



**DONALD C. WEGMILLER**  
**In First Person: An Oral History**

American Hospital Association  
Center for Hospital and Healthcare Administration History  
and  
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**DONALD C. WEGMILLER**

**In First Person: An Oral History**

**Interviewed by Kim M. Garber  
On June 28, 2017**

**Edited by Kim M. Garber**

**Sponsored by  
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**EDITED TRANSCRIPT**  
**Interviewed in Chicago, Illinois**

**KIM GARBER:** Today is Wednesday, June 28, 2017. My name is Kim Garber and I will be interviewing Donald Wegmiller, who began his leadership career at the Fairview Hospitals in Minneapolis in the '60s. His first position as administrator was with the Fairview Southdale Hospital, which has been called the first satellite hospital in the United States. Don went on to become the President/CEO of Health Central and then headed up Health One Corporation. His later career was in management compensation and consulting. He is a co-founder and Chairman of the Scottsdale Institute. Don, it's great to have the opportunity to be with you here this morning. Thank you for coming to Chicago.

**DONALD WEGMILLER:** It's a pleasure, Kim.

**GARBER:** I'd like to start by asking you about your childhood and your family members or teachers who helped form your values. Your parents, Harold and Mary Wegmiller, made their home in Duluth and would have been young adults during the Great Depression. How did that experience shape their values?

**WEGMILLER:** It did definitely shape their values. My mother was cautious about any kind of expenditure – perhaps not the day-to-day loaf of bread, but certainly a new car was a monumental decision. My mom would question any kind of big decisions, much more so than my dad. He would say, "That's great," or "That's dumb. Don't do that." Mom would ask a lot of questions. I began later in life to appreciate that and how helpful it is to have a person ask you questions that shape your thinking. My sister and I grew up appreciating that making a financial decision was important and something that should be thought through.

**GARBER:** Your father would have been in his late twenties at the time that the Second World War broke out. Was he in the service?

**WEGMILLER:** No, he wasn't. War broke out in December 1941. He was born in December 1912. By the time they began drafting, he was 30. He was working in an industrial plant that made war materials. They didn't start out to make war materials, but they were commissioned by the government to make war materials. He was deferred – told not to go in – "You stay there and work." I think he regretted it. I think he always had a feeling that he should have been doing that, even though the government told him, "We don't want you to do that. We want you to be here making equipment for us." I don't think he bought into that totally.

**GARBER:** I wonder if he felt that other people in town were looking at him and thinking that he was an able-bodied man so why wasn't he overseas?

**WEGMILLER:** Absolutely right. He was a very able-bodied man, very fit, very strong. Yes, I suspect you're right. At the plant, almost everybody was deferred, so he probably didn't get it there, but out in the world of Duluth, he probably did. He never mentioned it, but he probably did.

**GARBER:** Did you have the opportunity to know your grandparents?

**WEGMILLER:** I did. I spent summers with my grandparents in Minot, North Dakota. My relatives who lived in Minot worked for the Great Northern Railway. I would take the train all by

myself from Duluth to Minot, and I would spend the summers with Charles and Grace, my grandparents. It was wonderful. They were great people. I started playing baseball out there. I did that for three or four years.

**GARBER:** Is there anything else that you would like to say about your family's values that might have influenced your later leadership career?

**WEGMILLER:** My dad was hard-working. If he wasn't working in the plant, he was mowing the lawn, washing the car. He was always busy. He had an enormous amount of energy. My mom was more of the leader in terms of knitting the family together. She had a terrific sense of humor. I came to appreciate both of them, even more so later in life. It was a perfect time to grow up.

**GARBER:** Did your mother work outside the home?

**WEGMILLER:** She did after my sister and I went off to school. She became a cook in a small local family restaurant. She loved it. I was impressed that she would do that. She loved interacting with the owners and the customers. It was great fun when she went to work.

**GARBER:** You went to high school at Denfeld High School. I previously interviewed your friend, Scott Parker.<sup>1</sup>

**WEGMILLER:** I've heard of him.

**GARBER:** You met him later on when you went to grad school.

**WEGMILLER:** Right.

**GARBER:** He mentioned that you have a photographic memory. Is that true?

**WEGMILLER:** No, I don't think that's true. I have good memory, and I find it easy to remember facts because my mother and father were not receptive to opinions. "I'd like to go down to Minneapolis to the state baseball tournament, and I think that would be fun." Fun was not an acceptable answer. They wanted to know, "Who are you going with? When? Where? How? Why?" You couldn't just give opinion answers. If you're going to give factual answers, you need to know the facts. Although I thought it was horribly unfair that I would have to do that as a junior in high school, I came to appreciate that a conversation that involves facts is a much more productive conversation.

Later in my career, I valued this highly. People who worked with me would say to me, "Why do I have to have all of these details?" I would say, "They're not details. They're facts. I'd like to know how this will play out in terms of the impact on other people." They would say, "Well, I think it will be fine." I would say, "No, we don't accept, 'It'll be fine.' I want some facts. Have we surveyed anybody about this?" I read an enormous amount and I remember what I read, but I doubt that it's photographic.

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<sup>1</sup> Scott S. Parker was the founding president of Intermountain Healthcare in Salt Lake City where he served for 23 years. His oral history: Her oral history: Garber, K.M. [Ed.], (2013). *Scott S. Parker in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from [www.aha.org/chhah](http://www.aha.org/chhah)

**GARBER:** Let's talk a little bit more about high school. Did you have formative experiences? Did you play sports? Were you an outstanding student?

**WEGMILLER:** I enjoyed school from kindergarten through graduate school and beyond. There wasn't any aspect of school that I didn't enjoy. Now in high school, of course, there was a lot more social activity. I played hockey and baseball in high school. We had a great baseball team. We went to the state tournament and finished runner-up.

I was recruited by Arizona State University and offered a full ride scholarship to play baseball. I didn't take it. My dad never forgave me for that. It was a big disappointment to him that I didn't play professional baseball. He had played professional baseball in the high minor leagues and was about ready to go to spring training the next year with the Chicago White Sox when he fell off a ladder while painting a house with my grandfather. He broke his collarbone and he never got his pitching strength back. He went to spring training but his fastball had dropped from 82 mph to 72 and he was cut loose.

I was supposed to carry on that tradition. I was to go to the major leagues and I was to become a big baseball star. I was interested. I loved baseball. We had a great team and we did very well, and it was very flattering, of course. This was 1956 and Arizona State was called a university, but it wasn't a university. I was more interested in education than baseball. I wasn't going to make the major leagues. I played very well, liked it, but I didn't have that as my dream.

Sports were a very important part of my life also because you learned group values in team sports. I was captain of the team in my senior year. You learn how different people react in stress situations. That was helpful to me later in my career in evaluating people, either for performance or for hiring or for discharge, because you could begin to see people who were not team players. They were there for themselves. We had a great pitcher in high school, but it was all about him. It wasn't about the Denfeld Hunters. It wasn't about the team going to state. It was whether he could start the first game. That was the only thing he was interested in.

The coach expects the captain to tell him what's going on with the team. Kids aren't going to go up to the coach saying, "Let me tell you what's happening," – kids don't do that. So, the coach pulls the captain aside and says, "What's going on with Freddy? He's not the same." "Well, he broke up with his girlfriend." You got into the habit of knowing your group because somebody expects you to know your group.

I've often thought that I had the wrong major as an undergraduate. I would have been better off, in my opinion, instead of majoring in business and economics, to major in social psychology or group psychology. As a manager, it's your job to knit various diverse people together to work as a team. Health care administration is not an individual sport. It's a team sport. You need to know who's on your team and what's bothering them. I minored in psychology, and I loved it, except that they didn't have group psychology at the time.

High school was formative to me in a lot of ways. I've just described some of them. And I enjoyed every minute of it. It was just terrific.

**GARBER:** We've had a number of interviewees in this oral history series who have spoken of the value of team sports in high school. I'm starting to think that there's a very strong link here.

**WEGMILLER:** I believe it.

**GARBER:** Were you and your future wife, Janet, in the same class?

**WEGMILLER:** We were in the same class. We met in the junior year. As a lark, some of my buddies said, “You know, they’re doing this play. We ought to try out for that!” I said, “Are you nuts? I’m not going to do that.” They said, “No, it will be fun. We’ll all do it together.” The student director of the play was Janet Listerud. We didn’t start dating right away because she thought we were all buffoons ... and she was absolutely right.

Later in the next year, we talked some more, we were in a couple classes together, and I thought she was really terrific. I don’t think it was reciprocated. We started to date and it was fun, and as things progressed, we got more and more serious. She went off to nursing school at the same university that I went to. She went to St. Luke’s Nursing School in Duluth and took all of her academic classes at UMD – the University of Minnesota at Duluth, where I was. We continued to date. It got serious, and then we couldn’t both go to school because neither of us had any money. We weren’t getting to spend any time together because she was working nights as part of her education, and I was working days and afternoons. We said, we should start a family, which was probably not the wisest.

We got married at the end of our freshman year, and she dropped out of nursing school and helped put me through undergraduate (I also had a scholarship) and then through graduate school. She built the household and it was just fabulous. We’ve been married now for sixty years, so I think it’s going to work out.

**GARBER:** You were married in what year?

**WEGMILLER:** 1957 – that was just about our sophomore year.

**GARBER:** That is really young.

**WEGMILLER:** Really young, absolutely. Back in the day, age didn’t mean anything. Today it’s different. I would guess that a good 40 percent or more of our high school classmates were married before they got out of college. Nobody seemed to think that was crazy. It probably was, but we didn’t think so.

**GARBER:** You mentioned that when you went to UMD, you were on a scholarship. Was that an academic or athletic scholarship?

**WEGMILLER:** It was academic, which wasn’t as good as the athletic scholarship, which my father would point out to me. It was a James A. Wright Scholarship. Mr. Wright was an attorney in town who valued education. He created a number of scholarships every year; I think it was something like \$3,000. Sixty years ago, that paid all of your tuition, all of your books, all of your fees, so it was in that sense a full-ride scholarship. It didn’t pay for housing and lodging and meals and so on, which my dad pointed out that Arizona State University would have paid for.

**GARBER:** Were you living at home then?

**WEGMILLER:** Yes.

**GARBER:** Did they have a Greek system at UMD and did you pledge a fraternity?

**WEGMILLER:** I don't know if they had a Greek system. I wouldn't have pledged a fraternity. That wasn't the deal back then, particularly if you were an athlete. You didn't do fraternity.

**GARBER:** Did you play ball for UMD?

**WEGMILLER:** I played ball in the first year, but I had to work. I became an orderly at St. Luke's Hospital. Starting college, I was asked, "What are you going to take in college and why?" I was torn between pursuing Pre-Med or Business. I had interest in both. We were playing basketball one day in my back yard, and this guy from next door, a fellow by the name of Don Cook,<sup>2</sup> came over and said, "Can I play?" He was a few years older than we were. So we said, "Sure, old man, you can come in, but we'll kick your butt."

We played and talked and he asked all the kids what they were planning to do. When he asked me, I said, "Well, I don't know. I'm torn between going to medical school and going to business school." He said, "You might be interested in something that I'm doing. I'm in graduate school for hospital administration." I said – as anybody would – "What is hospital administration?" He said, "It's kind of a mix between medicine and business. You're in a medical environment - a hospital – but you are the business end of that. You have a mixture of both, and your graduate school will mix both. You will go to school with medical students and you'll go to school with business students." Let me send you some material – I'm going to the University of Minnesota." I said, "What are you doing in Duluth?" He said, "I'm doing my residency." He described all of that.

Later on, Don Cook and I got to be good friends. He was a long-time successful health care consultant for Booz Allen Hamilton, the big health care consulting firm, even bigger than Hamilton Associates. What he said was very interesting. One of my favorite things is to be with doctors. Doctors are very special people.

**GARBER:** I'm intrigued by your mention of your job as an orderly at St. Luke's Hospital in Duluth. Was that where Janet was working? How did you get into that?

**WEGMILLER:** I just applied for an orderly job. It became apparent to me that I would have difficulty getting into graduate school because I was intending to go straight through, which meant that I would have been 20 years old at the time of application. I said to myself, I better have some experience in health care – one to demonstrate that I have interest in this; secondly, to learn something about it; and third, be able to give some experiences that I had learned from. I applied and got a job.

Janet was working at St. Mary's Hospital at the time, and that was how we both got through school. I would work in the afternoon, she would work at night, we'd take care of our baby, Katherine Lois, and my mom would help out in other hours so we could each get some sleep. We would wave to each other on the bus. She was in a bus going this way and my bus was going that way. We didn't spend much time together.

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<sup>2</sup> Donald M. Cook was hired by Booz Allen Hamilton in the '60s, becoming vice president and partner. He later served as CEO of two hospitals before returning to consulting. [University of Minnesota Duluth. 60<sup>th</sup> class reunion at UMD. *Alumni portraits*. <http://www.d.umn.edu/unirel/homepage/11/alumni1951.html>]



The experience as an orderly was fabulous. You get in on the ground floor and learn how a hospital operates and what nurses and nurse aides do, what dietitians do, what everybody does. People in hospitals will help you do anything and they'll spend time with you if you have a sincere interest and you're not just bothering them. I always found that to be such a positive thing, because my dad would talk to me about how it was in his day. In his day, you wouldn't do that. You were working. You were paid to work. You don't sit around and talk about baseball or what you're doing. You work. He didn't quite ever understand it. He'd say, "You went to the dietary department and talked to the dietitian. How could you do that?" I said, "It was on my lunch hour. I wasn't shirking my duties." He would say, "The dietitian is a professional. She has stuff to do. She doesn't have time to talk to you." I'd say, "Dad, it's different in a hospital. People are very open and welcoming." "I don't get it," is what he would say.

I found that to be a terrific environment, so I became very interested. Obviously, I was preparing to apply for graduate school. I thought that because I would be 20 years old at the time of application, I wasn't going to get in. I had talked to Don Cook about this, and he said, "There was nobody that young in my class. I think the youngest guy in our class was somebody we called The Kid, and he was 25 or 26." I applied to seven graduate schools. I know. I know. That's idiotic.

**GARBER:** Not today.

**WEGMILLER:** Not today, but back then? Graduate school? Health care administration? Really? Seven? I was sure I wouldn't get in. I was sure I wouldn't get in to Minnesota, because Minnesota was – and is – in my opinion, the premiere program and everyone recognized that. Even Ray Brown<sup>3</sup>, a good friend with Professor Hamilton,<sup>4</sup> would agree. "Well, at this point in time, yes, Minnesota is pretty good. Jim Hamilton has built a great program."

Minnesota was very particular, and they always announced their selections last, "If you want to go to Minnesota and you applied somewhere else, you were going to have a big decision to make, we want you to make a big decision and we're not going to help you make that decision. We're going to select last. You're going to make a decision to Cornell or Michigan or Iowa or UCLA." Those are all the programs I had applied to – and others. Should I accept a full-ride scholarship to Cornell? Janet said, "Are we going to go to Ithaca or not? This is March 1, and Minnesota doesn't select – and it's the best program – until April 1."

