Department of History and American Studies
University of Mary Washington

Mary Washington Healthcare Oral History Project

John Fick, III

Interview conducted by
Jess Rigelhaupt
in 2013

The Mary Washington Healthcare (MWHC) Oral History Project began in 2013 and recorded 100 hours of interviews over the next two years. The project was designed to document the history of MWHC's expansion and record the recollections of people involved with its transformation. The oral history interviews were with board members, administrators, physicians, nurses, social workers, and community members. Beyond a story of expansion or a single organization, the interviews record successes and ongoing challenges with the transformations in health care and hospital-based medicine over the last thirty years.

Oral history is a method of documenting the past through recorded interviews. The interview is between a narrator with firsthand knowledge of significant historical events and an informed interviewer. The goal is to expand the historical record, record firsthand accounts of social, cultural, and political changes, and preserve the recorded interview. The recording is transcribed, lightly edited for clarity, and reviewed by the interviewee. The final transcripts are archived in Special Collections in Simpson Library at the University of Mary Washington. The interview transcripts are available to researchers through the library and the project website, mwhchistory.com.

Oral history is a primary source and is not intended to provide the final, verified, or complete history of events. It is a spoken account, often recorded in a single interview. It records and preserves an interviewee's memories and narration in response to questions by an interviewer. The interview is reflective and irreplaceable.

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Interview 1 - October 18, 2013

01-00:00:00
Rigelhaupt:
It is October 18, 2013. I'm in Fredericksburg, Virginia, doing an oral history with John Fick III. And I would like to begin by asking you about how you became involved with the Mary Washington Hospital Foundation Board in 1990.

01-00:00:24
Fick:
I had just come back to Fredericksburg from Williamsburg and taken over the family business. Prior to that I was a pharmacist and I had a pharmacy in Williamsburg for fifteen years. We were doing a golf tournament each year at J.F. Fick, and we were giving them money to the cancer center. They had a cancer center out on Route 3. We had been doing that for about three years. Xavier Richardson came to me at that time, about 1990, and he knew where the money was going. He asked me to become a foundation member because of the philanthropy that we were doing. When we did that, we merged the golf tournament into the Mary Washington Foundation Open, which last year was the twenty-fifth year. J.F. Fick has been the major sponsor for twenty-five years. I think we raised somewhere around $2.9 million for the community. One of the goals was always to put the money straight back to the community. It was always something with the hospital, if it needed a piece of equipment or we helped buy the da Vinci robotic machine. We put some special equipment in the neonatal care, all kinds of different things. The Moss Free Clinic was a recipient for a couple of years. We always sit down and we just chat about where should the money go this year. We were quite successful. We raised over $100,000 a year every time we did it. I like to think it was one of the best golf tournaments in town because it was sold out. People were waiting. Actually, we had to go to two courses, so we had two distinct tournaments going on at the same time. That started my board involvement there. Then, Bill Poole retired. He was a former board member, at that time I think it was, with Mary Washington Hospital. They asked me if I would be interested in moving up to what I call the "big board." At that time, I think this was 1994; they had just built the new hospital up on the hill. Fred Rankin became the CEO. Bill Jacobs had retired. I came on and of course being the first year, you just learn. It's orientation.

[03:00] You learn and you get acclimated to health care terms. Being a pharmacist I already had a considerable background in health care, which it made it a lot easier for me to understand all the terminology. This was '94. Maybe about in 1995 or 1996 they decided to make me an officer; I became secretary treasurer of the organization. Tom Williams was chairman, Joe Wilson was the vice chair, and I was secretary treasurer. Fred Rankin served as an ex officio member as an officer. That's when I really got involved. I got involved mostly on the finance side. The finance committee meets monthly and they prepare the budget for the system. During this time we opened a brand new hospital and it was filling up quickly, just because of the population. We'd been fortunate in Fredericksburg to have a growing population each year, and it still is growing. The beds were full.

We had to do an expansion of the new hospital sooner than we thought. We added more beds, and of course we went to the bond market to do that. Not only that, but we were having to add service lines as well. We had a cardiovascular surgeon, Dr. Armitage, come to town, which brought interventional cardiology and cardiac catherizations. They didn't have stents then, but they do now. That was a new service line. We created some joint ventures with Medical Imaging of Fredericksburg. It was growth. It was bricks and mortar for ten years or maybe longer. We just built things because we had to. The hospital was doing well because we were busy. I remember in 2006 our emergency room was the third largest emergency room in the state of Virginia. It was bigger than MCV (Medical College of Virginia/Virginia Commonwealth University) and UVA (University of Virginia). We were seeing 130,000 patients a year. When you get that volume, of course, you have wait time problems. It was a three or four hour wait time and people were not happy. We had to fix that. We started a triage plan, which greatly reduced the wait times. Most of those years we were adding service lines and we started to do some of the Centers of Excellence and the Heart Institute.

[06:00] Now we have five Centers of Excellence and the Human Motion Institute, which I just visited last year with a brand new knee. That's really a super Center of Excellence. Also, we're noted nationally for our stroke center. We've received many awards for our stroke center. We've always been a little bit ahead of the curve for health care. The trustees all do continuing education and we go to the big one, it's called the Governance Institute, which is a health care think tank. We all go one or two of the Governance Institutes. It's comprised of health care people all over the United States, from hospitals all over the US. There will be speakers and we'll go into little breakouts, and they'll probably be ten people in there. We just talk about how we do things at Mary Washington. Invariably we are ahead of the curve, with systems three times the size of us. We've been doing these things for years. We've always been progressive. The board is not afraid to seek out new things and new service lines. Because of that, our board is very active. I have a wonderful board. We just kept building. We added another wing onto to Mary Washington, and then we put in an endoscopy center. We redid the nursery and made it more mommy-friendly and daddy-friendly. We added the fifth floor. We've done a lot to the property. We also redid the pharmacy. That was all internal building, which took money. But we had it. We were making money at the end of the year, and we were just piling it right back into the organization. In about 2007, the board did not plan well for board succession. Mr. Williams, Mr. Wilson, and me, the three officers, all got off at the same time—all three, they're gone. We amended the bylaws and Mr. Wilson became chair for three successive one-year terms. I jumped off the board for a year, because you have to. I stayed off for a year, then came back a year later, and became a member of the executive committee as an at-large member.

[09:00] Then after the three successive terms of Joe Wilson, then I became chairman of the board in 2009. I have been in that position since. My term is about to end. It's going to be over at the end of 2014. However, we created—and this is newly done this year—a past chairmen position; I'm going to fulfill that as the first past chairman. It's a three-year term. It's simply there to assist the new chair. The chair takes a lot of work. It's about fifteen hours a week for me. I'm in constant contact with

Fred Rankin, all the time, and his executive team. It takes a lot of work. I developed a succession plan for the board, and so I have a successor. It's my vice chair Alda White. She has been shadowing me this year and next year to get a hand on the chair. I meet with Fred monthly, and we go over either the executive committee agenda or the full trustees agenda. The board meets six times a year. They meet every other month, and on the off months the executive committee meets. The executive committee is one of the only committees that has the power to vote on things without the full board being present. However, I report what the executive committee does at the full board, so they know what we've done and it works quite well that way. It's nothing nuts; it's just like we have to make a decision on a bond or sell a bond because we're going to get a better deal, stuff like that. And then sometimes we'll talk about physician issues as well. I have had a wonderful—I'll call it a career. It'll be twenty-one years when I'm done. Even though I am a pharmacist, I've learned a tremendous amount about health care, about the administrative side of health care. It's been rewarding. It is a lot of hard work, but very rewarding. The problem today is health care is getting much, much more complex. If the Affordable Care Act goes live next year, which for all intents and purposes I expect it will, it's going to change the face of health care in the United States greatly. It's going to change the face of health care with respect to the hospitals and with respect to the providers, the physicians. We've got to get together and work together.

[12:00] We just created this IPN, Integrated Provider Network. The physicians and the hospital have created this network. It's an alliance. We've agreed to work together to be able to provide this type of health care that we're going to have to provide in 2014 and beyond. It's called population-based health care. It's changed now. Where it used to be fee-for-service, it's no longer that way. All your payments will be bundled and you are going to have to farm out those payments because everybody will be involved in the treatment of the patient. Not only in the hospital, but when the patient is discharged to their home; it continues there as well. Personally, I see a greater involvement in the outpatient side of this system than in the inpatient because they're not going to let you stay in there very long. I see people getting discharged with high acuity levels and when they're really sick. We're going to have to take care of them in their homes as well. I see that as the new wave of health care: following the patient all the way to the house, and then actually providing really good health care within the home. It's changed greatly, and it's just a new day for health care and a new world. We're all trying to figure it out. Everybody is and not just us, but every hospital is. How to work with it? How to deal with it? It is value-based medicine now, which is what they call it. You've got to tighten your belt. You have to do cost analysis across the system to make sure that we are efficient. And we can't have unforced errors. That's the new face of health care. Back to the hospital—I jumped ahead of myself. In the 1990s, we decided to create a holding company. It was called MediCorp Health System. Tom Williams, Joe Wilson, and I were the first officers of it. Before that, there was Mary Washington Hospital. They had nine boards. Every subsidiary had a board with community members on it, with a whole full board. It was overwhelming and there was no central board. We created a holding company. We created a board. We eliminated all but of maybe five of those subsidiary boards. We kept he foundations alive. We kept MediCorp Properties, which was the property side. Then we have MediCorp Services, which we have because we do have some for-profit

entities. We have Medical Arts Pharmacy and Homecare America, which is the durable medical equipment homecare place.

[15:00] You have to keep that separate from your non-profit status. We did that, and it worked fine. Then we did a study in the community. We hired a group of folks to do a study to find out the name. What do you associate when you hear "MediCorp?" And lo and behold, people were confused. The only the association was Mary Washington Hospital. They didn't really understand what MediCorp was. In the 2000s we decided to make a name change, and it became Mary Washington Healthcare. That name change has resonated and is much smoother for the population. They now associate Mary Washington Healthcare with the whole health system, with everything that we do. They understand it's a brand image. We've also expanded a lot more into media and advertising as well—billboards, radio, TV, ads in the newspaper, which you have to do. You need to run the hospital just like a business. You need to market yourself. You need to market that brand. Over the years we've done many joint ventures. Probably in the mid-2000s, we started purchasing physician-owned practice. We became a trauma center in 2008. All those physicians are employed by the hospital. We created the trauma center, which really put a feather in our hat because there was none around and people had to leave. They had to go to Inova Fairfax or they had to go MCV or UVA. Now we're here. You don't have to go away. One of my goals over the years as a board member is to have people be able to stay here for their health care and not have to go someplace else. Another goal has been to recruit the best physicians that you can possibly recruit. We've done an excellent job. We have world-class physicians now. Our neurosurgeon, Dr. Poffenbarger is world-class. The cardiovascular doctor, Dr. Na is outstanding. We have these services now. In the past, people had to leave town for these services. We're here for you now, and that's our new little tagline, "Here for you." It's worked quite well.

[18:00] We kept growing. Then we all met and we debated it for a long time, do we need another hospital? Mary Washington was full. The census was full all the time. We decided to expand, but the question was, where are we going to do it? Do we go to Spotsylvania or Stafford? How far away? Or do we go out Route 3 west? After considerable debate, we found that our northern market, our market share in North Stafford, was less there than any place else. We had good market share in Fredericksburg in Spotsylvania. It was in the upper sixties, which is wonderful. Anytime you have a market share from the sixty percent range it is outstanding. That's where our market share was less in any other area in the market. We decided to build a brand new hospital. Then a couple years, a year and a half, later we have Stafford Hospital. We're tracking people now from the lower end of Prince William. We track zip codes and we know where they come from. They're coming from lower Prince William all the way up to Route 234. Stafford is a much smaller hospital; it's a 100-bed hospital and it doesn't have all the goodies that the big plant has. But you're only six miles away. The trauma, the surgeries, and the big time stuff comes down here. We have a higher level neonatal care unit at Mary Washington than we do at Stafford; although we did bump up our neonatal care at Stafford to a second stage. We have neonatal and perinatology—we have it all at Mary Washington. We can handle little babies too. We pretty much do everything. The only things that we don't do are

burns and transplants; that is a level one trauma center. We're pretty much positioned to be able to handle almost anything that the community needs. We see a lot of trauma simply because of our proximity to Interstate 95 and automobile accidents. It seems like it gets worse every year. But that's it in a nutshell. I've been privileged to be an officer almost my entire career on the board. It was thirteen years of secretary treasurer. I have been able to watch this whole enterprise grow and become what it is today.

[21:00] We just recently built a women's center up on the hill. Next door is our new cancer center. We have state of the art equipment in there. We have wonderful oncologists and we have surgical oncologists. That is another whole aspect of the hospital and the cancer treatment center is just outstanding. The women's center was done basically when we surveyed our patients; they were being seen at Mary Washington. The wait was long and it just wasn't a good experience. We surveyed and they said this is what we need. We built it for them and they love it. It is all women and it is beautiful. You have to listen to your community and you have to find out what the community needs are and what they want. We also do a community needs assessment. And we created what's known as the Board Citizens Advisory Group. We actually have community members who belong to it and who actually sit in on department meetings inside Mary Washington Hospital. There are four levels of participate. You can come to the meetings or if you really want to be hands on, you can get into a department meeting and participate. Another thing that we did—and I was just reading an article a minute ago about how there is apparently a severe critical shortage for board members in the health care system, something like 1.2 million are needed. We've never had that problem. What we have done is we have created what is called Citizen Community Members, almost like a minor league team of board members. The Nominating Governance Committee puts a slate of folks out every year. We have ten of them; there are ten positions available. We contact these people and ask them if they're interested in doing this. It allows them to serve on a board committee, a trustee committee or maybe two. I appoint all committee people and I'll only put them on one their first year. It's too much to ask them to do two; it's too much to learn. They're that board as a Citizen Community member for two to three years. Then when there's a board vacancy, we pull from that pool because they've already had the experience. I invite them all to our annual meeting in December. They all attend the big board, the trustee board meeting. They get an idea of how much data flows through that meeting.

