

Viewpoint

AN EXECUTIVE PUBLICATION FROM THE SCOTTSDALE INSTITUTE

JANUARY 2017

When Dennis Murphy took his mother to the movie “Brooklyn” she said it was like watching her life on screen. Like the movie’s protagonists, his mother and father were Irish immigrants and met in a dancehall, just swap Chicago for Brooklyn. Growing up in a large Irish Catholic family in Chicago was formative for Murphy, 52, president and CEO of IU Health (<http://iuhealth.org>), a \$6-billion, Indianapolis-based academic health system with 14 hospitals serving the state of Indiana. A pioneer—he and a cousin are the only ones in the sprawling

family to leave Chicago—at age 14 he left the urban environment for a Franciscan seminary in the middle of Wisconsin to study for the priesthood. “It’s how I think about leadership—the idea to serve,” he says of the experience. After earning an undergraduate degree at Notre Dame and a master’s in healthcare administration from Duke, Murphy spent a decade at Johns Hopkins Hospital in a variety of roles, moving back to Chicago as VP of ambulatory services and financial planning for the University of Chicago Hospitals, and then COO and executive VP at Northwestern Memorial HealthCare. He joined IU Health in 2013 as COO, becoming president in 2015 and CEO in 2016. A self-described nomad, Murphy is also the apple that didn’t fall too far from the tree: he and his wife, Kristy, with whom he has three children, make the three-hour drive to Chicago often to be with family members who just can’t leave the Old Sod.



DENNIS MURPHY, PRESIDENT & CEO, IU HEALTH

Very few hospital CEOs can say they’ve worked at four academic medical centers (previous: Johns Hopkins, University of Chicago, Northwestern Memorial). How does IU Health compare to the “typical” academic medical center? And how do you see the role of academic medical centers changing?

At the very core of all these organizations is the idea of balancing multiple missions: providing great clinical care, conducting excellent research and education and extending those elements to the community and society. Each has a slightly different emphasis on that balance given their resources, time and institutional culture. When you consider IU Health, it’s very comparable in its expectations relative to the others. IU Health is a bit smaller on the research side, but that makes it less bound by the past as it pursues new research strategies. On the education side, IU Health partners with both the largest

medical school and the largest nursing school in the country. That’s a remarkable set of resources—and a really pleasant surprise as we think long-term. There’s an engine here. When I was at Johns Hopkins they re-established the nursing school. Neither Northwestern or University of Chicago has one. The schools are a great set of assets that you can scale over time.

When I left Johns Hopkins it was really just two hospitals and a suburban multi-specialty practice. They were just bringing on a third facility, their first community hospital. Today, 20 years later when I talk to friends back there a lot has changed. It’s the same with the University of Chicago and Northwestern even in the past three years, with the latter expanding from two hospitals to twice that many. The University of Chicago has not acquired many hospitals but has partnered with several. It reflects the trend of academic medical centers becoming academic health

systems to broaden their reach to more patients. IU Health is a combination of push and pull—seeking acquisitions when it's strategically sensible and being approached by hospitals wanting to be a part of the health system to help them sustain quality, leverage IT and overcome capital constraints. It's also a blend of facilities, with three of its 14 owned hospitals academically based and the others suburban, rural and primarily community-based.

In the past year, IU Health has separated from three northern Indiana hospitals (Starke, LaPorte and Goshen) and announced an agreement to lease Frankfort Hospital. What is IU Health's system strategy, geographic and otherwise? How much hospital consolidation do you think lies in Indiana's future?

Two-and-a-half years ago we undertook a process to review and revise our strategic plan, and a key element was to define an effective geographic footprint for population health. LaPorte, not even in the same time zone as Indianapolis, and Goshen were more likely to send patients to Chicago, Ann Arbor or Detroit. It made sense for these assets to go somewhere else for quaternary services. We wanted to concentrate capital, management time and effort in areas where we could really improve the health of populations. The opposite is true of Frankfort Hospital, which is 25 miles from an existing facility in Lafayette in which we have primary care doctors. That was an affiliation we didn't seek out. It was a county hospital and the county executives came to us because they believed we'd do a good job managing the facility and the population of that county.

