

Department of History and American Studies  
University of Mary Washington

Mary Washington Healthcare Oral History Project

William F. Jacobs, Jr.

Interview conducted by  
Jess Rigelhaupt  
in 2013

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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](http://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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00:00:00

Rigelhaupt:

It is June 11, 2013. I'm in Fredericksburg, Virginia, doing an oral history with William Jacobs. If I could begin by asking you if you could describe your first day of work at Mary Washington hospital.

00:00:24

Jacobs:

Wow. That day was vivid in my memory, because not only was I moving down from Fairfax Hospital to this lovely community. The secretary I had was already there on the job, which I hadn't hired, Miss Peggy Labbe. And so we greet each other, hadn't met really. She asked me if I wanted her to stay, and I said, "Of course." No one had said anything to her. I went in my office, and I'm looking through these papers, and just trying to get names of board members and what have you. Josiah Rowe was the Chairman of the Board at that time. Anyhow, I could smell something; it almost smelled like cat urine. I'm sniffing and I'm looking around the office, and looking up in the ceiling. There was a construction program going on, but I couldn't see anything. I had to go back out and say to Peggy, "Peggy, there's a terrible smell in my office. Do you have any idea what it is?" And she said, "Oh, yeah." She went to the powder room, got a big glass of water, came into my office, threw it into the vented air conditioner, and left. And the smell went away. It was an old air conditioning unit where the sewage vent wasn't working properly. If you put water in it, it covered it up, and then the smell didn't back up. That's my first day on the job. My secretary threw water at my air conditioner.

00:01:56

Rigelhaupt:

And was your office in the hospital at Fall Hill?

00:02:00

Jacobs:

It was, in those days. First, there was a construction project going on; they were finishing up a construction project. I was in tail end of the building dock where Physical Therapy was housed. Then there were no windows, and no air conditioning that worked properly. Then there were a series of temporary offices.

00:02:21

Rigelhaupt:

And how did you choose to accept the position at Mary Washington Hospital?

00:02:28

Jacobs:

That's a great question too. I'd been at Fairfax Hospital twelve, thirteen years. Something like that. I went to see my boss who had hired me, and I said something like, "You know, I see some things

going on in our organization that I'm not real pleased with and I'd like to have more involvement with." And we sat for a while, and he said, "You know, there comes a time when every bird has to leave the nest." [03:00] He said, "I think you're ready to take on your own work." I said, "Okay." I searched around a little bit, and got an interview, and was accepted to come down to Mary Washington in Fredericksburg. I'm glad I did.

00:03:11

Rigelhaupt:

And what do you remember about the search process?

00:03:15

Jacobs:

The search process. I remember a couple things. The first interview I had wasn't at the hospital. It was off campus—or as I call it, "off campus"—in an accounting office. I had done some homework, and they told me who the search committee was, and there was a doctor on there. I said, "Well, that's good. That's good." I went to the search committee, and as we were talking about what's going on, I said, "Well, I thought there was a physician on the search committee." There wasn't. It was Dr. Woodard, Prince Woodard, who was the President of the College, then Mary Washington College. But it said "doctor," and I assumed it was a physician. The board and the medical staff didn't really do a lot of talking and planning in those days. They were cordial. Each had its own role, and they left them there; which, obviously, I didn't think was the thing to do, any of it. The search committee was proper. The very first time I had sixty minutes. At the end of sixty minutes, they're still asking me questions, and I'm asking them questions. The next thing I know, I see a person coming up the walkway that I recognize, who was the administrator of a small hospital in the valley. I said, "Well, we're going over our time, because your next interview is already here!" They were a little bit embarrassed. But they said, "That's all right, we'll keep talking." Anyhow, I felt good about it, good folks. I had one more interview after that.

00:04:56

Rigelhaupt:

Who were the board members that you remember being most active in your hiring?

00:05:04

Jacobs:

Joe Rowe was the Chairman of the Board. He was very, very active. And an accounting person, Bill Thompson. Bill Thompson had the accounting firm downtown. It's still there, but I'm not sure he's involved anymore. He was very, very involved, and a good person. Who else was involved? I can't recall. But it'll come back to me. Mrs. Elnora Johnson, I believe, and a Rick Johnson. Not related. Those two names, those three or four names, I remember. They were good people and asked great questions. I could tell two things: number one is they were very, very committed to the organization. I also sensed they wanted to make some changes. [06:00] They weren't looking for the status quo to

be preserved, and nor was I prepared to come into a situation at that age, young age, and just sit back and retire. Health care was changing. You couldn't sit still.

00:06:16

Rigelhaupt:

Did you get a sense in that first interview what some of the changes the board had been thinking about?

00:06:26

Jacobs:

No, I didn't. And like many boards—at least they were sensing that changes were coming, and they were looking for leaders to come in and say, “Here's what these changes might be, here's what the trends are.” Rather than having to educate a board about changes, they were ready but didn't know where to go. They didn't know what the impact was going to be. They heard from places like the Virginia Hospital Association that changes in Medicare reimbursement rates were coming, the Certificate of Public Need requirements were getting greater, and things like that. There was a shortage of physicians in certain areas, and they were looking for some leadership as to where do we go. What's our plan? What's our strategy? I got excited about that, because that's what I did for years up in Fairfax.

00:07:25

Rigelhaupt:

You start. How would you characterize some of the initial changes? You know, thinking about that first year you're on that job. But where did you want to see Mary Washington Hospital go?