[24:00] It's a good way for them, also, to determine whether they like what they're doing. If it's not your cup of tea, then you can write me a letter and say, "Thank you very much, but I'm done." But that has never happened. Everybody that we picked is loving it. We have this wonderful pool of future trustees to draw from. We're going to lose maybe four trustees at the end of 2014. There will be four people coming up from the minor league team. We invite them to all the functions. We invite them to go to the educational sessions. We try to do education sessions for the board members almost monthly. We belong to the VHHA, which is the Virginia Hospital and Healthcare Association. This group of Virginia hospitals has two meetings a year. They always bring in really, really interesting speakers. They bring in nationally known health care speakers. Everybody's invited

to that. Then the Governance Institute, you're welcome to go to that once a year. Continuing education is a major function of the board. It wasn't always like that. It's only been in the last six or seven years that we've decided that, in order to stay abreast of what's going on in health care, you have to continue to educate yourself. They know when they're getting involved that it's expected of them to attend these sessions, and they do. Almost all of them do. It makes you a better board member and it helps the hospital. We're here to serve the hospital. We provide oversight, but we're getting a little more into the nuts and bolts, just because it's so complex. Then Medicare changes their rules weekly. We have new rules every week. So you have to learn new rules again. It's just changed drastically in the last year and a half. I don't know if you're familiar with readmission rates, what happens there. If you come in with a heart attack, you get treated, and are sent home. If you come in that hospital within thirty days, not for a heart attack, but if you sprain your ankle. We get dinged; it's called readmission. We treat you for you. That's something that the board's paying close attention to. Medicare calls it RAC (Recovery Audit Contractors). What they do is they look at patient charts and determine whether the care is medically necessary or not.

[27:00] Then we have to challenge them. And you know, that could run into millions of dollars; where they're looking at these patient charts. Then the newest thing is called observation status, that's the new baby. That's when you get admitted—you're either a true inpatient or you're an observation patient. An observation is what it is, observation. You really don't get a whole bunch of tests and you're just kind of like in a holding tank. Then if they find out that you need to be admitted, you jump over to the other side. Right now our observation patients are about thirty percent of our admissions, which is so new that there's no benchmarks. Nobody knows what the right number is. But it takes a lot of capital away because Medicare does not pay the same rate in observation status versus inpatient. That is another financial issue that the board has had to deal with. The board is more acutely involved now than it was when I first got on. I was almost always involved because of finance, because it was a major part of the corporation. You had to keep the finances going. I've been on every committee in the hospital at least once, which I think a chairman should do before you become chairman. I've been through the entire system and I had been chair of almost every committee as well, or vice chair, before I became the chairmen. It's a lot of work. It's very rewarding. It's just going to be some challenging times here in the next four or five years with the Affordable Care Act. Then each year Medicare starts cutting reimbursements to hospitals, and the same thing is going to happen to some of the doctors as well. That's why we got this IPN going. We can work together to provide value-based health care and do it properly because we must be efficient. It has to be done right because you get charged for not providing value now. The board approved its bylaws and charter, and we're going to go live in 2014. What we're going to do first is we're going to take over our associates at the hospitals. There are 6,000 covered lives there. We're going to be managing their health care, to see how well we do. Then if we find that we do well, which I expect us to, then we're going to offer a product to the community. We're going to go after the governments, Stafford, the city governments, and the county governments. They have interviewed my company.

[30:00] I'd love to be able to find better health care at a cost savings. That's our plan. That's the type of delivery system we're going to see in the future I believe. There are Accountable Care Organizations, which really no one knew what they were when they first brought them out because they really didn't explain them. We're going to eventually end up into an ACO arrangement with as many physicians as we can get into it. It's all based on covered lives. And you tag along with an insurance company as catastrophic coverage. We have an arrangement with an insurance company as well. We're going to do all this care and we're going to manage care. We're going to do it for a set amount of money. It's all going to be bundled, so you forward it out to whoever provided the care. It's inclusive of the pharmacy. The whole continuum is in there. That's the new challenge for the board. I won't be chair, but I'll be sitting on the sidelines. Mary Washington has been a wonderful hospital for this community since 1899. It's been a rewarding experience for me to watch it grow and to see the service lines that we now offer. We're a health care center now. We're not a little community hospital anymore. There are a lot of folks that still think of it as a community hospital, but we're a regional health care center now. There's no need for you to leave town, unless you get burned really badly burned or you need a transplant. That's what I've tried to create and this board has created with the executive senior team and executive management. We work closely together, the board and Fred's team. It's important that we do that. We have a wonderful strategic plan, and we keep tinkering with that and remodeling it yearly. We have a strategic planning retreat every year and it usually focuses on a topic. Last year the IPN was the topic. It was when it was briefed to the entire board. There's always a plan. We actually even create scenarios and strategic planning, these horrible scenarios. They are "what ifs," and how are we going to react to this. And that's good because you don't know—some of these may come true. We're prepared for it and we're always looking forward. We don't look behind, we always look forward. One of the bigger challenges going forward is revenue.

[33:00] It's generating the revenue needed to function. Fortunately we don't have to build anything anytime soon. I think we have all the services already. We don't need anything else. That helps as well. Even the hospital opened twenty years is getting some age on it too. We are looking at redoing patient rooms, brightening it up, and changing some things there. It's totally different when you go to Mary Washington and when you go to Stafford. Stafford is all brand new and sparkling. The whole place is new and there is new everything. We've got twenty years on Mary Washington Hospital and we're working on that now. You can't do it all at one time because you don't have enough cash or the capital budget. It's a work in progress. We need to continue to recruit world-class physicians, that is part of the deal too. You have to have a medical staff that's world-class and provides the best health care that they can possibly provide. That keeps the people here, too. If we can do it and we do it right, then they are not going to go someplace else. That was the goal: keep them here.

01-00:34:23
Rigelhaupt:
So you discussed a number of things that I want to have more questions on. But one of the things you said was the board is looking forward. And I'm going to ask you to jump backward a little. But to touch upon one of the major themes you talked about, the relationship between the board, administration, and physicians, and the potential for integrated medicine. And I'm wondering if you could reflect back on even those first few years you were on the foundation board, so the early 1990s. What kind of culture was formed in the relationships between the board, administration, and physicians that has continued? Do you see what—

01-00:35:19
Fick:
Yes, I do. I think actually in the early years, the relationship was not good at all between the hospital and the physicians. I think when I first got on, there was a feeling of distrust. They didn't trust the hospital and the hospital was "out to get them." I'm not sure why. But fast forward, a lot of those docs are not here anymore. They're retired and they're gone. The younger groups that are coming out now and finishing their residency, they're taught totally different medicine. [36:00] They are much more savvy and clinically skilled. They understand that they need some help on the business side, which is what we can do. They trust the hospital much more. We're not out to get you. We're out to partner with you. And we've tried to use that word "partner" all the time. We really do. At times it was frustrating with the board level because we're trying to do this and there's still some folks that distrust us. And there is a small group—not a group, you can count them on one hand—that still feel that way today. This IPN, we had to build their trust in order to even think about starting this thing. We've bent over backward for them there. The board is twelve people: we [MWHC] have four votes and they [physicians] have eight. One of my trustees is on it, and then I think Mr. Rankin is on it. It has one vacancy to fill, but the rest of them are docs. That's pretty much what they wanted and we allowed them to do that. We have some control over our tax-exempt status and stuff like that. But by and large it's theirs. They run it and that has helped a lot. I feel that it was a tough time in the 1990s. There was a lot of distrust. They really didn't want to partner. They didn't want to do any joint ventures: "No. You leave me alone. I'm fine. I'm busy." It has gotten better over the years. But their practices have changed over the years. You don't have primary care doctors doing rounds anymore. They don't do that. We have hospitalists now. We have pediatric hospitalists. We have intensivists who run the ICUs and are the trauma surgeons. Because of the face of medicine has changed so much, the primary care doctors and even the internists, make more money in their office than they do in a hospital. They don't make any money during rounds. As a matter of fact, it's lost time. They are staying in their offices and they are seeing patients. That transition took a little while, too, to get them to understand the role of a hospitalist. Some of them jumped on it right away; otherwise it took a little bit longer. Now, pretty much everybody is joining that route. They're admitted, they follow the care, and then report back to the patient's family physician at the end of care. [39:00] It seems to work fine. I think most hospitals are coming to that now. That is a huge change in health care. Before this, with rounding, your family doctor came in to

see you at night, to see how you are doing, Mrs. Jones, and listen to your heart. They don't do that anymore. They just can't afford to because the amount of reimbursement is not profitable. That has been an expense for the hospital as well, but it's yielding better patient care because patients are being followed more closely. The primary care doctor may get to see you only once a week or twice. This hospitalist is seeing you every day. Technology is allowing him to get that information back to the family doctor quicker. He can see x-rays now in his office. That is another huge change for when I first got on the board is technology. It's unbelievable. Now the newest thing that everybody's working on now is electronic health record, EMR or EHR. We're going to do this, but it's just going to take a little bit of time. The IPN is going to partner with the hospital to share patient information. All these doctor's offices will be linked up with the hospital. When you get that type of flow of information freely, it's just amazing. You could get everything you want. Pretty soon the general public is going to be able to do this too. You can look up your own health record and have it downloaded into your PC at home. Now they've got things like FaceTime, where the doctor can actually examine you. They can take your blood pressure. This is a new wave of technology in the health care system. You don't even need to go to their office; you just do it at home. That is kind of spooky. There are places where they are doing it, which we learned about at one of the seminars we went to. There is a hospital in Florida that is doing it now. It's something your watch can do. You plug in your iPhone with an adaptor and it can record your temperature, diabetes checks, and everything. It's crazy, but that probably will improve health care. It will be better access. [42:00] If we can do that through technology, do it right clinically, and be able to diagnose that way—that's just a whole new gambit that the American public will experience at some point. It's not ready yet. But the EHRs are going to be the newest thing. The physicians will all be able to talk to each other. That will be nice when that's done because it's time consuming when you have repetitive stuff. The patients will like it too because if you have your own health record, they don't have to ask you the same question fifty times. But yes, it was not that good. I'll be honest. There was a lot of distrust. It took a long time to work on that. That was one of Fred's goals: get the trust level back up. The board was working on it as well. We're there. We're not 100 percent, but we're much better than it was in the 1990s and the early 2000s. I think it's just been the change in health care that the physicians have come to realize that, "We need the hospital. We need to work together. We can't be separate entities anymore because we're just not going to be able to make it." With that mindset, that started the IPN.

01-00:43:41
Rigelhaupt:
What are some of the things that the board did in the mid-1990s, which sounds like about the time period you're talking about? And you may want to speak for administration a little bit, because it sounds like the level of the board you were on worked very closely with senior administration. What were some of the things the hospital, the board, the administration did to try and build trust with the physicians?

01-00:44:08
Fick:
We attended medical staff meetings. We used to not do that. I've been to them before, and hospital administrators would be there. We would have a presence. We would do networking and social functions with them, where all the board members and many physicians would get together socially. The foundation does that as well. It is just more to get to know each other. That process started, and it got better. We were doing more of them. I felt that there was a closer bond between the board and the physicians. We had the administrators, the executive vice presidents, present at medical staff meetings. That helped as well. [45:00] If there was a question that they would be able to answer it right there. Or at least if there was a muddy issue, they could clear it up; because you know how rumors fly. That is what happened. We made a consorted effort to have better relationships with the doctors. We started doing physician surveys. The medical staff at Stafford one year, and then we do the medical staff of Mary Washington the next year. The board gets to see them. Those doctors are not afraid to put down how they feel. When we find that there are areas that are not working for them, we address it. We take action, and we try to make their lives better. One of the biggest things now is a tagline we used maybe three or four years ago, "Make my day better." We want to make your day better. How can we make your day better? It was mostly on the inpatient side in the hospital, when they were in there and typing in the charts. It could mean not having to go through seven different screens to get something in the patient's chart or find something in the patient's chart. We did a lot to streamline technology so that the steps were decreased. That was what we were trying to do: how can we make your day better? The board interaction with them was mostly social. We have a physician board education system that is held at Jepson. We have been doing that for maybe the last five years. There are probably 150 docs there. Most of my board is there, and in key management. We will have a presentation, and then sit around and chat about how we can better work together. The IPN has really brought a lot of them together. There are 400 and something docs that are signed up to participate. We have ownership in it. The docs can own it, buy ownership in it. Or you can be a participant in the IPN and still reap the benefits. There are close to 400 of them in here, and this thing just went live a couple months ago, for signing up purposes. We've got key physicians and a good bunch of medical staff now in the IPN. One of the things I told the administration and I said before we pull the trigger on this thing: "I've got to have one of every specialty in there. If we are going to take care of our associates, I don't want them to have to go to Richmond to get care. [48:00] Don't tell me you can't do this." I think we have almost all specialties are covered with at least one physician, and some specialties have three, four, or five. Everything, and that was important. If you're going to do this, then you've got to be able to offer the care. It has gotten much better and we have made a concerted effort. We told them that we will partner with you, make your day better, and do what we can do for your practice. That's what we've been trying to do, and it's much better. I know, for example, with our computer system, physicians did not like it in the beginning. Nobody likes change. When Spotsylvania [HCA Spotsylvania Regional Medical Center] opened up they all had privileges over there too. They came back and they hated it. I mean hated it. They would tell me. I said, "See, it's not so bad here after all." But nobody likes change, and they still complain about it.