The discipline around implementing this strategy is always difficult. Sometimes you have to decline when an interesting organization approaches you because a deal would cause you to lose focus. For the next few years we want to succeed in the central and south central parts of Indiana, managing population health well and becoming a destination for our quaternary facilities.

There are other options besides consolidation, such as partnerships. Our market experienced a consolidation frenzy in the past, resulting in many hospitals integrating with systems. Today hospitals are being more thoughtful in that process, an evolution rather than a Big Bang. For example, we may put our IT or physicians in a facility to see if the cultural fit is appropriate before we contemplate further integration. Some of these facilities may remain partners and never consolidate with us and that's fine. Becoming more flexible across the spectrum of relationships is really important.

“We've discouraged use of the word 'discharge' because it connotes a break in care and we want to think of it as a transition to care in a different environment.”



Renderings of consolidated new downtown hospital to be built on Methodist site.

IU Health plans to merge University and Methodist hospitals into a new consolidated hospital at the Methodist site, while also constructing a new Bloomington Hospital, at a cost of well over \$1 billion. How are you “selling” these costly projects to your stakeholders and the public? How will these projects impact other hospitals in your system and competitors' systems?

At Bloomington Hospital, the real sell is simply honoring a commitment we made when they came into our health system, it's part of what they asked for. We have a great swath of Hill-Burton hospitals coming of age, in the 50-to-70-year-old timeframe. They've been added onto and the cores of these hospitals are very old. Bloomington fits that model, a very successful facility but with an antiquated core, not well-suited to new models of care. This is a new opportunity to define and create a care model based on shorter inpatient stays, more homecare and use of advanced technology. On both of these campuses we have shared-patient rooms, which raises infection-control, privacy and other issues. All of these elements came into play in Bloomington.

The Downtown Indianapolis campus has a couple dimensions. Although they are physically separate facilities, we operate as if we have a single adult campus with the same management team and license. The challenge is to create a common culture and achieve efficiencies. We know overhead costs are too high when we operate two facilities that are only about a mile apart. They're also fairly antiquated and we need better rooms for patients. The other “sell” is that we're not building one monolithic replacement hospital. As I've said, “We're not putting \$1 billion on black in Las Vegas.” This will be a series of projects over multiple years, sized and paced based on market changes during that timeframe.



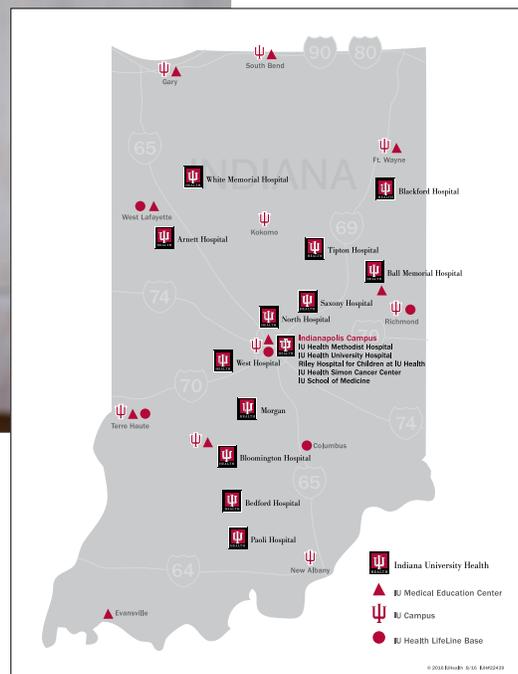
The core principle across both projects is flexibility to change. The only certainty in healthcare is that change will continue to occur; that's been true my entire career. You have to build facilities with a flexible architecture that will endure.