00:07:42

Jacobs:

They had in those days “long range planning committees,” which I renamed—I mean, I say “I.” I don't mean to think it was only me. It was very much a collaborative effort between the staff and the board. We renamed it the Strategic Planning Committee. The chairman was, of all people, the current Mayor of Fredericksburg, Mary Katherine Greenlaw. She was as energetic then as she is now, and very interested in what's going forward. One of the first things she shared was, “There was a hospital up north that bought some property up in Stafford. They think they want to build a hospital.” And I said, “Well, that's an indication, again, of the changes. You have the financial changes and you have the competition.” Because everybody was thinking—not “everybody,” that's an overused word—but many experts and other folks were saying with the new Medicare regulations, new federal government regulations, there'll be a competition for patients. There will be a forcing people out of the hospitals. If you can keep them out of the hospitals, because that's where the expenses are, then you can save some money. That's what the federal government was trying to do, to save some money. Of course, I'm not saying they're wrong, and they should. [09:00] Those things were going on. I broke it into three or four points. Financially, what do we have to look at

our finances? How strong are we financially? We considered what-if situations. What if we have a ten percent reduction in patients, or a twenty percent, or a thirty percent? Where's our physician manpower? Where are we short of physicians? I'll come back to that, because that was kind of interesting, though. I'm doing the master plan on physicians, the manpower. The third area was facilities. Where are facilities? We had just come through an expansion program. I won't mention the company that built the program, but they are notorious for building cheap buildings. I would just leave it there. This was a cheap building. Even though we had a brand new addition, I'm starting to talk about needing to do some changes for parking, for outpatient services, and things like that. People were looking at me kind of strange. I said, "Let me give you an example. It's a four story building; you can't get hot water to the fourth floor in the new wing. Okay, that's a problem. I mean, I think hot water is essential to a patient's wellbeing." But we got that all corrected. There were some things like that. There was a big demand coming for outpatient services, outpatient surgery. We went through a strategic analysis of who we were, where we were strong, and where we were weak. We came back and said, "Okay, on the facilities we identified, we didn't have any place for outpatient surgery." That needed to be corrected. Financially, we were financially okay, but no depth. When I say depth, I mean the organization had not built up any type of reserve. So if there were a big financial hit to the bottom line, there was no place to go. We started to look at our staffing issues. That was another thing. They had some staffing issues, which we tried to correct. We worked out a great program with Germanna Community College. We helped fund their nursing program to expand the RN program. That was a big asset. We started a physician recruitment program. That was very controversial to some people, particularly physicians. I said, "Well, we don't have enough physicians in ABC areas." They said, "Well, I'm not busy." I said, "Well, maybe you need to look at why you're not busy." Anyhow, I was able to show them now many people were leaving the community for care, mostly going to Richmond, VCU, Henrico Doctors', and, at that time, I think it was the old Richmond Memorial Hospital. We had a lot of people leaving the community at that time. I said, "We need to develop programs to enhance that." [12:00] The emergency room was hard to get into and hard to park. Once you got there, we had long waiting lines. We went through a facility plan there, we went through a physician staffing plan, hired some physicians to run the facility, and to get that up to speed. That worked out pretty well. Those were some of the areas we were looking at. Then we put together an outpatient center up in Stafford on Garrisonville Road, 610. We put in doctors' offices, lab, X-ray, physical therapy, as I recall, and a couple things like that. Because from that area, almost all those people were going north. And they were only fifteen minutes or so away from Mary Washington. We changed that. We worked out a relationship with the FBI Academy. We did their medical backup for their training programs and injuries, pre-physicals, things like that. That we could get people willing to say, "Let's go to Fredericksburg, rather than going up north." We began to work out a program to say Fredericksburg will be the center as a hub, but then we have to have some other programs coming in. I don't know how far you want to go with that, but that's why we ended up doing nursing homes out in Bowling Green and one out in Colonial Beach. We did a facility down in Spotsylvania. Next thing you know, we were the only health care organization for the city in four or five counties.

00:13:34

Rigelhaupt:

It sounds like that's happening over a few years.

00:13:39

Jacobs:

Yes. That took a couple years. Here is a kind of interesting, kind of a cute story, since I mentioned Joe Rowe. We hired some physicians, and we purchased an old newspaper building down in Bowling Green. We converted it to physicians' offices and got some physicians in. I think one of them is still there. His name will come to me in a little bit. Dr. Kelly was one of them, but he moved to Richmond. And the other one was—her name will come to me before we finish. The building was owned by the little local newspaper. We worked out a deal with them. They said, "Okay, now here's the deal. You can buy the building. It's okay, we'll help you get the zoning. But we get—" and remember, Joe's got the newspaper—"but we get the opportunity to be the first one to announce who's going in the building, not the *Free Lance-Star*. I had to agree to that to get the building. [15:00] They just thought it was kind of fun to pull one over on the large, big newspaper. Joe Rowe was real good about it. He just smiled and said, "That's okay."

00:15:00

Rigelhaupt:

These changes you're talking about, and you identify needing to have them in your first year as President of Mary Washington Hospital. Were they mostly being driven by you and administrators? Was the board heavily involved? Physicians? How would you describe those dynamics?

00:15:22

Jacobs:

Again, at the risk of repeating myself, but that's a good question, because as I said, it's a team effort. Obviously, it's somewhat driven by management. But management can't do it by itself. The board has to understand, be available, be agreeable to, and say, "I think this make sense." We work with them and then physicians. It's like a three-legged stool: the board, management, and the physicians. I'm not leaving out the community because they're involved through the board. That's what we did. During this process, in order to get this accomplished, what I felt was needed—and I'd seen a little bit of this—was we needed to have a holding company. A holding company is just that. It holds the assets of these other companies. We formed something called MWH MediCorp. Then we had, at that time, five subsidiaries. That was part of the strategy. What we did in the nursing home section would not affect the hospital, because the hospital is in one corporation and the nursing homes in another. We also, at that point, we inherited—it was kind of a funny thing. I'll come back to it—a laundry, the old Sunshine Laundry. That was a commercial laundry. The IRS says that certain commercial activities, no matter where they are, are taxed. Nothing wrong with that, but we didn't want that taxing to be interfering with our not-for-tax status. We created a taxable subsidiary. We put the laundry in there, the pharmacy in there, and a couple little things like that where it would