01-00:49:27
Rigelhaupt:
So I'm going to take you back to the mid-1990s, too, and have you try to talk a little bit about another you've brought up. You related it to the IPN, and as you've discussed the Affordable Care Act is changing financial incentives, and hospitals and doctors have to work together in new and different ways. But as you said in the mid-1990s, Mary Washington Hospital made a concerted effort to build trust and new relationships with physicians in the area. And another thing you've said earlier was that Mary Washington Hospital has been ahead of the curve. And I'm hesitant to say that you as a board could have anticipated the Affordable Care Act in the mid-1990s—

01-00:50:17
Fick:
We didn't. But we've been ahead of the curve with new service lines. I'm talking about service lines. I'm talking about branching out into ambulatory care. We've started creating some joint ventures with doctors at that point. We were just trying to make health care better, and anticipating what's needed in the future with new service lines. The hospital is a major physician recruiter for practices. We recruit physicians to help and actually financially assist new doctors in practices as well. [51:00] We track how many physicians we need. Right now we need forty-four primary care doctors. Now. Those are some of the services that we have done. Keeping ahead of the curve is mostly with offering new service lines, and starting to build this medical center that today has the mindset of having the care for all; almost everything you could possibly need. Probably the last draw was when we did the trauma center. The only service that we were lacking was trauma. With level two trauma almost all of the serious head injuries are treated here. It keeps them here now. We have got world-class neurosurgeons. We recruited those guys in order to make this trauma service work, and we have cardiovascular surgeons and thoracic surgeons. We have one of the finest thoracic surgeons I think in the whole United States: Dr. Tim Sherwood came out of John Hopkins. The guy does magic. That's what we've done and we've been able to recruit these world class physicians. It took a long time. It took time. Then we just kept growing and growing, and kept getting bigger. We had to expand because we were running out of beds. Finally, we pretty much built out the hospital. We couldn't go up any higher, and we couldn't go down. That's when the serious question about us building a new hospital started. We spent a lot of time on that. We spent a good year talking about it, and finally we decided it should go in Stafford. That's where it is and it's still growing. It has been open four or five years, and it's still struggling a little bit. The old thinking was if you build it they will come, but that didn't work. I think a lot of it is based on our population base here. We're such a transient commuter-oriented population that a lot of people who work in D.C. get their health care up there. Our military influence has a role as well. And then it's just the people; it's hard to change. They still want to come down here to Mary Washington Hospital. Even when you have got a hospital a mile away from you, you want to come down here. I don't think we anticipated that. [54:00] We're getting a lot of folks that are from the lower end of Prince William who were unhappy with Potomac at that time, which is now Sentara. But it's doing fine. We're getting better. We're

getting bigger. It will be full one day. That is one of the things I mean with "ahead of the curve." We are offering these different lines and building these Centers of Excellence, which has helped us greatly in our marketing efforts as well. It wasn't that way in the 1990s. It was just the hospital and the practice of medicine was different. It was fee-for-service, the old way. You went in, saw the doctor, you had your health care insurance, and the insurance company paid the physician a nice fee. The patient paid the copay. It's all changed now. The fee-for-service is done. They had to adapt as well to this new payment model. It's not even completely here yet, but what you're getting reimbursed is much less than it was in the 1990s. They were busy and they're still busy. We're fortunate where we live because of the population, and all these physicians are busy. With some of the practices you can't get in for three months. That was a stumbling block in the IPN. Physicians said, "Why do we need to do this? I'm busy. I don't need any more patients." But finally, and it took a while, they figured it out. We have got to work together. They're beginning to see and feel the effect of Washington on them. The ACA and then simply Medicare just saying, "I'm sorry, this what you're getting paid. We're reducing these rates." It's on the hospital side too. Then Medicaid is even worse. Their practice of medicine has changed, and so you have to adapt. If you don't want to adapt, unfortunately, I don't think you can be here. They're slowly realizing that. The younger physicians, they figured it out right away. Some of the older guys, they keep saying, "Maybe I won't be practicing when it hits." But that's fine.

01-00:56:35
Rigelhaupt:
So again, staying with the mid-1990s. This is about the time that Mary Washington Hospital started the cardiac program, and in my understanding the cardiologist was an employee of the hospital—

01-00:56:51
Fick:
Yes, he was. Actually, no. Our first was Dr. John Armitage, and he had his own practice. [57:00] He was not an associate. Then several interventional cardiologists came to town: Dr. Martyak and his practice, and then several others. Eventually, we did merge Dr. Armitage's practice—we bought his practice. That was one of our first outside acquisitions, you might call it. We had physicians employed inside, like the anesthesiologist group. We had some psychiatrists who were employed, but not big surgery and nothing major like cardiovascular. That was a big deal for us. It was a big deal for the community to have a cardiovascular surgeon here that could do a bypass surgery, valve replacements, and stuff like that. Then the interventional side took off with the caths (cardiac catheterization) and things. Those two service lines right there were big, really big for us. It was major. It was a major draw for the community. Prior to this, you had to leave. You had to go down to either Henrico Doctors' or Fairfax or someplace to get it done. That was something that started in the 1990s. We had a joint venture with imaging, too. That was in there as well. That's been huge. Then we created the surgery center, and that was big too. The physicians have a stake in that as well. We own a majority, but they own a portion as well. That's been a big draw, with the outpatient surgery. The FASC (Fredericksburg Ambulatory Surgery Center) has been huge. We were the only

one in town. Actually, they had one over at Dr. Willis's office, but they were mostly doing eye surgery over there. That was a big deal and then imaging has always been huge. We've got image centers all over the place now. There's one everywhere. The other thing we did was we built Lee's Hill Freestanding Emergency Room just to take some of the pressure off of Mary Washington. And it did. It did what it was supposed to be. That's a complete emergency department. Next door to it is an imaging center, so it's one stop shop. If you need x-ray, a CT, or something you could get it right there. They draw blood and have a lab; they do everything. [01:00:00] That was another big deal for the community. It took some of the pressure off of Mary Washington, and also the wait times. The wait times—that was a problem with the board. It was a big problem with the board because there were letters to the editor in the paper and not good ones. The board finally told the administration, "We have got to do something here." We spent a lot of effort and time on figuring ways to make the flow in that emergency room better. And we did. Actually we did it so well that it was written up in *US News and World Report*. [Dr.] Jody Crane, who was the chief architect of that, was immediately on the speaker board for every hospital in the United States on how to do this, because apparently everybody else had the same problem too. That really helped the ER. The patient satisfaction scores greatly improved after that because there was no three hour, four, or five—I heard seven—hour waits. It was jammed. I think we have an ambulance go every fifteen minutes. We didn't have any urgent care centers back in that time, which we have now. The ER was the only game in town after hours. If you called any doctors' primary care after hours, the answering services said call the ER or go to the ER. That has helped. We have the NextCare centers. We have a bunch of urgent care centers now, which has taken some of the load off of the ER too. That's fine and they needed to have some of that. They were way too busy. It creates dissatisfaction to have to wait four hours to get seen. That was a big deal too when we did that. We have looked in our geographic area and see where these services might be needed and we have responded to it. The last two built up on the hill are the cancer center and the women's services center. We even had a hand in the Moss Free Clinic. The health system donated land for that. That's been a wonderful jewel for the community. It takes some of the indigent care out of the hospital. [01:03:00] The Moss Free Clinic sees these patients and provides health care and free medicine for them. It's a big deal because the hospital is doing that. Last year, it was $56 million dollars in indigent care we provided to the community. That's a reflection of the recession in 2008. Remember those years there? People lost their jobs and it's still not back. We are still seeing a lot of indigent care now and self pay. There are four million Virginians that are underinsured and we have a whole bunch here in this area. There is a huge need.

01-01:03:55
Rigelhaupt:
And I think in the Moss Clinic and the community benefit part is somewhere that I want to get to in a moment. But again staying with the early 1990s. When you came on the Foundation Board, I imagine that the new hospital, I don't know what number it'll hit before it's not new, but since it's twenty—

01-01:04:21
Fick:
It's twenty years.

01-01:04:22
Rigelhaupt:
But I'm still going to call it new. It was probably under construction.

01-01:04:29
Fick:
It was because it was it was 1993 is when they cut the ribbon to open. There was a campaign at the foundation to help raise money for the bricks and mortar. I think it was over $10 million, and we did it. I was on the steering committee and meeting with people. We had a consultant. Somebody would give you $5 million, somebody would give you a $1 million, and then a whole bunch of people to give you $10,000. It was a progression like that. I was on the committee and we had prospects to go talk to. Pretty much everybody opened their pocketbook. It was a successful campaign. The campaign funded, probably, some of the infrastructure and equipment for the new hospital. I was on the Foundation Board then, because we opened it in 1993. It was September of '93, because we had our twentieth last month. I really wasn't involved in any of the building design or anything like that at all. I was strictly on the philanthropic foundation side. And then I came over the next year in 1994 to the hospital board. [01:06:00]

01-01:06:00
Rigelhaupt:
While you were on the foundation board between 1990 and—

01-01:06:07
Fick:
It was '91 and—I got on in '91 and got off at '94.

01-01:06:16
Rigelhaupt:
As a pharmacist you have a familiarity with health care coming in. What were you most excited to work on, and to have the foundation be able to try and work toward in terms of health care and then reaching inpatient care?

01-01:06:33
Fick:
I remember at the time we were doing that golf tournament. It was always going to some medical need in the hospital or in the community. In the 1993 the Moss Free Clinic was started in the old hospital. I practiced pharmacy there since inception. I volunteered at the Moss Free Clinic. We were

able to provide for them too through the golf tournament for a couple of years. Then we started the oyster roast, which is coming up next month; that goes to the clinic as well. The Foundation is the fundraising arm for the system. Now we have two, but they are all under one umbrella and they have their own board. They provide the philanthropic need for the system. Actually the foundations are very involved with the community needs as well, the community needs assessment. They were the architect of that through CBOC (Community Benefit Oversight Committee). They are the ones that are the main steering committee for the community advisory association. That is done by the foundation. They do a needs assessment each year, and they just finished it; it has sixteen different things the community has asked with respect to health care. Diabetes is a horrible problem now. I don't know how they're going to do it, but smoking cessation—at least if you could get people thinking about it. Diabetes is horrible, especially in kids. Another major concern in this area is mental health. I see that at the clinic as well, and it's everywhere. Mental health is a huge concern and there are not a lot of resources for it. [01:09:00] That was one of the concerns of the citizens of our group. There is a plan for each one of these different disease entities that they recognize. It involves a hospital, it involves the foundation, and it involves a community. The community has to have a hand in this as well, in helping solve these issues. Obesity is another that that's a problem. It is at least one of the ones that is on their list. The gem for us is this Citizens Advisory Group, and their active participation in the community health needs. Actually I created it. It's a sub-committee of my executive committee. Joe Wilson is the chairman of it and he has done an outstanding job. We are one of the benchmarks in the nation for how you do this. How did you form it? Hospitals call us and want to know how we did it. It has been immensely successful. There are always health needs in any community no matter where you live. We've identified them, and we have a plan on how to at least make it more manageable, or at least for people to understand it. Being a pharmacist one of my biggest is diabetes; it's rampant, and it's rampant among kids. It is mostly because obesity with the kids. It's a horrible problem. Diabetes is not good; lots of other things happen to you with diabetes. That's a big deal. Another area that concerned me is we have a large amount of cancer in this community. We have way more than the state average and the national average. I don't understand why. A lot of it is colon cancer and a ton of it is childhood leukemia. I get a cancer report every year for this area. It's huge and way, way higher than the state average or the national average. Why? How does that happen? Are the power lines doing it? Are there environmental factors doing it? Probably so. But we've been unable to identify them. [01:12:00] It's a big concern. And that was one of their concerns on the community health assessment.

01-01:12:09
Rigelhaupt:
So tell me the story of building the community advisory, the sub-committee that you formed—

01-01:12:14
Fick:
It's called CBOC. We put CBOC together. Joe Wilson and one of my trustees is on there. They met, and they started brainstorming about how are we going to make this happen. We had one years

ago—and I can't remember the name of it—but it really wasn't very effective at all. We had representatives from planning District 16 on, and we still do. There is much more excitement about it. The citizens are involved and they want to be on it. The board has to approve of them. They fill out a lengthy questionnaire of why you want to do this. We just approved our new members last Tuesday. These people want to be involved, and that's good. They are the ones that come up with the assessment. It's been a win-win for us, where it wasn't before. In the past, you were appointed and the attendance was horrible; we finally said we'll do away with it. Then this CBOC was resurrected a couple of years ago and really rolled. It is going strong now because people can get their hands on it. They can get deep into it if they want to. They meet quarterly. There is always a good exchange of information.

