



GORDON M. SPRENGER
In First Person: An Oral History

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GORDON M. SPRENGER

In First Person: An Oral History

**Interviewed by Kim M. Garber
On July 18, 2019**

Edited by Kim M. Garber

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EDITED TRANSCRIPT
Interviewed in Chicago, Illinois

KIM GARBER: Today is Thursday, July 18, 2019. My name is Kim Garber and I will be interviewing Gordon Sprenger, who served for nearly his entire career in leadership in Minneapolis, first with Northwestern Hospital, and then with the organizations that followed the legacy Northwestern Hospital. These included the merged Abbott Northwestern Hospital and the health systems LifeSpan, HealthSpan Health Systems Corporation and Allina Health. Gordon, it is great to have an opportunity to speak with you today.

GORDON SPRENGER: I'm delighted to be here – looking forward to it.

GARBER: We always like to start these interviews chronologically and talk about your early years. You were born in 1937 in Conger, Minnesota, which is about two hours south of the Twin Cities in Freeborn County, near the Iowa border. How did your family come to live in Freeborn County?

SPRENGER: Conger was a farming community of 165 and I think today there are 164. My grandparents, who were farmers in Germany, came to Conger. In this town of many German immigrants, everybody was related to everybody else. My uncles and aunts and my parents were all involved in small businesses which served the farming community around Conger. My father was a bulk oil distributor, distributing heating oil and tractor fuel oil.

GARBER: Your parents were married in 1928 and had three children during the Great Depression. How did your parents cope with those difficult years and how did that experience shape your family's values?

SPRENGER: They were very patriotic, as the whole community was, particularly during the war. We used to go through drills in our community. I always would laugh about it because I said, "Who would want to bomb Conger, Minnesota?" Being a farming community during the Depression, everyone lived off the food of the land and meat on the farms.

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

SPRENGER: I certainly did. My grandfather on my father's side, I did not know as well. He died when I was very young. But the other three, I did get to know well.

GARBER: Do you have a sense that you learned any of your values from your grandparents?

SPRENGER: I learned hard work and integrity. They had a strong faith. The Lutheran Church was the center of attention within our community. My grandmother ran the grocery store. My grandfather ran the creamery. I had uncles that had the lumber yard, I had uncles that had the bank and I had a cousin that had the hardware store. I learned a tremendous amount of what it meant to take care of each other.

GARBER: It amazes me that all those businesses could have been supported in a town of 165 people. There must have been a large rural population.

SPRENGER: Yes, a large rural population and the businesses were very small. The closest

location of a community where you could go to purchase significant services or goods was Albert Lea, Minnesota, which was twelve miles away. In those days, that was considered a long distance.

GARBER: It would take a while to get there.

SPRENGER: Thirty to forty minutes, yes.

GARBER: Albert Lea is the county seat. I read that your brother attended a one-room school. Did you also?

SPRENGER: I certainly did.

GARBER: For which grades?

SPRENGER: One through eight.

GARBER: How many kids were in the one-room school at any given time?

SPRENGER: About twenty in the total school, three in my class.

GARBER: In a one-room school with so few students did you find that you all bonded together?

SPRENGER: We naturally bonded. In this small community, we didn't have cars as young people that we could go elsewhere for our activities or our fun. About 90 percent of the students that were in school were my cousins. I saw them after school. Any activity that we wanted to have after school, we had to develop ourselves.

As I listen to my grandchildren talk about taking accelerated courses in school – I definitely was taking accelerated courses, too, because the schoolteacher would take the three in my class for maybe 20 minutes or 30 minutes, while the rest were to do their homework. It was all in one room, so everybody could hear everything. When she'd finish with us, my goal was to listen to the lessons two or three grades ahead and try to do their work. I always felt like I was pushing myself to learn at a level beyond the grade that I was in.

GARBER: Do you know when the school closed?

SPRENGER: It closed in the '60s.

GARBER: You went to Albert Lea for high school. Did you participate in sports?

SPRENGER: No, I didn't for a couple of reasons. One was the difficulty of getting home if I stayed for practice after school. But secondly, I broke my leg when I was in early high school, which then led me more into student government. I was involved in debate and speech programs, in theater, in music. Those were held during the school hours.

GARBER: How did you break your leg?

SPRENGER: When you play volleyball or softball in farm fields, they aren't beautiful level

lawns. When I was playing, my foot went into a hole in the ground, and that's how I broke my bone.

GARBER: Were you good at debate?

SPRENGER: I was told that I was good at debate. My debate teacher was proud of our team. We had our fair share of winning debates. The discipline and the process of debate and how you needed to present your case was helpful to me as I proceeded through my education and into my career.

GARBER: Did you have a sense while you were in high school that you knew what you wanted to do?

SPRENGER: Didn't have a clue. My world was very small. My knowledge of occupations was limited to small businesses and the farmers around Conger. I knew I wanted to be in business. I knew I didn't want to be a farmer. I knew more what I didn't want to do than what I wanted to do. My goal was to get whatever education that I needed in order to potentially become a small town businessperson.

GARBER: That education probably would have been just a high school diploma. But you went on.

SPRENGER: That's right.

GARBER: What was the impetus to go on and end up at St. Olaf for your undergrad?

SPRENGER: My parents only went through the eighth grade, and that was true of most of the older adults within my community. They didn't go on to high school. My parents felt very strongly about education. There was no question as I was going through high school that I was going to go on to college. They wanted me to have something that they didn't have. They wanted me to succeed in a way that they weren't able to succeed because of their lack of education.

GARBER: Your parents were very supportive of your educational desires. But why St. Olaf?

SPRENGER: Again, my world was small. I knew nothing about universities except the University of Minnesota, because I would listen to their football games on the radio. Beyond that, I didn't really know the opportunities that were out there in terms of colleges and universities. We didn't have counselors and advisors in high school in those days. I asked one of my closest friends, Phil Knudsen, where he was going to college. He said, "St. Olaf." I said, "That sounds reasonable." It was about a two-hour drive from Conger to Northfield, Minnesota. I applied, got accepted, never considered any other school. Most of that was just lack of knowledge.

GARBER: It worked out beautifully for you.

SPRENGER: Absolutely.

GARBER: You met your future wife there.

SPRENGER: That's right.

GARBER: Many years later, you and your wife established a scholarship at St. Olaf. Could you tell me about that? What is the Gordon and Dolores Sprenger Endowed Scholarship?

SPRENGER: That came about because they invited me to become a member of the board in the '80s. My three children also went to St. Olaf, and two of them met their spouses at St. Olaf. I was on the board at the time that they were going through college, so I was able to observe what college life was like when my children were going through. I chaired a capital campaign. One of the major purposes of the campaign was for scholarships.

Both my wife, because she was a nurse, and I, because of my career, understood the value of nurses. We understood that nurses were going to become more and more valuable as health care was continually evolving and changing. This was an opportunity for us to develop this scholarship. I also wanted to recognize my wife. She was a very important part of my career, and this was an opportunity to do something that was important to her.

Every year, we are invited back for Honors Day to meet the student. Many of them have shared how much this support has meant – that it allowed them to go on into nursing, which they wouldn't have been able to do without it. It has been gratifying to us.

That is one of the nursing scholarships that we have. Later, at Abbott Northwestern, we also established a scholarship for nurses who want to get advanced degrees or develop training in specialty areas. That was important to us – that nurses be allowed to emerge as leaders, as an important profession within the hospital to be represented at the table where decisions are made. In order to do that, they need to have the knowledge, they need to have the leadership skills.