require us to pay taxes. Nothing wrong with that, but it would not affect the other corporations. Then we had property that we would own. It could be land, or it could be buildings like physicians' office buildings. We'd have a separate company for that. Then the last one we formed—and you said you talked to Xavier Richardson—we formed a foundation. And why have all these companies, why have all these corporations? Because what you do is you get a board for each one of those that's mission is driven by the board they're on. The hospital is looking at quality of care, physician recruitment, taking care of patients in the beds, and things like that. But we didn't need to be worried about the nursing homes. The nursing home board had a different kind of board, and the properties board had a different board. The foundation board was that if you were on the foundation board, you were expected to donate money, or make contact with your friends who would bring in donations. [18:00] That's what we did. Then we had a for-profit board, which was primarily a small board with management on it. That was to make a profit and do those kind of things. If we have time, I'd like to say something about Sunshine Laundry. There's a spring comes down off of the College Hill area. Oh, what is that street? Not Hanover, but across from Hanover. Maybe it was College Avenue. There's a spring down there. They used to have a huge laundry, and it was owned by a family. Somebody had given the stock to Mary Washington Hospital. We were part-owner and we get a dividend every year. I sent my financial officer and I said, "We get this dividend from this company. We don't know anything about it. I don't mind dividends, but why are we getting it? And if we're a stockholder, we don't get any reports! Don't they have an obligation to report?" So anyhow, it was announced that there was an annual meeting—and I would make up the date, 10:00 a.m. on June the 11. Mike Starling, who was my chief financial officer, he goes there at 10:00 a.m. and they said, "Oh, you just missed the board meeting and stockholders meeting." He said, "Oh dear, I thought it was ten o'clock." "No, it was 9:00." "Okay." Next year we got notice that it's 10:00 a.m. on June the 11. He decides to go fifteen minutes early. They said, "Oh, you just missed the board meeting and the stockholders meeting." He said, "Wait a minute here." There was a little bit of gamesmanship going on. They did not want to tell us how much the company was really worth and how much stock we really had. We hired an investigative attorney and found out that they need to do something with the laundry. That is they need to either sell it us, or sell it all and we'll take the cash. They decide to donate it. Now we have 100 percent of the laundry, and we're running the laundry for a couple years. It just didn't make sense. There are big commercial laundries are out there, and we couldn't really do well on it. We did a joint venture with a couple hospitals. We had a summer looking at buying laundry equipment that we didn't want to invest in. We worked out a deal with then-Mary Washington College, and said, "If we can come up with a fair price, would you be interested in buying the laundry?" Let me tell you, their eyes were this big, because what's one of the biggest problems they had then and maybe still do? Parking. Laundry was a great match. It's right there below Marye's Heights Apartments. It's where that parking lot is. We sold them the laundry for, I don't know, peanuts. They were fine with it, we were fine with it. Knocked the old building down, which was an eyesore, and made a nice parking lot out of it. [21:00] Sunshine Laundry. I still have a hat that says "Sunshine Laundry" on it. Maybe you should take it to the roadshow. [laughter]

00:21:17

Rigelhaupt:

What did you get as a sense of how Mary Washington Hospital was perceived by the community when you first started?

00:21:27

Jacobs:

Another interesting story. I'm probably full of more stories than you may want to hear. If I could just back up for a second to the holding company. One of the things I forgot to mention, and then I'll answer your question about the perception. Because it is crucial how you're perceived. But I went over to then—the First National Bank. It has another name. It's part of a bank out of Maryland. It's right there across from the school. Stuart Payne was the President of the bank. And he was one of the bankers in the community that came to me and said, "We'll help you out if you introduce us to physicians and they need some loans. We'll help them out, get loans, get them started." They were very good about that. But the bank, a single bank, no branches, one bank. He had a holding company. When I chat with him a little bit about what the purpose of the holding company was, he said "Change is coming on in the banking industry. I want to make sure we're ready. So I created a holding company." Bells and whistles went off, and I said, "Okay, that's a good idea." I copied a little bit of what was going on here with the banking industry. What the banks did to get away from some of the regulations was to create a holding company, then have a bank. They could do certain things at the holding company that the regulators couldn't touch that the bank had to follow. I thought that was pretty clever. Back to your question on the perception. I had a company out of Richmond, Virginia that came in and did a community attitude survey; that is what we called it at that time. We told them what we were up to and when I was looking for it. Because one of the things I had heard in my interview process was about the emergency department, and it didn't have a good reputation. The other thing I kind of heard was that if you really need medical, you go out of the community. Those two things just stuck in my head, and I figured I got to deal with the big issues first and then come back to that. This company came in and did what was called a community attitude survey for me. They didn't just talk to people who had been patients. They talked to people who were patients, but many people who were not had never been in there. [24:00] They asked, "What do your neighbors say about Mary Washington Hospital?" That's crucial. Because if you tell your neighbor not to do something or that this was a great thing, they're going to be influenced. The survey comes back and they said, "We have not a very good reputation." The reputation was, "If you can stay away from the emergency department, stay away from the emergency department." From that, we could develop some plans, restructured how it was run, how it was operated, and hired a group of board-certified physicians to run that service. We also then looked at why people were leaving the community. That fit back into what I said earlier on our physician survey. We didn't have very many of the new physicians, like cardiology. I think there was only one board-certified cardiologist in the community. Now there are probably twenty, twenty-five, maybe thirty. We didn't have a neurosurgeon. We didn't have a cardiac surgeon. That's where that recruitment went in. And once people said, "You don't have to go to Richmond for that care, you can get it here." We put

together a community attitude positive campaign. I hired a woman to run that program for me, and she did a fantastic job. We changed the image. We started putting out reports to the community about what we're doing and where we're doing it. We started outreach programs: cancer clinics, mobile units to go out to the community to do breast cancer detection. We had mobile mammography units and things like that. Next thing you knew, we had more physicians and we had more people coming to the hospital. When Medicare rules changed, when the regulations came, they created this new financial mishmash of many things. We were really ready. They were called DRGs. Everything had to fit into about 500 diagnostic-related groups. Now that's a bureaucrat's dream come true. What's a diagnostic-related group? GOK. God only knows. They did that. Of course, the physicians somewhat said out of the side of their mouth was "DRGs means 'damn rotten government.'" But we really thrived very, very well under that program. We structured how we charge, kinds of patients, and the services that we would provide. We hired some infection-control physicians so that people could get out of the hospital at an appropriate time. We started outpatient surgery so they didn't have to stay overnight. At one time, we had an outpatient overnight service called Amy Guest Wing, and some of those people would go into that as a step-down unit. [27:00] We were really ready for it, and I think the community could see that.