IU Health is one of five owners of the Indiana Health Information Exchange, and you serve on its board. With many public HIEs struggling to sustain themselves across the country, how does the Indiana HIE sustain itself and will it be able to continue to do so? What benefits does IU Health gain from Indiana HIE?

It's really interesting and maybe the best example of the difference between Chicago and Indiana. I served on the board of the Metropolitan Healthcare Council in Chicago, which was trying to put together an HIE that shut down for two reasons. First, in Chicago, no one bought into the value of sharing data over the HIE. Data was considered a competitive asset. Second, the Chicago HIE had no viable economic model. Indiana, in contrast, has four major health systems and a series of county-based hospitals none of whom views data as a competitive asset. People want to ensure the best care for patients. IU Health is the only major academic medical center in the entire state, which may also make the competitive threat seem lower. Chicago has multiple competing academic medical centers. Eventually, all providers see their patients accessing care in multiple facilities. So they see the benefit to sharing data.

Also, to do so requires a fundamental commitment to the HIE. I've been here three-and-a-half years. While at times, people are concerned about the price of keeping the HIE going, they have persisted because they find value in the HIE in the transfer of patients, especially for organizations taking on risk. You still have to manage

Statewide map shows IU Health's geographic footprint.



your patients when they're out of network. That's different from Chicago whose market size makes an HIE difficult. Advocate is the only Chicago system to pull off an ACO to date. So, it's both a philosophical benefit and a business benefit—the transfer of patients, and how the HIE actually helps them in ACOs.

You also serve on the board of the Indianapolis-based Regenstrief Institute, a renowned healthcare research center with a record of innovation in health information technology. What is IU Health's relationship with Regenstrief and what's the impact to IU health of having access to such a resource?

Historically, Regenstrief did two things incredibly well. They were one of the first developers of an EMR, and they've also done informatics research. The EMR was eventually shuttered because of market competition and Regenstrief changed their focus to information-based clinical research and process improvement independent of any platform. That's where IU Health can be their learning laboratory. We have everything from a 25-bed rural hospital to a major academic medical center. As we think about new models of care, process improvement, unique environments of care and telemedicine in the future, we see Regenstrief as a great partner.

They have a wonderful new president in Peter Embi, MD, who came from Ohio State where they had a very close relationship with clinical provider systems. It's our

goal to see that happen—and not just for IU Health. I fundamentally believe that a big portion of what we do in healthcare is the business of creating and managing information, especially all of the diagnostic information which generates treatment and care plans. So, having Regenstrief as a resource helps us get better at our mission. I don't know of any peer I have in the country who says they're happy with their EMR. So having a resource to help us is key. I can see Regenstrief out my office window. It's comforting to know the resource is so close.

IU Health recently hired Mark Lantzy as senior VP and CIO. Does this signal a new direction in IT? What are his top responsibilities and strategies, and how are you changing your approach and investments in IT security to protect against ransom-seeking hackers?

Across academic health systems the CIO is becoming one of the roles assumed by non-traditional candidates.

When I talk to peers in Seattle it's clear that, regardless of the healthcare organization, they're drawing people from Microsoft, Amazon and other non-healthcare companies for IT leadership. You're not necessarily seeking people with healthcare backgrounds. Mark is that prototype of CIO. He's spent time in the defense industry and the healthcare-payer space, so he brings a breadth of experience outside of the healthcare provider space that helps us think of IT in a different way. Mark can handle both the utility aspect of IT—ensuring the computers work when our 30,000-plus employees and 8,000+ doctors come to work—as well as the innovative IT-enabled aspect of changing the way care is delivered. He'll guide IU Health in using information to design personalized healthcare and drive competitive advantage.