My wife also felt strongly that, when you're taking care of a patient, take care of the whole patient. When I entered the field, most nurses were diploma nurses and two-year degree nurses. As technology came along and nurses were invited into leadership positions, they needed to understand not only the health issues of a patient, but also what that person was going through in their life. A liberal arts education like St. Olaf College provided these skills. They could learn sociology, psychology, many of the disciplines that went beyond the clinical skills that they needed. That was important to us.

GARBER: You just touched on the explanation of why the hospital diploma schools of nursing went away in favor of a different educational model for nursing.

SPRENGER: We had wonderful nurses who came from the diploma school. I don't know that the institution could have survived without those nurses because they spent a lot of time in clinical training. They were on the patient floors and they were assisting with patient care. When we had snowstorms, or other disasters, it was those nurses who were living on campus, who would help take care of patients in the hospital. They would help support the full-time nurses who were at the institution. This was not just during times of disaster. Many times, we'd hire them for a shift. That helped them with some of their expenses, particularly as they got into their second year of the diploma program. They were a great resource for employment. The four-year nurses were not right on campus, they were not spending all their time in clinical experience like the diploma nurses were.

GARBER: The diploma nursing students were actually living in a –

SPRENGER: Dormitory.

GARBER: – dormitory on the hospital campus. They were right there. But the fact that nursing students needed more education, ultimately closed the diploma schools.

SPRENGER: That’s correct. In fact today, Abbott Northwestern does not hire any nurses that are not four year degree nurses.

GARBER: I’ve got to imagine that’s true of many institutions.

SPRENGER: I think it is.

GARBER: At St. Olaf, why did you choose economics as your major?

SPRENGER: In a liberal arts college, it was the closest thing to a business major that I could find. I had a double major in sociology. That was an important piece of my education, as I looked for a career. Over the holiday time as a senior, I started my interview process with major corporations, because I had expanded beyond the idea of being a small businessperson. I hoped to attain a position within a major corporation. I interviewed with General Mills, major oil companies, Firestone, etc. I remember thinking, “There’s got to be something more than this.”

My advisor, Dr. Solgee, was head of the sociology department. I went to him and poured out my soul. He said, “Let me look at your paperwork here.” When you started college, you took a test, and they would try to determine what you would be good at. He said, “I would say you should either go into the ministry or be a social worker.” I said, “I know I have a passion for wanting to work with people and help people.”

He said, “Have you ever considered health care administration?” That was the first time that I had ever heard those words. I said, “What is it?” He said, “I think you ought to visit with Carl Platou.¹ Carl was CEO at Fairview Hospital in Minneapolis.

I sat down with Carl. Carl said, “What do you know about a hospital?” I said, “Nothing.” He said, “My best advice is that I’ll hire you as an orderly, because that’s going to put you at the front line. You’re going to be working with nurses, patients, physicians – all of the personnel within a hospital. You’re going to see it from the ground up. If you decide that you enjoyed that and that was something that you really wanted to be a part of, I would suggest you go into health care administration. But I would certainly take the time to really understand what goes on in a hospital.” This was the greatest advice that I got. I have given that advice to many young people.

GARBER: I’ve heard from other leaders that they had experience as an orderly and that it was invaluable. I also noted your comment about your double major in sociology, and was remembering back to another leader who mentioned that he regretted not having taken sociology courses. I’d also like to note that it’s stunning that one conversation with Dr. –

¹ 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 Star Tribune*. <http://www.startribune.com/local/155858835.html>]

SPRENGER: Solgee.

GARBER: One conversation focused and guided you. That's amazing, the power of one informed conversation.

SPRENGER: That's right. When my grandchildren – and I have thirteen of them – talk to me about my college experience, they just shake their heads. They can't believe that I did not know my opportunities before I went to college. Also, my children and grandchildren all have or had at least one professor that they were close to. That is my advice – find at least one professor who can be a mentor.

GARBER: Let's go on to grad school. Did you go right from undergrad to graduate school, or was there time between?

SPRENGER: No, there wasn't. I went to the University of Minnesota, which had its master's program in health management, directed by James Hamilton.² It was a field that was new at that time. The program was about five or six years old when I was interested in going on to graduate school. I remember my interview with Professor Hamilton, in which he said, "A young whippersnapper like you, who doesn't know anything about hospitals? Why should I take the risk of bringing you into my graduate program? Our focus is when you go through this program, you're going to be a hospital administrator within a few years." There weren't that many hospital administrators at that time who were trained. He was able to carry out that statement because the graduates were very much desired. Boards of trustees in hospitals wanted people who were trained.

He said, "I've never taken someone right out of an undergraduate school before. I think I have good reasons why I don't. What will you do if you don't get accepted?" I said, "I'll get a job in a hospital and I'll apply next year."

In April, I got a letter saying that I had been accepted. The first day of class, I thought I was really dressed up for grad school with a nice shirt and white bucks. Professor Hamilton's secretary saw me and said, "I just gave my last tie away to one of the foreign students." For some reason, I hadn't gotten the message that Professor Hamilton expected you to dress like you were a hospital administrator from the first day that you entered the classroom. Of course, I ended up in the front row. He never mentioned me by name, but it was clear who he was talking about when he said, "I want to make it clear that from this day forward, you will behave, and you will dress as a hospital administrator." At noon, I ran back to the dormitory and put on my one sport coat and white shirt and tie. I never made that mistake again.

GARBER: The other professors adhered to the same standard?

SPRENGER: Absolutely.

² 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.

GARBER: He was the program director, so they would.

SPRENGER: Oh, absolutely, yes. Part of that was the discipline, too.

GARBER: They were socializing you for your chosen profession, in every way.

SPRENGER: That's right.

GARBER: We've had many stories about Professor Hamilton from others in this interview series. How did you feel about his teaching style?

SPRENGER: I appreciated his teaching style. He also ran a consulting service, and the faculty of the program were his associates. They would bring real case studies to the classroom. He had confidence that we would keep information confidential. We heard all the details about situations that they faced when they would consult with hospitals. They consulted on physical facilities planning and also on management issues, particularly on how you work with boards of directors, how you work with a professional staff.

You've probably heard about the Minnesota model of case studies and the fourteen steps, which were a part of his discipline of how you approached issues. I would break that down into three steps, rather than going through fourteen. He had a famous saying – "Never assume." Never assume you know all the answers. Never assume you know all the information. You look at the problem or the situation. You break it apart. You involve the stakeholders. You put the problem back together with this new knowledge, and then you would make a recommendation or take action. By the time we got through graduate school, it had become a natural process for us. I didn't say, "Well, now I'm at Step 3," or "I'm at Step 6." It was a process. Those fourteen steps provided discipline so that we didn't just rush to conclusion.

GARBER: I understand that Minnesota has a strong alumni network, sometimes known fondly as the Minnesota Mafia.

SPRENGER: You're right.

GARBER: Could you talk about the value of networking throughout your career?

SPRENGER: Networking with the University of Minnesota alumni was very important to my career. It gave me many opportunities. The allegiance that everyone had back to the university lead us to hiring University of Minnesota associates as we took positions of leadership.

Jumping ahead a little bit to Northwestern Hospital, which was the second hospital that I worked in – Stan Nelson was the administrator.³ Stan was a great believer in developing networks and I saw the value of that. He would take me along as he would meet with colleagues from around the country. You've maybe heard the initials "HRDI" – Hospital Research and Development Institute – in which we counseled companies which were making products for the health care industry. They

³ 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.

wanted our advice as to what we needed? What was lacking? What wasn't working? An important part of that was interacting with people from different parts of the country.