00:27:28

Rigelhaupt:

It sounds like the Emergency Department was one of the first places you put some significant attention.

00:27:34

Jacobs:

Yes.

00:27:37

Rigelhaupt:

Could you offer a little more detail in that process in the sense that, you know, unlike another organization, the physicians in the emergency department are not employees?

00:27:48

Jacobs:

They weren't then. Some were and some were not. They were more contract positions, but if you were a surgeon you would be on call to come in if there was a surgical need. There would be a built-in time when you had to get there if you were seeing patients, or if you were in surgery. When the emergency departments first started, you go back in the fifties, it was kind of a true emergency. You didn't go there unless you really had a major accident. It shifted in the '70s and early '80s, and people went there because they either couldn't or didn't want to go to a doctor's office. So all of the sudden, you have a big, massive influx. What we did was we said to our physicians in the community, "Okay, you have office hours during the day, 9:00 to 5:00, roughly. If you're a surgeon,

you do surgery in the morning, go to the office in the afternoon, and you can't come to the emergency department." We worked with them, worked with all the physicians, to hire people full-time. All they did was work in the emergency room twenty-four/seven. They did not take on private patients either. If I'm the doctor, I see you, I do some stitching, and you follow up in my office the next day, that stepped on the toes of our physicians. We said, "If you need to follow up, you have a surgeon. If you don't have a surgeon, here's a surgeon that you should call." The physicians agreed, and they were very cooperative. They agreed to say, "All right, if there's someone here who doesn't have a doctor, we'll take turns being on what we call rotation." So today would be Doctor A, tomorrow would be B, C, and D; it went all the way through, and then you start over again. The patients got treated well, fast. The physician in the emergency department at the end of their shift—most of the time, they work a ten or twelve-hour shift—they get home and relax, come in the next day or the next night, very refreshed and ready to go. That was going all throughout the country, which led to another change that's just started in the last five, six years. [30:00] Hospitals now have hired fulltime physicians to be in the hospital, not in the emergency department. They're called "intensivists," who are there to take care of very sick people, mostly in the intensive care unit. But they'll be available if somebody else needs them. Because nowadays, most of the time, you don't go to the hospital unless you're really sick. It's not that they don't want you, it's just it's not set up for anything else. It's almost one giant intensive care unit, except for OB.

00:30:34

Rigelhaupt:

And it sounds like that was less of the case as you were beginning your career at Mary Washington Hospital. Or was it still primarily, you know, sick, acute care, versus the kind of health care that you were describing, people coming into the emergency room for?

00:30:56

Jacobs:

The change comes about with the payment, okay? Most of what comes into the hospital are Medicare patients, particularly on the inpatient side. And then there's the Medicaid side. That makes up about sixty percent or so of your inpatient. Other people came in the emergency department that probably had private insurance, but they didn't want to wait. If you free up the emergency department, you can get them through there faster. If it's still not fast enough, then you all of the sudden saw the rise of these freestanding walk-in clinics, like Patient First, and Med First—I don't know what all the names are anymore. That was a change. But the emergency department change at the hospital was primarily on the physician side; in fact, almost exclusively. The patients didn't change, the physicians changed. That was good because, if you think about it, the business of a hospital is to take care of primarily inpatient people. If you can make it easy for people to come into the entranceway, the emergency department, and they need to be admitted, then they get admitted to the hospital. It's like a continuous flow from the community, to the emergency department, to the inpatient bed, to home. If the emergency department's not staffed for that properly, then they don't get there, and then you don't get the patients in the hospital that you need to maintain the quality of

care, the finances, the staff, and things like that. That's where the change was; it was not so much on the clientele as on the physician side. Does that make sense?

00:32:32

Rigelhaupt:

It does. And you said physicians became agreeable to having emergency room positions as Mary Washington employees. Were there any particular cases where you can recall hearing some conflict, or some discussion about what that might lead to, or concerns from physicians about the changes you're describing?

00:32:58

Jacobs:

Not really. [33:00] There may have been a little bit. There's always the concern. There was always a concern: how many positions is the hospital going to hire and then compete with me? I was able to show them that you only need six or seven or eight physicians—there's probably ten or twelve now—to man that—or woman that, because they're both men and women—to man that department. For us to do everything else would require hiring two or three hundred physicians. You do the math; it was financially impossible. Not that it wasn't desirable, but it was impossible. I think everybody felt a little bit more breathing room on that. We did it case by case. Another area was infectious disease, which I mentioned. We didn't have a specialist in infectious disease. People would come in and we didn't know what was wrong with them. We knew there was some kind of infection, but you would have to send them away. We worked out a program, and the people needing an infectious disease physician are almost entirely inpatients. We have to hire that person. The infectious disease physician would work with the attending physician, as you called the private physicians. Physicians are like anybody else, that's part of your team. I don't just bring another manager in and say, "All right, this guy works with you, and I hope you like him." You say, "We have to hire somebody else, and here's what we need. Do you agree, do you not agree? Can you help me out?" We do the same thing. It was a collaborative effort and it worked out very well. As time goes on, you do some similar programs, and other special diseases. I think neurosurgery was one partially subsidized by the hospital. But also, people don't realize that there are rigid rules, particularly by the IRS, on how much money a not-for-profit corporation, like a hospital, can give to a for-profit corporation, which is what a physician is. It has to be service-related. You can't just say, "Okay, we're going to give you some money to start a practice." You can't do that. It has to be service-related. That's why you employed the physicians in the emergency department, because they were then employed by the hospital and fit under our umbrella. But if I say, "Okay, I'm going to give you \$150,000, take care of some people." It has to be related to something. Otherwise, I'm taking money away from a non-tax to a taxable, and that's frowned upon. There's some controversy over IRS, but it has its rules, and rightfully so. If you get a not-for-profit status, it means you don't pay taxes only on your profit. That's all it means. It doesn't mean you can't make a profit, but we don't have to pay taxes. [36:00] In return for that, not-for-profit hospitals are required to give a certain amount of free care. It amounts to about two or three percent of their annual operating

budget, which probably is in the neighborhood of \$5, \$10 million of free care. That's why you would see, nowadays I think it's called the Moss Free Clinic. In those days, we just called it Free Clinic. It was open with volunteers Mondays, Wednesdays, and Fridays. You could structure it in such a way that you didn't have to give away expensive car. If you come in the Emergency Department, we're giving you care. That's expensive: nursing time, room time, doctor time, et cetera. Whereas if you take a free clinic, you get the same services in a less intense setting; you can save everybody time and money and get good treatment. I haven't seen the Moss Free Clinic, but I think it's in a freestanding building up on the new campus.

