. The new company, first, gives member hospitals immediate access to a wide range of resources to assist their physician-partnering activities. Second, it gathers and processes information that can be used to enhance decision making throughout the system. □

 For further information call Kevin P. Conlin, 314-802-2080.

## SUBSCRIPTION CHANGES?

# Please Let Us Know!

Does your *Health Progress* mailing label need updating? Do we have your correct name, position, and address? To correct any problems with your subscription, please attach the mailing label from your last issue and write in the new information below.



NAME \_\_\_\_\_

POSITION \_\_\_\_\_

COMPANY \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Mail to:  
Circulation Coordinator  
**Health Progress**

4455 Woodson Road  
St. Louis, MO 63134-3797

Or Call Us at  
**314-427-2500**