01-01:14:05
Rigelhaupt:
So the Citizens Advisory, the community health needs. It strikes me as this also involving aspects of primary care in public health, which have traditionally not been a focal point of acute care hospitals. Why has Mary Washington Healthcare and the system become closely linked with public health systems and concerns of primary care in—

01-01:14:41
Fick:
We work closely with the health department and social services. That's the mental health side of it, a lot of it. Primary care is a problem. We don't have enough of them. They have identified these things, and then actually we have members of the health department and social services who are members of the advisory council who wanted to do this. They asked, "Can we do this?" They share their information because they deal with this. They know what the needs are. They have been an integral part of shaping our health needs assessment because we're all working together now. Whereas before they did their thing, we did our thing, the health department was the health department, and social services was social services. Now it's just too big. There are too many needs: the mental side of it, the diabetes, and the obesity. You have got to work together as partners to try to address it. It takes a lot. It's education. It's community education. It's education to mom and dad. It's education in the school systems and the teachers. They are with the kids six hours a day. We provide education on better eating and things. We finally started working together and not having everybody going in their own direction. In order to do this, to make it work, you have to do that. The hospitals are acutely involved in it. A lot of the things involve the hospital: inside the hospital there are health fairs, educational sessions, and all kinds of different things that the hospital itself is going to do with the community. The hospital will try to educate them on these health risks that we have identified. All of them are pretty common. Probably everybody has the same ones, but some are more critical than others. I just read this report and it's sixteen pages long; each one of the key areas has a subset under it on what they are going to do. It's really, really involved. This was completed last week. Then we have a report to the community about it.

01-01:17:27
Rigelhaupt:
And how many years has this been running now?

01-01:17:31
Fick:
I think maybe three or four? It's young. The first one just really didn't work. My executive committee, we did it. We created it. I said, "I want to do this." I got somebody who I think would be chair. He was really involved in it himself. Then it started. [01:18:00] They got this steering committee together, branched out, started the advisory committee, and it just kept growing and growing and growing. And then they did the community health needs assessment. They did that a couple of years ago, which was a huge report. Then what they do is they bring it out each year, and then they take a look at it. What we did accomplish? Or what strides were made? Is there anything new that we need to put on it? Are there any new processes that need to be done? That is what they just completed. It was a draft and the board hasn't even seen it yet. Unfortunately, the chairman gets to see everything before everybody else. [laughter] The committee's work has been well received, and it wasn't that way before. It was more of a situation where we have ten members on the board and three of them show up; it just was a waste of time.

01-01:19:14
Rigelhaupt:
And is this something that works closely with the foundation board and—

01-01:19:18
Fick:
Yes, it is. The foundation is probably more involved than the trustees. It's a sub-committee of my board, but the foundation is the one who is actually running it. All the meetings are there. They have a staff person that handles the meetings and the minutes. It is really an arm of them. I'm thinking about changing it to being all of them and letting them have it as an arm of themselves. And then I'll have one of my trustees sit on it and then report back to me. We've got it going so well now; people are really interested and it could almost stand alone. It is standing alone, but all the work is done at the foundation. I get a monthly report of what's going on from the Foundation president, and also from my trustee who is a member of it. We know exactly what's going on all the time.

01-01:20:34
Rigelhaupt:
So I want to try and see if there are some historical roots to this. Not only in the first iteration but something that happened in the mid-'90s. As you mentioned the Moss Clinic opens in 1993 and I think this is part of that community health interest coming out of Mary Washington Hospital and the foundation. [01:21:00] But also as you talked about—the hospital itself became a regional medical center, started doing more and more specialized care, higher tech care. And I can't help but

wonder if there was a danger that the specialized care, the acute care could have taken the hospital farther away from the community and public health needs. And yet, it seems as though that did not happen.

01-01:21:30
Fick:
No, it didn't happen because if you remember the community owned the hospital. Remember that the community—that you could pay a dollar or two dollars and become a member of the hospital that actually had voting privileges? You voted for the board, the trustees. We were one of the only hospitals in America that was structured like that. Probably well before my time it was really greatly attended by almost everybody. Then it got down to mostly the Fredericksburg city residents. It finally got down to where we had more associates as members and attendants than we had citizens. We did away with it back in the mid-2000s. No, they were very involved and they met a couple times a year and gave the hospital's report to the community. They actually elected the trustees; I got elected through them. No, they didn't do the officers; they just did the trustees. The community involvement has always been there. We didn't mine it enough like we have done now. It has just been a totally different animal than it was before because there's involvement now. There are people that are actually coming in, signing up, filling out this huge questionnaire, and being involved and active because they're stakeholders. They are stakeholders in the health care of this community. They care about it. The hospital has always been community-oriented. Sometimes it was so community-oriented that I said, "We'll never get away from being a district community hospital." There are some that still think that. We had to service the population, and the population was growing every year. First of all, we needed bricks and mortar and we needed to build more patient rooms. [01:24:00] We had to add these service lines in order for us to continue to grow. And then we went from little community hospital to big regional medical center. The community's been very supportive all the way along. We have just done some marketing techniques to make them more knowledgeable of who we are. The name change was huge. We did a study. We outsourced it to professional people. They surveyed 4,000 people about name recognition and where do you do your surgery and where are your doctors. It was a huge report when we got it back. It clearly said they don't know what "MediCorp" means. All they knew about was Mary Washington Hospital. We did that name change, which was a huge marketing ploy for us that worked. Now we have brand image. Brand image is huge. Look at me here. What do you think about when you see the Clydesdales? It is the same kind of deal. We need to create that brand image, and Mary Washington Healthcare has done that. Now we're working on "Here for you." That's our new tagline. If you look at the billboards and the ads in the newspaper, they say "Here for you." We're still working it. We have a whole media department and now that's a marketing department, which we didn't have before. It is letting the community hear us more and getting our name in their minds when they need health care. That is how you build your brand awareness. But it's always been community. It's always been that way since I've been on the board. It's just gotten bigger, but I think the community wanted it. They wanted these things. It has been a pretty good partnership by and large. They have accepted us, and all the things we have done. We still have a pretty good market share, over sixty percent.

Spotsylvania Regional Medical Center took some of it away, which is expected. But sixty-three or sixty-four percent, that's pretty good. It is real good, as a matter of fact. The community is still supporting us, but it has always been that way. I think we'll continue to do that. That's why there is the IPN. One of these days we're going to offer a product. We're going to compete with Anthem in our community. We are still doing that for the community. The Centers of Excellence are all about community. They are all wonderful, all of them. [01:27:00] I never really saw a disconnect there between the community side of it. Of course, there were some of the local Fredericksburgians that would be vocal. But you have that in any organization, or any time your community is involved. It has been pretty good. Now we've got the docs working on the right side; we're with them, they're with us, and we're working together on things. It's just really shaping up to be a wonderful organization.

01-01:27:37
Rigelhaupt:
So when you came on the Board in '94, was the campus as it is now imagined? Did you imagine it growing the way it did, but also attracting other health care providers in terms of Kaiser or Pratt?

01-01:27:56
Fick:
Pratt has always been there. We had a master plan. We had all that land and the campus was there. The ambulatory services building was there and we got Tompkins-Martin Plaza into there. The FASC, the surgery center, and then the medical imaging came in. Then we did the Moss Clinic up there, and then the last two. It's a medical complex. All those buildings up there, most of them are physicians. Kaiser is in there. You have got Health South across the street in the rehab place. There has always been a master plan that said it would remain a "medical campus." On the outside we have a bank and some restaurants and stuff, but by and large it's mostly physicians. We are getting ready to do two more pieces of property and they are going to be medically oriented as well. We could not expand the hospital on the main campus anymore because we ran out of room. We could not go up any higher. We built that parking deck. The Board made them build three levels, but they only wanted to do two levels. My finance committee said, "We're doing three." They have thanked me ever since. We have gotten out of things, too. What do we do? What do we do best? We sold Chancellor's Village, which was assisted living. We also sold two nursing homes because that wasn't our core business. We have eliminated some things over the years that have not been core to our business. The board has done this. The board and board members have worked with management to do this, such as Carriage Hill Nursing Home. [01:30:00] We may eliminate some more before it's over with. We haven't decided yet which ones, but there are some on the chopping block because they are not core business.

01-01:30:28
Rigelhaupt:
Were there any concerns when you came on the Board, and you said you were the secretary treasurer on the finance committee, about the finances?

01-01:30:40
Fick:
We were making $10 million and $12 million a year net. The payment structure was different. You actually got paid. You made money. The reimbursements were much higher than they are now. Whenever we did a big project, we would go to the bond market and finance it with bonds. We used to take our depreciation expense, which was between $30 million and $37 million a year, and that would be our capital budget. We would spend $30 million a year just on inside improvements. Or we built an endoscopy suite, which cost $4 million. But the big stuff, the bricks and mortar stuff, went to the bond market because it was huge. We didn't overspend. We always knew what we were going to do and we did it, but we weren't frivolous. It was beautiful. It's not that way now.

01-01:31:48
Rigelhaupt:
Part of my asking about the finances is you said the bond market. I think it was $300 million for the new hospital. But then when you entered the bond market and that you're dealing with a financial industry. And again, you have stake holders that you have to answer to and bond holders.

01-01:32:15
Fick:
You have the rating agency you have got to deal with. It is not so much the bondholders themselves, but the agencies. We just had that meeting. The bonds are not really long-term bonds; you can refinance them and get a better interest rate and cut $3 million or $4 million in the process. We did that lots of times. We did a whole lot of that refinancing. They just reissue them again at a better rate, which saved $3 million or $4 million and is a smart move.

01-01:33:00
Rigelhaupt:
Part of the reason I'm asking is in some way the concern with the rating agencies and bonds also takes you a little farther from the community. Did you have to answer to—?

01-01:33:16
Fick:
It does. But it's part of doing business. It is part of the business model. We were downgraded last year and we didn't have a good year. We lost a lot of money last year. Thankfully, we don't have to build anything. We don't have to go to the bond market to do anything, because probably interest rates will be higher. That's just the business side of being a board member. It is a community board,

but there is a whole lot of business stuff that you have to do in being a board member. You have to understand the clinical side of it too. It's not just being a community board member. As a matter of fact, it is very involved on this board. Maybe that is why they are having a shortage? It is very time-consuming. The board works on committees; the committees do all the work. Then they report to me at the big board meeting, which used to last only an hour and a half. Now it is three hours because there are more things to report. All the work is done in the committee. Every board member is on at least two or three committees and the work is done there. It is a lot of time. There are more things than just being a community member. It's much more involved than that. [01:34:40]

[End of Interview 1]

Interview 2 - November 6, 2013

02-00:00:00
Rigelhaupt:
It is November 6, 2013; I'm doing a second interview with John Fick, III. And I'd like to pick up with some of the questions we didn't get to last time. And I'm wondering if I could begin by asking you to talk about what you remember about the origins of the Community Benefit Fund. It was probably called the Community Service Fund.

02-00:00:30
Fick:
It was a Community Service Fund. It's now called CBOC—C-B-O-C. Actually, CBOC was started, I guess maybe two, three years ago. I made it a subcommittee of my executive committee, so that we could have a place to put it. The executive committee can meet quickly. The old community services committee was doing fine, but we wanted to branch out and hopefully garner more support from our community citizens. This committee is designed to allow community citizens to become members of it. There is a subsidiary called the community advisory board, and that's where the actual citizens are. The CBOC is a group of hand-picked members from both foundations and there are two member of my board on there as trustees; there's an executive from the hospital, from Mary Washington Healthcare, and I think maybe one or two community people on it. Their goal was to establish the committee, run with it, and to garner interest in the community to step up and take interest in the health care issues within our community. We identified the community as Planning District 16, which is our primary service area; it includes Caroline, King George, Spotsylvania, Stafford, and the City of Fredericksburg. They have done a phenomenal job. I don't know how many members we have, but it's well over a hundred. There are four different areas that you can become a member of. They meet quarterly. You can become just a member of the citizens' advisory group attend the quarterly meetings and get an update on the progress of their strategic plan. Or you can drill all the way down to, depending on how much time you have, and actually become a member of a committee within a department inside the hospital. If you have a special knack for OB/GYN, you can go into our birthing and delivery. [03:00] So it allows community citizens, who may have experience in those different medical departments, to actually have a hands-on approach. That has excited everybody and that was a step that I don't think anybody was doing when we started it. I do know that it's blossomed really well, and we're getting calls from other hospital systems across the United States, to say, "How did you do this? How did you start up?" We're sort of like the benchmark for the nation. Medicare (Centers for Medicare & Medicaid Services) now requires you to have something like that; they require you to reinvest back into your community. It is all aligned with the indigent care that we give and the charity write-offs that we do. I just saw the numbers yesterday at the hospital. For 2012, it was $101 million. It is a combination of different things. But the bottom line just for the indigent write-off care or community care was $56 million, which is a huge number. That ties in with the community advisory council as well as CBOC. They've both been very successful. We approved five new members at our last meeting. They go through an

executive committee, and we approve the memberships. We approved five new members in September. There are always a couple of new members to approve each month, which is fine—which is great—and that's what we want to do. What they do is they do a strategic assessment of the health needs of the community, and I think I told you last time that I had just received a report; there were sixteen areas that they defined as critical issues for our community. As you might guess, smoking is an issue, obesity is an issue, especially childhood obesity. Diabetes and childhood diabetes are huge issues. Adult-onset diabetes, mostly because of obesity, is a major concern, not only here, but in the nation. We've addressed those as well. Another big issue which is very important for this community is mental health. There is a tremendous shortage of mental health providers in our community, and there's a significant need for it. I see that quite a bit when I practice pharmacy at the Moss Free Clinic. Most of our patients are not only are they indigent, but they have multiple disease states, usually three or four. [06:00] They could take anywhere from five to twenty prescriptions a day, depending on the disease state. When you're taking twenty different prescriptions and all you're doing all day long is taking pills, it messes with your mental status, your mental faculties, and causes stress and anxiety just doing it. Plus, add the stress and anxiety of where's my next meal coming from? It's a huge issue for us in this community, and unfortunately, the state has continued to cut resources to the social services boards and the mental health boards in the city and the county. You know, somebody has got to take up the slack and we've jumped in this as well. But the community benefit has been a real success for us over the last three years and it's continued to grow. We are going to continue to address these issues and try to find workable solutions for them. But it's in partnership with our citizens, which is why it works. It's not just the hospital doing it, it's not my board doing it; it's working in concert with concerned citizens, who have the same concerns we have.