Minnesota was a unique state with early HMOs and managed care. I was called many times to speak to or meet with colleagues in other parts of the country on this subject. I never apologized for taking a great idea from one of those meetings and implementing it back at my own institution. We would bring our successes. We'd bring our failures. It was a marvelous way of learning, but also of expanding my own knowledge about different ways that I could deliver health care in my community that had been found to be successful in other places.

GARBER: Part of the Minnesota training was an administrative residency. Yours was in Milwaukee at St. Luke's Hospital.

SPRENGER: Yes.

GARBER: What kind of work did you do there?

SPRENGER: First of all, I was a resident there. Then I needed to go into the military. Mr. Knisely,⁴ who was the administrator of St. Luke's Hospital, didn't forget me while I was in the military. He felt that I fit the culture and he needed a junior administrative person on his staff. He was one of the most important mentors that I had in my career. He was totally transparent. He developed the culture, particularly for the administrative resident. They all came from the University of Minnesota. He knew Mr. Hamilton very well. As an example, I was invited to every board meeting, every medical staff meeting, every executive committee meeting, one-on-one with leadership of the board. I had a fabulous exposure to what was going on within the hospital.

Board meetings were in the evening. After the board meeting – this would be 9:30, 10:00 at night – he would invite me into his office, put his feet up on the desk and he'd say, "All right, tell me what we did wrong tonight. Tell me what you would have done differently. Ask me any question you want to ask me. Why did I approach this issue this way? Why did I approach this board member this way? How would you have done it?" That kind of experience, you can't buy.

Going back to St. Luke's after my military service was like going back home because I had been exposed to everything within the institution. It was a specialty hospital that was developing their cardiovascular capability early, and it was adding facilities as the programs continued to expand. One of the major areas of my responsibility in coming back was to supervise the building of the physical facilities that were necessary for the expansion of the specialty programs.

GARBER: Let's add some details to explain where we are in time. You talked about your administrative residency at St. Luke's, going away for military service and then coming back. We're talking now about the early '60s. Were you drafted?

SPRENGER: Yes. I had a deferment to finish my graduate program in health care administration. I graduated in June 1961. In August, I reported to the Air Force for a minimum of a

⁴ Merton E. Knisely (1914-1989) served for 33 years in leadership at St. Luke's Medical Center (Milwaukee) until his retirement in 1976. [Aurora St. Luke's Medical Center. (2015, May). *History of St. Luke's Medical Center*. https://digitalrepository.aurorahealthcare.org/cgi/viewcontent.cgi?article=1001&context=aslmc_books]

three-year commitment.

GARBER: Where did you do your basic training?

SPRENGER: In Mobile, Alabama.

GARBER: This was during the Vietnam War, however, you did not go overseas. You got a very interesting assignment at an Air Force Hospital in the Bay Area in California.

SPRENGER: That's correct.

GARBER: That base doesn't exist anymore, does it?

SPRENGER: No, it doesn't. There has been consolidation of bases and military hospitals.

GARBER: This was an exciting time in your life – you had completed your master's degree, just gotten married, and had an assignment to a military hospital in the Bay Area. It's interesting that there was a different leader at that hospital each year you were there. Why was that?

SPRENGER: Many of these were senior officers. They were planning to retire, and were given the opportunity to choose their last base. Many wanted to be assigned in a location that they planned to retire in. We had senior officers who were there for short periods as they would finish out their military career. It was not because of any lack of performance.

It frankly was a benefit to me. The commander of the hospital looked at my resume and saw that I had gone through graduate school and through a residency in hospital management. He said, "I suppose you want to run the hospital." I said, "Sir, I am certainly looking forward to being a part of your team and doing as much as I can to provide good health care for the military personnel and the retirees, and for the families of the military."

While the commander was interested in the mission of the air defense command hospital, he wasn't that interested in the details of running the hospital. He sort of made me the COO. I met with some of the hospital personnel and found out what the issues were. We had a number of professional people who had many years of education. Like me, they had been deferred from the draft but now needed to be part of the military. Many were physicians who really didn't want to be there and wanted to get on with their lives. They had already spent many years in education, were in debt, had young families.

But we developed a collaborative spirit and worked together, even though it was highly regulated. The bureaucracy was deep. The military is driven by discipline of regulation. For a lot of the long-term military people, it was like the book that told you what to do and how to do it. I looked for things that I and other professionals felt we could do to enhance what we were doing. I was told numerous times, "Lieutenant, you're going to be court-martialed. It doesn't say you can do this." I said, "Show me where it says we can't do it." Their focus was, you do what you're told; that you can do. If it wasn't spelled out, you didn't do it.

I had a wonderful opportunity to be innovative and creative. Did the colonel call me down to his office several times when he found out certain things we were doing? Yes, he did, and gave me a lecture. I went back and continued to do what I felt was best for the institution and its patients.

The base had an air defense command mission. Our job was to have fighter planes that were ready to take off at a moment's notice. Running a hospital or a major clinic many times came in conflict with how the rest of the base would operate. They would need to do drills at 2:00 AM because when you send fighter planes in the air for the drill, you need to do it at a time when the commercial airlines aren't as numerous. However, starting at 7:00 AM, we had a full clinic and, even when these drills would occur, everyone had to report for duty. It was hard for people to report for drills from 2:00 to 5:00 AM and then be ready to come back at 7:00 AM and see a full day of clinic.

I made a deal with some of our professionals. We would bring a couple of professionals in during drills, because we all lived there on the base. I said, "We want you here in five minutes if I need you. I'll report that we are ready if we are needed." Those were the kinds of ideas that were very practical – and the commander knew it. He developed trust that if we were needed, we would be there.

Obviously, we had the inpatient side of the hospital always staffed 24 hours. I'm speaking of a very large outpatient clinic.

GARBER: How did a military hospital in the '60s differ from a typical community hospital?

SPRENGER: It was hierarchical. The military hospitals were directed by the book, "This is how you do it." They didn't allow for a lot of innovation, particularly on the administrative side. On the professional side, physicians were allowed to practice medicine as they felt was in the best interest of their patients.

Military hospitals had a level of care that they could provide at their base, and if specialty care was needed, family members would be referred to a local community hospital that had capabilities that they didn't have. A military person was put on an airplane and flown to wherever the burn center, or other specialty center, was. The military was very good in terms of centralizing highly specialized care.

GARBER: It sounds like a variation on a hub-and-spokes kind of model.

SPRENGER: Yes – well stated.

GARBER: Is there anything else you'd like to say about your Air Force years?

SPRENGER: No, I don't think so. I had three fabulous years of training, much of it self-taught. We didn't have a large management staff. I was it and we had a few department heads. I would get calls from department heads saying, "You know, we've got a problem here, and such-and-such is happening. What should I do?" I said, "Do what you think you should do." I learned the art of delegation, because I couldn't possibly be involved in everything that went on within the institution.

The official name of the role that I had was "registrar," which was a unique title in the military.

GARBER: It occurred to me there is probably something that's different with military hospitals. There would be no board, right?

SPRENGER: Absolutely. But when you say no board, you have a very strong commander.

GARBER: After you received your discharge from the Air Force, you went back, as you mentioned before, to St. Luke's, where you spent three or four years in the late '60s. Is there anything else that you'd like to say about your years at St. Luke's in Milwaukee, or shall we move back to Minneapolis?