All of the programs gave a couple weeks for you to decide because you were supposed to have made your decision before you applied. That's how it was. Why are you applying here if you haven't decided to come here? It was a logical thought process.

I said to Janet, "Are you willing to roll the dice with me and we're going to bet on Minnesota?" She said, "I'm with you." We turned them all down until April 1 and, by some strange good luck, we

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<sup>3</sup> Ray E. Brown (1913-1974), served as a hospital administrator at the University of Chicago Clinics and Hospitals as well as director of the Graduate Program in Hospital Administration at the university from 1951 to 1962. [The American Hospital Association's 1963 Distinguished Service Award to: Ray E. Brown. (1963, May 1). *Hospitals, J.A.H.A.*, 37(9), 44-49.]

<sup>4</sup> James A. Hamilton (1899-1985), was director of the Program in Hospital Administration at the University of Minnesota from 1946 to 1966. His oral history: Weeks, L.E., (Ed.). (1983). *James A. Hamilton in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center.

got into Minnesota by the skin of our teeth. I had a good academic record. I graduated summa cum laude but I suppose many of the applicants did. I doubt that was a distinguishing characteristic.

What scared me was that at Minnesota you were required to have an interview “in the field” with somebody who was in health care administration besides Professor Hamilton and others at the school. You had to go into the field and see if you could pass muster with somebody practicing health care administration. My interview was with Harold Weed,<sup>5</sup> a former naval officer, who was the assistant administrator at St. Luke’s Hospital, where I worked. My posture wasn’t good enough, which he pointed out to me. I sat through the interview pretty much like this [demonstrating] and the interview began in the usual way interviews begin, “Tell me why you want to go there.” He had my dossier in front of him and he was leafing through it. He said, “How old are you?” I said, “Well, I’m going to be 20 in September.” He closed the dossier and said, “Come back when you’re 25.” That was the end of the interview.

How did that make me feel in terms of success at the University of Minnesota? What would his interview report be like? Probably not the best. I didn’t do anything wrong. I didn’t say anything stupid. But that would be his report: “He’s 20 years old. Jim (Professor Hamilton), this kid is wet behind the ears.”

When these other offers came in, I was faced with making a decision without having all of the facts. One of the facts was, will I be accepted at the University of Minnesota? I had no access to that answer. I learned more about making decisions when I couldn’t get all of the facts. I learned how to assess things, not take wild chances, but assess them – very valuable learning experience. I’ll never forget it, ever.

**GARBER:** Why do you think Minnesota accepted you?

**WEGMILLER:** Later, I asked that question of Mr. Hamilton. You didn’t get direct answers from Professor Hamilton. You got answers that make you think about what it may have been. This was shortly after I graduated and he was in Minneapolis again. He was also a consultant, busy around the country all the time. He was back in Minnesota and, for some reason, he came to Fairview, where I had done my residency and was now employed as an assistant administrator. He came by and said, “Kid!” He never used your name. “Kid! How do you like it?” I said, “I love it. It’s terrific.” We chatted for a while. He was not a chatter, so if you had something you wanted to know, you’d ask him, and if you didn’t, he went away. He was busy – things to do.

I said, “Mr. Hamilton, I was pretty young when I came in.” “I know that,” he said. “Why did you accept me, when everybody else, including my interview, thought I was too young?” “Yeah, Hal was a little hard on you. I didn’t think he treated that very well,” he said. I said, “I was just 20 years old. Why did I get in?” “Why do you think you got in?” he said. This is how discussions went with Professor Hamilton. He said, “Did you ever think that you had enough academic standing to offset that?” I said, “No, I didn’t think so. I had good academic standing, but I assumed everybody had good academic standing.” He said, “Don’t assume. If you assume, it makes an ‘ass’ out of ‘u’ and ‘me.’ I said, “Yes, Mr. Hamilton, I remember that very well. I will always see the word ‘assume’ and think ‘ass,’ ‘u,’ and ‘me.’ But is that a correct assumption?” He said, “Do you think it’s a correct

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<sup>5</sup> Harold V. Weed, Sr. (1919-1987), served in the Navy during World War II and in Korea before becoming an assistant administrator in Duluth. [Harold Weed 67. (1987, June 3). *The Dayton Review*. <http://dyr.stparchive.com/Archive/DYR/DYR06031987P06.php>]

assumption?” That’s how the discussion went. I never did get an answer as to “this is the reason.” Evidently, his hint in terms of questions was that he thought I would be smart enough to be able to learn what to do. I guess! I don’t know. I never will know, but I sure appreciated it.

**GARBER:** That’s the Socratic method of teaching, isn’t it? Is that the way he conducted his classes?

**WEGMILLER:** Absolutely. If you did poorly, he would tell you right away. If you made incomprehensively stupid answers, you would be told, but if you did well, you would never know. You would be asked further questions because, in graduate school, we were constantly doing case studies. Because Hamilton Associates was one of the leading health care consulting companies at the time, they had written up hundreds of case studies of real world consulting issues that they had encountered. We would use them, and then we would make presentations as to what the problem was. Professor Hamilton had invented the twelve-step method of case study analysis that they used in the consulting company. I still use it today. I probably skip a few steps, but I can tell you what the twelve steps are, if you’d like? You wouldn’t!

We would constantly make presentations – but his Socratic method would not result in him giving a simple yes or no evaluation. You had to think this through for yourself. It was invaluable. You don’t appreciate this at the time because you’re used to growing up and having teachers say, “No, that’s the wrong answer – here is the right answer. This is a check mark. This is a plus.” As you go through grade school and high school you get used to that, so when somebody won’t give you the answer – it’s frustrating but valuable because the real world does not give you answers. You have to figure them out for yourself. It was a terrific educational experience, probably undervalued by all of us at the time but totally valued throughout our careers. Anybody from Minnesota still talks about “assume,” “Twelve-Step Method” – and other things like that.

**GARBER:** I understand that Professor Hamilton was very in-your-face.

**WEGMILLER:** Intimidating.

**GARBER:** Intimidating. How did you as a young man withstand that kind of teaching? Did you incorporate any of it into your later leadership style?

**WEGMILLER:** Probably, unfortunately, yes, because when you’re a health care administrator, you’re not a professor any more. Professors are trying to teach you something. As a health care administrator, you’re running a business. And so probably I was a little bit, as some of my residents and fellows and others would point out, I was a little harder on them than I needed to be.

I learned that the best way, at least with Professor Hamilton, was to over prepare. I would try to anticipate every possible question. I would have facts and numbers, which were very important to me. I always felt that when it came to making a decision, it was easier to be able to point back and say, “I relied on this, this, this and this fact to come to that opinion. That’s how I arrived at this.”

I found him to be a lot less intimidating than I saw him be with other people, particularly people from the military. We had great people – Lt. Bill Green<sup>6</sup>, a very successful officer in health

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<sup>6</sup> William J. Green, Jr., served as commanding officer of the Naval School of Health Care Administration, among other positions. [American College of Hospital Administrators. (1979). *1979 Directory*. Chicago: ACHA.]

care in the Navy, and Captain John Hoffman<sup>7</sup> from the Air Force. The military is a command-and-control structure, so they would rely on, “I’m in charge and what I say is what it is.” They would deal with Mr. Hamilton’s intimidation with, “Well, I’m in charge. I can do that.” He was brutal with them. He would say, “So all you need to solve this problem is to give people orders. Is that correct? And your order is therefore 100% perfect. Is that correct?” He would keep on until the lesson was made that you need more than just the authority to issue an order. You need to know the details of the problem.

He would walk them through the twelve steps. “Do you know what the problem definition is? You just know it’s a problem. Do you know exactly what the problem is?” He would say, “Well, you say you don’t need to know, because you know what the answer is? You know what the answer to a problem is, but you don’t know what the problem is?” – and on and on.

This was extremely valuable. It reinforced my feelings that the more you prepare, the more you know the facts of a situation, the better your opinion will be as to what should be done turns out to be. I still use that process today. It’s built into me now, thanks to Professor Hamilton.

**GARBER:** Before we leave the discussion of your graduate program, I’d like to ask you about the value of networking.

**WEGMILLER:** I think networking in health care administration is one of the most important tools that you have available because this is a diverse industry. Everybody knows that. People are doing different things to solve the same problem. If you don’t know them and what they’re doing, you pass up the opportunity for all that continuous education. The only way to get that is by networking. Scott Parker has been invaluable to me professionally as well as personally because he was running systems – first of all, Samaritan and then Intermountain.

The University of Minnesota Alumni Association is the strongest alumni association. It’s referred to in the industry as the “Minnesota Mafia.” Because of the way Hamilton constructed the program, our class was in a single cohort – that is, all 26 of us took all the classes together. Everything we took was together. We became tied to all of these people for two years – one year academically, and then we would get together as residents as well.

In graduate school, we had study groups, so it began there. Later on, fairly early in our careers, Scott and I, Ed Connors<sup>8</sup> at Mercy, Roger Larson<sup>9</sup> at what is now Legacy in Portland, and Ray Woodham<sup>10</sup> at Albuquerque got together because we were all running these things we called

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<sup>7</sup> John E. Hoffman, Jr., (1927-2010) served in the Air Force and later became the director of health planning with the Pennsylvania Department of Health. [American College of Hospital Administrators. (1979). *1979 Directory*. Chicago: ACHA.]

<sup>8</sup> Edward J. Connors served as superintendent of the University of Wisconsin Hospital & Clinics from 1960 to 1968, later becoming president of Mercy Health Services. His oral history: Weeks, L.E. (Ed.). (1983). *Edward J. Connors in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center.

<sup>9</sup> Roger G. Larson served most of his career in leadership positions at Swedish Medical Center (Englewood, Colo.) and then at Emanuel Hospital (Portland, Ore.) [American College of Hospital Administrators. (1981). *1981 Directory*. Chicago: ACHA.]

<sup>10</sup> Ray Woodham (1918-2009) served nearly his entire career in leadership at Presbyterian Hospital in Albuquerque. More details about his life and career can be found in: *Ray Woodham remembered*. (2010). Chicago: American

“systems,” and we networked together. We would meet three or four times a year. Somebody would chair the meeting and develop the agenda around the issues. When physician employment came up, that was a big topic that we would discuss.

Scott and I went on to join an organization called HRDI – the Healthcare Research and Development Institute.<sup>11</sup> We were members of that for 20 or 25 years, where 35 CEOs of what we called the “leading organizations,” would meet with businesses in health care – Eli Lilly and American Hospital Supply for example, were part of HRDI. Networking became de rigeur. It was just what you did. You couldn’t do without it. It is the only way to learn what’s good, what’s bad, how you make it work, why does it fail. Networking is like breathing. I can’t imagine doing this profession without networking.

**GARBER:** Did that early group, that first one that you mentioned for individuals who led systems, have a name?

**WEGMILLER:** Yes. For the first year or two it was just Ed and Scott and Ray and Don getting together. We would bring our chief operating officers or other people with us periodically. Then it grew larger. Steve Morris<sup>12</sup> came in, others came in, and we became Associated Hospital Systems. Then Associated Hospital Systems merged with United Hospital Systems – John Casey,<sup>13</sup> Jerry Jorgensen,<sup>14</sup> people like that. It later became Premier, which now is the giant GPO. We didn’t set out to do that. That wasn’t the purpose. The purpose was to learn from one another, but somebody came along and said, “You ought to take advantage of the fact that you’re working together and purchase together.” We said, “Oh, okay, fine, we’ll do that.” We didn’t set out to become a GPO but we did.

**GARBER:** Before leaving your University of Minnesota years, I’d like to ask you about the Wegmiller Professorship in Healthcare Administration that you and Janet recently endowed. How did that decision come about?

**WEGMILLER:** I value my graduate education and Professor Hamilton and the University of Minnesota and all of the opportunities immensely. Back then, you got your job in this field 90 percent because you were from the University of Minnesota and you had worked with Professor Hamilton. When you wanted to change jobs, you contacted the university and Professor Hamilton.

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Hospital Association, can be accessed here: <https://www.aha.org/oral-history-project/2018-04-03-ray-woodham-remembered>

<sup>11</sup> The Healthcare Research and Development Institute (HRDI), which was founded in the late ‘50s as an educational forum for hospital leaders, later became a for-profit company that facilitated consulting meetings between a few executives at leading not-for-profit hospitals and selected vendors of medical supplies. In 2007, under pressure primarily from Connecticut Attorney General Richard Blumenthal, the group was reorganized as the not-for-profit Health Education Network. [Bogdanich, W. (2007, Jan. 25). Conflict case at hospitals is settled. *The New York Times*. <http://www.nytimes.com/2007/01/25/business/25buyer.html>]

<sup>12</sup> Stephen M. Morris (1928-2011), became president and CEO of Good Samaritan Hospital (Phoenix) in 1966 and was later CEO of SamCor (Phoenix), which operated Samaritan Health Service. [Stephen M. Morris obituary. Retrieved from <http://www.legacy.com/obituaries/azcentral/obituary.aspx?pid=147980394#fbLoggedOut>]

<sup>13</sup> John T. Casey served as CEO of Presbyterian/St. Luke’s Medical Center (Denver), chair of United Healthcare System and later of American Healthcare System among other leadership positions. [2 alliances join, form for-profit giant. (1984, September). *Modern Healthcare*, 14(12), 12.]

<sup>14</sup> C. Jerome Jorgensen served as president of Health One Corporation in Minneapolis, United Hospital (St. Paul) and Stormont-Vail Regional Medical Center (Topeka). [American College of Healthcare Executives. (1990). *1990 Directory*. Chicago: ACHE.]

It would have been an enormous affront to him if you didn't do that.

It wasn't just graduate school. It was the Minnesota Mafia. It was Professor Hamilton. It was the university. It was the alumni association. It was everything, and if something is everything to you when you're starting your career and continuing your career, you might want to give back. I have enormous appreciation for it.

Janet and I talked about what we were going to do in terms of the blessings that we have received. I have never made a major decision in my life without her making sure it was the right one, and I value her opinion immensely. She said, "The university has made you what you are, whatever that is! You could make sure it continues."

We talked to the university about how we could make it continuous. They said that we could endow the program director position. We said we would do that. It made us feel good. I hope the university feels the same way. They say they do, so that's all that counts for us. It was just a payback. It was something in appreciation for everything that happened in our career – everything – and it was *our* career, not my career, because I didn't do anything in this without Janet.

**GARBER:** What does it mean exactly when you say you have endowed the program director?

**WEGMILLER:** They have a program in the University of Minnesota Foundation that if you provide them enough resources – in this case, \$2 million – that principal and all of the earnings from that principal are dedicated in perpetuity to that particular position that you designate. It can't be taken away. They can't change anything. The program director then has these resources for as long as she or he is going to be there.

This is important in attracting a program director, because the program director candidate says, "You tell me that this is the budget, but budgets change." Here's a part of the budget that does not change. There are hundreds of thousands of dollars every year that come from this endowment that you have direct control over, and the university can't do anything about it. A program director candidate then realizes, "Oh, that's something I can't get in another program."

