

ISP Communique

Executive Interview Series

Program Updates

Issue 3

May 2008

In This Issue

[Executive Interview Series](#)

[ISP Transition Update](#)

[Unpacking with Care: A Suitcase of Traditions](#)

[Weckwerth is Macebearer](#)

[Health Market Watch](#)

[The German Perspective on Global Healthcare](#)

Executive Interview



Mark Dixon is the President and CEO, Community Hospitals of Indiana, and a member of the senior leadership team for Community Health Network (CHN), Indianapolis, Indiana. CHN generates revenues in excess of \$1 billion annually from four Indianapolis based hospitals (Community Hospitals East, North, and South as well as the Indiana Heart Hospital) and a partnership with Community Hospital Anderson in Anderson, Indiana. CHN employs over 250 physicians located at over 70 sites of care including numerous primary care, urgent care, and specialty care sites. At present, CHN is pursuing integrative strategies with several medical specialties. Mark trained originally as a pharmacist, completed his MHA at the University of Minnesota in 1984, and worked at Abbott Northwestern Hospital for 18 years, serving as CEO for 4 years. He has been at Community Health Network for 5 years.

Zismer: By all indications Indianapolis is a consolidating market with most health care delivery dominated by four health systems; each health system employs primary care and physician subspecialists. What, in your opinion, has driven accelerating consolidation in Indianapolis?

Dixon: As is the case with many larger cities with competing health systems, market share has become an important issue: the ability to acquire and hold market share in specific geographies and specialties to ensure the organization's ability to sustain mission and financial performance into the future.

Prior to my arriving in Indianapolis, large numbers of primary care physicians consolidated with health systems. Geographic markets were staked-out and health system-owned primary care

sites became effective "front doors" to health systems.

Consolidation of specialty groups followed; larger single specialty, independent practices. Some remained loyal to one health system, some became competitors of community health systems and others used more than one health system for patient referrals.

Recently we've seen health systems expanding with new hospitals in strategic locations, including for-profit business models co-owned by health systems and physicians. Independent specialty physicians are beginning to favor integration with community health systems.

Zismer: It wasn't very long ago (perhaps 10 or 12 years) that local health system leaders expressed opinions that "Indianapolis was different, that the health care delivery markets were stable. Each health care system had its own markets. Indianapolis would not be as competitive as others." What happened? What sparked fairly rapid competition and market consolidation?

Dixon: Several factors seem to have contributed to consolidation. Methodist Health System merged with Indiana University Health System, including Riley Children's Hospital, to form Clarian. Clarian moved to expand market share locally and regionally.

A large, successful cardiology practice moved to develop a for-profit heart hospital. The community hospital that enjoyed most of the referrals from this group, St. Vincent, joint ventured the facility to retain some portion of the cardiovascular market.

The commercial payers consolidated - fewer, larger payers with more bargaining clout was the result. Early on, at least one of the larger payers actually acquired primary care practices. That strategy ultimately failed.

Other, large single specialty and multi-specialty medical groups formed.

As discussed, primary care physicians sold their practices to community health systems. Now over 500 primary care physicians in Indianapolis are health system employees. Incidentally, if each has upwards of 2,000 patients in their panels, then over 1 million people (most of the population of Marion County) are more or less "affiliated" with one of the health systems for their care.

Zismer: It would appear that the next emerging wave of consolidation involves the full integration of the specialties. Is this an accurate portrayal?

Dixon: I've already touched upon the effects of a consolidated market on the specialties. There was a two-stage response. In the first stage we saw specialists form larger independent groups. Some were loyal to one health system, others were not. Some attempted to leverage their business and economic models with expanded clinical enterprises, e.g. specialty hospitals, surgery centers and expanded ambulatory ancillary services. As mentioned earlier, at least two hospital systems participated in specialty hospital partnerships. Both were heart hospitals. One of these was developed by our system in partnership with physicians. Another health system pursued a different strategy: two strategically located general hospitals as for-profit ventures; equity ownership was offered to physicians as a means to align strategic and financial incentives.

As the marketplace becomes more complex and payers pressure specialty services revenues we're seeing more of the specialties consider full integration with community-based health systems. Our system is pursuing integration with cardiovascular specialists now.

Zismer: What about increasing capital demands and the independent practices, such as electronic health records, related information technologies, consumer demands for specialized facilities and expanded amenities of providers?

