Productivity Is Part Of Mission

The Ministry Needs to Move Past "Ethereal Discussions," a CEO Says

In September we talked with Bob Porter, CEO, DePaul Health Center, St. Louis, about some of the problems faced by leaders in Catholic healthcare today. Porter earlier participated in a discussion of salaries and benefits in the ministry ("Toward a Compensation Philosophy," Health Progress, May-June 1999, pp. 56-58).

It used to be that an aspiring healthcare CEO first earned a master's degree in hospital administration (MHA), then found a job in a hospital, and proceeded to work his or her way up. How are these things done now?

MHA-type programs are still the primary route to senior leadership roles in healthcare organizations. But we're now seeing leaders arrive via other avenues—from backgrounds in business or medicine, for example; an increasing number of physicians are becoming interested in executive leadership. There's a diversification of backgrounds in healthcare leadership, which I think reflects the diversification of the challenges healthcare leaders face.

Today the best healthcare executives blend the two worlds they live in. On one hand, there's the very disciplined, commercial world in which a certain product is exchanged for a fee. On the other, there's the more traditional, not-for-profit world in which one's first commitment is to community service. The new healthcare leaders know they must have a range of expertise that enables them to function in both worlds. In fact, they have to integrate the two worlds and make them one.

Now that's a big order. How do you compete aggressively and effectively with other organizations while, at the same time, cultivating a mission-driven, community-based organization whose first concern is the needs of the people it serves, not the return on investment to its shareholders? There's a tension here, one requiring a broader range of skills than such leaders used to need.

How should we judge the quality of a healthcare CEO's work today?

Look at multiple indicators, not just financial and mission indicators alone. CEOs now have a diverse set of responsibilities—financial stability, market performance, community health status, quality of patient care, and others. Particularly in the not-for-profit sector, if you're going to be true to your mission, you must consider more than the traditional financial measures of success. That doesn't mean you can ignore those measures, however. You have to be disciplined enough to pay attention to both financial measures and mission measures.

The key word today is *stewardship*. A healthcare leader must extend scarce resources as far as possible in meeting community needs.

Lay leaders are taking over the role formerly played by women religious. How can they best maintain mission as the driving force in Catholic healthcare?

First, we need to move past ethereal discussions of mission and ask ourselves: What form does it actually take in our organizations? And we need to cast it in measurable terms, just as we do more traditional kinds of organizational performance.

Mission need not be less prominent in Catholic healthcare as the number of sisters declines. Yes, the sisters did the groundwork and established the heritage. But there remains in lay leaders and employees a great sense of identification with the mission of Catholic healthcare. It's just a matter of defining what mission is, sharpening our ability to recognize it when we see it,

deciding how we can best measure it—we need to get better at that.

After all, mission in healthcare has various dimensions. It's not just extending ourselves on a charitable basis to people who lack the ability to pay. It's also treating people with a compassion and kindness that reflects our understanding of human suffering, that reflects our understanding of the critical role of God's love in helping people handle suffering. It's dealing with the whole person, providing support for his or her spirituality as part of the healing process. It's serving the common good, helping our communities become healthier.

These things are not as easy to measure as, say, market share, operating margin, and productivity. But they *are* measurable.

Is it more difficult these days to attract employees committed to mission?

Healthcare workers have always sought meaning and dignity in their jobs, I think. But it's perhaps more difficult today to help staff people *comprehend* how they can carry out our mission, especially given the nature of the challenges we face.

Our people know we can't solve our market and financial problems at the expense of mission. Yet it's often not easy to see how those two dimensions can be integrated with each other. So the big question is: How do we as organizations help employees discover ways to *live* their sense of mission despite financial challenges?

Sometimes there's a disconnect between the simple interpretation of "mission" and its more complex reality in today's world. We need to help people understand that coping with financial challenges, being responsible stewards of our resources, and dealing with organizational change are different dimensions of mission. It's not okay for us to be irresponsible about our financial status when our communities are in need. It's not okay to be less than diligent about productivity.

That's where the difficulty lies today—in helping staff members make those connections. There's no difficulty in recruiting good people.

Most healthcare organizations have been hurt by budget cuts under the Balanced Budget Act (BBA). In what areas has the impact been sharpest at DePaul?

We're feeling it most in areas like home health and skilled nursing. Of course, the BBA has added financial pressures to a ministry that was already struggling. But DePaul continues to fulfill its commitment to our patients and its community—and does so in a way that maintains a reasonable, respectful work environment for its staff.

This is the toughest job facing a healthcare CEO today—integrating disparate interests in a world of shrinking resources. The BBA just adds to the intensity of that challenge. For someone like me, the most disappointing thing is knowing that the BBA is just one more stress on a system that was already in need of significant reform.

Are BBA cuts having any effect on staff morale?

Fortunately, our staff shares a sense of common purpose. It was a desire for work with meaning that brought them into healthcare in the first place. They're also intelligent and realistic. And we try hard to keep them informed and involved, so they'll feel as though they're part of change—not victims.

If people feel as though they're partners in change, they'll remain positive even when the changes are difficult. Morale begins to suffer, I think, when an organization tries to shelter its employees from the reality it's up against. That's when people start to feel fearful. With the fear comes a serious deterioration in morale. People become less hopeful because they know they have no part in trying to create a better future.

But our employees don't expect us to protect them from hard realities and they don't want to run away from them. They want to face them with us.

Nurses and other healthcare workers are attempting to form unions at several St. Louis hospitals. What are the implications of this for DePaul?

I think we have to keep people participating, engaged, and informed. If they are all those things, then, I'm convinced, they won't feel a need to be represented by a third party, to make sure their interests are protected.

It's not a question of the organization succeeding at the expense of its employees, of one versus the other. We have to succeed together. Everyone's interests have to be integrated. You have to bring people into the process, so that they feel their interests are being respected. And if that's done, there's no need for a third party.

If you fail to do that, and people feel compelled to reach outside, you're likely to wind up with a much more adversarial, power-based kind of relationship—one based on strength and power, winners and losers. The healthier and more effective approach is one that recognizes that there can't be winners and losers in health-

Continued on page 62

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INTERVIEW

Continued from page 51

care. We have to prevail together.

This isn't an ideological motivation: to keep unions out. It's a practical motivation. Employers who genuinely respect the people who do the work will make a practice of collaborating with them in finding solutions to problems. I'm confident that, if we create that kind of environment, third parties won't be a factor.

One local healthcare organization has reportedly told its registered nurses to spend no more than five minutes on a given patient. Assuming it exists, what would you say about a policy like that?

That sounds like a rumor, and it's impossible to comment intelligently on a rumor. I will say, though, that it's hard to fathom how any healthcare provider would place an artificial limit on time spent with a patient.

There *are* fewer resources in the current healthcare environment. It is not possible to spend the same amount of time as we used to in the intimacy of patient contact. To continue providing compassionate care for patients, we need to mobilize other resources—the patient's family, for instance, and others who can be part of the care delivery team. Together we can provide the same supportive, loving, holistic care that patients have a right to expect.

But this brings us back to productivity standards. If I talk a lot to our staff about saving money and time, that's in part motivated by the fact that 10 or 15 minutes saved is 10 or 15 minutes that could be spent with patients. Our organizations must be as efficient as possible because resources are extremely limited and the need continues to be overwhelming. I don't ever apologize to our staff for talking about costs. But I always talk about costs in the context of our mission of service to patients and the community. —*Gordon Burnside*