PERSPECTIVE

Challenges and Opportunities Facing Health Administration Practice and Education

Lawrence D. Prybil, Ph.D., FACHE, professor and associate dean, College of Public Health, The University of Iowa, Iowa City

This article focuses on three interrelated themes. First, I address five major challenges that leaders in the practice community are facing today. These challenges have a direct relevance for those of us in the academic community. Second, I outline five key qualities that practicing leaders are looking for when selecting new health administration graduates to join their organizations. Responding to the interests and needs of these leaders is one of the academic community's basic responsibilities. Third, I highlight opportunities for our health administration programs and faculties to partner with the practice community and to reexamine research efforts.

FIVE CHALLENGES FOR HEALTHCARE LEADERS

In the 1980s and 1990s, I served in two multiunit health systems. Today, I stay in touch with practitioner issues by serving on the governing boards of several healthcare organizations, including the Sisters of Charity Health System. Although I have some experience in this area, I think it is important to hear the perspectives of current leaders in the practice community. Therefore, I approached 35 CEOs of hospitals, multiunit health systems, and healthcare alliances in 19 states across the country and asked them questions. The first question was "As a CEO in the contemporary healthcare environment, what do you see as the two or three greatest challenges that confront you and your organization as you strive to carry out its mission?"

Twenty-nine of the 35 CEOs responded to this question (their names are listed in the acknowledgment section). Although these leaders' comments do not necessarily represent the views of all executive leaders, they are thoughtful and provide useful insights. The five challenges cited most frequently are listed below.

1. *Sustaining the organization's viability and mission in the face of growing resource needs and reimbursement constraints*

Most healthcare organizations are faced with an aging population, growing numbers of uninsured and underinsured persons, the need for costly technology, and

Editor's note: The following article was taken from the keynote address delivered by Dr. Prybil at the plenary session of the AUPHA-ACHE Leadership Conference on March 19, 2003. Although substantially similar in content, this article is not a transcript of the address.

other pressures that require greater resources. At the same time, both governmental and private payers are constraining reimbursement, and most organizations' income from investments has been affected adversely by events over the past three years. Twenty-five of the 29 responding CEOs believed these factors represent a problem for healthcare executives, governance, and clinical leaders who are responsible for maintaining their organizations' viability and mission and for responding to their communities' needs. In February, PriceWaterhouseCoopers (2003) published a report, entitled "Cost of Caring: Key Drivers of Growth in Spending on Hospital Care," that informs us of the impact of these factors on hospitals. To a considerable degree, however, the same factors affect all providers of healthcare services and, at least indirectly, all health-related firms.

2. Meeting the multifaceted workforce crisis that exists throughout the country
Twenty-two of the 29 responding CEOs identified workforce issues as a principal challenge. Their deep concerns mirror the position taken by many healthcare organizations, including the American Hospital Association, that the healthcare industry is in the midst of a real workforce crisis. This crisis is not simply about the short supply of workers, although we are experiencing significant shortages of nursing personnel, certain physician specialists, and other professional caregivers. Other dimensions of the workforce crisis include:

- changes in the skill mix to meet new service requirements,
- high levels of dissatisfaction expressed by many nurses and other employees about their work situation, and
- the tremendous need for care continuity in a period where recruitment is difficult and turnover is high.

All of these elements affect the cost and quality of care. A study prepared by the VHA (Voluntary Hospitals of America [2003]), entitled "The Business Case for Workforce Stability," found that the average annual turnover rate in hospitals is nearly 21 percent. The study also documents the adverse effects of high turnover rates on cost per discharge, severity-adjusted length of stay, return on assets, and other quality and cost variables. This is a report worth reading. It paints a sobering picture. The CEOs know that our problems have no easy solutions and that we have to address their root causes, not just their symptoms.

3. Ensuring patient safety and good clinical outcomes; reducing variability in quality and costs; and demonstrating positive impact on the health status of individuals, families, and communities
Over the past decade or so, there had been little evidence to indicate that managed care programs have had a positive impact on improving access to and quality of healthcare services or containing healthcare costs. The Institute of Medicine (IOM) reports—*Crossing the Quality Chasm* and *To Err Is Human*—and other studies have described serious problems and defects in the U.S. healthcare system. As does

the IOM, the CEOs I spoke to agreed that we need to provide care that is safe, effective, patient centered, timely, efficient, and equitable. But they understand clearly that we are a long way from fulfilling these six aims.