Dixon: As the health systems reach integration "critical mass", that is many, if not most, of the physicians required to meet mission, quality, strategic and financial goals are fully integrated with the health system (including ours), I see a shift in structure and strategy:

- Physicians will play a larger role in health system leadership and management,
- Clinical outcomes can be improved as we collectively become more efficient operators,
- More capital will be applied efficiently to a range of novel physician partnership models,
- Our clinical focus will be expanded to disease management,
- We'll be better positioned for a range of new payer models coming down the pike (including risk models),
- Productivity, overall, should improve.

In my opinion, health care management will become more complex, but in many ways more satisfying and even fun (again).

Zismer: When the health systems reach "critical integrated mass" what changes with the processes and models of care?

Dixon: I believe that the new models of care we're seeing unfold in Indianapolis and Indiana have the potential to better serve patients and communities if we apply the new potential wisely.

My experience in Minnesota showed how more integrated models of care can provide enhanced benefits to patients, as well as to those who pay for care.

While there is no doubt that Indianapolis is a consolidating health care marketplace, how we as leaders apply the potential of the new models is in our hands.

I think the good news is that, based upon how the systems are competing, the consumers should win, better quality, enhanced customer service, moderating price inflation.

Zismer: Any advice for our students in the MHA executive and day programs?

Dixon: Just pay attention to market behaviors and market needs. In health care we tend to wonder why the markets (especially the payers) don't just leave us alone and trust us - just pay for what we decided the patient needed and, by the way, pay enough to fund our individualized missions. That may have worked at another time and place.

Also pay attention to how "rational" markets in other industries behave. While we like to believe healthcare is "different", in many ways it is the same, especially when the buyers no longer elect to accept the cost inflation rates imposed by the health systems.

Zismer: Are patients and communities better served if consolidation and integration continues in the Indianapolis markets?

Dixon: I believe they can be, providing we recognize that while market forces will continue to dictate health care delivery behavior, we, as leaders, will retain a responsibility and accountability to apply the resources and potential of our organizations to their highest and best use in furtherance of our missions to serve our communities.

Zismer: Last question. Will community-based health system governance be affected by market effects on health system business models?

Dixon: Probably. We'll likely see more community health system boards include employed physicians as members.

Mission strategies may become more keenly focused on measurable health status and clinical outcomes of those served rather than more generalized goals of service to communities. Board members may be held to higher standards of accountability for the performance of the organizations (including higher standards imposed by regulation). As local and regional health systems move north of a billion dollars in annual revenue and the markets become increasingly complex, the jobs of health system directors will become more complex.



Construction Update: Progress on the New ISP

Bill Henry, consultant to the New ISP design and development

Raw materials for the new edifice have arrived on site: 3 Regents' certificates, 42 graduate credits, 2 on-campus session per certificate, 27 topical courses offered in the UofM Public Health Institute each spring, 25 existing ISP units, preceptor groups, 27 School of Public Health online graduate courses, 40+ years of culture and tradition, and barrels of faculty, student, alumni and staff interest. We are now assembling these materials to build the new ISP, following design principles that include academic integrity, accreditation standards, University and School of Public Health requirements, National Center for Healthcare Leadership competencies, financial considerations, and response to the market. Small wonder hard hats are required!

Our intent is to bring a program to the University Board of Regents for review and approval in late summer. As you might imagine, a number of structures must be erected prior to that event. However, because we are not building the new ISP *de novo*, but rather from elements that in many cases already exist, we hope to "fast track" the process. We expect the new ISP to open in May of 2009. It will be based on three Regents' Certificates of 13 credits each:

Certificate 1. Introduction to the Principles and Applications of Health Systems: design, structure, governance, operations, ethics, financial management and leadership.

Certificate 2. Care Delivery Process Improvement: a focus on operations excellence, quality management and related methods, models and techniques.

Certificate 3. Advanced Health Systems Leadership and Management: a "deep dive" into complex, integrated health

systems strategy, operations, finance, capital formation and leadership (a case-study focus). Physicians as leaders and executives in integrated health systems will be emphasized.

