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An Interview With Norm Ledwin: Continuous Change in Healthcare Management

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Managed care continues to enter Maine--a trend that alarms some and is welcomed by others. Norman Ledwin, president and chief executive officer of Eastern Maine Healthcare and Eastern Maine Medical Center (EMH/EMMC), believes managed care has the potential to greatly improve the state's ability to provide high quality, economical healthcare for its citizens.

In a December, 1995 interview with Maine Policy Review Ledwin discussed managed care as well as related healthcare changes underway in Maine.

Maine Policy Review (MPR): Let's start with managed care. Where does the state stand regarding managed care? How does it affect the people who use this hospital?

Norm Ledwin (Ledwin): In Maine managed care is about four percent overall; in Bangor it has about two percent penetration. The attitude in Maine is somewhat provincial concerning managed care--nobody wants it to happen. Unfortunately, state government and Maine businesses are signing benefit plans with managed care companies. We seem to want progress without change. Some people view managed care to be a financing mechanism, but it really is not. It is a methodology for patient care. Many insurance companies around the country have linked managed care with dollars. But I see managed care as management of the milieu of care for a patient depending on their particular condition, physical or mental, regardless of the payment mechanism. Although some of my colleagues in the state are hopeful that it won't come to Maine, I am a proponent of managed care both from a reimbursement point of view as well as general care programs. I support Maine's initiative to bring Medicaid into a capitated program. That may be somewhat of a revolutionary statement and may draw a lot of criticism. But when I talk about that, I am not necessarily suggesting that the system ought to be dictated or managed by insurance companies unilaterally, as they are formatted today. So I am not a proponent of maintaining the Tufts, Harvards, Blue Crosses, and so on. I am also not suggesting that we ought to wipe them off the face of the earth. But, their role will have to be different and possibly focus on adjudication of claims and database management, until a provider-supported network or provider networks can accomplish that same task for less money. Now, from an economic point of view, a question has to be posed in a way that says, "Why do we want to send dollars generated in the state of Maine outside the state of Maine?" And I would very much use the analogy that Governor King used during his campaign, "No fish shall leave Maine with its head on." The question is why should any healthcare dollar generated by consumers in Maine leave Maine. Now that leads to another controversial subject of why outside insurance companies should come to Maine and take 14 to 20 percent of the healthcare dollar out of the state? Should Maine support car salesmen in Boston or in Bangor? So, I look at it as not only a healthcare issue but clearly an economic impact issue. An incentive or mechanism to maximize the retention of these dollars in the state of Maine needs to be developed.

MPR: Why is this view so revolutionary? Do your colleagues around the state see other options to forestall the advent of managed care?

Ledwin: No, there seems to be a belief (figuratively speaking) that the toll gates on I-95 will create a barrier and we will never have to worry about managed care coming to Maine. It's like our kids--maybe if you don't talk about it, it will go away. Well, healthcare reform will not go away because it was not initiated by the healthcare providers, insurance companies, or even by the President and Mrs. Clinton. Healthcare reform was initiated by business and industry. Historically, one of the first movements towards managed care was in Pennsylvania when Alcoa and Air Products decided to initiate a buy-right program and a collection of data on a state-wide basis. That has spread across the country and will eventually come to Maine. One of Maine's immediate needs is to update the 1985 State Health Plan. Until we do, the shotgun approach, which creates duplication and excess, will continue in our state. The acquisition of one of everything whether or not it is needed will not serve us well. We do have some outside penetration with respect to business and industry that will be setting healthcare policy. We have Bowater, Champion, Georgia Pacific, Fleet Bank, and other corporations which are all managed from outside the state. People in our state have to recognize that there is change occurring in other parts of the country, and corporate CEOs outside this state will increasingly dictate what's going to happen to these major corporations in Maine. Whether we like it or not, it will happen. The fundamental economic principle is that if a CEO can save one dollar on the benefit line of his or her corporation, it drops directly to the bottom line. CEOs keep their jobs if they satisfy their stockholders, and they can do that by increasing dividends. When a dollar is taken off the benefit line and drops directly to the bottom line, you now have money to pay stockholders which secures the CEO's job. So there's a fundamental business principle that has generated the movement towards managed care and we should not lose sight of that. The corporatization of medicine is for better or worse sweeping across our country. Stakeholder versus stockholder and public social policy versus private business dilemmas will be facing healthcare professionals every day.