**GARBER:** What sorts of things would the director spend these funds for?

**WEGMILLER:** The program director can add faculty, buy a researcher – if the university can't do it. He or she can dedicate funding for a new program or a new element of the program. For example, Dan Zismer,<sup>15</sup> who was the first program director to be part of the endowed professorship, needed startup funds because the Saudis had come to him and said, "We want to send 20 people. Can you set up a program just for us?" Dan, because he could see that global health care was going to become even more important, wanted to try that. The university didn't have money for this startup. Dan would need to fly to Saudi Arabia and have people come back and so on. While the Saudis were willing to pay for their students' training, of course, they would not pay the University of Minnesota for the university's startup expenses.

It's those sorts of things that the typical university budget does not provide for, but which are

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<sup>15</sup> Daniel K. Zismer, Ph.D., is professor emeritus in the Division of Health Policy and Management at the University of Minnesota. He served as director of the master's program from 2013 to 2016. [University of Minnesota. *Daniel Zismer*. <https://directory.sph.umn.edu/bio/sph-a-z/daniel-zismer>]

important to a business-oriented program director like Dan Zismer. Otherwise, Dan probably would have never taken that job.

You have to put enough money aside so that the earnings are significant. You promise the money up front but you don't have to write a check. We've paid for it for about five or six years now and will complete it in the tenth year. The accumulated earnings all go to the program director.

**GARBER:** One of the important features of hospital administration graduate programs – not only in Minnesota but at other places at the time – was that they were set up as two-year programs. The first year was academic, the second an administrative residency. Other leaders who have participated in this oral history series have mentioned the value of the administrative residency, not only for the year itself, but because oftentimes, it turned into a first job.

**WEGMILLER:** Indeed. Mr. Hamilton had dossiers on all of the residency opportunities – every mentor who became a preceptor had to provide a dossier on the residency, the hospital, the organization.

**GARBER:** What was Fairview like when you came on board and started working with Carl Platou?<sup>16</sup>

**WEGMILLER:** Carl Platou was unique in that he was not interested in the administration part of health care administration. He wanted other people to do that. For a young resident coming in, this gave enormous opportunity because he would delegate to you and then go away – not ignore you – but go away. You would learn how to do it. You got a lot more latitude to try and fail, try and succeed and so on.

Fairview was a small community hospital across the river from the University of Minnesota, in the Riverside neighborhood, an inner-city working-class neighborhood. It wasn't Northwestern Hospital, where all of the Lake Minnetonka crowd went. Primary care physicians dominated the medical staff. It was 90 percent a primary care hospital with a few surgical specialties at the time. For a resident, it really didn't make any difference. You were not there to transform the world. You were there to learn as a resident.

The match process was unique. You would read all of the dossiers and you would put down your first, second and third choices and then Mr. Hamilton would decide where you were going to go. I did not get my first or second choice. My first choice was St. Luke's Hospital in Kansas City with Bob Molgren.<sup>17</sup> My second choice was Charles T. Miller Hospital, which is now United Hospital, with Bill Wallace<sup>18</sup> and my third choice was Fairview. St. Luke's was the dominant hospital in Kansas City

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<sup>16</sup> Carl N. Platou (1923-2012), attended the graduate hospital administration program at the University of Minnesota, earning his degree in 1951. Platou went on to a leadership role in creating Fairview Health Services (Minneapolis). His oral history: *Carl N. Platou in first person: An oral history*. (1993). Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center. [Obituary: hospital visionary Carl Platou transformed Fairview. (2012, May 31). *Minneapolis StarTribune*. Retrieved from <http://www.startribune.com/local/155858835.html>]

<sup>17</sup> Robert A. Molgren served as executive director of St. Luke's Hospital (Kansas City, Mo.) from 1957 to 1966. [American College of Hospital Administrators. (1972). *1972 Directory*. Chicago: ACHA.]

<sup>18</sup> William N. Wallace served as president of the United Hospital (St. Paul) and its precursor, The Charles T. Miller Hospital, from 1972 to 1980. [United Hospital Foundation. (2014). 30 years of community service. *Fall Newsletter*.



– still is. The Charles T. Miller Hospital was the dominant hospital in St. Paul. Fairview was Carl Platou’s hospital, but as a hospital it was not comparable to St. Luke’s or Charles T. Miller, nor did it claim to be.

Mr. Hamilton said, “You’re going to go to Fairview. You’re going to work with Carl, and you’re going to learn different aspects than running a hospital. You’re going to learn about vision. You’re going to learn about future. You’re going to learn not so much about strategy, but about tactics.” I didn’t quite grasp what he was driving at, but that was absolutely a 100 percent accurate description of Carl. You were going to learn about running a hospital, but you were going to learn that on your own. He was not going to teach you. He expected you to have learned that in graduate school, and now you were going to apply it. If you made a mistake, it was not going to be fatal to Fairview. You were just a resident. You were not approving the fiscal year budget.

You were on your own right away. You did a rotation through various departments, as all residents do. When it came time for interaction with the senior staff, you were on your own. You needed to set up the meetings with them, make sure that they were meaningful meetings. The same was true with Carl. Carl would regularly set up a meeting with you, but it wasn’t his agenda. It was your agenda. He would evaluate you based on whether you could put together a meaningful agenda or did you just talk?

Carl’s focus was always on the future. It was never about yesterday or today. It was never about the history of Fairview. He would give you a book and you could read about it, but we would not talk about the past. We talked about the future. We didn’t talk about the present because that’s already been decided. We are what we are, and we can’t change it today, but we can change it tomorrow. That was valuable learning.

Fairview wasn’t much at the time, but he had a great vision for Fairview, and that was that it was going to become a multi-hospital system. It did, very quickly. I graduated in 1962 and was running the satellite hospital at the end of 1965. That was expected. That wasn’t, “Oh, wow, isn’t that unique?” No. If you’re any good, do you want to move ahead or do you just want to sit there and relish what you’re doing? It was great. It was terrific. That’s what Fairview was like. John King<sup>19</sup> followed me the next year, and John and I worked together for years, and greatly respected and loved working together.

**GARBER:** Where do you think that Carl Platou got the idea of developing into a multi-institutional system?

**WEGMILLER:** Part of Carl’s genius was that he went after the business leaders, not the social leaders, of the community for his board. He went after the people who rolled up their sleeves in businesses. Did they have to do some community service? Yes. Did they go to the annual society

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[https://www.allinahealth.org/uploadedFiles/Content/Business\\_units/United\\_Hospital/Foundation/About\\_the\\_foundation/UHF2014-fall-news.pdf](https://www.allinahealth.org/uploadedFiles/Content/Business_units/United_Hospital/Foundation/About_the_foundation/UHF2014-fall-news.pdf)

<sup>19</sup> John G. King served as President/CEO of Legacy Health System (Portland, Ore.) from 1991 to 1996. Earlier he had been in leadership at Evangelical Health Systems (Oak Brook, Ill.), Holy Cross Health Systems Corporation (South Bend, Ind.), and Fairview Hospital (Minneapolis). His oral history: Garber, K.M. (Ed.). (2015). *John G. King in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from <http://www.aha.org/research/rc/chhah/King%20-%20Transcript%20-%20FINAL%20for%20WEB%20-%2020121815%20-%20Rev.%201.pdf>



balls? No. No, these are the guys that worked.

Don Grangaard<sup>20</sup> was the CEO of what is now U.S. Bancorp. I forget what it was at that time. It was probably First Bank. Another thing about the residency is that Carl would set up opportunities for us to sit in on meetings. I remember John King and I doing this together – sitting in the back of the room when he would talk one-on-one with a board member. The one-on-ones with board members were not about issues or the problems of running the hospital. He was smart enough to know that any good board member would say, “Carl, that’s what we pay you for. Don’t ask me about that.” He asked, “How do you run your business?” Grangaard said, “The important thing in banking today, Carl, is you can’t have a bank anymore and be successful. You need to have branches and you need to go where the people are and you have to have convenience.”

I think that one of the places he got the idea was from people like Grangaard, who saw the future of their businesses. Carl was smart enough to say, “Why wouldn’t that be important to us?” In some cases, it wasn’t, because we’re a human business, but Grangaard’s was very important to him. There may have been others – I don’t remember and I didn’t sit in on every meeting that he had. Carl would often refer to this idea. He wrote an article – and I did some drafting for it – for the *Harvard Business Review* about how this could be applied to health care and that branches or, as Carl called them “satellites,” could be very valuable. These satellites would work together as a group, as a single controlled group, just like the bank did. That is part of where he got it – maybe a lot of other places, too.

**GARBER:** The branch or satellite hospital concept was at the time a pioneering concept.

**WEGMILLER:** Yes.

**GARBER:** I’ve seen it referred to in the literature that Fairview Southdale was the first satellite hospital in the United States, which I thought was a remarkable statement. One would think there were other two-campus or three-campus hospitals.

**WEGMILLER:** Not very many, but there were others.

**GARBER:** What was a satellite hospital and why was it different at the time?

**WEGMILLER:** Carl was known for some hyperbole! I think I’m putting that nicely. I intend to, so I hope I am. Carl introduced John and me to Bob Toomey<sup>21</sup> of Greenville Hospital System and gave us the latitude to go spend two or three days with Bob. Greenville had multiple hospitals. Whether they’re called satellites or branches didn’t make any difference. We learned an enormous amount and Bob Toomey and I would meet regularly during the rest of his career. He later became program director of the program at Duke, and he brought me onto the Duke faculty.

Those multi-hospitals – and there were very few of them at the time – were basically two

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<sup>20</sup> Donald R. Grangaard (1918-1999), when a young man, started with First Bank System (Minneapolis, now known as U.S. Bancorp) as a clerk and was named president and CEO of the bank at age 50. [Donald Grangaard, retired CEO of former First Bank System. (1999, March 7). *Minneapolis Star Tribune*. <https://www.highbeam.com/doc/1G1-62470148.html>]

<sup>21</sup> Robert E. Toomey (1916-2001), served as director of the Greenville Hospital System (Greenville, S.C.) from 1953 until 1978. [American College of Healthcare Executives. (1992). *1992 directory*. Chicago: ACHE.]

existing hospitals that came together for whatever reason. That was true of Greenville. Carl thought he was different because he set out to build a new hospital in a new place and specifically design how the two hospitals would work together, as opposed to two existing hospitals having to negotiate how they're going to work together. There was no negotiation. We built it. We owned it. We were going to run it the way we wanted to run it. Whether it was the first or not really doesn't make any difference. The point is, it was a deliberate strategy to go out and build this system.<sup>22</sup>

Much later, after I was gone and probably even after Carl had left, Fairview did acquire other hospitals. That was not Carl's idea. When we talk about The Ridges in a bit, that was a third hospital, a second satellite. That was Carl's vision of what the multi-hospital system would do. We would build them, own them, control them, run them. Not go to other existing hospitals and bring them in. To that extent, he was unique. However they came together, it's the concept that I was interested in. I didn't necessarily think it's the only way to run a system or build a system. Carl did, and so, "you pays your money, you takes your choice."

I was privileged to be a part of that from the very beginning. Chuck Lindstrom<sup>23</sup> – the first administrator at Fairview Southdale and a lifelong friend – and I hired every department head, designed every room in the hospital and had complete latitude to do so. At the beginning of the process we met with Carl, and the natural thing, we thought, would be to tell him how the project was coming. He had no interest in that at all. He was interested in how the community relations were. "Well, Carl, we're still working on building the hospital." He said, "That's a building. I don't care about a building. Make a nice building but let's move on. That decision has been made. You people are implementing it. Good for you. I trust you. Let's talk about the future. Where will we go from here? What will it be like in its second phase?" We said, "Well, Carl, we don't have it open yet!" He said, "I don't care about that. That's not what I want to talk about." Does that give you a glimpse into Carl Platou? Give you a glimpse into Jim Hamilton as to how knowledgeable he was about his preceptors? You're going to go to Carl because you're going to study vision, not about hospital administration. He was absolutely right. I'm thankful my third choice ended up being my residency.

**GARBER:** Your career would have gone in a whole different direction.

**WEGMILLER:** Could very well have and it probably would have been equally as much fun. But this was the one, and I thought mine was pretty fun, too.

**GARBER:** Did Hamilton Associates consult on the project?

**WEGMILLER:** No, they were not because it was just a building project. Carl had his vision. He didn't necessarily rely on consultants' vision. I don't mean this in a negative way – but there was never a warm, fuzzy relationship between Jim Hamilton and Carl Platou. It wasn't negative – I don't mean to imply that – but no, they weren't involved. Ellerbe was the architect, Mortenson was the

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<sup>22</sup> Fairview Southdale Hospital (Edina, Minn.), a new hospital built on a greenfield site donated by the Dayton Corporation, was completed in 1965. [Sullivan, J. (2008, Winter). A tale of two hospitals: Fairview story began in 1906. *About Town* [City of Edina]. <https://edinamn.gov/ArchiveCenter/ViewFile/Item/202>]

<sup>23</sup> Charles C. Lindstrom was administrator at Fairview Southdale Hospital and then CEO at St. Luke's Health System (Kansas City, Mo.) from 1966 until his retirement in 1995. [American College of Healthcare Executives. *1998/99 member directory*. (1998). Chicago: ACHE.]

builder, and I'll talk about them when we talk about The Ridges. Fairview Southdale was a fascinating experience for me, a guy in his 20s building a \$10 million hospital brand new from scratch. Back then that was a lot of money.

**GARBER:** What an exceptional experience.

**WEGMILLER:** Exactly right.

**GARBER:** It is so much less complicated when you don't have to put together two pre-existing legacy hospitals.

**WEGMILLER:** Exactly.

**GARBER:** You don't have to merge the cultures along with everything else.

**WEGMILLER:** Absolutely.

**GARBER:** What were the functions, then, that you didn't have to build into the new hospital that you were sharing with the existing Fairview Hospital?

**WEGMILLER:** That's a very astute question, because that's the difference in running a successful system – in my opinion, but I think it's based on some facts. When you don't have to negotiate a whole bunch of relationships and end up with a compromise, that's good. Let's start at the very top – governance. Today this is de rigueur. We had one board. We didn't have to go recruit people to a Fairview Southdale board, and then the Fairview Southdale board would talk to the Fairview board, and they wouldn't all agree, and so on – that's how systems were. Rightly so. "This is our hospital. We have our board. This is your hospital." We learned from Bob Toomey. He said, "If I could, we would only have one board." Carl said, "We will have one board. It starts at the top. We will have one Chief Executive Officer for both hospitals."

You could be the Chief Executive Officer at Fairview Southdale, but you knew who was running the system. In terms of relationships, we never at Fairview Southdale even thought of doing patient billing and so on and so forth. I mean, why would we? It was already being done. Right from the beginning, backroom functions were one. From the very beginning, you just didn't duplicate things which would be stupid to duplicate.

As far as picking people – Chuck and I decided, with Carl's approval, that the first candidate we wanted to see for any department head position at Fairview Southdale would be somebody from Fairview. This was if they wanted to – obviously, we weren't going to draft them and take them away. The head of our new rehabilitation department at Fairview Southdale was Dick Craven, who had been the assistant who worked for Harry Dando, the head of the rehab department at Fairview. He wanted to run his own department. In him, we had a known commodity who knew the Fairview system, knew how the rehab department operated. He knew doctors. It was a brand new hospital but he had years of experience. The physicians referring to rehab said, "Oh, Craven! Yeah, we have total confidence in the rehab department."