There's no one nationally who's not investing heavily in cybersecurity. Mark's defense-industry background helps us ensure protection against ransomware or other type of breaches. Anthem here in Indianapolis has gone through this so we've seen it first-hand. No one can ever be 100-percent prepared against these types of attacks but I know that we are building robust systems of defense.

IU Health is both an academic medical center and a statewide health system, really an academic health system. It also owns its own health plan. What is IU Health's population health strategy and how do all of these components work together to support that strategy?

Our population-health strategy very broadly is based on the fact that we're not going anywhere. We're responsible for the care of the people in our catchment area. So, we have to figure out how to provide better healthcare at a lower cost. IU Health controls 30 percent of our core market, so one in three people feels IU Health is their care provider. We're responsible for them. How do you design and engineer systems of care for those patients? Where does your responsibility for patients start and stop? Historically it started when the patient showed up at your ED and stopped when they left. We've discouraged use of the word "discharge" because it connotes a break in care and we want to

think of it as a transition to care in a different environment. What's great about being an academic health system is that you can bring in amazing talent from the education pipeline, ask them to help engineer systems of innovative care and develop research that ideally differentiates us from non-academic health



IU Health's flagship Methodist Hospital.

systems over time. We hope that we can innovate faster and better because of our research base.

On the population-health side, everybody is learning how to do this. The question is, "Are you willing to learn or are you being dragged into it?" I give my predecessor credit for committing to a health plan and to the idea of managing populations. We're doing it willingly. Some health systems are trying to exist in fee-for-service as long as possible. We hear from doctors frequently that our strategy is the right way to manage patients' health so we feel like we are on the right pathway.

How do you factor in the likelihood for dramatic change in the federal government's healthcare policies as you go about running IU Health and making billion-dollar decisions involving bets on what will happen in the future?

Somebody asked me what I lose sleep over and I said about 50 different things every night. Change has been a fairly consistent element in healthcare the last 50 years. A lot has focused on changes in reimbursement. We try to get our organization to focus on universals that will persist regardless of reimbursement: How to manage quality? Create a great patient experience? Improve the overall cost of care including both the unit cost per patient and the total expense? It's not about just lowering the unit cost of an x-ray, but did the patient need the x-ray at all? We know we have to manage the reimbursement changes. We just don't want to see our entire team consumed by that issue.

The other effort to manage this change is to build a culture in which everybody understands the idea that change will be a constant. How can you be flexible and resilient? You're not always going to get it right.

For me personally it's been a great challenge coming into an organization with a great opportunity. How do you engage more than 30,000 people to make a mutual commitment to our goals and to each other? I tell

employees, "I'm not saying every one of us will be doing the same job 10 years from now, but I hope we'll all be working for IU Health." Part of my job is to tell the story of the amount of fantastic work being done here.

~ *Chuck Appleby*

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Related Resources

At the time of this interview, IU Health and Dennis Murphy were featured in a New York Times front-page story. Read it here: <http://www.nytimes.com/2017/01/02/us/politics/obama-health-care-affordable-care-act.html>. You can also follow IU Health on Twitter @IU_Health.

Check out the SI Teleconference, "IU Health Pilot to Route IHIE Data into the EMR," Jan. 25, 2017. <https://scottsdaleinstitute.org/teleconferences/2017.asp>

Read the recent *SI Inside Edge*

[Patient Safety, All-Cause Harm and IT: The Revolution Will Not Be Voluntary](#)

which features an IU Health team that is transforming patient safety by embedding patient safety in the EHR.

Check out the following SI Teleconferences on population health, HIEs and academic health systems at <https://scottsdaleinstitute.org/teleconferences/2016.asp>

December 12

Utilizing HealtheIntent in an ACO at Memorial Hermann

December 7

Pop Health Journey at Geisinger Health System

October 17

Michiana Health Information Exchange

October 12

Universal Care Center at UW Hospitals and Clinics: The Role of Technology Visioning and Planning

September 19

Advocate-Cerner Partnership Creates Big Data Analytics for Pop Health



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