02-00:07:18
Rigelhaupt:
So the CBOC you're describing, do you see links between it and the Community Service Fund that—

02-00:07:25
Fick:
The Community Service Fund—both of our foundations have the Community Service Fund. It was set up, at least in the beginning, with Mary Washington Hospital Foundation. Stafford had not been built yet. It was a different name at that point. But what it does is it issues grants. It uses some of the money from the Pratt Fund, which I was telling you about, and some of the interest earned on that. There are monies in there that have been restricted to the Community Service Fund; they use the interest earned off those monies. We grant two times a year, I think, in the fall and the spring. The grants are all tied to health care needs. It has got to be something within the realm of health care, but that's a loose term. Some of the things aren't clearly or directly related to health care, but they are related to ancillary services within health care. We granted money to the Head Start program. Now, that's not directly health care, but diet and nutrition are health care. They allow some latitude

in there so that they can grant to people who actually are providing some sort of health care, preventative and wellness care. It's been hugely successful. [09:00] We award probably $300,000 to $400,000 every grant period. That usually means ten to fifteen awards, maybe even more. People get a nice chunk of money to run their programs. If you follow the guidelines you're successful, and you do what you say you're going to do, you can come back next year and get it again. CBOC has an indirect role in that. The foundation still controls the Community Service Fund, but CBOC is the arm that determines the strategic directions of the Community Service Fund and then addressing the health care needs of our communities.

02-00:09:52
Rigelhaupt:
You had a hands-on view of this, both as a board member and as a pharmacist. What grants have you seen, or areas have you seen, the Community Service Fund have perhaps the most influence?

02-00:10:09
Fick:
They have done several. They've worked with the community services board and done several grants. One of the other deficiencies that we have is pediatric dentistry. They have done some grants for a mobile dental van. We still do have a mobile mammography van. There are grants for health and wellness, especially with children's nutrition. There have been some grants to try to at least address childhood diabetes and obesity. But there's not really one that stands out; it's a combination of several health things that are addressed each year. Some of it has to do with physical fitness as well; you need to have physical fitness. There are a whole host of things that you need to do to try to take care of some of these community issues. It's a cross-section of several different entities that they give to, and they do it. You can come back if you follow the grant guidelines. There's another organization in Virginia called the Virginia Health Care Foundation (VHCF), a health care safety net. I'm on the board of that too; I told you I'm on too many boards. We make grants—this is a public-private partnership with the state of Virginia. We make grants to free clinics in counties all over the state of Virginia, Fredericksburg included, for positions in town that are providing indigent care. [12:00] The Moss Free Clinic got a grant to hire a psychiatric nurse practitioner, one of the first in the state. The way they work their grants is, it's a three-year grant and the money decreases each year; at the end of the third year, you are supposed to self-fund it. Most of the grants that they do have been very successful. They will fund a dentist to come into a free clinic and pay his salary to provide dental care. There is a really big access problem to pediatric dental care across the state of Virginia, and it's mostly related to Medicaid. It's just that Medicaid does not pay enough for the dentist to accept these patients. And then there's a compliance problem where they don't show up. They book chair time and they don't show up, so they lose revenue because somebody else could be in the chair. There is a major problem of access in that particular category. They give grants for anything like that. Actually, right now we're undertaking a program to fund nurse practitioners to go back to school and become psychiatric nurse practitioners because of the need for mental health in

the state. We're doing that right now at the Virginia Health Care Foundation. They work in concert with communities and community benefits, as well.

02-00:13:40
Rigelhaupt:
What are some of the ways that a Community Service Fund, through the hospital foundation, has worked with the Moss Clinic?

02-00:13:49
Fick:
They haven't worked directly with the Moss Clinic. The foundation works directly with the Moss Clinic on funding. We just had the oyster roast last week. I don't know how much was raised, but all that money goes to their endowment. The foundation supports it that way. You remember I was telling about my golf tournaments that I had. I know at least two or three times that all the monies went to the Moss Free Clinic. They don't actually give grants to the Moss. They could, but the Moss has never actually gone to it. The foundation usually is responsible for the clinic side, with some other fundraising activities that we do at the foundation.

02-00:14:33
Rigelhaupt:
Was it a strategic decision to have the Moss Clinic on the hospital campus?

02-00:14:43
Fick:
Yes, it was. We were down on Hunter Street, where the old health department used to be, and we were outgrowing that space quickly. It was a strategic decision to put it up on the hill so that we could coordinate our services together. [15:00] That is what we are doing now. And we're even doing it more now, with the advent of the Affordable Care Act, Obamacare. We are getting ready to see these exchanges come out here shortly. We are not quite sure what they're going to look like, but they're coming out. The Moss Clinic will play a role in that as well, especially since Virginia has decided not to go into Medicaid expansion. There are a whole group of folks that are going to be left out there with no health insurance. They are below 138 percent of the federal poverty limit. The Moss Clinic will play a huge role in that because they don't have access and they don't qualify for the exchanges. The exchanges go for like, 139 to 400 percent of the federal poverty level. We have this group of folks that are in this chasm and they don't have health care. It's a big deal. We're in the process of linking the Moss Clinic up with electronic medical record that will talk to the emergency room at the hospital, which is mostly where the patients come from; they come in the emergency room to be treated, and then they're referred up to us [Moss Free Clinic] after they're treated. That's the conduit right there. We will be able to use an electronic medical record to streamline and check in on all the stuff you've already done it in a hospital; you just get online up here and you're there,

which is a great service and very helpful. You don't have to spend a lot of time reentering the same information over and over again.

02-00:16:53
Rigelhaupt:
Is this something the hospital is largely donating, the technology and the time to install?

02-00:16:59
Fick:
Yes they are. It's called Allscripts. Remember I told you that if it wasn't for the hospital, I don't think the clinic would exist. They graciously over the years provided all of the labs, all of the imaging. If you need a stress test or any type of medical procedure, they've done it. The foundation of course grants them a certain percentage of the Pratt Fund every year as well, for their operating capital.

02-00:17:34
Rigelhaupt:
How did you first get involved with the Moss Free Clinic?

02-00:17:37
Fick:
I got involved with the Moss Free Clinic almost at its inception. When they formed it back in 1993—actually we just celebrated twenty years—it was in the Amy Guest wing of the old hospital at 2300 Fall Hill. [18:00] It was me and Steve May, who is a pharmacist at Goolrick's, along with Dr. Moss, and a few other doctors that started it. I didn't actually form it, but I was one of the early pioneers on the pharmacy side. I have been practicing there since 1993, and it's evolved immensely over those years. This is another success story for our community, and it continues to do that. It is the health care safety net that we have here. In order to take care of these folks that can't afford it—they all work, but they can't afford to buy insurance. Some of them may be able to qualify for the exchanges because we increased our level. We used to be at one hundred twenty-fifth level of the federal poverty guideline, which is really bad, and we increased it up to two hundred percent. The two hundredth level now is part of the exchanges. Some of those folks may be able to go on insurance plans from the exchanges and will be eligible for some subsidy, either from the federal government or some tax credit, depending on how they qualify. But all that does is if they go to the exchanges, it just opens a door for more people down here that don't have it. We're not losing anything; we're just opening the floodgates again.

02-00:19:42
Rigelhaupt:
I want to go back to the Moss Clinic a little bit, but you mentioned a few minutes ago that there's a significant portion of payment that the hospital is never going to receive, that's donated care. And

yet, the hospital, Mary Washington Healthcare now, as a system, makes a commitment every year to put money into the Community Service Fund.

02-00:20:13
Fick:
The foundation does.

02-00:20:15
Rigelhaupt:
But I thought the foundation—

02-00:20:18
Fick:
Actually, the foundation is the fundraising arm for the hospital. The hospital doesn't do any fundraising, the foundation does it. The money that goes into the Community Service Fund comes from donations to the foundation, and they fund it through there. The hospital does not write a check to the foundation.

02-00:20:40
Rigelhaupt:
But was there a time that a portion of revenue over expenses was given directly to the foundation?

02-00:20:49
Fick:
No. The foundation has always stood on its own. They have a budget every year that they want to meet through fundraising. [21:00] Actually, the foundation has given money to the hospital. There have been a couple campaigns—there's a campaign going on right now for the cancer center and it's a $6 million campaign. I think were at $3.5, maybe $4 million right now. They are the arm that gives money back to the hospital. The hospital does not per se write a check to the foundation. Now, the hospital does provide services to the Moss Free Clinic, which I would call in kind services, like lab, radiology, and stuff like that. It is in kind, but they actually don't write a check. The foundations stand alone, both at Stafford and Mary Washington.

02-00:21:54
Rigelhaupt:
And I may be mixing up the terminology, but I thought there was a time where a large portion was given to start out.

02-00:22:05
Fick:
No, they took that from the Pratt Fund. It's always been a portion of the Pratt Fund to help start the Community Service Fund. I can't recall the hospitals ever writing a check directly to the foundation for the Community Service Fund. It has always been a function of a foundation to do that.

02-00:22:42
Rigelhaupt:
So, when you spoke of being involved with the Virginia Health Care Foundation, is that similar to the Fredericksburg Regional Health Council, or is that a separate organization here also?

02-00:22:57
Fick:
That is separate. The F.A.R.C., that was the parent company of the Moss Free Clinic. I'm not even sure it's still here anymore, F.A.R.C., Fredericksburg Area Regional Health Commission, something like that. I was on that board—actually, I was president at least three times—but it was always under the name of the Moss Free Clinic. It was probably F.A.R.C. doing business as the Moss Free Clinic. That was just a name that was brought out. In the very beginning of their life, they were sort of acting as a center to the CBOC in trying to address community health issues. But it has morphed into the Moss Free Clinic; we no longer use that terminology anymore. [24:00] It's just Moss. It's brand recognition. Remember I told you about that, brand recognition. Nobody knows what F.A.R.C. means except maybe me, but it's the Moss Free Clinic.

02-00:24:22
Rigelhaupt:
Now a lot of physicians volunteer, or take patients' referrals, from the Moss Free Clinic. Have you seen or heard, either through informal conversations, or even more formal conversations, the ways in which the practices that the clinic has been able to do, have influenced physician practices in the region?

02-00:24:48
Fick:
First of all, we're taking patients and we're seeing patients at the clinic that can't pay. If they were seeing them in their office, they still can't pay. We're taking some of that indigent care away from them, that's non-compensated care anyway, which is holding up an appointments block for them. It benefits them financially because we are taking the folks that are indigent. Then they are volunteering to come over there and help us treat them. It's a give and take thing. The same thing with the specialists; we have a relationship with all the specialists in town to do the same thing. Some of those specialists will actually come to the clinic and see patients. Orthopedic surgeons come over there; they'll have like a back clinic one night of the week. You will have orthopedic surgeons come in. The entire medical community has opened up their arms for this clinic, and that's another reason

why we are successful. We would not be able to do it without specialists. The primary care guys—nurse practitioners, physicians assistants, and docs come from the ER—are the ones that do most of the volunteering. It has been a wonderful relationship and a wonderful partnership with the medical community. They understand the role of the clinic and they understand what we're doing. Same thing with the hospital: the hospital understands what we're doing. We are keeping people out of both places. We are treating them and getting them well. There are a lot of success stories out of the Moss Free. We have got people well and they've gotten a job. They are productive, and now, some of them come back and volunteer at the clinic. It's been a great success story.

02-00:26:47
Rigelhaupt:
What have you learned by your actual work at the clinic? You see it in a first-hand way that I think other board members do not, perhaps. What is it you've learned that you bring back to the board meeting? [27:00]

02-00:27:02
Fick:
The biggest part that I've learned, especially for me, is that first of all, all these people—they're real people and they're real sick. I get the opportunity to use my skill to give back to them, and that's the gratitude. It overwhelms me that I have the skill, that I'm able to donate my time, and give back to these folks to try to make them well. That is what I get out of it. Then the same thing with the board as well: it's giving back and it's all about giving back to the community. All of my board members do that. They are not only on one board, but they are on several boards. We all have this good community spirit about giving back, and I think that's extremely important. I have the skill [as a pharmacist], and I'm using it to give back. I don't want anything in return, other than I feel good about doing it, and I feel really good about it. I know that I've helped somebody at the end of the night. I can't help them all, but the ones that I did touch, I feel that they're better off because I'm trying to heal you. That's my personal gain from that.