We had a brand new hospital with years and years of experience in the leadership. In an acquired system, you've got two people, and you've got to pick one if you want to have a combined department. Then the other one is upset, and thinking, "How come I didn't get picked?" Later in my

career, I had to go through all that.

There is a significant and good difference between building your own system versus acquiring others to be a part of your system. You can't always do that if you're building a system, as everybody is finding out today. I can only imagine what Rod Hochman<sup>24</sup> is doing at Providence-St. Joseph's. They've got 42 hospitals and I suspect 40 of them came through merger and acquisition. That's an awful lot of compromise and negotiation. He didn't do it one by one because now you combine entire systems. Would it be better to just duplicate, like banks? Banks acquire other banks, but in six months, those people are gone and the acquiring bank's people are in there. We don't do that in health care. That would be rude.

**GARBER:** Do you have any other learnings from the Fairview Southdale startup?

**WEGMILLER:** It was 1965 when it first opened. We had a lot of firsts. They seem pretty insignificant now but this was 50 years ago. We were the first all-private room hospital. We were the first hospital that had carpeted floors. People thought, "You can't have carpeting. They're filled with bugs." All of our corridors were carpeted so it was very quiet. Some of the patient rooms were carpeted in departments – OB, for example. We didn't want to have any potential risk of infection.

They were all firsts at the time and some people said, "Tsk, tsk, tsk – you shouldn't do that. Big mistake, putting down carpeting. Big mistake, all single rooms. You don't have flexibility to add another bed in there when you get full." We didn't want that kind of patient experience. They were right, but they were also wrong as far as advancing what health care was. We had the luxury of starting from scratch. Why wouldn't you do that? It would have been such a waste of an opportunity. We had lots of things like that. I think both Chuck and I would agree, it was a very smooth experience. Would we agonize over some of the change orders and things like that? Of course, but by and large, we opened and it was full immediately.

Part of Carl's genius was to have put it in the right place, right across from the first enclosed shopping center in the country. The Southdale Shopping Center, developed by the Dayton Corporation (which is now the Target Corporation), was in an upscale suburb. The area was growing rapidly. You couldn't have designed a better spot to put a brand new hospital. It filled up immediately. Doctors really didn't have any choice because their patients came to them and said something like,

Patient: "You're gonna put me in the hospital downtown in the Phillips neighborhood where Northwestern is? Why can't I go to the brand new hospital which is twelve blocks from my house?"

Doctor: "Well, but I try and do all my practice at Northwestern."

Patient: "That's okay, I'll go see somebody else."

Doctor: "Oh, all right, all right, all right, fine. I'll get privileges at Fairview Southdale."

They didn't have any choice. We ran a good hospital and the doctors liked it. They left Northwestern, brought their practice there and within five years, we had to double the size of the

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<sup>24</sup> Rodney F. Hochman, M.D., serves as president and CEO of Providence Health and Services (Renton, Wash.) [Providence Health & Services. *Rodney F. Hochman, M.D.* <https://www.providence.org/about/leadership/rodney-hochman>]

hospital.

Were there challenges? Yes, but they were day-to-day. I used to spend an hour every morning just sitting in the doctor's lounge. Was this a waste of time, an hour sitting in there? No, it was the most productive hour because that's where I really found out how we were doing. We discovered issues that way.

Otherwise, things can become a huge problem, the doctors sign a petition of no-confidence and they stomp into the administrator's office and demand the firing of so and so. I sat in the doctor's lounge. On a human basis, one human will talk to another about an issue or a problem. There were problems. Hospitals are not perfect. They're far from it. I would learn about issues early on from a human being, not from an angry doctor talking to an administrator, which is a horrible relationship. Group psychology – social psychology. We'd head problems off while they were little teeny brushfires before they became a raging forest fire. I spent an hour in there all the time and, because of my bad personality, I would pick on the doctors all the time. Most of them loved it and we had great fun.

**GARBER:** This reminds me of the coach asking for reports from the captain of the baseball team.

**WEGMILLER:** You're absolutely right. You wouldn't, as captain of the baseball team, learn all of this stuff on the field. You learn it in the dugout. You learn it because it's you and Fred, not the second baseman and the captain. Those are lessons you don't ever forget.

**GARBER:** Is there anyone else you'd like to mention before we move on?

**WEGMILLER:** All of the department heads were significant and many remain lifelong friends – for example Dorothea Tenney, the director of nursing, and Sherry Rakes, who was the head nurse in the ICU. Dick Craven, Al Westerberg in admitting, I could go on and on. It was a great group of people, a great group of friends. Mary Colbert, the medical record librarian, was like a mother to me. They all took care of me. They all taught me how to be an administrator with people who were senior, in terms of age and experience, and how not to be a jerk. You just can't buy that kind of experience. It was fabulous. Everybody was important to me, everybody.

The docs were the same way, thinking, "We've got to help this guy. He's a young guy." I was smart enough to listen to them, and I was smart enough to have facts on issues when we would discuss them and not just wax eloquent about my opinion. I still value facts over opinions. They appreciated that. They're scientists. They appreciate facts and data and had in their experience found out that a lot of administrators didn't bother with those. Carl, by the way, was one of those, but that was okay because he had the vision to create stuff. That was not a negative comment about Carl, but he didn't bother with facts and data and detail.

**GARBER:** He had you for that.

**WEGMILLER:** He had John King, he had me, he had Chuck and Dean Roe,<sup>25</sup> a whole

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<sup>25</sup> Dean K. Roe (1929-2014) was the founding president of Froedtert Hospital (Milwaukee). Earlier in his career, he was associate administrator at Fairview Hospital (Minneapolis) and then administrator at the Milwaukee Psychiatric Hospital. [Uebelherr, J. (2014, May 30). Roe used patience, determination, vision to open Froedtert Hospital.

bunch of people, yes, right, absolutely.

**GARBER:** Did Fairview and Fairview Southdale have one medical staff?

**WEGMILLER:** No, it was two medical staffs, because at the time, the Joint Commission would not allow it. Would we have done one? Absolutely. Is it the right thing to do? Well, of course it is, like the board. The Joint Commission would only accredit you if you had your own medical staff. This was a new deal. This was a new deal to the Joint Commission. This was a new deal to AHA. It was a new deal to everybody. How were we going to do this? The Joint Commission decided no, we have medical staffs so that they can run their own business. It changed and now you can have one medical staff in a system.

**GARBER:** Do you recall who the chief of staff was at the time?

**WEGMILLER:** Oh, I can tell you every name, if you'd like. Bob Wagner, Dick Galbraith, Rick Simmons.<sup>26</sup> Fairview Southdale became much more of a physician's specialist medical staff than Fairview was. I had to learn all about what was important to different specialties. For instance, I spent a lot of time learning about orthopedics. I would go seek out a doctor in that specialty who was willing to be a teacher, because I wanted to know things like: is it different being an orthopedic surgeon than it is to be an internist?

I would ask stupid questions like that, and the surgeon would go, "Oh, my God." That was not said out loud, but I'm sure it was thought. Then the answer would be, "Yes, it is, Don." So I would ask what I hope were intelligent questions. "What do you value as being more important to you as an orthopedic surgeon than to an internist? Isn't it just good nursing?" The response was, "Well, of course, those are the basics but we need to have specialty people helping our patients as well." I remember Fritz Drill<sup>27</sup> telling me this time after time, "A primary difference for the orthopedic surgeon is that we do a lot of our work in an operating room while an internist does it in an office. If we don't have a team full of specialists, we lose two-thirds of the value of our specialty. We need to have orthopedic nurses on the floor. We'll train them to be orthopedic nurses, because they don't learn that in nursing school." They taught me all that, what it is that's different about it. You don't get that in school. They don't get it in medical school.

This was a you-teach-me-and-I'll-teach-you. I was 26, so it wasn't quite as easy to teach them about why a hospital had to do what it did. They would listen and they would say, "Hmm – yeah, I suppose that's important. Okay, I see why you're doing what you're doing. I don't like it, but I see what you're doing." I don't know how you could get a better experience. I wouldn't trade it for anything.

**GARBER:** What was it that got you interested in writing for the professional literature?

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*Milwaukee Journal Sentinel.* <http://archive.jsonline.com/news/obituaries/roe-used-patience-determination-vision-to-open-froedtert-hospital-b99281077z1-261287131.html>

<sup>26</sup> Robert W. Wagner, M.D., was an obstetrician with Southdale ObGyn. [Southdale ObGyn. *History*. <https://www.southdaleobgyn.com/about-us/history/>]; Richard Galbraith, M.D., a neurologist, was a founder of the SafeKey Corporation and a proponent of the use of face masks in ice hockey. [SafeKey. *Meet the team*. <https://www.safekeycorporation.com/pages/meet-the-team>].

<sup>27</sup> Frederick Drill, M.D., is an orthopedic surgeon. [Healthgrades, *Dr. Frederick Drill, MD*. <https://www.healthgrades.com/physician/dr-frederick-drill-xj5pr>]

**WEGMILLER:** I've found that writing forces you to think more clearly about a topic. I've found that it's a real challenge to make sure that you convey the topic in a way that somebody else can understand what you're trying to say. I've found it helpful to sharpen my skills in communicating to someone else face-to-face or in a presentation. Writing is a very good discipline because when I read it back, I find out that, no, that doesn't convey what I'm trying to say at all. I've found it to be positive and helpful to develop my own thinking about that topic.

Helen McGuire<sup>28</sup> ran the extended care/post-acute care aspects of the American Hospital Association. My first job at Fairview was to build and develop an extended care unit – this was before I had the assignment at Fairview Southdale. Helen McGuire was interested in that. She contacted me and said, “We need more people talking about extended care and how it works and what are the relationships?” I told her that I'd be glad to share that. Carl liked it because it got Fairview in the news. Carl liked having Fairview in the news! I personally didn't care about that aspect of it.

Be that as it may, I enjoyed that and it spurred me on. When we got into the satellite hospital development, people were interested in that. Bob Toomey asked me to write something for his medical staff, a private correspondence, about that. I began to see that if this helps somebody else, I'm delighted at that. More importantly, it's really helping me express myself and tell about my colleagues. Really why I've enjoyed writing, is that it is something for me. If it helps somebody else, good, but it was something for me.

I ended up doing more presentations than I did writing. That's a challenge because you're face-to-face with people who can ask you questions right then and there, and you need to have an answer. If Helen would call and ask me a question, I could say, “Let me check that and I'll get back to you.” I had two or three days to come up with the right answer. When you're making presentations, you have ten seconds, and I love that.

**GARBER:** You were trained to do that.

**WEGMILLER:** Well, yes.

**GARBER:** By the master.

**WEGMILLER:** Yes, that is true, you're right about that but I enjoyed it, too.

**GARBER:** The relationship with Helen McGuire, which led to some articles in *Hospitals Magazine* – actually, they were high-profile articles. They were annual administrative reviews. They were pretty prestigious.

**WEGMILLER:** I didn't know that at the time. I knew they were annual administrative reviews but I didn't realize they were important.

**GARBER:** The articles, the presentations and then you also did committee work on these topics for your state hospital association. Did this all play into your Hudgens Award in 1969? Could

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<sup>28</sup> Helen D. McGuire was director of the Division of Long Term Care for the American Hospital Association. [U.S. Department of Health, Education, and Welfare. (1968). *Personnel qualifications for Medicare personnel*. [https://archive.org/stream/personnelqualifi00unit/personnelqualifi00unit\\_djvu.txt](https://archive.org/stream/personnelqualifi00unit/personnelqualifi00unit_djvu.txt)]



you talk about that award?

**WEGMILLER:** I'd love to, except I have no idea how it came about. I don't know how my name got submitted for the Hudgens Award.<sup>29</sup> Evidently, although he never admitted it, Carl submitted my name. I was stunned. I had no idea about why or what. Maybe it had something to do with writings and profile and so on.

I think it had to do with two things – one, the concept of “satellite hospital”; but secondly, that there were so few CEOs of a hospital who were under 35 years of age. I don't know what the number was, but there were very few at the time. Now we have all of these bright young kids who are under 40, and it's great. That wasn't the case back in 1969. There were very few people running hospitals – at least brand new hospitals – let me put it that way. I think it was more about the concept than it was about Don Wegmiller.

**GARBER:** We are talking about an award from the American College of Healthcare Executives award. You were the first to receive it.

**WEGMILLER:** Yes, in 1969. Years later, I was talking with Tim Stack,<sup>30</sup> who was also an awardee, after an AHA meeting. He said, “You know, we're missing an opportunity, Don. We should organize a Hudgens Society and keep in contact with all of the Hudgens awardees.” We did organize and it still exists. When we first organized it, and we would get together for a day and a half or two days, our annual attendance would be eight, ten, twelve awardees. Back then, it was more common to get together face-to-face. Now everybody's schedule is so jammed. We're meeting again in October and an awardee, Carrie Owen Plietz,<sup>31</sup> is inviting us to Wellstar in Georgia. There will be six or eight of us – maybe more. Rulon Stacey<sup>32</sup> is trying to reactivate it.

It was a fabulous networking opportunity. I got to know Rulon Stacey. John Casey and I got to be best friends through the Hudgens Society. It was learning from one another at different stages in our careers, with the young guys coming up – like Rulon Stacey – and the senior guys like John Casey and Ken Ackerman,<sup>33</sup> one of my closest personal friends. Networking is key to this profession.

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<sup>29</sup> The Robert S. Hudgens Memorial Award for Young Healthcare Executive of the Year is presented each year by the American College of Healthcare Executives to an outstanding young health care leader. [American College of Healthcare Executives. *Robert S. Hudgens Memorial Award for Young Healthcare Executive of the Year*.

[https://www.ache.org/abt\\_ache/awards/hudgens.cfm](https://www.ache.org/abt_ache/awards/hudgens.cfm)]

<sup>30</sup> R. Timothy Stack (1952-2012) served as president and CEO of Borgess Health (Kalamazoo, Mich.) and later of Piedmont Healthcare (Atlanta). [R. Timothy Stack, former CEO of Borgess, dies at 60. (2012, July 31). *MLive*.

[http://www.mlive.com/business/west-michigan/index.ssf/2012/07/r\\_timothy\\_stack\\_former\\_ceo\\_of.html](http://www.mlive.com/business/west-michigan/index.ssf/2012/07/r_timothy_stack_former_ceo_of.html)]

<sup>31</sup> Carrie Owen Plietz served as CEO of Sutter Medical Center (Sacramento) before moving to become executive vice president and COO of the WellStar Health System (Marietta, Ga.) hospital division. [WellStar (2016, January 14). *WellStar announces new leadership roles*. <https://www.prnewswire.com/news-releases/wellstar-announces-new-leadership-roles-300204569.html>]

<sup>32</sup> Rulon F. Stacey, Ph.D., served as president/CEO of Poudre Valley Health System (Fort Collins, Colo.) before becoming a managing director with Navigant's health care practice. He was installed as chairman of the American College of Healthcare Executives in 2011. [American College of Healthcare Executives. (2011, March 19). *Rulon F. Stacey, PhD., FACHE, installed as ACHE chairman*. <https://www.ache.org/pubs/Releases/2011/chair.cfm>]

<sup>33</sup> F. Kenneth Ackerman, Jr., served as president of Geisinger Medical Center (Danville, Pa.) before moving into leadership positions with McManis Associates, Gallagher Integrated and Integrated Healthcare Strategies.