MPR: How do we move proactively in that area? Can one hospital like Eastern Maine Medical Center take the lead?

Ledwin: Yes, and we have, but the message has not been warmly embraced. For example, we were proactive in the state against the Maine Health Care Finance Commission (MHCFC). It isn't that we disagree with a public mechanism. I am very much in favor of a report card on cost and quality in healthcare, just like the paper companies for their clients and just like many other industries. They cannot send a second rate product to *Time*, etc. and expect them to use it, and we can't have low quality and high cost in healthcare and expect business or government to buy it. So, we were not in favor of MHCFC because it was not effectively accomplishing cost control because of its restrictive approach and more importantly, it was hurting business and industry in this state. This was the first state that I have ever been in that the regulatory commission created incentives for hospital administrators to build bricks and mortar and not to modify the delivery system. So, it was a very unique environment because we were not focused on the right medium for taking care of patients. In Maine, we have focused on the number of beds in our systems, the size of the building, etc. as measurements of success for a hospital. Well, a hospital should not be the focal point of care anymore. We need to create an integrated system of care which involves a

lot of participants. A movement to outpatient services, ambulatory settings and other forms of care should be encouraged.

Secondly, I think we ought to move toward the "managing of care" and be compensated appropriately. You can be economically successful in a managed care environment and we should move in that direction. We might be non-profit, but that just means that we're in a different place in the tax code than for-profit organizations. We need that money to regenerate the systems that we have in order to provide the technology and the care to the community. And if we don't have that money, we just won't be able to accomplish our mission. "No margin; no mission." We have the same business principles as any other company. So, I think we ought to move in that direction. Blue Cross, Atna, Tufts, and Harvard wouldn't like to hear this statement, but if you're going to maximize the dollar for healthcare and increase services, then you need to start thinking about sending an increased percentage of the healthcare dollar to the providers.

So under a capitated program, if you take full financial risk, which we are willing to take at Eastern Maine, let us be the healthcare dollar bank. Why should we give it to a third party that's removed from the business that we do? Make us financially accountable and accountable for outcomes. But when you give us the healthcare dollar and you don't strip away a percentage of it for profits or administration that ends up outside the state, we then have the ability to expand services. Now, we must be accountable to the public for that. As an example of this concept take the City of Bangor, with 35,000 people, and if you care for them on a \$2,000 per member per year capitation, that's \$70 million within this community. If an outside insurance company with a 14 to 20 percent overhead and profit administers the program unilaterally, you're going to take \$9, \$10, \$11 million out of this community and out of this state. Under that condition, how do we support the home construction industry, bank tellers, mortgage companies, a new automobile mall or other economic development opportunities within our own community? We need to grow the economy in Bangor and Maine not Boston, New York or Philadelphia.

MPR: How about customer perceptions? According to surveys, some opposition to managed care comes from customers who are frightened of losing their physician-client relationship and also from physicians. What do you think about this?

Ledwin: Change creates fear and anxiety. Human beings don't like change and that's why we need to provide a great deal of education and insist on managed care programs addressing quality as well as cost. We must also consider the four psychological factors in change: ego, autonomy, control, and denial. Ultimate choice and unlimited access will most probably not be available unless we use some of our own disposable income. Nobody, including the president of the United States, has asked the country on a referendum how much money we should spend on healthcare.

MPR: So, do we just need to accept that we cannot have as much healthcare as we might want?