00:36:58

Rigelhaupt:

So in some ways, it sounds as though the free care you're describing was one of the ways that the hospital was involved with public health?

00:37:12

Jacobs:

Yes, yes. We had a very close relationship with the Public Health Department. Now, one of the controversial issues we had during my time there dealt with the relationship we had with the Public Health Department. The Public Health Department had a prenatal clinic and they would take care of the non-paying patients—or the near-paying, like Medicaid patients—up until delivery. Then the patients would deliver at the hospital. That was the role we played. The problem with that was the transfer of medical knowledge and information about the patient. The patient comes into the emergency department, or through the emergency department after hours. She's ready to deliver, and we don't have any records. What was the prenatal care? Were there special medications? Et cetera, et cetera, et cetera. She may be by herself, or the family may not know. That was a rub. Sometimes, the physicians were less than cooperative. They would say, "We're not going to take care of them. Put them into an ambulance and send them to Richmond." That's an hour drive. There were some allegations from the Health Department and the government that we were so-called "dumping" patients, even though we were meeting the protocol. Virginia Commonwealth University, then the Medical College of Virginia, said "These are the protocols, send these patients to us." It still didn't make good sense. So we hired some obstetricians. [39:00] That did not go down well because it was perceived as a direct threat to the private practice of OB physicians. When in fact there were women who weren't being cared for. We decided we had to do it. The Chairman of the Board at that time was a gentleman named Bill Poole. Bill was at the *Free Lance-Star* and on the radio station side. He agreed, and we agreed that we had to do something with these people who were not receiving good care. We hired two physicians. I think now there are three or four. It did not go down well, but over time they began to see that it was probably good for everybody.

00:39:42

Rigelhaupt:

So before you hired obstetricians, if a woman was in labor, came in to deliver—

00:39:56

Jacobs:

[laughter] Yeah, it is.

00:39:59

Rigelhaupt:

I'm not going to enjoy seeing the transcript with this question. So—

00:40:08

Jacobs:

She's in labor.

00:40:10

Rigelhaupt:

Who's going to take care of her, though? Is it the emergency room physician? Were there obstetricians on call?

00:40:15

Jacobs:

No, not the emergency room physician. There were obstetricians on call. We would have to call the obstetrician. They were on call for all patients, period. During the day, if the woman was in labor, and if she was a patient of Dr. X, she would come in, still through the front. Through the Emergency Department is the easiest place to come in. We would put her on a stretcher and take her to the unit. We would call the doctor's office and say, "Your patient, Mrs. Smith, is here. She's in labor, this is the situation." He or she would make a decision how soon they could come in or should come in. If they were not a private patient, which means we didn't have a record—in comes Mrs. Jones in labor, again, through the ER, because that's the door for people to come in. Rather than the front door, which was—that's another funny story, too, about the front door sometime. They would come in and we would then call the OB on call; we had a roster. And I think, in those days, there were fifteen or so obstetricians. Today, it was Dr. X. We'd say, "Dr. X, Mrs. Jones is here, she's in labor, she's dilated, et cetera." Of course, he doesn't know anything about her. And it depends on where he was. Some of the physicians were more cooperative than others, and might say "I'll be in there as soon as I can." Others would say, "Call the rescue squad and send them to Richmond." And that's not good care, flat out. Even though we were told by a physician, and even though the Medical College of Virginia said that is good care. That was a controversy because there were ten criteria that these people had to meet. They met all ten of them, because they hadn't seen a physician. We didn't know their previous history. [42:00] Is this their first pregnancy, their second? We don't know what drugs they're on. We don't know anything about them at all. MCV had residents. That's how they learned and they said, "Send them down." That's what was going on. But still, in one level, it just didn't make sense. They should be examined by an obstetrician who can say,

this person has a certain disease or illness. I'm not a physician or a nurse. They'd examine, treat it, and say we can't deliver here for whatever reason. We'd send them to MCV.

00:43:12

Rigelhaupt:

Now the Dr. X on the roster. His or her turn, how are they compensated for coming in on call? Was it part of a contract? Could you explain that process?

00:44:28

Jacobs:

Remember I said there was a board of directors; there are physicians and there's a management team. Doctor comes to town—let's say he is an obstetrician so we can stay on target here. He or she says, "I'd like to practice medicine at Mary Washington Hospital, and here are my credentials." The management team puts together a process. We would review to make sure that the physician is exactly who they say they are, received the training that they said they received. Because you don't know; they can walk in off the streets, "I'm Dr. OB." We go through all that. Then we take that package and recommend to the Board of Directors that this obstetrician be given privileges to work at Mary Washington Hospital and to bring their patients. The board either agrees or disagrees. But if we've done our work, they would agree. The board would say, "Okay, obstetrician gets privileges." As part of that, you have certain rules you have to follow. One of those rules is you take turns on the roster and you take care of non-paying patients. So you get reimbursed? No. You're just required to do it. Most of them understood that. Unless there got to be a huge number, and then all of the sudden the physicians would say "What's going on here?" But that was part of the privilege. That's why they get privileges. And that's why I say we work together. They don't work for management. [45:00] They work in responsibility of the privileges granted by the board. If there ever were any problems as far as the privileges they had, management could recommend that the privileges be restricted or suspended. But we couldn't act on it; the board would have to say yes or no. It's an interesting process. It's not without its problems, but it works out pretty well.

00:45:23

Rigelhaupt:

This certainly sounds like a challenge as far as making changes, coordinating, but not in the same organization?