[Integrated Healthcare Strategies. *Biography*.

[https://www.integratedhealthcarestrategies.com/assets/bios/Ken\\_Ackerman.pdf](https://www.integratedhealthcarestrategies.com/assets/bios/Ken_Ackerman.pdf)]



**GARBER:** Let's backtrack a little bit to rejoining your career path. You've mentioned the Ridges Development Company – what was that?

**WEGMILLER:** Ridges Development Company was not Carl's idea. His idea was – we can't stop. There are other parts of the growing Minneapolis/St. Paul metro area that will need health care facilities. One of these areas was south of the Minnesota River in Dakota County, which is adjacent to the county where Fairview and Fairview Southdale are located. It was undeveloped. It was growing, needed facilities and he said to me, "You don't have a big job at Fairview Southdale anymore. It runs by itself." (I thought it took a little bit more than that!) "Why don't you take on developing the project? Figure out what we ought to put there, what could be done now and so on." Which I thought was fantastic. I loved it. He said, "We don't have a lot of money, so don't go spending millions and millions down there. We have enough money to buy a piece of property, so figure out what that ought to be."

Carl had done a bunch of the work and found a piece of property that was in some sort of legal difficulties, and had set about with the Fairview lawyers to acquire it, right at the confluence of two freeways in the community of Burnsville. It was ideal for a medical facility where access is important.

We put together a Ridges Development Company because Fairview didn't have money to be able to develop this on its own. This was the second satellite hospital. It hasn't grown as fast and as much as Fairview Southdale but it's a well-established hospital in that community.

The Ridges Development Company was Ellerbe Architects, who designed Fairview Southdale; M.A. Mortenson Company, the contractor who now builds billion dollar sports stadiums, got their construction start by building Fairview Southdale Hospital; and Fairview. Fairview donated the land. I was the CEO of Ridges Development Company. Ellerbe was represented, Mortenson and Fairview. We laid out a master site plan. We all contributed. Ellerbe contributed their architectural fees, Mortenson their contractor fees. We developed the land and split the profits, if there were ever going to be any – and there were, because we built properties – one-third, one-third, one-third.

That concept was weird. Architects didn't do that. Contractors didn't do that. The usual way to do it was – we build you a building, you give us the money for doing so. We convinced them that this was a new way to do it. Let's do it together. We did and it was hugely successful. We built a medical office building with a 24/7 emergency room, even though we didn't have a hospital. Back then that was viewed as crazy, if not stupid. It didn't turn out to be stupid, but that's what the industry said. "You can't have an emergency room without a hospital. Where are you going to put those patients?" We put them in an ambulance and sent them to Fairview Southdale and it worked like a charm.

**GARBER:** You had a freestanding emergency department in the '70s.

**WEGMILLER:** Yes.

**GARBER:** Wow.

**WEGMILLER:** Right. Everybody in the industry told us, "It can't work. You have to have a hospital." We said, "Why?" Most of the patients end up coming to the emergency room in an ambulance. Why can't they go to a hospital in an ambulance? We're going to have physicians. They're

going to stabilize them.” Anyway, the fact of the matter is, it works just fine, and is now, of course, de rigueur.

It was a very fun project because we did everything differently – architects and contractors and hospitals worked in a single corporate structure to develop something. Neither of those companies had ever done that before. Of course, neither had we. Back then, that was Fairview’s vision – we don’t care what the past was. Do it in a way that works for the future. We did, and it works, and it’s now a well-established medical community in Burnsville and doing very well for Fairview.

**GARBER:** What’s the name of the hospital?

**WEGMILLER:** Fairview Ridges. It sits close to a lake which Ellerbe and Mortenson labeled “Lake Wegmiller” on the site plans. I thought Carl was going to have a heart attack.

**GARBER:** Does that model that you described in which the architect, the contractor and the hospital are joint venture partners have a name other than a development company?

**WEGMILLER:** It doesn’t in health care, that I’m aware of, but I know that that’s how M.A. Mortenson built the new \$1.1 billion U.S. Bank Stadium – the football stadium in Minneapolis. This was a development company of which they were the lead partner with the State of Minnesota, the County of Hennepin and the architects. They formed a joint development company, and I kind of smiled to myself and said, “Well, every forty or fifty years, you learn something.”

**GARBER:** I’d like to move now into the next phase of your career, which also leads to an area that you’re particularly known for, as far as being a pioneer or a guru, or certainly an expert, in area of multi-institutional systems. When you were inducted into the *Modern Healthcare* Healthcare Hall of Fame in 2013, you were described in an article as “one of the first to push the industry to create multi-hospital health systems.”<sup>34</sup> What was the landscape like, particularly for not-for-profit systems in the mid ‘70s?

**WEGMILLER:** There wasn’t much on the landscape. It was like the moon. There were a few – Fairview, Greenville Hospital System, Catholic systems, Mercy – Ed Connors – Intermountain Healthcare, which wasn’t Intermountain Healthcare when Scott Parker got there.

It was not a well-accepted theory. What’s the point of having two hospitals – you will just have twice as many problems? What’s the big advantage? Scott and Ed and I and others had had experience with it – I loved my experience at Fairview, and saw that there were some real advantages to doing this. That wasn’t readily apparent, which means that if we thought it was a good idea, rather than just hiding it under a bushel basket, we ought to talk about it. We got together and shared experiences, and I’m sure others – Scott and Ed – wrote about it and said, “Here’s what we see happening.”

People were not saying, “Oh, wow, that’s great! Let’s do that.” No, it was, “I don’t know why they’re doing that. You run a hospital. That’s what you do. That’s how the industry works. You

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<sup>34</sup> [Barr, P. (2013, March 9). In the merging lane: Wegmiller was ahead of the pack in healthcare integration. *Modern Healthcare*, 43(10), H6-H7. <http://www.modernhealthcare.com/article/20130309/MAGAZINE/303099953>]

run a hospital. You have doctors there. Running two or three or four hospitals – I just don't get it.” That was the common response.

That attitude changed and I think for the better. Some of the things that we saw for the better were that you had enough scale and resources to be able to move to another community or communities and put in facilities. You didn't have to start everything from scratch. An example certainly was in the Health Central system when I got there, there were three metropolitan hospitals and a couple of outlying hospitals. We needed to replace the Golden Valley Hospital, which was a mental health hospital. This was when the HMOs decided to stop paying for mental health, and there was, therefore, no business. We revamped the entire campus – it was a beautiful campus. We had staff. We had resources. We did not have to start from scratch. We had a medical staff, which had to be revamped because it was largely psychiatrists and we were going to have only a small mental health presence.

We began to see that you could develop facilities bigger, better, faster when you needed to change a facility. Otherwise, you just close it down, sell it to a housing development – they love old hospitals – and build houses. We thought that was a waste. That was one reason that we thought multi-hospital systems had benefits.

Another was when we ran into the HMO phenomenon in the Twin Cities and they decided that they needed to approve all procedures. Physicians would have to call a 19-year-old clerk in the office at United Healthcare to get approval for a CAT scan or to get approval to refer to an orthopedist. They were driving the primary care physicians out of business, because the patients would say, “I can't wait around for this.”

The system had enough resources, so we went to the physicians and said, “Join us as employed physicians. We'll acquire your practice, and we'll negotiate for your payment, along with our payment as a hospital.” We had enough resources and enough market leverage that the HMO could not say no, because then they would have to say to subscribers, “You can't go to Mercy, Unity or Golden Valley.” The community would say, “But that's all the hospitals we have on the north side. We'll go to another insurance company.” So, the insurer would say, “Oh, all right, wait a minute, we will contract with them,” and with us meant with our doctors.

I won't go so far as to say we saved primary care practice in the Twin Cities but we certainly helped by acquiring those practices. Eventually, the community told the insurance companies, “Stop this approval process. We don't like it as patients.” They stopped it. With independent small hospitals, it would never have happened.

Those sorts of things began to pique the interest of the industry, saying, “We're having that problem with the insurers in ours but they could dump our one hospital in a heartbeat. It wouldn't affect their sale to subscribers at all. But five hospitals? Trying to sell an insurance contract without five hospitals in a metropolitan area? I don't think they'd sell that.

Slowly, but surely, the benefits of banding together – let's call it a “system” – began to emerge. I think we all felt that that was good. That was positive. Now some people today would say it's gotten too big. I have no opinion on that one way or the other. I can see where some people would have justification to say, “Forty-six hospitals? Really?” I think some of the same principles of advantages exist, but you can do anything to excess. I like chocolate, but I can do that to excess very easily.

**GARBER:** I started my question by asking about not-for-profits. But at the same time, of course, investor-owned multi-hospital systems were expanding. Did you find that you could take notes from each other?

**WEGMILLER:** Oh, sure. Tommy Frist,<sup>35</sup> for example, became a good friend. Did we take notes from them? Absolutely. Tommy said one of the things that he lamented at the time was, “How in the world do you develop a community that really loves the doctors and hospitals? Because we don’t get that loving, warm feeling a lot of times.” I said, “First of all, because the community doesn’t see any access to a system that’s in Nashville, Tennessee. You don’t have any local outlet for it. You don’t have local boards. I understand that. But how do you want the community to connect? They can go talk to the administrator.” That’s the kind of discussion that we would have. I would say, “I wish we had your purchasing power. Tell me how you manage that without taking away the individual uniqueness of a physician who wants to buy a particular knee replacement part?” and so on.

**GARBER:** I’d like to talk about how your next opportunity came about, where you went from Fairview to become the CEO of Health Central. How did that happen?

**WEGMILLER:** Fairview and Health Central entities entered into discussions about merger, which I was thrilled about. The entire west/metro/north Health Central and South Fairview would come together in a single system, and would be dominant, and would be able to do a lot of things that neither could do. For good and valid reasons, I suppose, those discussions did not come to fruition.

In the process, Carl asked me to conduct a lot of the discussions. Separately, he and Bob Van Hauer,<sup>36</sup> who later became my boss for about twelve months, would talk, and then John King and I would work with the administrators of the individual hospitals. I got to know them and I got to meet with some of the Health Central board members. We became known to each other.

The discussions broke off. Shortly thereafter, in 1976, several of the board members told me, “Bob is going to retire in the first part of 1978 and we’d like to talk about you succeeding him.” We sat down and they painted a vision of what they wanted to do. It was a more expansive vision than just the Twin Cities, which intrigued me.

Those discussions continued and it came to fruition. I joined Health Central as the Chief Operating Officer in November 1976. Van retired January 1, 1978. For 14 months we worked together. It was a great experience. He was a terrific guy, very operational; not the opposite of Carl but much more focused on the present. “Let’s make this railroad run on time and as efficiently as we can get it.” I learned a lot about operating from the top. I had been part of a system but not as the CEO.

**GARBER:** You wrote an outstanding case study, which was published in a 1978 issue of

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<sup>35</sup> Thomas F. Frist, Jr., M.D. founded the Hospital Corporation of America with his father, Thomas F. Frist, Sr., M.D., and Jack C. Massey in 1968. His oral history: Garber, K.M. (Ed.). (2010). *Thomas F. Frist, Jr., M.D. in first person: An oral history*. Chicago: American Hospital Association be found in the collection of the American Hospital Association Resource Center.

<sup>36</sup> Robert Van Hauer (2010-2007) served as administrator for the Golden Valley Health Center and helped in the merger that created Health Central, Inc., which he also served as CEO until his retirement. [Legacy.com. (2007). *Robert “Bob” Van Hauer*. <http://www.legacy.com/obituaries/twincities/obituary.aspx?n=robert-van-hauer-bob&pid=88716113&fhid=3204>]

*Healthcare Management Review*.<sup>37</sup> Because it details the formation of Health Central we're going to skip that part of your history. I'd like to explore the section in the article where you were talking about future plans. I'm curious as to how certain things that were itemized in that section of the article actually came to pass. One of the points was that the intention was to grow the number of hospitals in the Health Central system.

**WEGMILLER:** Yes, that was their vision.

**GARBER:** Did that happen? How did you target those hospitals that might be receptive to membership?

**WEGMILLER:** It did happen. I joined in 1978 and in 1993, when I left, we were 23 hospitals. We started with four – three in the Metro, and one in outstate Minnesota. We needed to grow both the Metro and the outside. At least in my opinion, we needed to, and fortunately the board agreed.

We did a couple of things to target the hospitals, although at least half of the hospitals that joined were what we called “over the transom.” Somebody would call and say, “We understand that you'd be willing to entertain hospitals joining the system. Tell us about that.” The other half, we probably gained targeting information, if you will, because we agreed to manage hospitals without owning them, and we agreed to provide them services without owning them through a shared services program.

We didn't start the shared services program for that purpose. We started it to increase our scale – remember the discussion I mentioned with Tommy Frist – I wish we had your scale, to be able to buy better? We increased our scale through the shared services program. At one point, that shared services program encompassed 200 hospitals in five states.

Now in the process of that we didn't just do group purchasing. We provided them with a lot of services – strategic planning, financial management and so on. These weren't small critical access hospitals. These were just hospitals that didn't have the resources, some of them, in very nice towns. We got to know a lot about them. When you're providing them financial management services or group purchasing services or any kind of strategic planning services, you get to know and you get to see, “This place could really be something if they had better management, better services.” We would target some of those – New Ulm, Long Prairie. New Ulm has become a terrific medical center for Allina.

We particularly targeted them when the medical staff felt that they were a part of the hospital. They had physicians on the board. That was part of our vision that the physicians and hospitals have to come together in some way at some point. If a hospital was already down that road – they didn't have to own physician practices – that's not what I'm saying, but they had somehow come together in a working relationship.

Let me give you an example – at New Ulm, they had a good working relationship. They needed a new facility, or at least a portion of one. We agreed if they became a part of the system, we would do that physical facility improvement. Our strategic planners sat down with the hospital and

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<sup>37</sup> [Wegmiller, D.C. (1978, Winter). From a hospital to a health care system: A case example. *Health Care Management Review*, 3(1), 61-67.]

physicians and said, “Why don’t we build an ancillary wing that we both operate? So you won’t have your x-ray machines and we have our x-ray machines. We will jointly have x-ray machines.” Keep in mind, this was in the ‘70s. That would have been a “communist plot” to a lot of physicians – this is somehow going to take us over. These doctors said, “No, it makes common sense,” so we did it.

It was those sorts of relationships begun through either shared services or managing the hospital that allowed us to try different relationships, particularly with physicians. They were fun and we learned a lot from them. Then we began to apply them later on in the system of Health Central. We’ll talk about that when we get into Health One and employing physicians. We learned a lot about that from other hospitals that we managed and that became part of the 23 hospitals by the time I left. Yes, we did grow the system – long answer for growing the system.