Ledwin: Well, I'm not so sure. If we say, "these are the services that will provide basic coverage," then you have to determine how much of your disposable income to use to augment that. Or, are we going to pay more taxes and have a greater array of choice and benefits? Unlimited benefits will probably not be available without some personal contribution. So, yes,

the concern is access and choice. But this can be done within certain parameters to allow 80 to 90 percent choice in a product.

At Eastern Maine Medical Center, we're the only hospital in the state right now that has a biostatistician on staff. We're the only hospital in the state that does actuarial studies associated with pricing. So we have gone past the traditional accounting mechanisms and cost accounting and gone into research, risk modeling, and discussion of biogenetics, genetic engineering, and genetic mapping. Those kinds of things are very forward thinking, and we need to be moving in that direction. We need to have clinical care pathways, an understanding of our capabilities, and most importantly, an understanding of the population's medical needs.

This goes back to my concern that the state does not have a current health plan. We do not know the incidence of disease per thousand population as of 1995. Maybe we knew it in 1980, but it probably has changed. We know in this region that we have a geometric growth of adolescent diabetes. Now, what do some managed care plans say--you can't do regular routine blood tests or tests on juvenile diabetics because it doesn't fit our model? Well, if we had the money and we were setting the care paths in this part of the state, we would allocate money for routine tests during adolescent development so that in future years we could alleviate heart disease, kidney disease, circulatory disease, and eye disease, which is a dominant problem with diabetics. Another clinical area of concern is soft tissue cancer in pediatric patients. There are other areas that should be studied. That's why I say that we have taken the "shotgun" approach to clinical programs in this state. We buy every widget and gadget that's made whether it is needed or not.

MPR: What about the relationship among institutions? Can there be an Eastern Maine approach to managed care, or does it have to be state-wide? Can the two major hospitals in Maine drive change?

Ledwin: If the two major tertiary institutions drive it, we will hear adverse comments from other hospitals that it's unfair, it's a way of trying to put them out of business, and so on. "The great debate" is how will Maine be postured to deliver care. A current controversy is whether Maine is over bedded. In my view, there is no question that we are over bedded from a licensed bed versus operational bed point of view. Further, we have a lot of capital sunk in bricks and mortar. We have not re-oriented those bricks and mortar to do the jobs that we need to do, we haven't looked at ambulatory/ outpatient care, skilled nursing, respite care, day hospitals, or many other things. One cause of this is the incentive systems created by MHCFC. Since that is now in the past, let's get on with the task of caring for people in this state in the appropriate setting.

We must have a creative dialogue about such fundamental questions as the composition and structure of a hospital. Every community hospital must assess its own mission and structure. A hospital in a community gives that community a certain sense of being. Also, it provides an economic base and jobs. One idea is to get rid of the term "hospital." Abolish it in our vocabulary and replace it with what I would consider to be a medical delivery center. Every community can have a medical delivery center. A physician's office is a medical delivery center and he or she gets licensed every year to do specific things. Eastern Maine is a medical delivery center, Maine Medical Center is a medical delivery center, and so on. Maybe they're licensed differently, but every provider has a common reference and maybe that will reduce the stress and anxiety in the state among communities. Then, the debate centers on the important questions of

what services should be delivered and how they should organize themselves to deliver them? Once we solve that fundamental problem, we won't be comparing ourselves based on the number of beds, etc. Clearly, we don't have too many delivery centers. And that's a very different statement than there are too many beds. And the reason I say it is because geographically we can't afford to have any of these urban or rural physical plants closed. But, what should happen is that these physical plants including Maine Medical and Eastern Maine Medical Centers, should re-orient patient care and the way we use our building.

MPR: You've done a lot to develop affiliations with other hospitals. Say a little bit about that and the rationale for it.