02-00:28:33
Rigelhaupt:
So part of what you, when you start talking about the community benefit, you mentioned the community needs health assessment. And, I imagine a lot of hospitals are doing that—

02-00:28:45
Fick:
They're all doing it because it's mandated. It's mandated by CMS now. A lot of them are scrambling because they don't know how to do it. That's why we were getting all these calls, "How did you do it? Can you send us a copy?" Like I told you, we were the benchmark because this is part of the deal. We were out of the gate a little bit earlier than everybody else, and ours has been quite successful. It is reviewed every year; we just finished the update and they took a look at the plan year over year.

What did we do? How did we affect this? Did we make progress here? Did we not make progress there? It is a moving target all the time. And it has to be; you have to prioritize what your health assessment is in your community. Some things are doable, and some things are simply not doable. You can put it in there. If you can figure out a way to get everyone to quit smoking, you will be the hero of the world.

02-00:29:58
Rigelhaupt:
But part of my asking about the community's health assessment is it also sounds like, as you said, the Moss Free Clinic just celebrated its twenty years, twentieth anniversary. In some respects, has this been going on in an informal way?

02-00:30:16
Fick:
It has. It's just never been put on paper. We tried to put it on paper, with the Fredericksburg Area Regional Health Council (F.A.R.C.) years ago. We addressed, I think it was maybe, six goals. They haven't changed. They are all still the same: high blood pressure, diabetes—diabetes wasn't as rampant back twenty years ago as it is today. But it is pretty much the same thing. It was a great idea, and we didn't have enough bodies to implement it. The Moss Free Clinic has been doing this for twenty years. Now we have a white paper that says this is what we decided that our health needs are for the community and this is the strategic plan that we are going to follow. That is the difference right there: we've been doing it—everybody's been doing it all along—but it's a white paper now. It had never been put down. Everybody has been thinking about it, but nobody had really taken action to actually go and implement it, or begin to implement it. Each one of these sixteen different strategic initiatives has a subset under each one, how to accomplish it and how do you go about doing this. A lot of it pertains to community education, just simply educating the public about these health issues. Almost all of it is communication.

02-00:31:48
Rigelhaupt:
When you say everybody's doing it, who are you referring to?

02-00:31:52
Fick:
If you are a hospital system, you have to have a plan, it was mandated by the CMS, which is Centers for Medicare & Medicaid Services in DC. You have to have a plan. You have to have a strategic plan. I think it's tied to Obamacare; it's only been mandated for a couple of years and it's probably tied to the Affordable Care Act. It is intended to make communities pay attention and take a look at what the strategic initiatives are with respect to your community's health. A lot of Obamacare deals with wellness and prevention and that's what these plans are.

02-00:32:47
Rigelhaupt:
Were there things—so, you said this had been going on, and you didn't even try to kind of paper it, years earlier.

02-00:32:56
Fick:
We wrote it down, but we didn't really follow through with it. [33:00] It was nice to write it down and pat ourselves on the back; we thought about it. The clinic went crazy. When we opened the clinic, it was non-stop. I mean, people lined up outside the door. When we first opened it, we were only seeing patients on Tuesday and Thursday night and we could see forty patients. I got there to work in the pharmacy, at maybe 6:30 or 7:00, and it opened up like at 4:00. Those people lined up; they brought lawn chairs and sat outside for like two or three hours just to be one of the forty. That's all we could do. We still can't do anymore; we do forty now and that's all we can see. We just don't have the manpower to do anymore. Sometimes we'll fill 150 or 200 prescriptions in three hours. You know that when you go in there it's work; you don't look up until it's 10:00. But that hasn't changed for twenty years, and it's always been in a growth mode. Almost all the patients we see now on Tuesdays and Thursdays are brand new; they've never been here before. It is a whole new population. It is all because of the 2008 recession, which sparked most of it. People lost their job, they lost their home, and they were unemployed. They had jobs, they had good jobs before, and they don't have them now. A lot of the growth is tied to the influx of the Hispanic population as well. I mean, we don't turn anybody down. It's been busy, very busy, and it's never slowed down; it's gotten busier.

02-00:34:47
Rigelhaupt:
Can you think of any things you've learned specifically that you can see came out of the Moss Free Clinic that made it directly into the community needs health assessment, some of the planning that's been associated with it since it was—

02-00:35:02
Fick:
Yes. In the last maybe five or six years at the clinic, we have delved more into preventative health care. We have the dental clinic now, and we have hygienists coming in from Germanna, who are doing preventative health care. We started a smoking cessation clinic at Moss. We started a diabetes clinic and a nutrition clinic. It's all tied to that community assessment, and everything I was just talking about; all those key issues of that community assessment. We are teaching people how to live better lives, to eat better, don't smoke, and lose weight. If you have diabetes, check your blood sugar; we give you the machine for free. Yes, it's been a direct relationship to that plan, and we're slowly winning. [36:00] It is taking a long time, but we're slowly winning. People understand that

they need to take better care of their health because most of their disease states were brought on by poor health choices. Almost every one of them, all the time.

02-00:36:25
Rigelhaupt:
Can you think of specific things that, besides the imaging, the labs, particularly around preventative care, that Mary Washington Healthcare has provided?

02-00:36:35
Fick:
Mary Washington. We do health fairs a lot. We have health fairs and we have the same sort of entities for patients who are there, but are we doing enough? No. We need to do better. The changing face of health care is going to force us to do better, because a lot of the Affordable Care Act is geared toward wellness and prevention. You are not supposed to go back to the hospital. When you get out you are supposed to stay out. The only way to do that is to teach you or educate you on how you take your medicine when you're supposed to, get your lab tests when you have to, and check your blood sugar. If you're on a blood thinner, go back into the Coumadin clinic and make sure you're not going to bleed to death. Stuff like that happens. That is what is coming down the pike. It's not here yet, but it's coming down, pretty quickly. It will be here probably in 2015, or somewhere around there. But that is what is going to happen. We all have to learn how to do health care differently than we do it now. It's about taking care of the patient at home, not in the hospital You can't stay in the hospital very long anymore. They won't let you and you have to get out, unfortunately.

02-00:38:22
Rigelhaupt:
In our last interview, you spoke a little bit about the new integrated provider network. Are there things that you have learned as an organization, that you've seen either working at the Moss Clinic, as chair of the board, from seeing the focus on public health in that system that you're trying to apply to the new integrated provider network?

02-00:38:49
Fick:
The network is composed of our local physicians, many of them volunteer at the clinic. [39:00] Many of them are specialists who donate their services to clinic patients It's all about this continuum. We have this group here that's been doing this for a long time. They have been donating it. It has all been free, which has been wonderful. The integration is more about adjusting the way we practice medicine and health care in a given community. I'll give you a new buzzword: it's called population health-based management. A new buzzword, and that is the way you have got to go. You manage a population. You don't manage a patient. You manage a patient population, and that's the way it's going to go. It is being forced that way right now. We're gearing up for that; we've got our

feet in the water right now, and we're going to get wet. It's a big deal because it changes the whole payment system. There's not going to be—they'll be a little bit, but not very much—fee for service anymore. The way it is now and the way it has always been is you provide health care and you get a fee. It is not going to be that way; it's going to be bundled payments, or you're going to guarantee a population. You are going to guarantee a population and insure it. We will take care of this much population for this much money per person, per disease state; it's called "managed care." That's the way it's going and it's all tied together. It is the integration part between the physicians and the hospital—the mother ship—that has to happen in order to succeed. You have to be partners and you have to be a team. You can't be doctors here and a hospital here anymore. It was that way a long time ago, but it can't happen any longer. Most of the doctors are figuring it out and we're working on it. We are going to go live here, in 2014. I'll let you know what happens—not there yet.

02-00:41:36
Rigelhaupt:
So, in our last interview, you used a phrase "ahead of the curve," and I think that some of the ways that Mary Washington Healthcare, MediCorp, Mary Washington Hospital, in previous states, has been conscious of the need for public health—

02-00:41:58
Fick:
They have. [42:00] We've always been forward thinking for new lines of service. Examples are women's imaging and the women's service center that we built next to the cancer center. This is a state of the art center. We have this machine up there. It is a linear accelerator, and there are only two hospitals in the entire world that have it, and we are one of them. We can do all this special stuff for cancer patients. We have doctors that we brought in, world-class doctors, who are able to do this stuff. They have this thing called Stereotactic radiosurgery (SRS) for the brain. Dr. Poffenbarger, our neurosurgeon, is the only one who can do it. He does them here and he does them at UVA. The technology is just unbelievable, with this stuff that is coming in here. Remember I told you I wanted to keep everybody in town? Nobody would leave for your health care? This is one of those things that has been keeping everybody here. We've always been just a little bit ahead of the curve. We are ahead of the curve on many hospitals now with the physician integration we're doing. A lot of hospitals have not started that yet. They have not gotten their physicians together yet. My board feels that this is the way we need to go in order to survive in the new health care of the future. It has to be teams; you can't be silos anymore and you've got to get rid of the silos. It's all team work. We all have to work together, and we have to do it less expensively and more efficiently. That's the new word: less expensive, more efficient. If you do that, the government provides bonus pools at the end of the year. We share the bonus pools. That is part of the incentive, sort of like pay for performance. If there were not any incentive to do it, then why would you want to do it? If it's the same old, same old, and I'm doing the same thing now, but they're cutting my pay and not doing anything to help me out, that is not an incentive. It is a pay for performance thing. That is the big primary incentive. Hospitals, doctors, and anything in the health care community—the reimbursement rates are

increasing. They are going to decrease every year, and you've got to figure out how to survive in the new environment. That's why we're doing this, so we both can survive. We can. [45:00] We just have to get better and not order unnecessary expensive tests, lab tests and unnecessary imaging. We have to learn how to work in this new environment.

02-00:45:12
Rigelhaupt:
Is part of this possible, in your assessment, because the board and the administration made a conscious effort, starting in the mid-'90s, to build physician trust, I mean you hinted at the fact—

02-00:45:28
Fick:
We did. It has been an ongoing affair. Did it happen overnight? Absolutely not. We have just chipped away at it over the years, and we have shown them that we really want to work with them. We want to be your partner; we're not against you and we're not trying to undercut you. I think probably the culmination of this IPN was a major deal. You can look at that culmination there to get all these physicians on board with us as a big deal. It has taken fifteen years to do. And you keep chipping away at it. The younger physicians have a different mindset; they're trained differently than the older guys. They are more interested in partnering with the system because they know they can't make it on their own; they understand that coming out of medical school. You can't hang your shingle anymore; it's financially impossible. You've either got to get with a group or you partner with the hospital. They understand that much more freely than some of the older folks who have been practicing twenty-five years. They're winding it down now, which is fine. But the young docs understand and they're trained differently in school, too. That is a feather for us. They're much more willing to integrate and become team members and partners. We are all doing this together; they understand it much better than some of the older docs. I can understand that too, because I'm one of the old guys too. I started practicing pharmacy in 1975. I'm in this same boat. I mean, health care has changed a ton since '75, and pharmacy as well. I understand where they are coming from.

02-00:47:46
Rigelhaupt:
What you just said, in terms of what you see as a generational divide between the physicians, something I've written down to ask was I noticed it from our last interview. [48:00] And I'd like to ask you to juxtapose that a little bit with the continuity at Mary Washington Healthcare, both in terms of senior administrators, and the board, I mean, you're almost twenty years in, why has the board and the administration been open to change, and forward-looking, as you said, even using this term ahead of the curve, when, as you hinted at, some of the physicians your age are less comfortable with some of the changes afoot?

02-00:48:40
Fick:
Because most people, as you know, don't like change of anything. I think physicians are probably a better example of disliking change than anybody else. They are very set in their ways. They practice one way, they do this, and they have been doing it all their life. And you're going to come in and say, "You've got to do something else." Two years ago, we implemented what's known as CPOE, it is a computerized order entry where there are order sets. I'll sit back and don't change it. All the order sets for different disease states are computerized and the younger guys loved it because it made their day easier. The older guys, because they're not technology savvy, had a hard time dealing with it, and they didn't want to do it. We said, "You don't have any choice. You have to do it and this is the way it is. It's technology." They grumbled and grumbled. Finally they succumbed and learned how to do it, but they were bucking it all the way. But that has been the case for a long time. It's just that nobody really likes change. I don't care what business you're in. When I make change here, they don't like it either. The younger guys are more tech savvy than some of the older folks are. I sympathize because I'm not that way either. If you have been doing something for twenty years and somebody says you have got to do it differently, then they don't like that. It's the same thing with the way health care is changing: what you have been doing for twenty-five or thirty years is going to drastically change within the next five years. I suspect that some of them will hang their shingles up and say, "You know what, I don't want to do this anymore. I'm done." I'm quite certain that's going to happen. But they have always been, after the grumbling's over, agreeable to the change. [51:00] We've gone back and forth and the board and administration have sympathized with them. Then they see some of the younger guys embracing it and they finally jump on board. But it takes a while for them to do that, and I fully understand that. I'm in the same boat they are. It's hard for them to do that, but they get it; they just don't want to do it. It's not like they don't see it's the way to go; it's just bucking the system. It is fine and that happens everywhere.