**GARBER:** As you were talking about that, it made me wonder what exactly it meant to join the Health Central system.

**WEGMILLER:** Now the assets were owned by somebody other than the New Ulm Hospital, for example. It made a difference because, although in some cases we kept an advisory group of people, they did not direct the future of the hospital. The Health Central board of directors became accountable for directing the future of the New Ulm Medical Center.

**GARBER:** These were actually acquisitions.

**WEGMILLER:** Yes, more or less, yes. We called them “mergers” because we did not write a check like Tommy Frist did. He had to because HCA was a for-profit when the hospitals were not-for-profit, that isn’t allowed under the law. You can’t buy a not-for-profit’s assets because the community owns them. They had to set up foundations and the money would go to the foundation. We could merge, and they can take one not-for-profit’s assets and put it under control of another not-for-profit. There were some legalities that caused us to do that.

Was it an acquisition? For all intents and purpose, yes, except for the money. We didn’t have to write a \$4.5 million check, which, by the way, was a much more efficient way of doing it. What would they do with \$4.5 million? They couldn’t give it to anybody because it belongs to the community. They could donate it to United Way, I suppose, but that takes it out of the health care system. Why not keep it in the health care system? So we did.

What did they get out of it? We built them a new hospital. That’s not so bad. We did that in a number of communities – Buffalo, Minnesota; New Ulm, Minnesota; Long Prairie, Minnesota. When you say “acquisition,” it triggers in many people’s minds, “That’s a bad thing. Now they’re gone. They got nothing for it and they’re gone.” That wasn’t our method of acquisition. They got a lot from it, probably more in many cases than it was worth. That’s okay. We were in not-for-profit health care. That’s fine. Because of the system efficiencies, we had some money to do that. A single hospital doing that? That’s tough duty.

**GARBER:** Were there ever hospitals that left the Health Central system?

**WEGMILLER:** Not while I was there. There were a number of hospitals that we approached and said, “Here’s some reasons and here’s some people you would talk to,” and they said, “No, thank you.” Interestingly enough, many of those would come back to us later – years later – and say, “We would like to join now,” and would have to hear, “I’m sorry, but that ship has sailed.

Your situation now is not the kind of situation we want to get into. Your medical staff is not supportive. They're angry. They're upset. Your facilities are way outmoded. The community isn't supportive of the hospital. Back seven years ago, when we approached you, that wasn't the case. But that ship has sailed."

**GARBER:** Those must have been emotionally wrenching meetings.

**WEGMILLER:** Definitely.

**GARBER:** To deliver that kind of a message to a desperate community.

**WEGMILLER:** Definitely, to the point where our management team would take turns doing that – because people would cry. I remember one board member in a community hospital who sobbed through the whole meeting. It ripped me apart, because it left that community with a very significant problem. We didn't have unlimited resources. We had to pick and choose as stewards of the resources. I felt bad because, in many cases, that same administrator who had said, "No, thank you, we can do this on our own. Thank you very much," seven years earlier was still sitting in the board room now. It's not hard, as a local community member to figure out that a mistake has been made here. That's not fun, but, you have to deliver the correct message. Facts – I love facts.

**GARBER:** Other points that you mentioned in your future plans section of the case study article had to do with the development of the ambulatory care programs. This was a time when ambulatory care was just starting to take off.

**WEGMILLER:** Yes, exactly right.

**GARBER:** I imagine that point came to fruition. You also talked about the desire to broaden the corporate services that were provided by Health Central to the member hospitals.

**WEGMILLER:** Yes, that was very much a part of our strategic development plan for the system. "Corporate services" is probably not that good a descriptor of it. We wanted to provide the hospitals with resources that no one of them could do, and a large number of those had to do with clinical services – clinical planning, clinical services, specialty clinical professionals. We embarked on that and did very well.

For example, we appointed the first chief medical officer in 1983. That was another "communist idea." We had a lot of communist ideas, or so they were called. We needed to have direct physician input into the corporate offices of Health Central, later Health One. Now, of course, that's de rigueur. You wouldn't have a system without a chief medical officer.

We recruited the dean of internal medicine in the Twin Cities, Dr. Al Schultz,<sup>38</sup> from the university and Hennepin County Medical Center, where he ran a huge practice – Hennepin Faculty Associates (HFA). Al came in and immediately set out to develop regional medical officers, so that the physicians there could go to their regional medical officer and say, "We need help on this. We don't know why you're doing that. What does corporate think about this?" and have a direct input to

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<sup>38</sup> Alvin L. Schultz, M.D. (1921-2001), an internist and professor, served in leadership positions at Health One Corporation and HealthSpan, among others. [Alvin Leroy Schultz. *Prabook*. [https://prabook.com/web/alvin\\_leroy.schultz/87481](https://prabook.com/web/alvin_leroy.schultz/87481)]

a physician leader into the system. Although the docs never wrote thank you letters, it was clear that they appreciated that, because systems weren't doing that.

Al Schultz was a master. He was probably the best strategic physician I've ever seen – very soft-spoken, very quiet – but he had trained all of the internists in the Twin Cities and they revered Al. He was The Professor, but he was a very practical guy.

I could give you five or six more examples but it's the same. We needed to bring services that physicians or clinicians in the hospitals could appreciate because they didn't have them before. These were not people telling them what to do. These were people saying, "What do you need us to do for you?" That was a different concept and it was pretty well welcomed.

**GARBER:** During the early '80s was the time when Medicare reimbursement shifted from cost-based reimbursement to the prospective payment system. What effect did that have on Health Central hospitals?

**WEGMILLER:** Not a great deal. There was more concern about it in the industry than was justified. To be fair, it was an unknown. Nobody really knew what the DRG system was and the government was doing it, so right away we were all suspicious of it.

I think it was a good reimbursement system. This idea of getting paid so much per patient day for somebody with pneumonia vs. per patient day for a patient recovering from quadruple bypass surgery – those are quite different costs. You got paid per patient day, period. What did that encourage people to do? "Well, we send all of our cardiac patients over here because we're not going to get paid on a per patient day basis nearly what it costs, and we'll go for pneumonia patients." I'm using that as a potential example. I don't know that many people did that but that was how perverse the incentives were.

Diagnosis related groups took into account acuity. Orthopedic patients had a set of DRGs and cardiac patients had a different set. It's actually a pretty smart system. Once you learned the system, you could plan a great deal better. It certainly didn't have any deleterious effects, but had the positive effects of letting us know how many patients we treated last year in DRGs 400 to 422, for example. If we had 5 percent more, we knew quite precisely what kind of revenue we were going to have. That's a good idea.

It got a lot of bad press and a lot of anxiety. That maybe had been warranted because of the way it was introduced but it did not turn out that way for Health Central.

**GARBER:** How did the organizations change as Health Central merged with Health One?

**WEGMILLER:** This was a different model than Fairview. I described how Fairview went about it. You build it, you own it, you control it and it has your name on it throughout history - FAIRVIEW. By that time there weren't any other places to build in the Twin Cities. If we were going to grow in the Twin Cities, we would have to do the Greenville – Bob Toomey approach. We needed to acquire, merge, joint venture with existing organizations who had a board and a management and a way of doing things and so on. You couldn't just take your name and put it on somebody else's organization and say, "You don't exist anymore." People don't like that.

When Health Central came together with Health One, for example, we took the name of



Health One, and their board was shocked. “You’re the dominant – we understand that. You’re going to run the system – we understand that. You’re going to allow our name to be the name? Wow!” In my opinion, that’s how you do things. It’s not an HCA model, where your name is going to be HCA, period. These are community hospitals and their communities need to feel as if they’re a part of this, not being taken over. You do things differently in that model than when you own and control everything – like HCA, Fairview. One of the ways is to recognize those organizations. It’s tough to keep up.

Some of the greatest people who came into our system came from that merger. Dick Blair,<sup>39</sup> the interim CEO, was their chief financial officer. He was a noted figure in health care finance who later became chair of HFMA and was probably the best strategic CFO I have ever seen and would ever work with. Foster North,<sup>40</sup> Susan Brink, who later went on to become Ascension’s chief government relations officer – people like that, national figures in the industry came into our organization from the Health One organization and that’s one of the things that we looked for when we talked to people.

Later on, Abbott Northwestern Hospital came in and Gordie Sprenger,<sup>41</sup> who succeeded me when I retired, had talent. At that time talent was a very important thing to us. We needed talent, talent that didn’t run hospitals, talent that ran systems – there is a big difference in the jobs. You’re not running a facility anymore. You’re running a people organization. Our model of acquisition had quite different factors in it than it did at the beginning when we were acquiring facilities. We know how to run facilities but now we’re running a system – big difference.

So yes, we went through a series of acquisitions and they were successful. Allina, which was the end result of all of this, is still the dominant system in Minnesota. Mayo would take issue with that statement, but Mayo doesn’t consider themselves a system, and I understand that.

**GARBER:** I was struck by your story about the choice of the Health Central versus the Health One name and how you did that to further relations with communities. Did the Health Central hospitals mind giving up the Health Central name?

**WEGMILLER:** Not particularly. Mercy Hospital is still Mercy Hospital to the northern communities. We never tampered with that. It was Mercy Hospital, a hospital of the Health Central system. We used to joke with them, and they would joke with us, saying, “When the merger comes, we’ll have a new name anyway. So what difference does it make?” Pretty much, that was the case. That’s how Allina came about. It was because all the other names were taken.

**GARBER:** Does Allina have some connotation?

**WEGMILLER:** No. It was one of those name search organizations. It couldn’t be this and

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<sup>39</sup> Richard Blair served 28 years as CFO for Allina Health System (Minneapolis). [Integrated Healthcare Strategies. *Biography*. <https://www.integratedhealthcarestrategies.com/assets/bios/b857ecb4-cb9c-432c-b838-380ebc02b378.pdf>]

<sup>40</sup> Foster D. North served as senior vice president of the Diversified Services Division of Allina Health from 1983 to 1997. [LinkedIn. *Foster D. North*. <https://www.linkedin.com/in/foster-d-north-01b4302/>]

<sup>41</sup> Gordon M. Sprenger served as administrator of Abbott Northwestern Hospital (Minneapolis) and later of LifeSpan and Allina Health. [Winje, H. (2010, May 23). Interview with former Allina CEO Gordon Springer. *Twin Cities Daily Planet*. <https://www.tcdailyplanet.net/interview-former-allina-ceo-gordon-sprenger/>]

it couldn't be that. They picked Allina. We had that on our list, but it was time for me to move. I had retired and so I didn't get a part in the final discussions of Allina. We called it Healthspan, but that was just a placeholder for the name to indicate that it wasn't Abbott Northwestern.

The Health One merger had something unique that turned out to be important. In our strategic planning, we went to the three health insurers HealthPartners, Medica and Blue Cross Blue Shield. They had 90 percent of the market in health insurance in the Twin Cities – still do. We went to them and said, “Look, we are who we are. We're going to grow, probably, in the Twin Cities. What sorts of things are important to you in your health insurance business that is something we could help accomplish?”

All three said the same thing, “There is this fiction among you hospital people that the St. Paul market is the St. Paul market and the Minneapolis market is the Minneapolis market. Our customers, for example 3M, have employees who live in Minneapolis and St. Paul but we have to have separate contracts because you are St. Paul hospitals and you are Minneapolis hospitals. There isn't one organization that has both. If there was an organization that had both, we would be very interested in contracting with them.” Although they didn't say this, it was because they could go to 3M and say, “We have hospitals in Minneapolis and St. Paul. We, as the insurer, can make sure that your employees have access wherever they live,” and that would be important to their marketing and contracting.

That was important to us in Health One. Health One had a downtown Minneapolis hospital – number three of three of them – and United Hospital, which was number one in St. Paul. With the merger, we now had a St. Paul hospital and a whole bunch of Minneapolis hospitals. This made a big difference because the health insurers ponied up what they said they would do. We had very advantageous contracts. Not until April of this year, 2017, 31 years later, did another system have hospitals in both Minneapolis and St. Paul.

There was an interesting article written, I think, in 2000 about the greatest things that have happened in various industries for the last 25 years. When it came to health care, it was the merger of Health Central and Health One as the greatest thing that happened in the Twin Cities health care market in the last 25 years. We were proud of that. It was because of all of this thing that we could bring together.

Why was Health One's name so important? We were now crossing into enemy territory – St. Paul – which detested the Minneapolis market. For example, when First Bank went there and acquired the banks in downtown St. Paul, communities picketed against it because they were from Minneapolis. You might say, “That's stupid and what difference does it make?” Emotions are very important around community facilities, and that's what a hospital is. Again – group psychology, social psychology – I wish I had studied it.

The United people said, “Our name is going to be on this thing? Health One, we're already Health One. We're part of it.” It worked. We had a great welcoming party at United Hospital. It was the funniest thing you have ever seen. We hired a comedy group, like an improv group, and mocked the St. Paul/Minneapolis divide. I thought I would die laughing. The United people gave them a standing ovation. There are things you can do if you understand group psychology and social psychology as to how to make people feel welcome.

**GARBER:** As you were talking about the divide, I wasn't saying, “Oh, this is stupid.” I was

saying, “Why?” Is it because a river runs through it?

**WEGMILLER:** The Mississippi River.

**GARBER:** The Mississippi separates the two cities.

**WEGMILLER:** Yes, but culturally, St. Paul is heavily Catholic and Minneapolis is heavily Protestant. St. Paul was founded by Irish Catholics, Minneapolis by Presbyterians. I could give you fifteen of those that are all polar opposites. They refer to the Mississippi River between Minneapolis and St. Paul as being 300 years wide. That’s the divide – it’s only about two blocks wide, but 300 year’s difference.

It’s a fascinating thing if you want to learn about how communities react to one another, which I spent many hours doing. I could then go to St. Paul and say, “You know, the Charles T. Miller Hospital?” They would say in surprise, “You knew the name of the hospital that’s now United?” I said, “Yes, I know about Charles T. Miller. Did you know that he went to school in Minneapolis?” They said, “No!” If you gather some facts and know some things, you can get people on your side a lot easier than people think because you respect them. They say, “You took the time to know about us. I guess you’re not as bad as I thought.”

Let me tell you a quick story about Dick Blair. We were finishing up the negotiations with Health One. Their board had approached us, not their management, and said, “We’ve just fired our CEO and we’re going to appoint Dick Blair. He’s a wonderful guy but we don’t want to go search for another CEO and be a separate system. We want to be part of your system. We need you and the management to get together and work it out, and we want them to meet with you next week.”

I called up Dick and said, “You okay with this?” He said, “Oh, yes, absolutely. We’re all for it. The one thing that would really help is if you would put together your vision of what it will be like for Health One to be a part of Health Central, particularly around the East Metro, because you know that’s going to be the problem.” I went to the team and they said, “That’s not enough time. We could put something together but it’s not going to be good.” Jim Rice,<sup>42</sup> who was our strategic planner, said, “I can take care of it. He and I had worked together for 17 years – I worked with him at Fairview before.