Students pursuing the MHA degree will complete all three certificates and a 3-credit capstone course involving a research project or a mini-residency, a process that we expect students will be able to complete in 27 months. Others will enroll in one or more certificates. Each certificate will begin in May with an on-campus session in Minneapolis, include online course work and web-assisted preceptor interactions, and a February "on-campus" session in a warm climate. We see this February session as simultaneously a key learning experience for current students, a "gathering of the ISP clan," and one of the leading continuing education events in health care administration. It will include keynote presentations by leading experts, seminars, networking and sharing of learning. In addition to current students, it will attract ISP and MHA alumni and others interested in emerging insights on current topics in health care.

You may know that we decided not to enroll students in Course 1 of ISP this year so that we could concentrate on developing the new program. While this no doubt was disruptive to the 14 students who had planned to be on campus this July, if those students apply and are accepted in the new program and complete it in 27 months, completion of their degree will have been delayed by only two months from what would have been the case in the old ISP.

We will endeavor to keep you abreast of progress on construction of the new ISP in these pages. If you have comments or questions, please me at 612-720-2135 or wfhenry@comcast.net.

**Unpacking with Care:
A Suitcase of Traditions**

by
Mary Jane Madden
PCA Director/Professor ISP



The traditions we repeat year after year are what bring a sense of security and predictability in the midst of our hectic and fragmented lives. For many of us in ISP the collective memories and traditions bind us together in an unforgettable way. Now with our new Director, Dan Zismer, we are immersed in the

wonder of what possible or dramatic changes face us in the coming years.

We acknowledge that change happens when something starts or stops. Often it is rational, planned and has a step by step process. ISP starts with an application and ends with a degree or credential once students have completed the step by step process. What happens in between is often driven by traditions and culture, the culture that binds us together in the ISP identity. Culture change takes 3 - 5 years no matter how fast you do it. With a new Director the culture will change, so let's figure out how we participate. Can our transition can be moved along so that everyone is on board or does it just take its course, we wait it out, and see how the chips fall?

According to Wm Bridges (2003) transition is a three part psychological process, not rational, not planned and happens within each person at a different pace. Endings, not beginnings, are the issue. We usually know how to begin things but rarely pay attention to endings. Knowing transition stages and facilitating movement through them could put those of us invested in ISP into the 3-year process rather than the 5-year.

Transition stages are:

Letting go

Neutral Zone

New Beginnings

Letting Go

Consider returning from a trip with a full suitcase. At some point, before you go on the next trip, you need to unpack. Maybe some things stay in the bag, but you empty some of it out. Letting go is unpacking things that are now in the ISP suitcase. It involves separating ourselves from some of the traditions we took for granted by creating "endings" for these traditions. It's these traditions that have bound us together and moved us forward. We each need to decide what to take out of our ISP suitcase knowing that everyone unpacks at a different time.

Ending things can create change resistance with the real impact depending on the personal investment in the past and in the change. For some it is the loss of what they took for granted and find familiar: "How can what we went through in ISP and what made us successful, not be required of others?" By consciously and deliberately planning for what we need to end, we can make a smoother transition.

The ISP culture is filled with traditions which define relationships about what is important and how you win and how you lose. It has rules: "don't get behind" and "no whining." It has a

language - "cheap is good..." And it has rituals ranging from a colorful orientation to days of classes, a boat trip, international health night, the Course I party, regional presentations and preceptor meetings and writing papers and sharing a listserve. Stories passed on for years have kept the traditions alive, along with the colorful personality of Vernon Weckwerth. Weckwerth led a culture based on student values, educational excellence and a commitment to caring for others. His commitment to ISP is unwavering, his style unquestionably unique. Consciously or unconsciously, the ISP culture binds students, graduates and faculty through its stories and traditions. And now, with a new Director the culture will change, new stories and traditions emerge and we will all need to decide what to keep in the suitcase and what to unpack.

We can use your help here. What are the "keepers" (or things we should leave in the suitcase) from your ISP experience and what would you empty out? Marching right along with change only creates resistance and sometimes rebellion. We don't want to move forward this way. In ISP we will unpack some things and are looking for ways to mark endings and create space for the neutral zone.

Neutral Zone

Neutral zones are the crazy times between old and the new when things seem hazy, unclear, and sometimes unreal. The result is a feeling of loss and confusion and a vacuum of uncertainty. For some this is a "scary" time steering people to push for the familiar. It brings low commitment and productivity and our ISP enrollment can suffer. Without this zone, however, creative ideas are lost and reaction runs rampant. We lose the "empty space" required for new beginnings to percolate.