Ledwin: Well, again there's a difference between Don McDowell at Maine Medical Center and me. Don believes that the way to accomplish an integrated delivery system is to have entities merge into Maine Medical Center or Maine Medical Foundation. I disagree. I do not want to manage a hospital in Aroostook County or Washington County and I don't think we can. The geographic distance is too great. I don't want to necessarily have them merge into Eastern Maine Medical Center. The reason is that we cannot provide the strategic planning and set the priorities for a community when we're not in the community. Therefore, it is inappropriate for Eastern Maine to develop a medical delivery systems for geographically distant communities. I think that's a function of the local community and the directors of that community health system.

Therein lies the reason why affiliation arrangements may work best in our region. I am quite aware that some folks don't want to be in an affiliated arrangement with Eastern Maine Medical Center. There is a concern about being overwhelmed and the loss of control and autonomy. Therefore, we are supporting an organization called Healthnet which is a very successful health organization in the state. There isn't another organization that started from scratch where the physicians have raised more than a half a million dollars to put together a new, integrated delivery system. It is truly a jointly owned, jointly governed organization, with a unique representation of business and industry on the board. While this may not be the ultimate model of accountability, we have created a check and balance with business and industry who ultimately pay system the bill for healthcare.

In terms of organizational development, we have also put together another company called Health First, aimed at increasing clinical services to folks who are not as well off as others. We will work very closely with Commissioner Concannon, Commissioner Peet, and the governor on a pilot project to bring managed care to the State of Maine in the Medicaid arena and the uninsured arena by June of 1996. And we are committed to the governor to work with him on data collection and establishment of a capitated rate. We are focused on increasing care to people. Increasing the services means dental, social work, transportation, and mental health. Our institution has a moral and social responsibility to the community and to the region to do what's right. Should we stop doing what is right for the region and the community because some people believe we are too forward thinking or aggressive? I don't think so.

MPR: You have expressed a very community- oriented sense of institutional development. Do the smaller communities think they can survive in this atmosphere and still have their own community medical centers or medical delivery centers?

Ledwin: Some folks believe that business can be conducted as it was in the '60s and '70s and some are anxious about change. My background is somewhat different than my colleagues. I came out of business and industry. So I reflect upon things from that base of reference. Every year an automobile production line is shut down and retooled to produce a new model. It still is a car, still drives, still carries people around. Progress comes with change, we must retool the assembly line for healthcare. We're still going to take care of people, they're still going to get better and have their surgical procedures, and get their medications; but they're going to obtain it in a different way. If we can't accommodate that kind of change I am fearful for this state because it creates a mindset that if you can't change healthcare then you can't change the paper industry, the fishing industry, or the basic economic development approach of Maine. If we are not creative and imaginative we may end up being 50th all the time on the charts and reports as compared to other states.

MPR: It is apparent that the King administration is listening to creative ideas about change. The business and industry community certainly are driving change at some of our institutions. Are we going in the right direction?

Ledwin: Yes. Governor King is a very insightful, creative, and enterprising gentleman, but remember his background and experience. This is his first venture into the political arena so if the political pressure does not alter his approach, I think he'll make great progress in the state. Institutions are also becoming creative. Eastern Maine Medical Center and the University are working together on new programs for the region. Look at the most positive things about Northern and Eastern Maine--a great educational system, both secondary and higher education, a great healthcare system, arts, and the airport. Those are the four cornerstones for economic development. We haven't used them enough to date. We're one sailing day closer to Europe. The airport is always open; Logan is problematic. Why don't we use what we have? Why aren't we in Europe recruiting European companies to have their North American headquarters in Bangor? We can bring industry to Bangor that can build upon our strengths, take advantage of a good work ethic, and capitalize on a forward thinking governor.

MPR: This legislative session has many healthcare issues in front of it. Tell us about this agenda and the policy making trends that will affect Maine.

Ledwin: Well, let's take for example the "Patient Protection Act." While this concept is all right, I have a problem with some elements of that bill, because it adds cost to business and industry with the point of service provision. Every provider that participates must be willing to change. That bill duplicates many existing statutes. It requires insurance entities or providers to set up new mechanisms to do quality and to prove financial stability. We are already doing these things. So, that bill appears to be an attempt to squash the creative ability to deal with healthcare from a clinical delivery point of view and a financing point of view.