Jim prepared a thick folder. Dick opened the meeting, talked about a number of things that we needed to accomplish in that, and said, “Now one of the things is we’d like to know is what you see.” I said, “Jim’s been working on this and has some ideas.” We had worked out a strategy, and Jim said, “Now you have to keep in mind that first of all, we have some legal obligations here. We are two separate organizations and because of antitrust regulations, we’re not allowed to give you this. We have a lot of strategy in this document. Secondly, if this merger isn’t approved, we’ve just given you a strategic vision for St. Paul, and if it doesn’t come through, you’re now a competitor of ours. Let us just assure you, we have that vision.”

There was not a single printed word in that folder. Blair later said, “You son of a gun. That is the slimiest trick I have ever had perpetrated on me.” I said, “Dick, did you get a strategic plan for

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<sup>42</sup> James A. Rice, Ph.D., is managing director and practice leader at Integrated Healthcare Strategies, a consulting firm. [Integrated Healthcare Strategies. *Biography*. [https://www.integratedhealthcarestrategies.com/assets/bios/Jim\\_Rice.pdf](https://www.integratedhealthcarestrategies.com/assets/bios/Jim_Rice.pdf)]

St. Paul?” He said, “Yes, but you didn’t have it that day!”

**GARBER:** The next stage in your career is a major shift. Before we start talking about that, is there anything else you wanted to say about the Twin Cities market or your experiences there.

**WEGMILLER:** The last peg occurred in the early 1990s, when Abbott Northwestern, which has been for years the premiere flagship hospital of Minneapolis, was brought into the system. That’s a more complex story and I’ll try not to drag it out. Remember that I said we had a downtown Minneapolis hospital, which was number three out of the three downtown hospitals – Metropolitan Medical Center? It was a good hospital but it was number three behind Abbott Northwestern and Fairview downtown. We had to do something with that.

The physical facility was fine but the whole strategy had been overlooked in the Health One organization. All of the attention had been spent on United Hospital. It was going to be a heavy lift with an uncertain outcome. The question was, do we want to do that, or do we just want to acquire number one or number two? There were a lot of different opinions. I was tasked with going out and talking separately to the CEOs of each of those organizations – Gordie Sprenger, who was later an AHA Chair, at Abbott Northwestern, and Rick Norling,<sup>43</sup> who was later the CEO at the Premier organization, at Fairview.

The discussion was what should be done about downtown Minneapolis in terms of hospitals. They both said that three hospitals were not needed and that they each intended to be one of the two that were left. I said, “You’re saying we should close Metropolitan Medical Center. What if we did? We would incur all of those losses, have to relocate all of the physicians, relocate 1,400 employees and you would do what? Write us a thank you note? Or is there some reason then that you would feel you would join with us?” They both said, “Yes, we would! Of course, if you’re going to do that.” I said, “We’re going to take it under consideration because it would make the downtown market strong for whoever is going to be there.”

I said to Rick, “There’s another party interested in this and that’s Abbott Northwestern.” I separately told Gordie, “There’s another party and that’s Fairview. Why don’t we do this? Why don’t you and I, Gordie, hire Booz Allen Hamilton to study it and find out whether there are advantages and so on over us doing a merger with Fairview, and Rick and I will hire Gerry McManis<sup>44</sup> – McManis and Associates – to study that same question with Fairview? Each entity will get the results and we’ll come to a conclusion.”

We did that. The directions to the consultant were, “Find out what the organizations are willing to do with the 1,400 employees at Metropolitan Medical Center, the 900 physicians, the physical facilities there. Would they see themselves being a part of Health One or would they just hire some of our people and then we would go away.”

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<sup>43</sup> Richard A. Norling served as president and CEO of Fairview Hospital and Healthcare System (Minneapolis) and then from 1998 until his retirement in 2009 of Premier, Inc. (Charlotte, N.C.) [Premier Inc. plans transition in executive leadership. (October 16, 2008). *Business Wire*.  
<https://www.businesswire.com/news/home/20081016005617/en/Premier-Plans-Transition-Executive-Leadership>]

<sup>44</sup> Gerald L. McManis, a management consultant, served as president of McManis Associates, MMI Companies and GLM, Inc. [Equilar. *Gerald L. McManis*. <http://people.equilar.com/bio/gerald-mcmanis-magellan-health/salary/59304>]

To make a long story short, Gordie said, “All the physicians can be given staff privileges at Abbott Northwestern if they want, no questions. We will accommodate their patient load. We’re in the process of developing a new inpatient wing. We’ll expand it. We will become a part of the Health One organization and we’ll hire as many of the people as we possibly can.”

Rick came back and said, “I’m not sure that our board will allow us to become part of Health One.” The consultants were reporting on this, not the individual CEOs, but I knew what was happening. “We’ll take on as many as we can but we’re not willing to do anything with the physical facilities.” I put forth the recommendation to our board that we take the Abbott Northwestern organization.

We had to deal with the physical facilities. Metropolitan Medical Center and Hennepin County Medical Center, the safety net hospital in Minneapolis, are located cheek-by-jowl. We went to the Hennepin County Commissioners, who were just in the process of authorizing a half a million dollar study as to where they might gain additional capacity. They were talking about a \$200 million expansion to their facilities.

We said, “For \$50 million, we’ll give you Metropolitan Medical Center, if you build a skyway, you get a whole new building.” They said, “Wow. What’s the catch?” I said, “There is no catch. We have other plans, moving on. Take it or leave it, it’s \$50 million or we’ve got a housing developer that would like to buy the property.” They said, “Don’t do that! It’ll block our expansion forever.” I said, “I understand that. Make a choice.”

Hennepin County Medical Center bought our property for \$50 million, which was debt-free, so it was a clear \$50 million. We relocated 1,392 of the 1,400 employees. All 900 physicians had privileges at any Health One hospital – St. Paul, Abbott Northwestern, Mercy, Unity. We thought it was a pretty good deal for the community. At the start of that, I went to the board and said, “If I can get this done, I need to move on. I’ll be 55 years old, and I’ve been at this business now for 35 years and I need and want to do something else. This is as good a system as I could produce. I don’t know what else to do and I don’t want to keep running a system. I’ve done it for 30 years.” They said, “Get it done and then you can leave. We’ll take it from there.” We got it done. Six months after we got it done, I left and moved on to the next part of my career.

It was a fun ending because we did something good for the community. They’ve added more facilities to Hennepin County Medical Center. It is spectacular. Safety net hospital? I’d go there in a heartbeat. It is beautiful. It has a fantastic medical staff. The community is significantly better off and that’s what we’re supposed to do in not-for-profit health care – do things for the community not for stockholders. There’s nothing wrong about that but that isn’t part of the system that I joined. I joined a not-for-profit system.

I’m proud of that and happy as to how it turned out, largely because other executives were willing to talk about something that may or may not have been in their interest. They were and it was great. Gordie was became my successor, which I knew would happen. I was leaving anyway, so having a good friend in there was terrific.

**GARBER:** As you were telling that story there was happiness and pride in your face at the wonderful sense of having made a difference.

**WEGMILLER:** No question – for everybody, and I there are very few opportunities you have to have a win/win/win, and when you do, oh, boy, it makes you feel great.

**GARBER:** You next moved into the field of executive compensation. How did that opportunity come about?

**WEGMILLER:** Gerry McManis came to me and said, “You know, when this thing gets done, what are you going to do?” I said, “I’m going to retire and go do something else.” He said, “I’m going to retire in five years from McManis Associates. Why don’t you come and run that?” I said, “Well, that’s great. That’s a terrific offer, and I’m very serious about considering it.”

Bob Tschetter,<sup>45</sup> a classmate of mine and Scott Parker’s in the 1962 class at the program was senior consultant in health care for Booz Allen Hamilton, and did the study for Abbott Northwestern and us, and asked me, “What are you going to do when you’re done? Why don’t you come and work with us at Booz Allen Hamilton?” I said, “That would be great. I’d love to. I’ve got to think about it.”

Gary Fink<sup>46</sup> was running a compensation company that our human resources department was working with on executive benefits. I was impressed by what they were doing and how they went about it but they were just five or six years into health care. They were working with First Bank and commercial enterprises. Gary Fink said to me, “Let me tell you what the market looks like in terms of executive compensation in health care. It doesn’t exist. Nobody pays attention to executive compensation for hospitals and health care systems. There is Mercer and Aon and people like that but that’s just a side interest for them. Executive compensation for health care is where it’s at.”

Every year, somebody would come in and present data to our board at Health One on what executives were being paid in health care and it was what it was, let me put it that way. One of our board members was a division manager at General Mills. At the time, Health One with Abbott Northwestern had 15,000 employees. We had assets of over a billion dollars – this is in 1992 – a billion dollars then was a lot of money. I was paid \$200,000 a year. The division manager at General Mills ran a 5,000-employee division and had revenues of about \$500 million – we had revenues of \$900 million – and had a base pay of \$500,000 and incentive of another \$500,000 plus stock options. That didn’t seem quite equal. He was making over a million dollars a year and I was making \$200,000, and we were a bigger operation. Gary Fink said, “That’s the problem with executive compensation in health care. Nobody takes it seriously. Nobody presents the comparison.”

Over a period of time, probably a year, Janet and I talked about this choice. I said, “If I go with Gerry, I’ll be working out of Washington, D.C., and if you’re going to stay here, that’s an awful lot of plane trips.” She said, “I’m not moving to Washington, D.C.” I said, “If Bob Tschetter and I work together, we’d move to Chicago.” She said, “Although I don’t want to, I might move to Chicago,

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<sup>45</sup> Robert A. Tschetter (1935-2013), a partner with the consulting firm Booz Allen Hamilton, became managing partner of the firm’s Health and Medical Division and later became chairman of the operating council. [Robert Tschetter obituary. (2014, January 22-24). *Savannah Morning News*.

<http://www.legacy.com/obituaries/savannah/obituary.aspx?n=robert-tschetter&pid=169218772&fhid=6031>]

<sup>46</sup> Gary C. Fink was a longtime insurance executive with The Prudential and founded a consulting firm in 1980 which later became Clark/Bardes Consulting-Health Care Group. [Support, encouragement and a soupcon of Woody Allen. (2005, Winter). *Wisconsin campaign insights*. [https://www.supportuw.org/wp-content/uploads/insights\\_05\\_winter.pdf](https://www.supportuw.org/wp-content/uploads/insights_05_winter.pdf)]

but I am not moving to Washington, D.C.” And I said, “Gary Fink said the office is in downtown Minneapolis.” She said, “This isn’t the way you should make the decision, but my preference is that we stay in Minneapolis.”

I talked to Gary, and he said, “We need to grow and build this company – there’s no sense in being number two or number three. We need to make this into the number one company in executive compensation.” I said, “You don’t even have a cash compensation person on your staff.” He said, “Your job will be to build this company. Go get those people. I’ll get the money, you get the people, and then let’s take over this market.” I said, “That sounds like fun.”

I joined them in 1993. When we sold the company in 1998, we were the number one company in health care executive compensation. We sold it for a lot of money, some of which I’ve given back to the University of Minnesota, and everybody was happy. John King says, “Don Wegmiller is the single biggest cause of the cost increase in health care because he drove all of those executive salaries up to where they deserve to be. He is the sole reason for the cost of health care!” Now we do have compensation in health care for executives that is comparable to similar positions in other industries, and I don’t think that’s bad.

We had a lot of fun doing it. The networking that had been done before was very helpful. Boards loved talking with people who had worked in health care. We built up a fabulous staff, which still is there today and I still am chairman emeritus, so I get to go to the Christmas party.

**GARBER:** The firm that we’ve been talking about – is that the one that’s called HealthCare Compensation Strategies?

**WEGMILLER:** It’s all of the above. It was MCG Healthcare, it was Healthcare Compensation Strategies. It is now called Integrated Healthcare. It’s just like Health Central. It’s the same company, but every time we added a new division or something like that we would change the name. We acquired a practice in Kansas City and we changed the name and so on, but it’s the same company. Now it’s called Gallagher Integrated Healthcare Strategies, because Gallagher bought it. So, yes, it’s all of those.

**GARBER:** And Clark/Bardes?

**WEGMILLER:** Clark/Bardes is the firm that bought us in probably in the 2000s. Management Compensation Group in 1993 then became Healthcare Compensation Strategies in 1999, which was sold to Clark/Bardes Consulting in 2002, which has subsequently been sold to Gallagher. After Clark/Bardes Consulting, it became Clark Consulting – I could go on and on about the name changes. The point is, it’s the same company.

**GARBER:** You left it in 2011?

**WEGMILLER:** I left it totally in 2011. I hired Ken Ackerman to run it in about 2005 – and Ken became the CEO. I stayed on as Chairman and left it totally in 2011, became Chairman Emeritus, yes. It’s a great company and they’re doing well. They had a banner year this year, as a matter of fact, for some reason. I don’t know why. Probably because I’m gone.

**GARBER:** During the time that you were working in executive compensation were you sorry you had left hospital administration or health system administration?



**WEGMILLER:** Oh, no – after 30 years? No. I definitely had a tug because Dick Blair was still there as the chief financial officer of Allina and I loved working with Dick Blair. Jim Rice was still there. Subsequently, I hired him at Healthcare Compensation Strategies, but I missed working with Jim and others. What I miss is the people. Did I miss working in health care administration? No, I had 30 years. It was wonderful.

**GARBER:** I would like to talk about governance. What are the characteristics of a good board chair?

**WEGMILLER:** I was blessed with having good board chairs. I think the characteristics are having a good, basic knowledge of the difference between governance and management. The board chair should respect the difference and should expect the chief executive officer to respect the difference and act accordingly. The role definition should be clear and understood.

Secondly, the CEO and the board chair should agree to a communication plan. For example, the communication plan should say that nothing goes on the board agenda without both agreeing, so that neither the board chair nor the CEO goes, “What??” during the meeting or just before the meeting. There are other aspects of a communication plan. How frequently do you want to have a communication? Do you want communication that is only in writing? I had a board chair that said, “You’re never going to reach me on the phone. We’re going to have to write and communicate that way.” I said, “That’s the plan? Great. Now I know and I’ll do it right.”

Thirdly, the board chair leads the board. The board chair doesn’t just receive input from the board members and pass it on. Sometimes board members go off on their own, just like managers do. That means the board chair has to step in and say, “[Rogue Board Member] you need to get in line.” That’s the board chair’s job. If the board chair learns of management staff contacting board members – the CEO should step in. There needs to be clear definition of leadership and who will take care of rogues.

That’s it. It’s no more complicated than that. Those are tough jobs. I remember one of our board chairs, Lee Canning.<sup>47</sup> We had a rogue board member who loved to contact Jim Rice and find out what the strategic plan discussions were going to be at the board meeting. Jim would tell me about this. I never talked to the board member. I called Lee and said, “Here’s what’s going on. Are you okay with that?” He said, “No, I’m not okay with that. I’ll talk with him.” That’s not unusual. It wasn’t mean-spirited. The board member thought this is how boards operate, because at his church, he did that all the time. This is a little different from church governance and Lee explained it to him, “You see, this is a business. We don’t do that in our businesses.”

That’s all. Good board chairs understand those three things and do them very well. Lee was an example of that. We sometimes make it way more complex than we need to. It’s just that. Let’s just communicate.