Pioneering work at the University of Michigan, Dartmouth College, and elsewhere has revealed the startling variability in levels of healthcare utilization, quality, and cost from community to community. In the early 1980s, John Griffith of the University of Michigan acquainted me and colleagues at the Sisters of Mercy Health Corporation with data on the large variation in use rates among Michigan communities where the Sisters of Mercy operated healthcare facilities. I recall our early efforts, which were far less than adequate, to understand the underlying reasons for the variations and to do something about them. A new study by Elliot Fisher and colleagues (2003) at Dartmouth, entitled "The Implications of Regional Variations in Medicare Spending-Part I: The Content, Quality, and Accessibility of Care" (as quoted in the *Wall Street Journal* [2003]) speaks graphically of this variation:

> The federal Medicare Program spends about 60% more for health care for beneficiaries in White Plains, N.Y. and Detroit than it does in Rochester, N.Y. and Grand Rapids, Michigan. Yet the quality of care delivered to patients living in 'high-spending' communities is no better and in some cases worse than what people in low-spending communities get . . . a large fraction of medical care is devoted to services that neither improve health nor quality of care.

Both healthcare leaders and the public at large are feeling a growing discomfort with the performance, the impact, and the cost of our nation's healthcare system. Closing the gaps and achieving measurable improvements are great mandates for executive, clinical, and governance leaders. It is a challenge for us in the academic community as well.

4. *Redesigning systems and processes, building new operating models, and overcoming both technical and cultural obstacles along the way*

Various reports, including those by the IOM, have illustrated the importance of assessing and redesigning systems and processes to bring about improvements in patient safety, quality outcomes, and costs. *Crossing the Quality Chasm* strongly recommends "the systematic identification of priority areas for improvement" (IOM 2001). Subsequent IOM reports—*Fostering Rapid Advances in Healthcare: Learning from System Demonstrations*, which was developed by a committee chaired by Gail Warden of the Henry Ford Health System, and *Priority Areas for National Action: Transforming Healthcare Quality*—also provide useful roadmaps for moving toward improvement goals. Great work is being done in many communities. Here are a few examples:

- At Texas Health Resources, a multiunit system based in Arlington, Texas, headed by Douglas Hawthorne, a strategic initiative called "The Patient and Family Journey" is transforming processes and services systemwide, from the point of initial contact through the care processes to discharge and follow-up care.

- At Sentara Healthcare in Tidewater, Virginia, with David Bernd's leadership, intensive care specialists remotely monitor ICU patients through electronic means. This remote ICU supplements and enhances traditional rounds and onsite monitoring. Sentara has reported that patient mortality rates have dropped between 25 percent and 35 percent since this system was installed. In addition, Sentara has achieved a 150 percent payback on its investment (*Trustee* 2003).
- With the leadership of Sister Mary Jean Ryan, SSM Health Care (based in St. Louis, Missouri) received the Malcolm Baldrige National Quality Award in 2003, making the system the first healthcare organization to be so honored. SSM's strategies involved a fundamental redesign of its systems, processes, and operating models and necessitated sustained commitment to overcoming the cultural resistance and technical barriers that arose during the transformation.

The CEOs spoke candidly about the vast amount of work that lies ahead. Many feel, and I concur, that redesigning systems and processes is necessary but not sufficient, that what is needed are entirely new operating models.

5. Maintaining access to capital to enable needed investments in facilities, technology, and equipment

Even with concerted efforts to improve the appropriateness of utilization and to enhance the efficiency of existing facilities, healthcare organizations clearly need large amounts of capital to meet the growing demand for services, to acquire needed technology, and to redesign existing processes. Firms like KaufmanHall and The Advisory Board and several CEOs with whom I work believe healthcare organizations need to generate an EBITDA (earnings before interest, taxes, depreciation, and amortization) of at least 14 percent to maintain long-term viability. Many organizations are not coming close to this standard. As Gary Mecklenburg of Northwestern Memorial Healthcare stated to me: "Healthcare will face a capital crisis in the near future and be unable to respond to the growth in demands. . . . [A] lot of institutions have no access to the debt markets and have not funded depreciation. With limited margins, how will we replace those old Hill-Burton hospitals or acquire contemporary technology?" Raising capital is an enormous challenge, particularly for small institutions that are not part of strong systems. With a broader, more diversified base, these systems are somewhat more likely to have access to capital, at least for the near term.