00:45:35

Jacobs:

Right. Well, they're in the same organization, but they're peers of mine, if you will. And it's the way it is in all hospitals, except the for-profit hospitals. Management in, like, an HCA hospital—the board of directors there is in Nashville—has a lot more say in what goes on with the medical staff than they do in a not-for-profit where the board of directors is right there in that community. If you're my physician, and you're doing things that I don't think you should do, and I report it to the

board; well, you play golf with some of the board members, or you may be at a social party with a board member and you say, “You know what Bill Jacobs’s doing, by the way? You got to stop it!” [laughter] But most of the time, if I did my work properly, that wouldn’t be an issue. It wouldn’t be. It generally wasn’t. Because he had talked to the physician first and said, “Here’s the issue, and here’s what’s going on. Do you realize whatever it may be?” And ninety-nine percent of them would say, “Whoops, I didn’t realize.” But you always have a one-percenter.

00:46:47

Rigelhaupt:

So again, staying with OB, you hire obstetricians. It sounds as though there was some controversy with local OBGYNs in the community, seeing potential competition. But did that mean that then they were off the roster, so to say? That, you know, emergency deliveries would have been cared for by OBs that were hired by the hospital?

00:47:21

Jacobs:

What we did was initially, with these two—I think there were three, but I’m not sure. But ninety percent of the time, they covered all that. But there were some times when they couldn’t, and so it was prearranged. Then we asked those private physicians, “Would you be willing to take a call to give these people a break on weekends, or nights occasionally? And we’ll pay X dollars to compensate for you.” A couple of them said, “Absolutely, we’d be glad to help. Glad to help out.” It was pretty seamless, the mother-to-be coming in, came in and if it was the night of the hired physician, they saw her. [48:00] If it was the night of a physician from in the community they did the delivery. These hired physicians lived in the community, and also saw their own patients. The community for the community’s sake; they were one and the same. It was the financial reimbursement. It didn’t take long for the obstetricians to say, “This is a good deal for everybody.” And they came around and said, “You know, this is a really good deal for everybody.” Sometimes the process requires you to make the step out there and have people shoot arrows at you a little bit. Then they can say, “Well, I didn’t really mean that.” It softens down, and then later on, they take credit for it. That’s okay, as long as you do the right thing for the right reasons. I think the obstetricians in this community do a good job, from what I know. And the OB unit is a great unit, and a big unit.

00:48:54

Rigelhaupt:

Did having OBs on staff facilitate the process of starting a new specialty, like neonatal?

00:49:05

Jacobs:

Yes. Well, seeing mothers with compromised babies is what did it. So if you’re going to have the mother and deliver here, if there are enough of them, it makes sense to hire somebody that’s a

neonatal specialist to take care of them. Yes, one leads to the other. Same way once you got more cardiologists—I think there was just one fulltime, board-certified cardiologist. Once you get four or five or six, all of the sudden, they're sending all these people to Fairfax, VCU, and Henrico Doctors', and some going to Houston to Dr. DeBakey. And next thing you know, there's two, three hundred people leaving your community. You say, "Well, it makes sense to keep them here and take care of them here." That's what was done as well. As I recall, that physician wasn't hired. He was recruited with the medical staff's input. They'd make the selection, and say, "Here's the guy, here's the team," and make that recommendation. But I think he was financially on his own. For me, as the CEO of the hospital, I wasn't trying to hire physicians. I was trying to provide quality care for the community. That's one of the challenges we have today, is the financial structure in the business. You have all these different payers: Medicare for the elderly, Medicaid for the poor, private pay, no pay. If you look at the reimbursement numbers, there are certain specialties where they're way out of whack. They'll pay a cardiac surgeon, as an example, dollars up here, and they'll pay a family practitioner who spends more time way down here. Our payment system doesn't make a lot of sense sometimes. But that's beyond my control, though. [51:00] You do what you can. And as I said, with the pie shrinking, so to speak, for inpatients. If you look at the new hospital up there—which I'm very proud of it, I had obviously a lot to say and to do about it—that's an expensive structure. If it's ten percent full, that's a heavy overtime. If it's ninety percent full, then your per capita basis for running that facility becomes very, very reasonable; and it's why their rates are competitive. Try to keep the rates down, because private commercial patients in this community mean business. If your health care rates go out of sight, then you're driving your local business out of the community, which you don't want to do. When people see that, they begin to see that there's a balancing act that goes on for certain things. That's one of the challenges, and I enjoyed that, trying to provide the community what it needed and keep business here. It is why you have some fundraising efforts and why you have some fundraising events. If you can buy some equipment through donated dollars, that's money you don't have to put on your books to pay for things and you can keep your rates down. I was proud of the fact that we had no increase in the rates, one year while I was here. I remember that. And that's not often done.

00:52:25

Rigelhaupt:

Let's talk a little bit about finances. What was the financial picture from Mary Washington Hospital like, when you began?

00:52:37

Jacobs:

As I said earlier, the financial picture was solid. The biggest challenge that I could see was they had undervalued their services, so to speak. If there was an opportunity to build something, they didn't have enough financial leverage because there wasn't anything to go to the market with and borrow money. People don't want to lend you money if you can't afford it. Which is interesting, all right? If I can afford it, why would I borrow it? But that's a whole other story. If you have some money in

the bank, and your rates were competitive, then you could borrow some money to build a new wing, or to build a surgery center, or an outpatient diagnostic wing, or what have you. That was the weakest thing I saw; they didn't that reserve so they could expand when needed. And that's crucial. They had a philosophy. Not a bad philosophy, but kind of pay-as-you-go. Pay-as-you-go works until something happens. It's like saying, "I won't save to replace my car. When the car dies, now I need \$20,000. Where do I get it?" [54:00] But if I've been saving a little bit for my car, then all of the sudden I got five or six or seven thousand dollars saved and I can go to the bank and borrow and spread out the terms over five years to get my car replaced. That's what I saw. But other than that, they were strong. They were strong.

00:54:18

Rigelhaupt:

The expansion you mentioned that happened. I don't know if it started in '79 or was completed in '79. I mean, I don't know how large, but, you know, it was I think about fifteen and a half-million dollars in bonds that went out. Was that a new practice? I mean, it was a couple years before you started. But was that something new for Mary Washington Hospital, that bonds were going to be issued, and debt was going to be taken on as part of its practice?