**GARBER:** You talked about characteristics of a rogue board member. Can you contrast that

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<sup>47</sup> Leonard John Canning, a journalist, became senior vice president at the Star and Tribune Co. (Minneapolis) and later the publisher of Minnesota Suburban Newspapers. [Furst, R. (2017, August 15). Former Minneapolis Star editor Leonard ‘Lee’ Canning dies at 87. *Minneapolis Star Tribune*. <http://www.startribune.com/obituary-former-minneapolis-star-editor-leonard-lee-canning/440626193/>]



with characteristics of a good board member?

**WEGMILLER:** A good board member is somebody who brings their expertise and contributes it through the channels of governance. That's the important part. We had a board member who was in marketing at a Fortune 500 corporation and he was superb. Every time he made a comment, he would say, "I know health care is different. However..." and he would explain how he saw the marketing implications of what we were doing. Fantastic! It was great! He did it in the board meeting in a respectful way, recognizing that there was difference. That's what you want from a board member – bring your expertise and apply it in a civil governance-oriented way.

One of the weaknesses of not-for-profit governance is that there is not enough accountability. I've served on 21 public company boards over the course of the last 25 or 30 years. Public company governance is leagues ahead in governance effectiveness because they are accountable to the shareholders, who you know by name. Who's the shareholder of a community not-for-profit board? The community. Well, is that Fred or is it Mabel? We don't know who they are. What are we accountable to them for? Running a good system. Do we have metrics for that? In most cases, the answer to that in not-for-profits is no. We can show them the financial report.

That isn't enough in public company governance. We have to show how effective the governance is. There are organizations who render written opinions to the shareholders about the board saying, "They're doing it right," "They're doing it wrong," and if they're doing it wrong, "We vote for the removal of those board members." Have you ever heard anything like that in a not-for-profit board? No, you haven't. There is significant difference in the public company governance because there's accountability. It's not because the people are any better.

I've learned an immense amount. I've had the blessing to have learned how other companies are run. Most of them are health care companies. Then I could bring this back to our organization – I couldn't pay for that education. Actually, they paid me to educate me so it was terrific.

**GARBER:** I'd like to continue this discussion about governance based on your experience as being the board chair at the American Hospital Association. This was quite a while ago – it looks like 1987.

**WEGMILLER:** Yes, that's when I was chair.

**GARBER:** What was that experience like for you? That's actually a three-year commitment, and longer, of course, if you take into account the board service that you would have had before then.

**WEGMILLER:** It was a fascinating experience. It was beneficial because you learn how diverse the health care system is in America and how each area of diversity has its own strengths and weaknesses. This is not a monolithic system. You learn that firsthand. That's invaluable and you begin to see – "They do it better in Texas when it comes to this than anyplace I've seen before." You take your notes and bring ideas home.

It takes some time but it's a free education on the better ways to do things in health care. It also increased my appreciation of how the American Hospital Association has a difficult job and they

do it well. I have respect for the AHA presidents I've known from Alex McMahon to Rick Pollack<sup>48</sup> and how they bring this diversity together into a unified voice. That's my perspective on it. It's a privilege that, unfortunately, only a few get to enjoy. You spend a lot of time at it but it's well worth it. Hopefully, you bring something to it, too.

**GARBER:** Do you recall what the most significant issues were that the AHA was dealing with in 1987?

**WEGMILLER:** Yes, in 1987, we were beginning to talk about quality – although nobody really wanted to. My investiture address was all about that, as a field, as an industry, as a part of society, we needed to start measuring our quality and putting it forth to the public. That was the beginning of that issue, not the end, because we didn't really do it for years after that. I can remember attending innumerable RPB<sup>49</sup> meetings over the three years and talking about this, particularly during my chair year because you are a little freer to talk about your ideas as part of the association. People said, "Yes, it's important. We'll get to that." Some said, "You know quality when you see it."

That's was the thing that stands out to me as the big issue. We didn't do a very good job on that in 1987, during my tenure. We introduced the topic. You have to introduce the topic to get it on the table and then it takes a while to get it through.

**GARBER:** I'd like to go on to the Scottsdale Institute, which you co-founded, along with Stan Nelson.<sup>50</sup>

**WEGMILLER:** Yes – Stan was another former AHA Chair.

**GARBER:** He was also a graduate of the Minnesota program as well.

**WEGMILLER:** Indeed – the Minnesota Mafia still is in control.

**GARBER:** What is the Scottsdale Institute?

**WEGMILLER:** Stan came to me and said, "These systems that you talk about all the time, and like I ran at Henry Ford, are not systems. We don't have a unified information system. The docs have stuff on clinical. Hospitals have stuff on financial. The information systems don't talk to one another. You and I need to do something about that." I said, "You and I? What are you talking

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<sup>48</sup> J. Alexander McMahon (1921-2008), was president of the American Hospital Association from 1972 to 1986. His oral history: Weeks, L.E. (Ed.) (1987). *John Alexander McMahon in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center; and, Richard J. Pollack has served as president and CEO of the American Hospital Association since 2015. [American Hospital Association names Pollack president, CEO. (2015, June 8). *Trustee*. <https://www.trusteamag.com/articles/894-american-hospital-association-names-pollack-president-ceo>]

<sup>49</sup> Regional advisory boards, later renamed Regional Policy Boards (RPBs) were established by the American Hospital Association in 1968 in each of the nine regions of the country to help foster discussion of issues and to advise AHA staff and board members. [American Hospital Association. *Regional Advisory (now Policy) Boards*. <https://www.aha.org/about/history>]

<sup>50</sup> Stanley R. Nelson (1926-2012), was CEO of Parkview Hospital (Fort Wayne, Ind.), Abbott Northwestern Hospital (Minneapolis) and Henry Ford Hospital (Detroit). His oral history: Weeks, L.E., (Ed.). (1987). *Stanley R. Nelson in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center.

about? I have a job. You're retired." He said, "We're going to start a new organization. We're going to call it the Center for Clinical Informatics. We're going to bring together all of the best minds in IT. I have a guy, Jim Reep,<sup>51</sup> who runs the biggest consulting company, First Consulting Group. They're going to give us staff and we're going to get this done. We're going to bring together the leading systems and we're going to collaborate."

That's what the Scottsdale Institute does. We collaborate among the big systems on issues in information technology for health care. We're about ready to celebrate our 25<sup>th</sup> anniversary.

It was originally an organization centered around CIOs. Now we're getting clinical people – chief medical informatics officers, chief nurse informatics officers, CEOs – all sorts of people interested in "How can IT help us do better clinical work?" Before it was, "How can we do better information work so we can share information about patients and finances and so on?" It's gotten finally to the thing that Stan wanted to call "clinical informatics" – that's what we said was our goal. Nobody could understand, "What's this Center for Clinical?" We decided to drop that and pick a different name. We picked the Scottsdale Institute because we both wintered in Scottsdale.

We have a great staff. It's doing a great job. The organization is doing well. We started another one like that ten years later called C-Suite Resources. Those are the two organizations that I'm running today. Stan told me in 1992, "You're going to be the vice chair, and if anything happens to me, you'll take this over. You have to commit to that." I said, "What? I can't even spell IT." He said, "That's a detail. We'll deal with that later." He was absolutely right, as he was on so many things.

**GARBER:** Let's wrap up. You've mentioned several encore careers so we have some sense of how you've crafted your retirement. How do you think you're doing? I've talked to some people who have confessed that they're doing horribly with retirement. The surprised look that you just gave me indicates that things are going well.

**WEGMILLER:** Yes. I think the reason they go well is you don't retire. The whole concept of "retire" – Stan said it better. You just move from phase to phase to phase. Phase 1 is you build your career. Phase 2 is you manage your career. Phase 3, you go into a different career. Phase 4, you find fun things to do that may have related to your career. You don't ever retire. I am a big fan of that philosophy.

I spend more time doing other things, like being with our grandkids. I don't ever stop being a part of the health care community. I don't see any point to that and I enjoy it. I even think sometimes these post-career things do good. I keep doing them. My wife likes that I don't hang around the house.

**GARBER:** That's a wonderful segue into my favorite question which has to do with how you managed work/life balance over the years.

**WEGMILLER:** I was afraid you'd ask that.

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<sup>51</sup> James A. Reep (1951-1999) founded First Consulting Group and served as CEO and chair of the board. [OBIT/James A. Reep, First Consulting Group, Inc. – FCG – chairman, dies of cancer. (1999, April 19). *Press release*. <https://www.thefreelibrary.com/OBIT%2FJames+A.+Reep%2C+First+Consulting+Group%2C+Inc.+FCG-+Chairman%2C+Dies...-a054403735>]

**GARBER:** That’s the typical response, too, of other successful health care executives – that it’s been challenging. I’d like you to talk not only about work/life balance but also if you would talk some more about Janet’s contribution to your career.

**WEGMILLER:** Janet is the primary reason why I’ve had the opportunity to have a career. She is a supportive, encouraging, critical thinker – without in any way judging a decision that I have made. If I have had success, she’s the reason for it. There are a lot of people that contributed, but she is the only reason for my success. She is the best partner I could have ever found.

**GARBER:** You’re skirting that issue of work/life balance.

**WEGMILLER:** The only reason that there was any balance was because of all of the deficiencies in my life balance, Janet picked up. As she accurately says, “You don’t know because I raised the children when you weren’t here.” Then she laughs. Unfortunately, that’s accurate. I was always mostly physically there but I read a lot. I communicated with people a lot. That takes time. The people who didn’t get that time were the family.

They never say anything about it. We always reminisce about all the great trips we took and the remembrances we have and the times we spent together. I didn’t have a good enough work/life balance that in retrospect wish I had had. Our family is fortunately still whole. We all love one another. We all live in the same community. Our six granddaughters, all grew up as kind of sisters. I guess it wasn’t as bad as I think it might have been.

Back in that time that’s what you were expected to do – devote your time to your career. Fortunately, that has changed in our culture and everybody will be the better for it.

**GARBER:** Is there anyone else that you would like to remember before we finish?

**WEGMILLER:** There are probably thousands but we don’t have time. The health care field provides you enormous opportunities for meeting thousands and thousands of people and they are for the most part devoted to seeing health care get better and do better. I’m not sure that exists in all other sectors. I don’t hear bankers talking that way, “We’re here to make sure that everybody in America gets the best banking they can.” Health care is different, unique and it draws people who have good motivations. If I could rattle off all those thousands of people I would have to thank, we’d be here a long time. It’s been great.

**GARBER:** Thank you very much for your time this morning.

**WEGMILLER:** Thanks, Kim.

## CHRONOLOGY

- |           |  |
|-----------|--|
| 1938      | Born September 25 in Cloquet, Minnesota  |
| 1957      | Married to Janet A. Listerud of Duluth, Minnesota<br>Children: Katherine, Mark, Dean |
| 1958-1960 | St. Luke’s Hospital (Duluth)<br>Orderly  |

1960	University of Minnesota - Duluth Bachelor of Arts in Business and Economics, and Psychology
1962	University of Minnesota Master of Hospital Administration
1961-1965	Fairview Hospitals (Minneapolis) 1961-1962 Administrative Resident 1962-1965 Administrative Assistant
1965-1976	Fairview Southdale Hospital (Edina, Minnesota) 1965-1966 Assistant Administrator 1966-1976 Administrator
1974-1976	Ridges Development Company (Minneapolis) CEO
1976-1987	Health Central, Inc. (Minneapolis) 1976-1978 Senior Vice President 1978-1987 President
1987-1993	Health One Corporation (Minneapolis) President
1993-1999	Management Compensation Group / Health Care (Minneapolis) President / Partner
1999-2002	HealthCare Compensation Strategies (Minneapolis) President / CEO
2002-2011	Clark/Bardes Consulting – Health Care Group (Minneapolis) Chairman

#### **SELECTED MEMBERSHIPS AND AFFILIATIONS**

Advisory Council on Social Security  
Member

American College of Healthcare Executives (formerly American College of Hospital Administrators)  
Fellow  
Life Fellow  
Member, Leadership Advisory Committee

American Hospital Association  
Chairman, Advisory Committee for the Center for Multi-Institutional Arrangements  
Chairman, Board  
Member, Advisory Panel on Multi-Hospital Systems

Member, Board  
Member, Building Codes and Regulations Committee  
Member, Committee on Long Term Care Facilities  
Member, Special Committee on Institutional Health Care Management  
Trustee

American Red Cross  
Member, Board

Associated Hospital Systems  
Governor, Board of Governors

Community Hospital Linen Services, Inc.  
Member, Board

Council of Community Hospitals  
Member, Board  
Member, Budget & Audit Committee

*Frontiers of Health Services Management*  
Member, Editorial Board

*Health Management Quarterly*  
Member, Advisory Board

Health Research & Educational Trust (f.k.a. Hospital Research and Educational Trust)  
Member, Board

Joint Commission on Accreditation of Hospitals  
Member, Planning and Organization Committee  
Vice Chairman of the Policy Advisory Committee

Mayor's Committee on Employment of the Handicapped (Minneapolis)  
Member

Minneapolis School of Anesthesia  
Member, Board

Minneapolis War Memorial Blood Bank  
Member, Board

Minnesota Department of Health  
Member, Committee on Economics

Minnesota Hospital Association  
Member, Certificate of Need Committee  
Member, Committee on Long Term Care  
Member, Conference on Geriatric Care

Member, Finance Committee  
Member, Foundation Funding Committee  
Member, Government Relations Committee  
Member, Planning and Resources Committee

Minnesota League for Nursing  
Member, Steering Committee, Department of Hospital Nursing

National Committee for Quality Health Care  
Member

Normandale Junior College (Bloomington, Minnesota)  
Member, Advisory Committee

Respiratory Disease Association of Hennepin County  
Member, Board

Trustee National Advisory Council on Social Security  
Member

Twin City Hospital Association  
Member, Committee on Community Relations

University of Colorado  
Preceptor, Program in Health Care Administration

University of Minnesota, Independent Study Program for Trustee Education  
Faculty

University of Minnesota, Masters Studies Faculty Committee  
Member

University of Minnesota, Program in Hospital and Health Care Administration  
Clinical Faculty  
Member, Goals & Objectives Committee  
Preceptor

### **AWARDS AND HONORS**

1962 James A Hamilton Achievement Award, University of Minnesota Program in Hospital Administration

1962 Scholarship Award, American Surgical Trades Association

1968 Outstanding Young Men in America, Board of Advisory Editors of the Outstanding Americans Foundation

1969 Outstanding President of the Year, 1968-69, Minnesota Jaycees

1969-1970 *Personalities of the West and Midwest*

1969 Robert S. Hudgens Award [Young Hospital Administrator of the Year], American College of Hospital Administrators

1971 Ten Outstanding Young Men of Minnesota

1972-1989 White House Staff Assistant to Presidents Nixon, Ford and Reagan

1973-1976 *Who's who in the Midwest*

1975 Consultant to U.S. Department of State, Division of Medical Services

1977 *Who's who in health care*

1987 National Healthcare Award, B'nai B'rith International

1988 Distinguished Service Award, Minnesota Hospital Association

2013 Health Care Hall of Fame, *Modern Healthcare*

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