02-00:51:41
Rigelhaupt:
Why hasn't the board and the senior administration stayed set in its ways. I mean, it's been a successful expansion—

02-00:51:50
Fick:
You've got to keep moving forward. The status quo is not acceptable. You have to keep moving forward. It changes every day and there is new stuff coming out now. We're learning something new every day. That is why we ought to do continuing education, and keep in front of what's happening. Actually, the board has been a good conduit to the administration. You know, we have pointed out things to them, "Hey, we need to be doing this and we're not." Until we pointed that out to them they had not really thought about it. We have a good relationship. They bring stuff to us and we take a look at it. We do due diligence on it and may make some changes or may not. At the end of the day, we are all on the same page. That is the relationship and it has been absolutely fabulous

between senior executives and the board of trustees. We don't always agree on everything, but at the end of the day we usually figure it out and it's a better idea than it was when it was brought in the room. That is what has been special. It still happens that way. I mean, my board doesn't agree with everything I tell them to do. But we talk about it and we usually end up with a better solution at the end of the day. That's how you do it.

02-00:53:30
Rigelhaupt:
What would you cite as some of the reasons that there has been a good working relationship between the board and the administration over the near twenty years?

02-00:53:38
Fick:
You want to know the single most relevant one? We are truthful with each other. We are honest and truthful. There are no ghosts in the closets, and that's a big deal. I mean, I have an outstanding relationship with the CEO. When I first became chairman, we met, and the first thing I said was, "I want both of us to tell each other the truth no matter how bad it is." [54:00] We do that every time we meet. There are no ghosts. If I have something on my mind to tell him, I tell him. It has been a wonderful working relationship. Our board is the same way: we are truthful and honest with them and we try not to cover things up. That is what has made us special, very special. That is why this board is an outstanding board. There is nobody on there that is afraid to speak up and speak their peace on anything. I welcome that. It has been an outstanding relationship. We have got some new folks coming on here, and we're going to lose four board members at the end of next year. I am one of them. We are going to have four brand new board members; we are going to lose three of them that have been on there for a long time. There will be some young blood on there at the end of '14. But, remember I told you about the grooming process? It's not like they're coming out of the cold and have never experienced the system. They have been members of the citizen committee, which is what I call the minor league team, the triple A minor league.

02-00:55:36
Rigelhaupt:
Has that culture that has been fostered between the board and the administration around trust and honesty, do you feel like that has gone out, kind of a bad analogy, you've kind of brought that to the physician community—

02-00:55:54
Fick:
It's better. It has taken a long time—a long, long time. I think there was more trust with the physician community at the board level then at the senior management level. It has taken a long time to foster that, and it's much better. We actually tracked that. Physicians do a survey every other year: we do the Mary Washington medical staff one year, and then Stafford medical staff the following

year. The questions that they ask are about relationships with senior executives and board members. Of course, the physicians are very honest. They'll tell you exactly like it is. We see the responses that are better. There is more faith. There is more trust on both sides, the board and the executive management. You have got to foster that. Then you can't just let it lie; it has to be continued to be fostered. [57:00] It's a moving target. You know, if you think you've got them all as your best buddies, you don't. It's something that you have to work on. It has to be worked on together, between the three entities: between the physicians, the board, and the senior leadership. When I say physicians, there is a distinct group of physician leaders in this community that participate within the hospital in leadership positions within the hospital. I have much more intimate involvement with them than I do with the primary care guy that is way out in the hinterlands and that I may see at a Christmas party or something. I work closely with the senior leadership teams of the physicians. They are more involved with the administrative side of the system, and the board side. We have a good relationship there, we see each other a lot, and we talk to each other a lot. They know what's going on in the system. Then they disseminate that information out to their ranks, usually at the medical staff meetings.

02-00:58:33
Rigelhaupt:
Could you say some of the people who have been most active within the health care system, the physicians?

02-00:58:40
Fick:
Yes. [Some of the physician leaders are] Dr. Pat McManus, Dr. Jeffrey Frasier, Dr. Michael McDermott, Dr. Tom Ryan, Dr. Becky Bigoney, Dr. Peter Carey, and Dr. Tom Martyak. Dr. Tom Janus was the key leader in putting the IPN together. We have these division chiefs, and the division chiefs are actually all members of the Medical Affairs Committee. They are actually meeting right after we finish here tonight. I've got to go to another meeting. The chiefs are intimately involved in what goes on at a board level as well. The Quality Medical Affairs Committee is one of the most important committees that I have because almost the entire system is discussed at that committee. If you are on that committee, you know everything that's going on, which makes it a great committee to be on. Sometimes I'll put new board members on, just to get them used to what is going on in the whole organization. They are department heads. [01:00:00] They have all contributed, and they're not shy about speaking up either. The Quality Medical Affairs Committee is the "physician committee" that deals with the medical staff. It is the committee that would hear any disciplinary actions on a physician. It all goes through that committee. That's an extremely important physician side committee. I have physicians on my board. I try to rotate them so that they can gain experience on all the different committees.

02-01:00:41
Rigelhaupt:
What if we stayed the board level, and I think this also speaks to both administration and physicians as well. Part of what is evident about the board is that people bring very different backgrounds to the board, and, you know, from people of business, different educational backgrounds, different work backgrounds, are there instances you can think of where people approached a problem differently based on their expertise?

02-01:01:18
Fick:
Of course. We pride ourselves on having a good cross-section of the community. What we do is each year, we have a spreadsheet that lists expertise in anything and everything: community, admin, legal, government, or political. There are names on there and I just go down the line and put a checkmark where I have expertise. Between all sixteen members of the board and the community members, we've got it covered. Everything is covered and we have this wonderful cross section; somebody has a little experience in everything. We redo it each year to see if someone has gotten experience someplace else that they did not have last year. That has been a huge tool for us to use, and we look at the geographic, and demographics as well. We try to bring board members from each of the counties. I think I have somebody on there from everywhere. We have lawyers, we have doctors, we have business people, we have bankers, we have educators on there, and we have political people on there. It's just a great cross section. Usually, somebody has an answer to whatever the question is. Somebody has probably done that before. [01:03:00] That's what's cool about it: we have this cross section of really interesting people on there that are very willing to share their expertise.

02-01:03:14
Rigelhaupt:
Is that diversity in terms of region and expertise—has that been consistent since you joined the board, or was that fostered over the last twenty years?

02-01:03:26
Fick:
It has been consistent. It has always been able to maintain a good cross section of individuals in the community since I've been on the board. If we are lacking somewhere then we will fill that position whenever a vacancy becomes available. We track where we are lacking; we know where we need to beef up a little bit, and we'll do that the next time a position is available. We have staggered positions and there's always a stagger group going on. Even when we appoint the citizens committee members, it is looked at the same way. We look at the nominating and governance committee, it is in charge of that. We'll have a list of candidates that mostly are suggested by the board members themselves and administration. Anybody can suggest a candidate and we vet all of those candidates.

Of course we have their backgrounds and stuff, and we do that as well there. We're not overly stacked in any one area and it's just a really good cross section.

02-01:04:53
Rigelhaupt:
The board has to make hard decisions. One of the former chairs said in a very succinct way, "If there's no margin, there's no mission." Can you think of instances where the different backgrounds that board members bring with them have had you approach investing in a new service, in a new program, has it affected how you guys talk about what you invest in, if there are decisions that you have to cut? You know, particularly, you mentioned mental health, that is a line that is not heavily reimbursed, compared to some high-tech surgery that might bring you more revenue.

02-01:05:44
Fick:
Actually, we outsourced mental health doctors' practices. Yes, there have been some painful decisions that we've had to make over the years. We decided that one of our core businesses was no longer in skilled nursing and nursing homes. [01:06:00] We used to have Carriage Hill, which was another red hole to throw money into. We decided that to cut our losses. It was the same thing we did with Chancellor Village, which was sort of medium-level skilled nursing facility. The board has been instrumental in sort of assisting the management to make good financial decisions prudent for the company; sometimes, putting a little pressure on them to do this. That's what I like about my board: we're not afraid to tell you that this is a loss here and you need to cut the strings because it's not pertinent to our core missions. We started talking about core missions about five or six years ago—maybe seven or eight. We thought that we were getting outside of our core mission—this is not what we do and this is not what we're supposed to do. We had these ancillary services out there that we draining on the mother ship and it was time to cut the cord. Management had a hard time dealing with it. They had not done that before. They just kept them up even though they were losing money. The board said, "No, you're not. We're done. It's over." I've been the driver of that for at least three of the five things we have done. Most of that stuff was done when I was chair of the finance committee. We take a look at everything. We take a look at the entire system. If it's not working, we need to get rid of it. You can't—there's no longer room in health care today for what I called "unforced errors," or poor business decisions on anything. You can't have it anymore because you can't have those errors. The margins are so thin that you have got to get everything you can get and be more efficient. We'll cut a service out in a minute. We debate it. When they bring new service lines—that is too big of a word. If we are going to a purchase a physician practice, there is a huge discussion that starts at the finance committee and looks at the pro formas of these businesses. They vet it and then they bring it back to the big board, and we vet it again. Sometimes it's just not a good decision to do this and we say no. They don't like it, but we tell them, "No. I'm sorry, we're not doing it." [01:09:00] We probably need to get a little more due diligence in the future, but we have always done that. I have no problem doing that. I mean, that's one of my jobs. That is my fiduciary

responsibility as a trustee to do this. That is the board's responsibility. It's our duty to manage the organization, and we do. [This portion is sealed until January 1, 2018]

02-01:12:20
Rigelhaupt:
I was going to transition into asking about Stafford Hospital, and its origins, but let me jump to where I was going to go towards the end of that line of questioning, because you mentioned that there are services that you have to provide, even if they're—

02-01:12:39
Fick:
We have mental health. We have Snowden and we have dedicated beds in Mary Washington and Stafford for mental health patients. We just decided to outsource the physician side of it, and we still do. The physicians are reimbursed by the health insurances themselves, rather than us owning them and paying them.

02-01:13:05
Rigelhaupt:
But that's not distinctly different from some of the emergency department physicians.

02-01:13:08
Fick:
The emergency physicians have their own group; yes, same thing. You know, I didn't want to be in the physician owning business. We are. We own like, thirty-three different practices now, but I'm not buying anymore right now. I am putting a hold on it.

02-01:13:30
Rigelhaupt:
So where I was going in terms of these services, mental health, that you know, with the reimbursement rates, no one can provide the care, at the rates it's reimbursed. How does that fit with the for-profit system that is here? And the reason I was trying to transition with that to Stafford is because at the same time the COPN was approved for Stafford the state approved Spotsylvania Regional Medical Center, which is a for-profit. How does a not-for-profit community hospital work within a broader health care system that does have for-profit organizations?

02-01:14:17
Fick:
[This portion is sealed until January 1, 2018] They have to deal with it too. It's a part of the system, whether you are for-profit or non-profit. The difference is that we can't turn anybody away. We have to accept you regardless of your ability to pay. That's the key difference between the two of us. We do that. It is part of our mission too. Some things we lose on and some things we don't. And

hopefully, we do better on the high-profit stuff and we cut our losses on the lower side. That is one of the juggling pieces that the board works with. How to do you offset these factors and minimize the loss as much as you can, knowing full well that you are never going to ever break even, much less make a profit? But you can cut the losses as much as you can. The trauma program loses money. Most of the traumas—indigent care, stabbings, shootings—just lose money. It just costs too much money to implement because of all the physicians. The trauma physicians are highly skilled physicians and surgeons; they get paid a lot of money.

02-01:16:53
Rigelhaupt:
The board and the administration plans years out, and I have to presume that you had a sense that something like the trauma program was not necessarily going to profitable, and yet it's a new program, five years old.

02-01:17:07
Fick:
There was consternation on that. We did it because—remember I told you that I wanted everybody to stay in town? That was one of the major reasons to do it. It brought world-class physicians here and that is the other reason. We knew that it wasn't going to be a problem. It was one of those service lines that can be offset by something else. We knew that going in, but again, you have to minimize loss as much as you can.

02-01:17:47
Rigelhaupt:
But something like the trauma program also requires education, EMS, and working in the community, and is this one of those ways, you know, it's a dollar loss— [01:18:00]

02-01:18:00
Fick:
I mean, you can't—it's hard to put a community benefit on it. There certainly is a loss, absolutely. I mean, you can't just look at the loss. You have to look at the indirect resources that it provides. The other thing it does is it provides a tremendous amount of revenue for the hospital side because most of the trauma patients are admitted. They lose here, but get admitted and you gain there. We know exactly how much it generates in direct revenue to the system, based on inpatient revenue from the trauma program. Same thing from the cardiovascular surgery program: I know exactly how much it provides to the system. That is the indirect benefit and the same thing with all the ancillary sides of it as well. We decided to have it and it brought world-class physicians. You don't have to leave town now for a traumatic brain injury, which is almost any head injury. Before, no matter how minimal it was, you were flown out. Now, you don't have to leave town now for a traumatic brain injury. We have trauma surgeons on staff all the time, and any orthopedic and oral surgeons; everybody is here.

If you come in here and you need five surgeons, they are there, twenty-four/seven, all the time. It is a conscious move we made five years ago to do that.

02-01:19:43
Rigelhaupt:
So that's one program, but let me ask you a little bit about Stafford Hospital, and what you remember about the earliest conversations, not in the planning stage, but the water cooler, the conversation of should we think about expanding? Where? What do you remember about those?