MPR: Where did that bill originate?

Ledwin: Maine Medical Society. It also gained the attention of business, the attorney general, and of course insurance companies. The difficulty is that we are Maine not Atlanta, Georgia. To develop the kind of competitive models that the attorney general thinks would be great is virtually impossible in Maine. At the federal level, one of the very disappointing things is the

lack of a budget. The Provider Sponsored Networks, anti-trust reform, tort reform and appropriate financing are in question. So, four major elements are endangered in the budget debate that virtually puts insurance companies in total control of healthcare in this country and eliminates any ability for providers to be creative because we can't move out of the box that Congress put us in. Instead of being supportive now, the American Hospital Association and the state associations are very concerned.

MPR: Isn't this going in the opposite direction from most trends in terms of federal control?

Ledwin: Yes, but it presents a great opportunity in Maine because we are not big, and we don't have some of the encumbrances of other states. My biggest concern is we are on the road to altering what here to fore has been a very good delivery system. It must change but we sit in an enviable position compared to other states. We have good geographic distribution--other than Bangor, Lewiston, and Portland, with regard to hospitals. We have the right mix of specialists and primary caregivers. The question here is whether each region can accomplish vertical and horizontal integration, and use the resources it has. For example, we have six home healthcare agencies in Bangor. Do we need that many agencies which create duplication and ineffective use of healthcare dollars? But when you start talking about merging, each executive director is going to be very concerned. For many years healthcare has been the "full employment act" in the state of Maine. That can't last; We may be able to compensate by re-employing some of those healthcare providers in a different form of healthcare. We must be careful that we don't perpetuate a downward spiral in this state and create more problems than we currently have.

MPR: How about tax-and-match? Is it resolved from your point of view?

Ledwin: Well, we're going to pay \$6.1 million this year off the bottom line to the state to help the governor. We're pleased to be able to help, but it cannot go on forever. The governor is very creative with lots of imagination. We went through the discussion with him on the MHCFC and other items during that budget discussion last year, and we recognized that he had a problem. The responsible thing to do, we felt, was not to create a political war over this, even though some people in this business wanted to go in that direction. That course of action could create a disaster in this state. Last year when the Healthcare Finance Administration determined that the state violated tax-and-match for nursing homes, Maine had to pay back \$7 million to the federal government. If we get into a fight with the state or we go into federal court and the Healthcare Finance Administration comes in, there's a potential we could pay back millions of dollars to the federal government which we can't afford. Also, look at what the state uses this money for. They use it for Augusta mental Health Institute and Bangor Mental Health Institute, and maybe they shouldn't have done that when they started the program up. But it's done, so let's work together on a solution. They have used that money to help take care of the impoverished people in the state. If they don't have it, they're going to have to raise taxes, which would put us way out of line with bordering states. Let's avoid this tunnel vision. We must ask the right question, which is, "What are the implications to this state if we blow this thing up?" So it's going to go away in '98. I don't like to pay \$6.1 million; I don't like to have to find that money in our budget; I don't like not to have full employment in the city of Bangor because I've got to pay \$6 million to the state. In the big picture, I think we would be irresponsible corporate citizens if we didn't participate in this program. In return, we got rid of MHCFC and the governor is looking at ways to put more money into taking care of women and children. So life's a compromise.

MPR: What is your view of the Maine Health Care Reform Commission?

Ledwin: There are a couple of things. First, our healthcare problems won't go away if we just ignore them. When the budget battle began last year, Senator McCormick suggested a bill to require a single payer system. That issue should have been settled right there. Instead a new commission was created. So what did that commission do? It came out with concepts that we already discussed. Now we also have a commission reviewing user fees for the municipalities, which will adversely affect non-profits. What are they going to come out with? The legislature should have dealt with the problem and not used a commission. We spent a lot of money and have had a lot of posturing. So, I think we knew going in that there was never going to be a single payer system in this state. The state can't afford it. Just no way can we afford a single payer system in this state without federal help. So, we wasted a lot of time because the legislature wouldn't take a stand.