00:54:52

Jacobs:

As far as I could tell, it was new. I don't remember the number, but that sounds about right, about \$15 million. I think, it was started in '79 and completed in '80, '81. That's when I came. It was already underway. Taxes and bonds for health care organizations is a good way to go because your borrowing costs are really low, you can keep your buildings modern, and you can give the community what it needs in services. When we built the Cancer Center out on Route 3, we were able to borrow a small amount of money. We had some fundraising for it. That worked out real well. If you don't do those kind of things, I don't know where you go. You say, "All right, you still have to leave the community and drive to Richmond." Driving to Richmond—and I live outside of Richmond but west of Ashland—is not necessarily a problem. But it depends on the disease. If you're driving down from Fredericksburg to Richmond to get cancer treatment, that involves radiation therapy and it involves chemotherapy, and that makes you sick. You drive down, got your treatment, and now you're sick, you're throwing up, and all kind of things like that. You either stay overnight, and you're going back and forth, five days a week. We're staying there all night. It's a major psychological and physical and financial impediment when it can be right here, in your own backyard. Capital financing is one issue and operating costs are another thing. You try to keep your operating cost as low as you can so that you can do the financing and not let either one get out of balance. Everything's a balancing act, so you get to juggle.

00:56:57

Rigelhaupt:

Did you get a sense that that changed some of the dynamics in the sense of the community and fundraising? It's clear that community fundraising was an important part of Mary Washington Hospital. But as it became more complex, required capital, lots of capital, debt, and bonds—did that change how it was going to be funded, in the sense that fundraising perhaps couldn't keep up with those kind of capital expenses?

00:57:32

Jacobs:

Well, you're right. I mean, the fundraising could never keep up with what was needed as far as the new buildings. Unless you go back thirty to fifty years ago, then it could. But that changed, you know, drastically in the '70s and '80s, particularly after World War II. We even had some federal grant funds, called Hill-Burton money. Then that was done because all these communities needed hospitals; they had the need for services but no hospital. The dollar amounts changed drastically. What was important about the fundraising? There were a couple aspects. One is it gave the community a opportunity for input, for some pride—rightfully so—to say, you know, "I bought a brick. I bought a piece of the wall. I made a donation, and there's my family name, there's my wife's name, or my child's name." It was a community ownership. The other thing—and just as important—was if you had some fundraising, when you were going to go borrow the money—remember I said banks want to loan you the money if you don't need it. But if you have some cash and they say, "Okay, so you can make your payments, and maybe you'll keep that in reserve. If there's a rainy day fund, so to speak, then you can pay your interest out of these reserves." The fundraising still was important, but if you had a million dollar in reserves and you're building a thirty million dollar project—or in the case of the new hospital, 200 and some million. You're never going to get that kind of money, but you could use that to pay some of the debt until you get things structured. It was very, very important, and still is. But no, it can't replace the dollars; just the magnitude is huge.

00:59:15

Rigelhaupt:

And was that something you saw changing in the '80s? Or would you date that earlier, the cost in terms of going up, that fundraising just couldn't be anything but a smaller and smaller percentage?

00:59:31

Jacobs:

Right. This was actually taking place about that time, in the late '70s, early '80s. And so you think back, what was also going on in those times? There were requirements now for different kinds of regulations within hospitals, such as fire control, fire damage. You had to have buildings that were fireproof, and things like that. What else was going on? The whole idea of something called computers was finally coming in. [01:0:00] They required their own massive building, all this

electrical, and conduits going through your ceilings, and things like that. The components of a hospital change. The operating rooms were built differently to have different air circulation. You had some areas of the hospital had to have 100 percent outside air coming in, and nothing could be recirculated. That requires a massive restructuring of your HVAC. There were all these outside requirements that were taking place on the building. It wasn't just the cost of manpower to build it. Then when you buy the land, you have to make sure it passed certain kinds of EPA things. And if it was water, you had to make sure it didn't violate the Chesapeake Bay Act. Then you had all this pre-work that was being done. The cost of both the building and in the preparation. Then the equipment that was going to into hospitals: there was cost for modern day equipment. All of the sudden you went from X-ray machines to CAT scanners, body scanners, full body scanners, PET scanners, operating room tables, operating room lights, and gamma knives. The equipment. A rule of thumb back in the fifties and sixties was that for every capital dollar you had, it would take fifty cents to operate. That meant that most of the money was going into building. Well, the capital went up. So did the operating costs, went way up. Now you got a magnitude problem. You got building costs up, and you need nurses now that are specially trained, you need physical therapists, speech therapists, occupational therapists, respiratory therapists, and on and on and on. The staffing issue, all of the sudden, went from a couple hundred dollars a day in costs to a couple thousand dollars a day, without anything else being taken care of. Changes really came about late '70s, early '80s, somewhere in there, then just have magnified. In 1975 or so, there was one of the first scanners that came out was called an EMI scanner. I don't know if you remember that. Well, people say, "Wow, that's really cool." What the EMI scanner—this is a piece of trivia—stood for, and we can thank the Beatles, EMI, Electrical Music Incorporated. It was their capital investment arm. The Beatles were making so much money that they were investing. They started investing in medical equipment in the '70s, because they saw what was going on. We had an EMI scanner. [laughter] And now we have records of EMI, I think.

01:02:53

Rigelhaupt:

So the technology is driving some costs?

01:02:57

Jacobs:

A lot.

01:02:58

Rigelhaupt:

The building requirements are driving cost. [01:03:00] Was there any sense that payers either, you know, it yet wasn't the center for Medicare or Medicaid services yet. I forget the name.

01:03:12

Jacobs:

It was called HCFA. Health Care Financial Administration.

01:03:19

Rigelhaupt:

Was there any recognition from payers? You know, either from government payers, private payers, that hospitals were facing significantly increased costs?