SPRENGER: It's again an example of the Minnesota Mafia and how it worked. Jim Hamilton and his associates did some consulting at St. Luke's, and when Stan Nelson needed to replace Scott Parker⁵ at Northwestern, he asked Jim Hamilton and Jim Hamilton's son-in-law, who was a classmate of mine...

GARBER: John Sweetland?⁶

SPRENGER: ...Yes. They said, "We think you ought to call Gordon Sprenger at St. Luke's."

They called. My first response was, I'm right in the middle of this building program, and I was not yet finished. I believed and was taught – you finish what you start. Stan said, "Let me tell you something, Gordon. If you weren't in the middle of something, I would have no interest in you." I reflected on that, and I thought, "Touché. You're right."

Stan only had one associate. There were three at St. Luke's. I would have more responsibility. Equally important was that my wife and I had grown up around our grandparents. We had young children now, and being able to go back to Minneapolis, close to where their grandparents were, was important to us.

GARBER: You returned to Minnesota by taking a job with Stan Nelson at the Northwestern Hospital. What was the Northwestern Hospital like in the '60s when you arrived? I believe it was a freestanding hospital, unaffiliated.

SPRENGER: It was an interesting hospital, particularly from a governance point of view. It was started in the late 1800s by a wealthy lady in the community as a hospital for women and children. The board was all women. When I arrived in 1967, it was still a board of all women, except they had an advisory men's board.

I'll never forget going to my first board meeting. The women were sitting around the board table and many of the men's advisory group were their husbands. They were seated not at the table; they were seated around the room. That lasted about a year, until one of the advisory board members, whose wife was chair of the board, said, "If you want us there, bring us to the table. We don't have to vote, but at least let us be part of the discussion."

The long history of an all-women board affected the kind of institution that it was. We talked earlier about the diploma schools of nursing. The board members really took an interest in those

⁵ Scott S. Parker was the founding president of Intermountain Healthcare in Salt Lake City where he served for 23 years. His 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]

⁶ John Sweetland (1927-2007), began his consulting career with James A. Hamilton Associates in 1959 and ultimately became president of the firm. [*John Sweetland obituary*. <http://findagrave.com/cgi-bin/fg.cgi?page=gr&GSln=sweetland&GSfn=john&GSby=1927&GSbyrel=in&GSdyrel=all&GSob=n&GRid=22459047&df=all&>]

young girls – they would bring them to their homes. They'd have parties for them. They would try to teach them social graces. They would stop by the dietary department and test the food. They maybe didn't know everything about the finances, or everything about the clinical care that was being given, but their interest and their commitment to that institution and quality patient care was phenomenal.

At the time that the discussions began between Northwestern and Abbott, Abbot's board was all men. It was also founded in the late 1800s by a single congregation, Westminster Presbyterian Church, in Minneapolis. Westminster built this hospital for Dr. Abbott, a member of their church, who was a pediatrician. Until Medicare, the church board of elders' agenda would include one line item – "Abbott Hospital." Their report usually was, "Everything's fine." As Medicare came into play, and things became much more complicated, they broke the hospital off as a subsidiary with a separate board. It was the all-men board, and all-women board that came together in these discussions.

GARBER: The discussions that you're referring to ultimately led to the merger of Abbott and Northwestern hospitals.

SPRENGER: That's correct.

GARBER: Stan Nelson, who was then president of Northwestern Hospital, proposed merger to the president of Abbott Hospital, Robert Millar,⁷ who liked the idea. Then they talked to their boards. Is that a common way for affiliation negotiations to go?

SPRENGER: It's natural that two leaders would start by having a conversation. You need to involve others quickly if it's going to move ahead. You start with your board, but physicians are key. If you're going to merge institutions, it isn't going to work if the professional staff, particularly the physicians, are not supportive of the merger.

Northwestern had a history of physicians who had enjoyed teaching but were also involved in clinical practice and applied research. Abbott Hospital was more a primary care institution. As we looked at bringing the two together, many of the physicians were on both staffs. The board members knew each other well. They were socially connected in the community. The male board members at Abbott had respect for what the female board members had done at Northwestern. Bringing the boards together was not difficult. The ultimate Abbott Northwestern board was diverse and early in including men and women.

GARBER: That must have been a unique situation in the U.S.

SPRENGER: It was and Abbott Hospital was the only institution in the country that was owned by a single congregation.

GARBER: That congregation must have been pretty big.

⁷ Robert C. Millar (1915-2001) became administrator of Abbott Hospital, Minneapolis, in 1961. He later became president of Abbott Northwestern Hospital. [American College of Hospital Administrators. (1970). *1970 Directory*. Chicago: ACHA; and, Personally speaking. (1971, February). *Hospital Topics*, 49(2).

SPRENGER: It was.

GARBER: And wealthy.

SPRENGER: Westminster Presbyterian Church was one of the larger congregations within Minneapolis. Many of the wealthier people, many of the business leaders and their families were members of that congregation.

GARBER: I've heard that before from others who have been part of this series – that there was an expectation that if you were serving on a hospital board, you had to be willing to put your hand in your pocket and support the institution financially.

SPRENGER: That's correct, depending on the resources available to the board members. Diversity of boards required they come from many different backgrounds. The ability to make contributions of money was only one of many considerations.

There was a growing belief that to be a superb specialty institution, you needed to have, obviously, excellent professionals on the staff of the hospital. You also needed to have questioning students around who would challenge them and would bring some of the latest thinking into the institution. They made the decision that they were going to start a residency program at Northwestern.

I went with this wonderful woman, the chair of the Northwestern board, to the CEO of one of our major banks, who she knew well, and who happened to have been on the board at Abbott as well. She walked into his office, made her case, and said, "I'm going to give you the opportunity of a lifetime. This is something I feel passionate about. I feel passionate about the hospital. I feel passionate about what we need to do to continue to develop this institution. I want to give you an opportunity to be a part of it."

He was sitting there smoking a cigar. He said, "How much do you want?" She requested a significant amount. He gulped and said, "Well, Ginny, that's a lot of money. We will carefully think about it, and I'll get back to you." She said, "How about if Gordon and I go into your waiting room and when you have decided, you can call us back in and let us know?"

He couldn't turn her down. In about a half hour, we got called back into his office. He gave us the amount she asked for. She knew how to make the ask, but more importantly, she knew how to make the sale. That was one of those "Aha!" moments for me, being an inexperienced fundraiser, and just coming to an institution that was going to need to raise money continually.

GARBER: Who are we talking about?

SPRENGER: We're talking about Mrs. Virginia Piper.⁸

GARBER: On the subject of competition, you had mentioned that military hospitals don't compete with each other. It would have been different when you got to Minneapolis. Do you have

⁸ Virginia Lewis Piper (1922-1988) served as board chair at Northwestern Hospital (Minneapolis) from 1964-1969. Swanson, W. (2014). *Stolen from the garden: The kidnapping of Virginia Piper*. St. Paul: Minnesota Historical Society Press.

reflections about the value of competition among health care providers?

SPRENGER: Senator David Durenberger, regarded as “Senator Health Care” in Washington DC, was from Minnesota. He was a proponent of the belief that what we needed to control costs was more competition. The business community believed that. The government believed that. In order to contain costs, they needed geographically-spread systems of care that included hospitals and doctors that could contract with purchasers and would have accountability for the population that they were contracting for. The competition was between the systems of care as to who could get these contracts.

GARBER: This sounds like the modern idea of population health but you’re talking some time ago, yes?