Neutral zones can vary in length. Recognizing that uncertainty abounds in the neutral zone, and that uncertainty often keeps people from enrolling, it would be to ISP's advantage to keep this time as short as possible. What suggestions do you have for shortening our neutral zone? What questions do you have or anticipate that we could deal with more effectively than we are? How could we reduce uncertainty?

New Beginnings

New Beginnings are more than a new start. We must ask WHAT traditions do we start. One thing I know is that the ISP values are intact with the new Director, Dan Zismer. He described his goals which carry on those Weckwerth began just after he walked off the mountain holding the stone tablets:

Continue the tradition of leadership and excellence in health care executive education for the practicing professional.

Ensure a curriculum that is relevant to the needs of practicing executives in a changing health care environment.

Attract and retain high quality faculty, preceptors and program staff.

Apply state-of-the-art distance learning methods and technologies to ensure ease of program access while maintaining proper rigor.

Offer a program where healthcare administrators turn for leadership.

Assure a culture where respect for individuality underlies decisions and which provides a supportive network.

ISP continues to be firmly rooted in the ground. But like any tree, how it looks will change with the season.

For our new beginnings to unfold, endings must be in place. Consider that ISP, as each person knows it, will change. The "ISP boot camp" experience of the 60s worked to build life-long bonds. What is today's way to build these same bonds? What traditions will fit with your new Director, our marketplace and our commitment? As we unpack the ISP suitcase we are thinking about old and new traditions, about the culture we have now and how to keep what we want and how to know what to end. We are asking hard questions as we relive past memories and we are looking for ways to celebrate and honor these memories so we can unpack part of the suitcase to make space for new traditions. We need your ideas!

What are the "keepers" in ISP?

What are meaningful traditions for the future? (We hope that this e-newsletter is one of them)

How do we keep a strong culture recognized by healthcare leaders?

What can we do together to move into the next phase of ISP?

What transition planning has worked for you?

Jot your notes and send them to me at madde001@umn.edu. You can be sure you will hear back.

Bridges, Wm. Managing Transitions: Making the Most of Change, 2003, Cambridge MA, Perseus Books.



Weckwerth is Macebearer at Graduation

Vernon Weckwerth was honored as the Macebearer at the School of Public Health graduation ceremony on May 19. The mace of the University of Minnesota is a symbol of peaceful leadership and is borne in graduation and other academic ceremonies by an honored faculty member. The graduation program noted "Carrying the mace is a great honor accorded to someone who is being singled out for tribute. Today's Macebearer is Distinguished International Professor Vernon Weckwerth."

Special congratulations to Vernon for this high honor!

Health Market Watch Dan Zismer PhD

Fitch Ratings' December 2007 issue of *Corporate Finance* examines the waterfront of hospital/physician alignment strategies and concludes that "a hospital or health system cannot meet its strategic goals without the close cooperation of its medical staff." The article goes on to conclude that physicians drive utilization, cost structures, quality of outcomes and strategic initiatives.

While these conclusions are not necessarily novel in today's healthcare environment, it is of note that Fitch cites "physician alignment" as a factor in a health system's credit position.

The report goes on to categorize integration models along a continuum from "low integration" (low risk/low return) to "high integration" (high risk/high return). Among the low risk/low return options are gain sharing, service line co-management, leasing joint ventures and medical directorships. High risk/high return models are those entailing closer structural integration including equity joint ventures, under-arrangement joint ventures and fully integrated delivery systems. Fitch notes a growing trend of physician employment by health systems.

The German Perspective on Global Healthcare

On May 19 and 20, the University of Minnesota hosted the fourth annual American and German Healthcare Expert's Roundtable.

Sponsored by the University's Interdisciplinary Center for German and European Studies, this year's Roundtable focused on "Health Technology and Health Care for All." At the request of Frank Cerra MD, senior vice president for health services, ISP Director Dan Zismer moderated the Roundtable.

Discussion at the Roundtable centered on the challenges that the US and Germany face in delivering health care that is simultaneously high quality and affordable. Zismer notes that the German health professionals, like their U. S. counterparts, are concerned with low rates of return for incremental dollars spent. Demand driven by industry advertising is a concern as well, especially in regard to use of pharmaceuticals. Germany has multiple sources of insurance coverage, but benefits are cooperatively similar across plans. Uninsured and underinsured people are a concern in both countries. Technology innovation appears to contribute less to rising cost in Germany as compared with the US health economy.