Other cited challenges include the following:

- Creating new models for mutually beneficial partnerships between healthcare institutions and clinicians, particularly physicians and nurses
- Dealing with threats from the growth of niche providers, threats that would leave hospitals with emergency services, charity care, and loss leaders
- Rebuilding public confidence and trust in healthcare providers and meeting rising consumer expectations for safer, more accessible, and more user-friendly services

- Identifying persons with the commitment, competence, and energy to take on leadership roles on management teams, on governing boards, and in clinical services

FIVE QUALITIES OF NEW GRADUATES

The second question I posed was "When you consider new graduates for fellowships or entry-level positions in your organization, what are the two or three qualities you consider to be most essential?" The responding CEOs cited the following fundamental qualities and skills.

1. Willingness and capability to work comfortably and effectively with others, both in formal and informal groups

The CEOs as a whole placed the greatest importance on a person's ability to work comfortably and effectively with others. They want and expect graduates to come into their organizations with a teamwork orientation, with interpersonal and project management skills, and with enthusiasm for building good relationships. Twenty-one of the 29 CEOs expressed the importance of teamwork. The CEO of a mid-size hospital in Massachusetts stated it well: "Anyone entering the field of health administration today must be team oriented, a coalition builder, and build respectful relationships with all elements of the organizational community."

2. Dedication to the mission of improving healthcare and the health status of individuals, families, and communities

A large proportion of the CEOs expressed the significance of this second characteristic. Organizational roles vary, of course, and the CEOs recognize this. Hospitals and the persons affiliated with them serve their communities in different ways than do insurers, long-term care facilities, public health departments, and so on. Still, we in the health administration field share a common mission: to contribute toward improving healthcare and the health status of those we serve. CEOs are looking for persons who are devoted to this mission and committed to helping the organization move toward this direction.

3. Initiative and an inquisitive, innovative spirit

CEOs are looking for self-starters who bring creativity, who have a willingness to think outside the box, and who have an innovative or entrepreneurial spirit. The emphasis the CEOs place on these qualities relates directly to our health system's problems and defects. We all need to take a fresh look at what we are doing and how we are doing it, to discover new and better approaches.

4. Analytical capability and problem-solving skills

CEOs also expect new graduates to have strong analytical capabilities and be able to identify, define, and solve problems. In selecting persons for post-graduate fellowships and entry-level positions at the Sisters of Mercy Health System and the Daughters of Charity National Health System, we looked for persons who had the ability to figure things out, identify the real issues, differentiate symptoms from

causes, and produce solid analyses with well-grounded conclusions and recommendations.

5. Honesty, integrity, and commitment to high ethical standards
The costs, human and financial, of failures in this area have been dramatized by recent financial and management scandals in the healthcare and business industries. Consequences of ethical breaches are always corrosive and sometimes catastrophic. Given this, and recognizing the widespread decrease of public confidence and trust in healthcare providers and insurers, it is not surprising that many of the CEOs stressed the importance of honesty, integrity, and solid knowledge and commitment to ethical principles. As the CEO of one large, multiunit system stated: "If we sense that there is a deep set of values underpinning the individual's character and behavior, then we feel there is a solid foundation and the opportunity to develop the technical knowledge, skills, and experience to make [that person] a strong leader."

Other cited qualities included the following:

- Excellent communication skills and being a good listener
- Adaptability and flexibility
- Commitment to continuous learning and improvement

A CALL TO ACTION FOR THE ACADEMIC COMMUNITY

I have been involved in health administration education for more than 30 years, serving on the faculties of Medical College of Virginia–Virginia Commonwealth University, University of Michigan, and University of Iowa and as a member of the AUPHA and ACEHSA boards. My commitment to higher education for health administration and policy runs deep.