MPR: What part of the healthcare system is important that has not been addressed?

Ledwin: Our role with outlying hospitals will be increasingly important and the intellectual dialogue will continue. The *Bangor Daily News* has fostered a debate. I don't believe there should be a great worry that Maine Medical is going to take over the southern part and Eastern Maine is going to take over the northern part of the state. In my view, that is just impossible to accomplish. The geography of this state mandates that services have to be delivered in the neighborhoods and the rural communities of this state. Anybody who is a native of this state knows better than I do that the transportation system and highways would not allow for elimination of the rural hospitals. Does anybody think that we're going to be able to move patients efficiently and rapidly from some of these rural areas into Bangor on a timely basis? So, when people view the two big tertiary centers as taking over, it's virtually an impossible task. Our infrastructure in the state would not allow that. Transportation, communications, and information systems need significant improvement in this state. So, unless you improve those multi-fold, you just can't affect a regional care system from a single hub.

What does that say about what we're trying to do? From the point of view of the Greater Bangor area, our role is to be a primary, secondary, and a tertiary care organization. Outside of the Greater Bangor area, we view our mission also as three-fold, a tertiary provider to the rural areas, a secondary or upper secondary provider to the rural areas, and a provider of support for the primary care mission of the rural delivery system. This is very different than the perception of most people about the two big institutions, but we have demonstrated that time and time again.

MPR: You mentioned communications. How close are we to having Eastern Maine more of a telemedicine center?

Ledwin: We will have telemedicine in Acadia, Eastern Maine, Presque Isle, and Blue Hill soon. Sebecook will also join us. We are meeting with hospitals to develop a single computer system an electronic medical record and a physician's electronic medical record in their offices--shared costs, shared governance, and an electronic medical network.

MPR: Is that primary medicine support or does that get into secondary and tertiary?

Ledwin: No, secondary and tertiary. We will have twelve channels, real time and the resolution is good enough that dermatologists will be able to diagnose skin disorders up in Presque Isle from Eastern Maine. This provides support to the primary care doctors so they don't have to send a patient all the way to Bangor. That will benefit everyone. And, since some of these institutions are attempting to reduce costs for financial stability, yet provide services close to home, this should help.

MPR: Will Eastern Maine Medical Center continue to work cooperatively with other hospitals in the region, especially as out-of-state companies increase their role in the region?

Ledwin: Yes. A good example of support is with the Quorum-managed hospital in Millinocket. If Eastern Maine did not follow its philosophy, we could easily put doctors in Millinocket and move those patients to Eastern Maine. But we have not done that and will not. We have worked with Millinocket, supported their pharmacy, their dietary service at cost, and their joint commission reviews and state reviews to help keep them successful. We are working with Millinocket Regional Hospital and Bowater to keep the primary care business in Millinocket. The labor contract at Bowater says that any of those workers can come to Bangor for healthcare, be paid a full day's pay and expenses. We have gone to work with Bowater and Millinocket to keep those patients in Millinocket; therefore Millinocket Hospital stays open. Now, how Millinocket hospital and that board organizes themselves to care for those people in Millinocket and East Millinocket is clearly up to them. I am concerned about allegations that Eastern Maine is trying to take over northern and eastern Maine. People will eventually recognize that things are a little different than they perceive. Of course, perception is reality as we know.



Norman Ledwin, who joined EMH/EMMC in 1993, has more than 20 year's experience in healthcare administration. He has long been an advocate of healthcare reform and has experience negotiating the kinds of collaborative service agreements and systems now being developed in Maine. Prior to his work in healthcare, Mr. Ledwin held leadership positions in industry and was a decorated commissioned officer in the U.S. Army.

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