SPRENGER: Yes, I am. It was the beginning of it. Competition in Minnesota was caused by the creation of health maintenance organizations. Interestingly, physicians took a leadership role in this development. We had a group health plan that went back many years and that had employed physicians who took care of the miners in the iron ore fields in northern Minnesota. There was another not-for-profit group called Group Health in Minneapolis, which was a group of paid staff physicians. They were not fee-for-service physicians. A third one, Park Nicollet Clinic, was a force in promoting group practice. They all were large clinics. We also had many independent doctors and about 25 independent hospitals in the community.

Young people ask me today, “What is the most important thing that you do when you’re in a leadership role within health care?” My answer is, “It’s the art of anticipation.” It’s being strategic. It’s being able to see over the mountain and know what’s possibly coming and be prepared for it. Now, it may not come, but if it does come, you’ve prepared for it.

As we saw buyers’ coalitions coming together, institutions gradually starting to bring their interests together, it became clear that we were not going to have 25 individual contracts with these big purchasers of care. There was going to have to be consolidation. That’s what got us started. I have to believe that it was in Stan Nelson’s mind, too, with Abbott and Northwestern. Today, consolidations have resulted in basically four major systems in Minneapolis and St. Paul.

GARBER: You mentioned that you consider that a leader should anticipate and prepare for the future. How? Do you engage strategic planning consultants? Do you travel around and talk to your colleagues? What’s the mechanism that gets you the vision?

SPRENGER: All of that. You travel around. You listen to your colleagues. I read a lot. I found myself in leadership positions where I was able to have dialogue with business leaders and government leaders. I became aware of where they were coming from and how frustrated they were in dealing with us as a health care system. We really didn’t have a health care system. We were fragmented as a system. They didn’t have one source to get care for the people that they were trying to provide for.

The art of anticipation is as much an attitude, a risk-taker, someone who applies Professor Hamilton’s fourteen steps. We haven’t solved all the problems in health care, obviously. The systems that have come together are in a much stronger position today to be able to address the issues than as separate, smaller boutiques.

GARBER: As you were talking about the art of anticipation and being a risk-taker, I was thinking about the buzzword today – disruptor – someone who is able to be a disruptor and the value of that, and failing fast and all that. Did you ever view yourself as a disruptor?

SPRENGER: It depends upon how you describe being a disruptor. I felt if I saw things that should change and I could get the support needed in order to make that change. We were definitely willing to take risk. It was going to take innovative, creative solutions in order to make the delivery system of health care more efficient. That was not going to be done by just letting it gradually happen.

Others around us were starting to shape how health care was going to be delivered – the HMOs, for instance. Medicare was starting to shape it. I felt strongly that those of us delivering health care had to be at the table. Anticipating where some of those forces were going and how we could be in the strongest position to be able to respond.

GARBER: Your career took place during a time that Medicare was implemented and changed significantly, ultimately. What do you think about the Medicare program? Was it a good idea?

SPRENGER: Absolutely. More people were covered. It provided some security for the senior population. The cost of health care was escalating. Technology was exploding. We needed some kind of a system to assist people as they enter their older years.

GARBER: What was it like for hospitals, at the beginning of the Medicare program, under cost-based reimbursement?

SPRENGER: It was probably the easier time of my career because it was cost-based reimbursement.

GARBER: Then, we came to the prospective payment system in the '80s, and things changed, but perhaps I'm anticipating the story. We've talked somewhat about the merger between Abbott and Northwestern Hospitals, creating Abbott Northwestern. Was there any thought it should be "Northwestern Abbott"?

SPRENGER: No. There was more desire to retain both names and their traditions.

GARBER: What were the most challenging issues related to the merger?

SPRENGER: The decision to locate on one campus. Spending time with all the constituents, staff, physicians, board members, donors, and community leaders to understand the case for merging on one site. We were a mile and a half apart. The first CT scanner was being introduced to the Twin Cities, and Abbott Northwestern was going to receive it under the certificate of need law of the state. Where should we locate it – at Abbott or Northwestern?

There was a lot of debate because it was seen as a symbol. Was Northwestern taking over Abbott? Or was Abbott going to be the center of this new combined institution? We had good support from key medical staff members, who said that even though Northwestern was more specialized than Abbott, we were going to locate it at Abbott, but as only the beginning of the discussion of the future structure of the merged institutions.

One of the major reason for the merger was to not duplicate technology a mile and a half

apart. We needed to solve this problem and decided the best solution was to locate everything on one campus. Each hospital had a long history in the community so this move was emotional for many. For instance, the merger was against the wishes of some of the Abbott physicians. What would happen to them if they moved to the Northwestern site? Would they relocate?

The board fully supported the consolidation on one campus but this was after extensive discussion. We engaged staff and physicians in planning the new facilities far beyond what you would normally expect. It was made clear to the Northwestern leadership that this was not a takeover, and there were physicians from both hospitals who needed to provide leadership in the consolidated institution. It had to be truly a consolidation of the two hospitals by retaining as much of their traditions as possible.

Our motivation wasn't to grow a big empire, but we were anticipating how health care delivery was going to look in the future. We wanted to help shape that future. It was not that I wanted to disrupt physician practices or move them out of their institution.

We were focused on the clinical side, and how we could provide an integrated system of physicians and hospitals in the community. For example, several local elementary schools approached us with a problem. In order to start school in the fall, students needed to have their vaccinations up to date. However, only about 60 percent had them up to date. The root cause was that there were a lot of parents who had trouble getting their kids vaccinated during the daytime. We established vaccination clinics that were open during evening and weekend hours. Within a year, the vaccination rate rose to 90 percent. This reflected what an integrated system could do.

Abbott Northwestern was in one of the poorer parts of Minneapolis. We started listening to the community, asking "How can we assist you with your health care?" My focus was health care, but I found out many times health care wasn't at the top of their list. Their top needs were jobs, housing, infrastructure, safety. That's what started us thinking that we had to have partners outside of health care.

Health care is broader than what we normally think and unless we address all of these issues, we were not going to have a healthy community. That's when we developed the Phillips Partnership, which included the CEO of Honeywell, a major corporation in our area, along with the support of Minneapolis Mayor Sharon Sayles Belton, the chief of police, the county commissioner, and the chief judge of Hennepin County.

We decided to meet monthly. We agreed that we would not be allowed to send a substitute, because we wanted decision-makers at the table. As the result of these meetings, we started to coordinate our efforts so that we could focus on all of the issues that the community was facing. As a result, the partnership improved the housing stock, lowered crime rates, and developed training programs for jobs. Through these efforts, we improved the health of the community.

We were concerned about safety. At one of these meetings, the chief of police said to me, "I've got a number of young men who want to leave their gangs, but they can't because they all have a tattoo that identifies them with their gangs. Where can I bring young men who want to leave the gangs? We talked to a group of dermatologists, and for a period of time, at 2:00 in the morning, we brought in these gang members who wanted their tattoos removed and, with significant police support around the institution, took the tattoos off. That was to solve a problem he had. He needed the

health care system to help him.

We were one of the largest employers in the south side of Minneapolis. An organization called Project for Pride in Living had a goal of training people to get entry-level jobs. Many of them were immigrants, minorities, people of color. We asked whether they would be willing to put a program together for us for entry-level jobs in health care.

This resulted in the Train to Work program. People would be taught the basic life skills required to be employees of the hospital. They also needed to be taught skills they would need to work in our dietary department or our maintenance department. We reserved a number of positions so that as they graduated from the program, they didn't have to compete with the rest of the community. They would get the first opportunity for those jobs.