Our academic programs are diverse, defining their educational missions and priorities in different ways. Some focus on preparing their graduates for management roles in provider organizations, while some focus on other roles and sectors. These programs, as a whole, contribute to improving our health systems. However, the academic community is at a critical juncture. Now is the time for program leaders and faculty members to pause and take a fresh look at their priorities and activities and relate them to the challenges faced by organizations and their CEOs in the sector in which they specialize. I ask this: Are you in touch with those challenges, and how are you addressing them through your educational, research, and public service activities? Some programs, such as Arizona State University's School of Health Administration and Policy, have done a reassessment along these lines. A reassessment of this nature may well lead to a need for tough decisions and major changes.

In line with my call for program leaders and their faculty to review and reassess their priorities and activities is another appeal: forge a closer connection with the practice community, beginning with ongoing dialog about their current realities and needs and extending that to forming collaborations. We in the academic community should reach out and engage our colleagues in the practice com-

munity more proactively, more creatively, and more extensively than most of us are doing now. There are mutually beneficial opportunities in doing so. Engagement between academics and practitioners can take many forms. The following illustrate our work at the University of Iowa:

- University of Iowa's College of Public Health has entered into a three-year partnership agreement with Wellmark, the Blue Cross Blue Shield plan for Iowa and South Dakota. These organizations have committed to developing annual action plans that identify projects and activities that will improve the health of families and communities in Iowa and South Dakota. The agreement also calls for collaboration in policy analysis, health services and health policy research, and other areas.
- The University of Iowa and John Deere Health, a subsidiary of John Deere & Company in Moline, Illinois, share a commitment to diversity and to providing opportunities for minorities to pursue graduate studies in health management and policy. Among other things, this partnership has led to scholarships for minority students, funded by John Deere Health, that are linked to summer internships, part-time job opportunities, and post-graduate fellowships.
- Over 60 percent of the University of Iowa's master's in health administration students now pursue joint degrees—MHA and MBA, MHA and MPH, MHA and JD, and so on. To provide these students with a window to the world of practice during their on-campus studies, the University of Iowa has created an MHA mentorship program that matches interested students with alumni and friends in the practice community. Students are matched with mentors who are practicing in organizational settings that are of special interest to the students, and both make a one-year commitment to a mentoring relationship; this time commitment can be extended by mutual consent. This mentorship program is proving to be very beneficial for our students and is a good way to involve our alumni and friends in the education process.
- Dr. Douglas Wakefield, chair of the University of Iowa's Department of Health Management and Policy, worked with the director of the University of Iowa Hospitals and Clinics to create and conduct a leadership program for clinicians and managers who aspire for broader organizational responsibilities. Several persons who have completed this program already are moving into leadership roles.

Many academic programs are currently working creatively with practitioners to enhance their offerings and address organizational needs. The opportunities are limited only by our imagination and our willingness to invest time and effort. If the academic community is unwilling or unable to strengthen these connections and demonstrate its relevance to the organizations' and leaders' challenges and needs, the practice community simply will look elsewhere. Many already are doing this.

Research

Every organization, whatever its size and role, must focus its resources and energy carefully. This principle certainly applies to many health administration programs; we realize many programs are not part of major research institutions. However, as a whole, health administration programs have fallen short in our commitment and contributions to health services and health policy research. This varies from place to place, as some programs are examples of excellence in research, and overall progress in this area has been made within the last 10 to 15 years. But who can say that our research productivity is sufficient or even close to it? The needs and opportunities for health services and health policy research are abundant, as illustrated in a recent *Health Affairs* article, entitled "A Research Agenda for Bridging the 'Quality Chasm,'" (Fernandopulle et al. 2003).

Now is the time for our programs and faculties to reexamine their research productivity and priorities and set a course for future development. There may also be value in collective assessment and reflection, which can take various forms—from holding informal dialog with other programs that have common interests to creating formal research collaborations. Advancing our overall research enterprise is imperative if we are to be viable in the coming years.

CONCLUSION

In many respects, health administration programs and faculties face challenges that are similar to those that confront our colleagues in the practice community. We too are challenged by the following:

- finding the resources needed to sustain and advance our mission in teaching, research, and public service;
- attracting and retaining a highly qualified workforce (i.e., faculty and staff) and top-notch students;
- defining measurable educational outcomes and documenting our students' attainment;
- redesigning our traditional systems and processes and building new models and partnerships that will enable better teaching and more research productivity; and
- finding capital to invest in the technology and facilities we need to compete for faculty, students, and research funding.