02-01:20:09
Fick:
I remember it vividly. The problem—we did extrapolations of our patient census at Mary Washington and we figured by 2008 or 2009 we were going to be out of beds if the population continued to grow as it did. Those were the water cooler talks. Plus, the other big one was where are going to put it? We looked at land all over. We looked at land west, south, and north. We didn't look east because there's no land; there's pretty much nothing over there. The biggest deal was the projections showed that we were running out of beds. [01:21:00] We couldn't expand on the hill anymore. It was done and we had already expanded. That is when the conscious decision was made to build another hospital. It would not be a big hospital, but it would be a small acute care hospital, such as it is. That's the main reason right there, because I was actually involved in that. I was there during that time, and then Stafford was born. We decided to go to the north because that had the least amount market share in our primary service area. It was the least amount because most of the people up there were going up north for their health care. That is directly related to the government, the commuters, and that sort of thing. A lot of military up there and the military was involved as well. We made a decision to go up there to try to capture that market, and that's what we did. We have not captured it yet; we're still working on it.

02-01:22:10
Rigelhaupt:
The board, administrators, I mean, there's a significant amount of work that goes in to simply file the COPN.

02-01:22:19
Fick:
Actually, the board has little or nothing to do with the COPN. That is the administration. The board is apprised of the process as it works through the state. We don't do any of that at all.

02-01:22:32
Rigelhaupt:
But in terms of even thinking about a discussion that had to have taken place. And then, first new hospital in thirty years to be approved, but it's not one, it's two.

02-01:22:46
Fick:
Stafford had been approved a couple of years before Spotsy.

02-01:22:53
Rigelhaupt:
I thought they were approved near-simultaneously.

02-01:22:56
Fick:
It was two years, I think, almost a year later. A minimum of a year. We had already started the process and it was too late to back out. We weren't naïve. We knew some day somebody was going to come into this territory. This is a lucrative territory. I call it the golden crescent—the 95 corridor—for any business doing business here. They were going to come, and so we just needed to understand HCA and how it worked. We had to try to get into their brains and their minds on how they function as a for-profit system. We spent a lot of time on that. We even had consultants come in to brief us on their *modus operandi* and how they work so that we could be prepared for it when they opened. The consultants had actually worked with HCA before. [01:24:00] We spent over a year doing that: trying to get into their innards and inside to figure out how they function and how can we compete with them. We never had to compete with anybody. We spent more time on that then we did at Stafford Hospital. The board spent more time to learn how to deal with them. We had an entire retreat on just doing nothing but how to get into Spotsy's head and compete with them.

02-01:24:31
Rigelhaupt:
What did you learn from opening Mary Washington Hospital, and expanding it, that you applied to Stafford Hospital?

02-01:24:39
Fick:
The key architect of Stafford Hospital was Walt Kiwall. That was his baby. He was the sole administrative lead on building that hospital. He built it all by himself. He would give reports to the board when we had meetings. And you know, it was just different. The hospital was much newer. The technology was newer, the materials were different, and it was nice; it was done very nice. It was his baby and it was successful. We came in under budget. I got a report, a monthly report on progress, on where they were, were they on budget, and the timeline. Everything worked out well. We didn't have too much to do with the details. We didn't pick out colors or rugs, and stuff like that; I didn't do any of that stuff. All I did was take a grand tour and cut their ribbon when it opened up.

02-01:26:02
Rigelhaupt:
You were involved with—you were already on the board during the transition when Mr. Jacobs left, and Mr. Rankin was hired as—

02-01:26:13
Fick:
I came on after Fred was CEO, 1994. I was on a foundation board at the time. Remember I started at the foundation board.

02-01:26:30
Rigelhaupt:
One of the other things you mentioned in the last interview is that the board constantly works on strategic planning, and what if scenarios, what are some of those that you can think of while you've been chair, that the planning really paid off? Things went well?

02-01:26:54
Fick:
One of the strategic scenarios was the physician integration, which actually happened. [01:27:00] But most of these scenarios are what you don't want to happen because they're all doomsday. These are really bad things that can happen. For instance, a union comes in and unionizes both hospitals; what are we going to do? CMS—more payment reductions to hospitals and doctors affects patient access to care. The physicians—what if there is a big fallout with the physicians? Or somebody else comes in and starts a provider network, IPN? Those are the type of the scenarios. They are nasty and they are not good, but they are possible. What if we lose our bond rating and we can't borrow money anymore? I mean, those are the types of things. There are a whole bunch of them; there's like seven of them. We look at them each year and decide, do we need to add this one? Do we need to pay more attention to that one? But it is always revised yearly, and discussed. They actually look at it at each strategic planning committee meeting and they talk about it. We look at competition. We have a report on competition. It is not just Spotsylvania, but Sentara, Novant in Prince William, and a little bit UVA and a little bit VCU, and some Inova. But mostly is Sentara and HCA. The biggest one I can think of is that we planned on the IPN. That was a big strategic move for us to do this. That is the biggest. Most of them are really horrible and you don't want them to happen. We have mitigating plans for each strategic scenario.

02-01:28:42
Rigelhaupt:
What models did you use for the IPN?

02-01:28:45
Fick:
We just stepped out of the box on this. We have the only model like it, where the physicians are the owners. In most of the other systems, the system owns it and the physicians sign on to be a part of it. This one is actually owned by the physicians and they have control. They have control on the management board. We have stopgap measures in there—the biggest part is they can't do anything that would affect our tax exempt status. But other than that, they're running it. There is a twelve member board, and they have eight and we have four members on it.

02-01:29:39
Rigelhaupt:
So the physicians own the entire—they own that.

02-01:29:43
Fick:
They own it if you decide to become an owner. Now, we're an owner too. Mary Washington Healthcare is an owner. As a matter of fact, we are the biggest owner, but only by the amount of money we're putting into it. [01:30:00] We own more shares, but the physicians are the majority of the board. We are the largest owner by the amount that we are funding for it to make it happen, but the board level is still eight to four. The physicians have control at the board level: it's not like we own 55 percent of it and we have 55 percent control. It doesn't work that way. They own it. The physicians that own it are the ones that decide to buy shares in it. You have owners, and you have participants. The owners put in capital and then they get a little more of the pay for performance than just the guys that want to participate in it. I feel confident that once we get it up and running and that little pot of gold over here will make a payout, people will start jumping on the ownership side pretty quick. It's a wait and see right now. But we do have approximately 120 owners.

02-01:31:05
Rigelhaupt:
I mean, this goes counter to a long history of physicians being skeptical about working with hospitals, and the AMA and the AHA not always seeing eye to eye on things. Do you think this was possible because of the trust that was built up? What would you say were some of the key reasons?

02-01:31:25
Fick:
You know what it is? It's survival. Pretty much survival. If you don't do this, you're not going to be here. If you don't partnership, you won't survive. It has taken them a long time to figure it out, but they have. That is why this initial offering was so successful. We have 391 docs that are partners in it and then there are like 120 owners. It's about survival on both sides: survival on our side and their side. That is why you have got to bring this together. It is not like kumbaya stuff—it's survival.

02-01:32:12
Rigelhaupt:
Was Kaiser Permanente, in terms of its longer history of evidence-based medicine, primary care, a model that—

02-01:32:20
Fick:
Kaiser has a closed HMO. We're not closed. We're open. We did not restrict physicians from entering into other managed care contracts with other providers. They are free to do that, as well. And, so, it's pretty open. The Kaiser model is strictly a closed HMO. You can only go to Kaiser doctors if you're in the system and you can only go to Kaiser-appointed hospitals, Kaiser specialists, Kaiser imaging, or something like that. Now Kaiser has a partnership, a contract with our specialists in town for them to provide services. [01:33:00] We just cut a deal with them that Stafford Hospital is going to be a core Kaiser hospital, which they came and asked to do that.

02-01:33:21
Rigelhaupt:
In terms of, you said the board, and I don't think it's purely competition in the sense of the difference between this business and your competitors, but trying to understand the health care field, watching other health care organizations. Did the board watch Kaiser, in the sense that even though they have space on the campus now—

02-01:33:45
Fick:
They have a primary care program. No, not at all. Kaiser was not even a part of this. The doctors would not have joined in our model. Kaiser is a closed system and patients can only see Kaiser physicians. If we had not done it this way, we would not have been able to pull it off. We could not have done it using the other way—most all of these other IPNs are owned by the system. You join the IPN and want to practice under that. It would not work here because all of our doctors are still pretty independent and they are all busy. The pain bullet has not hit yet, but it's slowly starting to hit; it has hit different specialties much more than others. And so, for the ones that have been hit hard through reduction in fees and reimbursements, the lights turned on quicker than those that are still fat and happy and have three month waits before you can get an appointment. That is what drove the way we put this thing together. That was the single most important reason of why we structured it this way: to get them on board. They were not willing to go because they have not had enough pain yet. But it's coming, and we are going to try to mitigate it. [This portion is sealed until January 1, 2018]

02-01:43:12
Rigelhaupt:
What are some of the things that the health care system does to recruit the physicians you need?

02-01:43:17
Fick:
We have actually a whole a department to do that. We recruit in the national medical magazines. There are seminars that we have these people go to, to recruitment seminars. We'll put it out, we'll advertise it, and we get a lot of people. Fredericksburg is a pretty nice place to live for doctors. People are interested here, but there is a shortage, a critical shortage in primary care.

02-01:43:53
Rigelhaupt:
But as you said, earlier, the organization is not buying practices right now, so these would be physicians that come on—

02-01:44:03
Fick:
The physicians that are here are already established in group practices and the new ones will go into one. There are a couple of group practices in town and they will go there. Like I said, it's very difficult for a physician to hang his shingle out anymore, by himself. It's just almost unheard of. You just can't make it and it's just not there. With the amount of overheard that you have, you can't do it; not even a specialist can do it.

02-01:44:38
Rigelhaupt:
But is this one of the ways, then, that as Mary Washington Healthcare has grown, and become a larger health care system, you have the resources to recruit—

02-01:44:46
Fick:
We have the resources. If a practice recruits, one of our establishment practices, there are subsidies that they will pay to the new physicians to come into town. It is a contract. He has to stay here for a certain amount of time and then we forgive the note, the loan. [01:45:00] We have a physician loan system in there to help them come in.

02-01:45:13
Rigelhaupt:
And is that a practice that has gone on all the years you've been involved?

02-01:45:17
Fick:
Yes, ever since I've been involved. We need to wind it down. I have to go to another meeting.

02-01:45:40
Rigelhaupt:
I guess it's true about health care, we never cover everything. You're coming up on your last year as chair. What would you cite as some of the achievements that you're most proud of as chair of the board?

02-01:46:04
Fick:
Having all these service lines that we didn't have when I got on the board and recruiting and keeping world-class physicians in this community. Those are my two biggest goals that have come to pass, and the gratitude. I had a good time doing it. This has been fun because I like it. I'm health care oriented. There are challenges, but we overcame the challenges. Then the other big thing was just associating with all these wonderful people that I have over the last twenty years. I've never met a person I didn't like. I've never met a person who didn't want to bend over backwards to help the system, or help the community. There is a lot of gratitude in doing this, but I'll tell you it's a lot of work, especially as a chair. It's fifteen hours a week for me now, and it's been that way since I started. I pretty much stick to my guns on this. If you have a real job, you can't be the chair because there's so much time that you have to be away from your work or your business. I'm fortunate that I don't have to be here because I have good people working for me. But it's tough, it's hard, and then there have been so many changes over the years. I've watched this thing of from back in the 1990s when everybody was raging about managed care and the gatekeeper theory. That didn't happen because the public wouldn't stand for it. Now the new buzzword is population health-based management; we'll see how that goes. To watch it, over the years, and see the service lines increase and the technology has been phenomenal. We have been able to address more medical issues and cure things that we were unable to do twenty years ago. [01:48:00] We are keeping people alive and improving quality of life. That is what it has been about. It's been fun and I've enjoyed it.

02-01:48:15
Rigelhaupt:
Last question. I've gotten the impression that hospital administrators and boards are always thinking ten years out; there's constant planning for the future—

02-01:48:29
Fick:
Yes, it is. We don't go ten. I'd say more like three years, three to five.

02-01:48:36
Rigelhaupt:
In three to five, where will Mary Washington Healthcare be?

02-01:48:37
Fick:
Wow. That's a hard question. You want me to tell you where I'd like it to be? I would like that we create what is known as an accountable care organization, and manage our population here and Planning District 16, which is 344,000 lives. If we are doing it successfully, that is what I like to see happen. We have our own insurance product at this time, and we would be offering it to businesses like me at a cheaper rate than Anthem does. That is what I'd like to see happen, and it can; we can do it. It takes a lot of work, but it's possible. All right?

02-01:49:27
Rigelhaupt:
The only thing I intend to do when I end is to ask you if there's anything that I should have asked that I didn't.

02-01:49:33
Fick:
No. I think you covered it more than I could. You jogged my memory better than anyone has in a long time. I really appreciate your questions. I mean, you've made me think about it more than I ever would have thought I was going to do. You took it in segments from my time on the board up to present. And actually revert back when there's—no, I think you covered everything.

02-01:50:04
Rigelhaupt:
Anything you'd like to add?

02-01:50:07
Fick:
No, this has been fun. I'm looking forward to the final product and anxious to see that. I know we really appreciate you doing this. This is a wonderful project for the system and the community.

[End of Interview 2]