We needed to take this fragmented system of health care that was focused on someone getting sick or hurt, providing them with care, then being sent back home, many times to an environment that was not healthy. That couldn't continue. That's not what the community expected of the health care system. They expected us to be more engaged in the community in a broader context.

GARBER: You talked about the Abbott Northwestern merger and that there was a physical consolidation. The two legacy hospitals were a mile and a half apart. Did you go to a different greenfield site where you built an entirely new hospital?

SPRENGER: No, we merged onto the Northwestern site. Although we had offers from two different suburbs to rebuild there, the board was committed to the mission of being an inner-city hospital.

GARBER: There was room on the existing site to build an entirely new hospital?

SPRENGER: No. We used the entirety of the existing Northwestern Hospital and expanded it to add beds and support services to accommodate the combined patient volumes. It was a true consolidation of the two, using what we could from Northwestern.

GARBER: Was the Abbott site then sold?

SPRENGER: Ultimately it was sold. We started out locating our mental health programs there and then also our alcohol rehabilitation programs. As those moved more to the outpatient setting, we eventually sold the institution. It was converted to lower-income housing.

GARBER: Abbott Northwestern Hospital went on to become part of a system that had different names and components. Could you describe that process?

SPRENGER: Yes. We were center city. We first started by talking with other institutions, located in other geographies, about whether they wanted to be part of our system. We started slowly. There was a fear of Abbott Northwestern being an elephant. We weren't looking for asset mergers initially. We wanted connections so that we could work together and present ourselves to insurers and the business buyer's coalition that we had the geographic locations that they needed. We were prepared to take some risk in terms of accountability. Initially that was focused on quality indicators. It was on having more standardized clinical protocols. It was on controlling costs. That's what they were very interested in. They were focused on our role in the community. The purchasers of care

saw that prevention was going to keep people from having to end up in the hospital.

All of this was a building block. Many of us believed that at some point we needed to start pulling this fragmented system of 25 small institutions in our community together. It started with physicians, many who were part of major clinics. On the clinical side we also wanted a system of care. The Mayo Clinic is a significant model in Minnesota. We weren't trying to duplicate their model. They had a unique mission. They were more global in orientation than we were.

In LifeSpan, there were three rural hospitals and several metropolitan institutions. The geography was limited and there were limitations in not having more central decision-making power. It was too loose.

Then we moved on to HealthSpan, in which we developed more consolidation of a number of institutions. We ultimately merged with Health One, which was another system under the leadership of Don Wegmiller.⁹ Minnesota had legislation that they were going to move towards requiring providers to have the ability to take risk for a population base. We didn't know anything about taking risk. We didn't have the insurance experience. That's what directed us to merge with Medica and develop Allina. We worked hard on putting the delivery system together starting with Abbott Northwestern, evolving into HealthSpan, and LifeSpan ultimately merging with Health One.

We assumed the state was going to execute on that legislation. We needed to prepare for that potential reality. Ultimately, they never did. Patients were not happy with HMOs, PPOs, and other forms of managed care, making decisions regarding what kind of care they got, when they got it, where they got it, with limited panels of providers.

GARBER: When HealthSpan and Medica merged to form Allina, you were part of a shared leadership, or shared executive, concept. There haven't been that many examples of this. Could you discuss how this came about?

SPRENGER: There was HealthSpan, which was a provider-based system. Medica represented the insurance skills. Both parties knew the necessity of combining their respective products and skills, but they both needed a significant seat at the table of the new organization.

Dr. Jim Ehlen,¹⁰ a respected physician in the community, had left clinical practice and became involved in establishing Medica and its management. I came from the provider side. We felt that the two of us needed to work together if we were going to make this an integrated system of the insurer with the provider. After several years the board decided they needed one CEO for accountability, and Jim left to take advantage of other opportunities. Ultimately, it was one of those experiments that was ahead of its time.

Because we were not-for-profit, we were supervised by the state attorney general. He had to

⁹ Donald C. Wegmiller was CEO of Allina Health System (Minneapolis) and is chairman of the Scottsdale Institute. [Former Allina CEO Wegmiller named Scottsdale Institute chairman. (2012, Nov. 14). *Minneapolis/St. Paul Business Journal*. <http://www.bizjournals.com/twincities/news/2012/11/14/wegmiller-allina-scottsdale-institute.html>]

¹⁰ Ehlen, K. James, M.D., an endocrinologist, has served in many leadership positions including at Humana, Allina Health System and EPIEN Medical. [EPIEN Medical appoints Dr. K. James Ehlen as CEO. *EIN Presswire*. <https://www.einpresswire.com/article/56320107/epien-medical-appoints-dr-k-james-ehlen-as-ceo>]

approve all of our mergers to make sure there would still be competition within the state. He was planning to run for governor. Health care became a focal point of his campaign. He decided that, since the state had backed off from providers needing to take risk, this merger was too powerful and that he needed to separate the two.

GARBER: How did people who were part of the early years of Allina know who was in charge? How did they know who to take issues to?

SPRENGER: There was confusion at times, and we dealt with it by involving each other when decisions needed both the insurer and provider perspective. It was obvious that we were working together in terms of what decisions needed to be made.

GARBER: Do you have any other learnings about flourishing in that kind of environment?

SPRENGER: I think it's difficult, particularly if leadership has the same expertise. We had different skill sets, we recognized that, and we were desirous of learning from each other. I would not recommend, for instance, that you would have dual CEOs running a health care system if both came with the same skills. Allina was formed with an insurer and provider needing leadership in both areas at that time.

GARBER: Is there anything else that you would like to say about Allina?

SPRENGER: Allina has never lost its community focus in providing holistic care. I retired a number of years ago. Dr. Penny Wheeler, an obstetrician, is CEO today.¹¹ I'll remember receiving a call from her when she was asked to take this position. She had previously worked alongside me in administration while I was CEO. She asked, "Do you think I ought to do this?" I said, "Penny, absolutely. What a health system like Allina needs is a strong clinical orientation." That's where it is today. We need to know how to develop better ways of taking care of patients in cost-effective ways, and be held accountable in terms of the quality of care that we give. "The most important skill is understanding what you don't know and that you surround yourself with people who do know what you don't know and can be a part of your team."

GARBER: I read Stanley Nelson's oral history interview which was done many years ago. He mentioned that in the early '60s when he started as president at Northwestern Hospital there was a large board, all women. One of his objectives was to bring men onto the board and increase diversity. You covered all that earlier today, but how does a CEO go about making a major board change like that? If we were talking about a hypothetical community hospital where the CEO wants to affect a major change on the board, is it something as simple as having multiple discussions with the board chair? What's the process?

SPRENGER: Well, you start there, but you have to have patience. You don't approach the board and say, "This is what we're going to do." You need engagement, discussion, and develop understanding why there needs to be a change. What's the reason? What do we need that's different? A case needs to be made as to why the board needs to change.

¹¹ Penny Wheeler, M.D., a board certified obstetrician/gynecologist, has served as chief clinical officer at Allina Health (Minneapolis) before becoming president and CEO at the system. [Allina. *Leadership team*. <https://www.allinahealth.org/about-us/leadership>]

In some health systems, you have individual boards for each community hospital, and then you have the system board. There were issues that were decided at the system level but they couldn't just make their decisions separate from getting input from the community boards. Each community was different and the needs of each community were different. So, it's patience. It's also working closely with the leadership of the board to help you in making that case and in executing it. Sometimes it necessitates bringing in a consultant because a third-party view is important for people to hear.