Both our healthcare system and the healthcare education field are faced with daunting challenges and exciting opportunities. The academic community has an opportunity and a duty to take stock of where our educational and research programs are today and to lead their reforms. This will require strong, creative leadership and a lot of tough decisions. I hope and believe that we are up to the challenge.

Acknowledgment

I am grateful to the following healthcare leaders for providing input:

Scott Anderson, CHE, North Memorial Health Care, Minneapolis, MN
Dennis Barry, CHE, Moses Cone Health System, Greensboro, NC
David Bernd, FACHE, Sentara Healthcare System, Norfolk, VA
Leo Brideau, FACHE, Columbia–St. Mary's, Milwaukee, WI
Sandra Bruce, CHE, St. Alphonsus Regional Medical Center, Boise, ID
Vincent Caponi, FACHE, St. Vincent Health, Indianapolis, IN
Christopher Carney, Bon Secours Health System, Marriottsville, MD
Mike Connelly, FACHE, Catholic Healthcare Partners, Cincinnati, OH
Brian Connolly, Daughters of Charity Health System, Los Altos, CA
Richard Davidson, American Hospital Association, Washington, DC
Gerald Fitzgerald, FACHE, Oakwood Healthcare, Inc., Dearborn, MI
Douglas Hawthorne, FACHE, Texas Health Resources, Arlington, TX
Michelle Hood, St. Vincent Healthcare, Billings, MT
Donna Katen-Bahensky, University of Iowa Hospitals & Clinics, Iowa City, IA
Sister Carol Keehan, Providence Hospital, Washington, DC
Bruce Lamoureux, St. John's Health Center, Santa Monica, CA
William Lane, Holy Family Hospital, Wayland, MA
Todd Linden, CHE, Grinnell Regional Medical Center, Grinnell, IA
Gary Mecklenburg, CHE, Northwestern Memorial Healthcare, Chicago, IL
Duncan Moore, FACHE, Tallahassee Memorial Healthcare, Inc., Tallahassee, FL
William Murray, FACHE, Sisters of Charity of Leavenworth Health System, Lenexa, KS
Judy Pelham, FACHE, Trinity Health, Novi, MI
Ron Reed, Mercy Hospital, Iowa City, IA
William Riordan, FACHE, St. Vincent's Medical Center, Bridgeport, CT
Thomas Royer, CHRISTUS Health, Houston, TX
Tom Smith, Voluntary Hospitals of America, Inc., Irving, TX
James Tinker, Mercy Medical Center, Cedar Rapids, IA
Dave Vellinga, Mercy Medical Center, Des Moines, IA
Gail Warden, FACHE, Henry Ford Health System, Detroit, MI

References

Fernandopulle, R., T. Ferris, A. Epstein, B. McNeil, J. Newhouse, G. Pisano, and D. Blumenthal. 2003. "A Research Agenda for Bridging the 'Quality Chasm'." *Health Affairs* 22 (2): 178–90.

Fisher, E. S., D. E. Wennberg, T. A. Stukel, D. J. Gottlieb, F. L. Lucas, and E. L. Pinder. 2003. "The Implications of Regional Variations in Medicare Spending–Part I: The Content, Quality, and Accessibility of Care." *Annals of Internal Medicine* 138 (4): 273–87.

Institute of Medicine. 2000. *To Err Is Human: Building a Safer Health Care System.* Washington, DC: National Academy Press.

———. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academy Press.

PriceWaterhouseCoopers. 2003. "Cost of Caring: Key Drivers of Growth in Spending on Hospital Care." [Online information; retrieved 1/1/03.] http://www.pwcglobal.com/Extweb/service.nsf/docid/.

Trustee. 2003. "Forward Motion." Interview with David Bernd by Mary Grayson. *Trustee* 56 (1): 20–24, 1.

VHA. 2002. "The Business Case for Workforce Stability" Study Summary. [Online information; retrieved 10/02.] https://www.vha.com/Research/public/research_workforcestability.asp.

Wall Street Journal. 2003. "The Implications of Regional Variations in Medicare Spending–Part I: The Content, Quality, and Accessibility of Care." *Wall Street Journal* 138 (4).