In the early mergers, each institution maintained their boards with certain powers while there was also a system board that had certain powers. As time went on, the community board powers became less in terms of resource allocation, and more about articulating the needs of their community to the system board. This would then be taken into account in the development of the overall strategic plan for the system. It was important that people at the community level felt they had a voice. Even though they're part of a system, they need to have input into what the system is going to do that affects their community.

GARBER: In his oral history interview, Stan Nelson also referred to the concept of a self-perpetuating board. What does that mean?

SPRENGER: With most not-for-profit hospitals, the board usually has a nominating committee. They nominate new board members, and the board decides whether they approve those new board members. They have terms to insure appropriate turnover. In our case at Abbott Northwestern, we had an association of past board members from many years past, and that association had two major powers. The first was that after the board went through its nominating process, the association would approve or not. The second major responsibility that the association had was in any disposition of assets. If you were going to merge or if, in some instances, you were going to sell off some part of your services or some part of your facilities or something of that nature, the association had the responsibility to ultimately approve that kind of action. Now after Abbott Northwestern, that was not true in Allina. The association went away.

GARBER: What are the characteristics of a good board chair?

SPRENGER: As a chief executive officer, you hope for support, and a good working relationship. They know how to manage a good board meeting. Getting all board members to contribute to discussions in these meetings is crucial. The board chair should not surprise the CEO if there is something of real consequence that is coming to the board. Equally, I believe the CEO should not surprise the chair of the board.

The board needs to be involved early on major decisions. The chair of the board has more information than the average board member and can provide honest and helpful input. The rest of the board many times looks to the chair – “What do you think?” The chair needs to be highly respected by the rest of the board. The board chair many times is the “face” in the community.

GARBER: Do you have tips on how to optimize the relationship with the board chair?

SPRENGER: I think it has to be a professional relationship, but many times it develops into a personal relationship as well. Trust needs to evolve, and that can't just suddenly happen. You need to pursue that relationship because you play an important role in providing leadership and information to the board. Lastly, and very importantly, the board chair has something to say about what's on the

agenda. This shouldn't just be a CEO meeting. It is a CEO-and-a-board chair meeting. I would review well in advance of the board meeting – these are the areas that I would suggest that we make sure that we have on the agenda. Many times board chairs would say, “Here's a couple of other things that we ought to have on there as well.”

GARBER: I'd like to go on and talk about the American Hospital Association. You served on the Board of Trustees in the '90s and were chair in 1996. What were the major issues during that chair year?

SPRENGER: Community care networks. In the '90s, it was being recognized across the country that as health care organizations, we had to look at the broad aspect of health, that it wasn't just disease. How would we develop community partnerships to prevent illness as well as care for the sick?

Patient safety had become a significant issue. The Institute of Medicine reported the tremendous number of errors that were being made in the care of patients within hospitals.¹² I was not well versed in this area. I was like many hospital executives, I think. We would look at statistics that showed how many errors were made, and we would compare that with other peer organizations. As long as we were within the range, we were satisfied.

Everyone is human. That's right. I thoroughly agree with that. Everyone is human and we will make errors, but controlling errors within institutions became a major focus while I was chair of the American Hospital Association. I was pleased to see the response of the field. Faced with the facts, it made us realize that we were not doing what we should in addressing this problem.

GARBER: Did you bring that issue back home?

SPRENGER: Absolutely. The Kennedy School of Government at Harvard has a program where they focus on a specific social issue. Their process is to bring in leaders involved with the problem, along with expertise from organizations that dealt with similar issues, to find solutions.

The Kennedy School held a program on patient safety that I attended. I was immersed for a week in learning how serious a problem we had. I left there committed that this was something that the field and I had to address. I went back to my own institution, met with medical leadership, nursing leadership, told them of my experience and laid out the facts to them.

I used the analogy of the airline industry. In the airline industry, they've developed a process where anyone can stop a plane from taking off. It isn't just the captain – anyone can if they see danger. It raised the question, for instance, in the operating room, if a nurse, a nurse anesthetist or an anesthesiologist saw a surgeon possibly operating on the wrong limb or that the patient wasn't ready, could they call a halt? Up until that time, there was mostly a captain of the ship model.

Understanding these issues went back to the Hamilton way. You took the problem. You broke it apart. You tried to get input from stakeholders. You put it back together into an actionable

¹² Work done by the Institute of Medicine's Committee on Quality of Health Care in America in the late '90s resulted in the landmark report: *To err is human: Building a safer health system*. (2000). Washington, D.C.: National Academy of Sciences. <http://www.nationalacademies.org/hmd/Reports/1999/To-Err-is-Human-Building-A-Safer-Health-System.aspx>

plan. That's what had to happen in the field. Did we eliminate all errors? No, but we were much more aware as to the magnitude of the problem, and put processes in place to avoid errors as much as we possibly could.

GARBER: Could you comment on the value of being a mentor?

SPRENGER: Those of us in leadership positions feel the responsibility for the next generation of leaders. Also, if we experienced strong mentors ourselves, we know the value of it. I see it as an important part of my role as a senior executive to mentor young people. They will call. We will have lunch together. We will talk. We will continue to stay in contact.

I learn as much as I hope I'm sharing with them. They see the issues and some of the problems, some of the opportunities, and they want to talk about why. Why does it have to be this way? Why can't it be this way? That's of great value to me as a leader.

It's a two-way street. Again, it goes back to the Hamilton days – the Minnesota Mafia – it was drilled into us that we were responsible for the next generation.

GARBER: How well did you handle work/life balance during your career?

SPRENGER: Not well. Circumstances dictated so much of my career. If I could have dictated when I would become CEO, it would have been when my children were older. I was basically 30 years old when Stan Nelson took the CEO position at Henry Ford Hospital three years after I was hired at Abbott Northwestern.

I'm a person who has a hard time telling people, "I'm sorry, I can't talk about that now. I need to go to my son's soccer game." Many an evening, I would end up on the parking ramp, getting ready to go to one of those sporting events of my children, and a doctor would catch me, and he had an important issue to discuss. I would take the time.

As my children have talked about it, they tell me that they never felt like they were ignored. They knew enough about what I was doing, and they knew my love for them and how much I would want to be with them. They understood.

The guilt was that I spent a lot of time at work. Almost every evening after the kids would go to bed, I would spend a couple hours reading. I would bring work home from the office. It was my age and the speed with which things were happening in my career that made it difficult for me to have good balance.

GARBER: I've heard that thought many times, and it makes me wonder whether it's the nature of the job. If you're a hospital or health system CEO, that's just the price you pay. I wonder if that's a true statement?

SPRENGER: It was a true statement at my time. The next generation after mine became more conscious of finding a way to find that balance. I can't speak for all the CEOs of today. Many I do believe have found ways that they can balance their life better than I did, or my generation did.

I also have to recognize that I'm a Type A personality. That's why I took work home with me so that I would be thoroughly ready for what I was going to be facing the next day. I can also say,

you can count on one hand the number of days that I did not love my job.

GARBER: I'd like to give you the opportunity to speak about your wife and her contribution to your life and your career.

SPRENGER: Dee is a special person, not only as my wife, but also the mother of my children. Due to her nursing background, she is a strong supporter of nursing and she has been one of my greatest critics. She has always been there, supportive of me. Without my wife, I don't know that I would have survived. She listened to me about my successes, but also about my failures and my disappointments, and would bolster me up, get me ready for the next day. She enjoys dialoguing with me about what I am struggling with and gives me her advice on important decisions. Dee also keeps me humble. Many times when I would come home at night, the first thing she would say is, "Gordy, the garbage needs to be taken out!"

Relationships are important to us. When we had new managers or new doctors, I wanted to get to know them better. To do that, there is no better place than in your home. Despite having young children, she would put on lovely dinner parties for a dozen people. Today, I see most of that being done in clubs or restaurants. The home was where we developed most of our relationships with the people that were important in helping me manage the institution. She was the most gracious hostess, volunteer, manager of the family, and enjoyed by all who met her – the perfect partner through the good times and stressful times of my career.

GARBER: Is there anyone else you'd like to mention before we close?

SPRENGER: I've mentioned Stan Nelson, who was very special to me. I have to believe that in working with the board, he was a significant factor in me getting the opportunity to be CEO at a young age. Mert Knisely at St. Luke's Hospital, and the way that he trained me during my residency and later employment. He always was open and willing to take the time to spend with me, to help me get my legs on solid ground. We've mentioned Jim Hamilton a lot. Jim Stephan¹³ was a COO of the program. Mr. Hamilton and his associates would mostly do the case studies, but there is much more about a hospital and running a hospital than many of these cases represented. Jim Stephan was the expert in – How do you run a laundry? What do you do about the boiler plant? What do you do about running a laboratory or an x-ray department? It was the nuts and bolts of managing an institution, and he was exceptionally good at that. I'm also grateful to my parents, who gave me the education and allowed me to have the kind of career that I had. Most importantly my family who was always there for me, supportive, loving, and understanding of the demands of a very special career.

GARBER: Any concluding words to students who might be considering health care administration as a career?

SPRENGER: It is a marvelous career. With a vast array of options in many different settings, health care administration offers so many opportunities. It's different today than when I started. The opportunities are broader. We were trained to be hospital administrators. Jim Hamilton's mantra was that we would be a hospital administrator within five years of graduating, because there was a shortage. When I was mentored, it was all about being a hospital administrator. Responsibilities like reaching

¹³ James W. Stephan (1911-1983) served in various management positions in hospitals and was a consultant with James A. Hamilton Associates. He became a professor with the University of Minnesota in 1946. [American College of Hospital Administrators. (1979). *1979 directory*. Chicago: ACHA.

out into the community, getting community input, putting community advisory groups together, worrying about jobs and housing and safety were never part of the discussion. That all evolved in my career. If I ever had a down day in my office, all I had to do was walk the patient floors and visit with patients and staff. Then I knew why I was there.

GARBER: Thank you for your time this morning.

SPRENGER: Thank you very much.

CHRONOLOGY

1937	Born April 30 in Conger, Minnesota
1959	St. Olaf College (Northfield, Minnesota) Bachelor of Arts in Economics
1960-1961	St. Luke's Medical Center (Milwaukee, Wisconsin) Administrative resident
1961	University of Minnesota (Minneapolis) Master of Hospital Administration
1961	Married to Dolores I. Idstrom of Princeton, MN Children: Michael, Kristen, Angela
1961-1964	USAF Hospital (Hamilton Air Force Base, CA) Registrar, Clinic Administration Officer
1961-1964	United States Air Force 1 st Lieutenant
1964-1967	St. Luke's Hospital (Milwaukee, Wisconsin) Assistant Administrator
1967-1971	Northwestern Hospital (Minneapolis) 1967-1968 Assistant administrator 1968-1971 Administrator
1971-1988	Abbott-Northwestern Hospital (Minneapolis) 1971-1975 Executive vice president 1975-1988 President/CEO
1982-1992	LifeSpan, Inc. (Minneapolis) President/CEO
1992-1994	HealthSpan Health Systems Corp. (Minneapolis) Executive officer

1994-2001 Allina Health System
1994-1999 Executive officer
1999-2001 President/CEO

SELECTED MEMBERSHIPS AND AFFILIATIONS

American College of Healthcare Executives
Committee service

American Hospital Association
Chairman, board
Member, board
Trustee

Community Hospital Linen Services
President

Council of Community Hospitals
Chair

Governor's Task Force on Nursing
Member

Health Political Action Committee of Minnesota
Chair

Hospital Data Processing Council
Chair

Ludgate Insurance Company, Ltd.
Member, board

Minnesota Hospital Association
Chair, board
Committee service
Member, board
Treasurer

Minnesota Orchestra
Chair, board

Multihospital Mutual Insurance, Ltd.
Member, board
Vice chair, board

Twin Cities Hospital Association
Chair, board
Secretary

University of Minnesota, Program in Hospital and Health Care Administration
Preceptor and faculty member
President, Alumni Council

Voluntary Hospitals of America
Member, board

AWARDS AND HONORS

1961 Sabra Hamilton Award, University of Minnesota
1982 Distinguished Alumnus Award, St. Olaf College
2001 Distinguished Service Award, American Hospital Association
Who's Who in America

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INDEX

- Abbott Hospital (Minneapolis), 12, 16, 17
- Abbott Northwestern Hospital (Minneapolis), 4, 5, 12, 13, 14, 15, 16, 17, 18, 20
- Allina Health (Minneapolis), 1, 18, 19, 20, 25, 26
- American Hospital Association, 6, 21
- Belton, Sharon Sayles, 16
- Co-CEOs, 18, 19
- Durenberger, David, 14
- Economic competition, 14
- Ehlen, K. James, M.D., 18
- Fairview Hospital (Minneapolis), 5
- Governing board, 11, 19, 20
- Group Health (Minneapolis), 14
- Hamilton, James A., 6, 8, 11, 23
- Harvard University
 - John F. Kennedy School of Government, 21
- Health facility merger, 12, 14, 15, 17, 20
- Health maintenance organizations, 14
- HealthSpan Health Systems Corporation (Minneapolis), 18
- Hennepin County (Minnesota), 16
- Honeywell, 16
- Hospital Research and Development Institute, 7
- Hospitals
 - military, 9, 10
- Knisely, Merton E., 8, 23
- Knudsen, Philip, 3
- Mayo Clinic (Rochester, Minnesota), 18
- Medica (Minnetonka, Minnesota), 18
- Medicare
 - implementation period, 15
- Mentoring, 22
- Military service, 8
- Millar, Robert C., 12
- Minnesota mafia, 7, 11, 22
- Nelson, Stanley R., 7, 11, 12, 14, 19, 23
- Northwestern Hospital (Minneapolis), 7, 11, 12, 17
- Nursing
 - education, 4
- Park Nicollet Clinic (Minneapolis), 14
- Parker, Scott S., 11
- Patient safety, 21
- Phillips Partnership (Minneapolis), 16
- Piper, Virginia Lewis, 13
- Platou, Carl N., 5
- Project for Pride in Living (Minneapolis), 17
- Regionalization
 - Hub and spokes model, 10
- Social determinants of health, 16, 17
- Social networking, 7
- Sprenger, Dolores Idstrom, 3, 4, 11, 23
- St. Luke's Hospital
 - Milwaukee, 8
- St. Olaf College
 - Gordon and Dolores Sprenger Endowed Scholarship, 4
- Staff development, 17
- Stephan, James W., 23
- Sweetland, John, 11
- U.S. Air Force Hospital (San Rafael, California), 9
- Wegmiller, Donald C., 18
- Westminster Presbyterian Church (Minneapolis), 12, 13
- Wheeler, Penny, M.D., 19
- Work-life balance, 22