01:03:34

Jacobs:

There was a lot. The payers started to ask for contracts, and they would try to get special rates in their favor. They'd say, "Well, if your charges are X, or a dollar, we'll only pay ninety cents of the dollar." There was a negotiation there. That was on the private side. On the federal side and the state side, you don't negotiate. They say, "Here's what we're going to pay you." And by law, you have to take it. You have no choice. Either that, or you don't participate in Medicare and Medicaid. So sixty, sixty-five percent of your community would have to go someplace else. Basically, you can't do that. The government just says, "Here's our rates," and what have you. They would put into place certain criteria. Some of the commercial payers would say, "Oh, by the way, we're not only going to pay just a percent, but we don't want to pay for what we think should have been done in a doctor's office." They would set up a review. Then the private industry said, "Let's create something called health maintenance organizations, HMOs." Then these patients would come in and they would have a wraparound fee. All of the sudden, the payers—all payers—started to figure out, and say, "How do we compress your fees? How can we compress your fees?" That started probably in the early '80s. If Medicare is going to do it, private insurance is going to say, "Well, why should we get stuck with paying the bill?" They're still stuck with a lot of it, and that's pretty obvious. If you have a dollar cost, and Medicare probably pays eighty, eighty-five percent of your cost and Medicaid, maybe ninety percent of your cost. So who's picking up the rest? The private payers—the Blue Cross, the Aetnas, the Humanas, the United Healthcare, the Travelers—they are picking up more. Now they're resisting that as well. They're asking for other kinds of things, such as set rates. We talked about relationship with physicians. Early on, the payers tried to say, "All right, tell you what, Mary Washington Hospital? We will pay you so much in admission. This patient comes in, we'll pay X. We're going to pay you a certain amount." [01:06:00] And the Y never comes up in my conversations; it's always X. [laughter] Okay? And I said, "Wait a minute? Who admits sick people to the hospital? Me? I think a doctor does. And then who treats them? Who orders the tests? Who makes orders? Who discharges them?" I didn't hear management in there yet. And I said, "But you want me to control that?" They replied, "Yeah, we do." I said, "No, it won't work." And it didn't. But what is working is that there's still pressure by saying, "All right, we're not going to pay." In the early days of Medicare, by the way, if a patient stayed too long, they wouldn't pay the hospital, but they still paid the doctor. Hmm. That was interesting. The rationale, from HCFA, was that they still need medical care. They may not need hospital care, but they need medical care. Now that's

changed. They're one and they're tied together in a bundle type of thing. That's why I said we're probably headed down that way where we're going to have an all-payer country in some time. Good or bad, I don't know, but I think we're headed that way.

01:07:14

Rigelhaupt:

But it sounds as though both Medicare and private payers were trying to control costs. At the same time, the kind of care you're trying to provide the community is going up in terms of specialized care. You mentioned cardiology, neurology, cancer care. Is this the role of management and the board in the middle there, to try and figure out how to balance one half trying to go down, and the other half trying to go up?

01:07:53

Jacobs:

I think definitely is. I think that's that balance that I mentioned earlier, that they're trying to find. It plays out in many ways. Who better can see the trends than the management team? It doesn't mean they can change them and it doesn't mean they know how to totally control them. But that was my job. That was my team's job: to see what was going on, what's going on in our community, what's going on in the state, and what's going on in the big picture. How do we fit? What you try to do is—and that's, again, going back to MediCorp. Can you get people out of the hospital sooner into a nursing home? What better way to do that if you own the nursing home? You have some say in, "Okay, this patient is ready to go." That meant that Medicare patients, instead of staying eight days, maybe they stayed six days. They were still getting good care. We would send them to the nursing home or into a rehab unit, at a lot less cost, for a ten day or twelve day stay, and then home. It forced, I think the prudent organizations—not just management—to take a look at that. [01:09:00] The other thing—and you see it today, very big—it also created opportunities for hospitals. When I left Fairfax Hospital to come to Mary Washington, we were in that process. We were buying up or merging with other hospitals. The reason you do that is it cuts down your overhead and spreads your cost out, which means your community costs are even less. Where do you get less redundancy? Most of the cost of that is in your staff. You don't need two of these and two of these and two of these; maybe you need one, one and a half. You can save a lot of money. Yes, it is pushing you that way, and that's not bad. Nowadays, in Virginia, I'm just trying to think. 1980, there were probably 100 independent hospitals and twenty affiliated. Now we're in year 2013 and I'd say there are five unaffiliated hospitals and the rest are part of systems. A huge shift in twenty-five, thirty years. Huge shift. In three or four years, there won't be any unaffiliated—my prediction—including Mary Washington. You can't resist it because the insurance programs will drive you that way, the costs will drive you that way, and you're going to need capital to do some things, sooner or later. We have the Norfolk Facility of Sentara, which is not-for-profit. They just bought Potomac Hospital up in Woodbridge. They now have eight hospitals. Inova, which is part of the old Fairfax system, has about six or seven hospitals. HCA has seven or eight in the state, including one right here in

Spotsylvania. There are other systems, and that goes back to their costs and their overhead. You can centralize your finances, billing, and a lot of things. And what does that do? That reduces your cost.

01:11:03

Rigelhaupt:

But the other players are teaching hospitals.

01:11:08

Jacobs:

That we haven't talked about. Okay, sure.

01:11:16

Rigelhaupt:

Well, you came from a teaching hospital, right? Fairfax had residents.

01:11:20

Jacobs:

Yes, but we weren't a university teaching hospital. We were a teaching hospital, yes.

01:11:25

Rigelhaupt:

Were there things that you thought were worth emulating, coming from a teaching hospital, that you tried to bring to Mary Washington Hospital?

01:11:39

Jacobs:

That's an interesting question. Probably not, because if you're going to do that it requires residents, students, supervisors, and it's a whole new ballgame. Fairfax was a teaching hospital, but not a university hospital. We didn't have teaching programs in all aspects. [01:12:00] There were really only three in the state: VCU, UVA, and Eastern Medical. Those were the only three in the state. It just takes a huge amount of overhead and staff. Even if one wants to or must emulate them, you just can't do that. There's a role for teaching hospitals. When we need to max out with what we're able to do, then you refer them to those centers. You do work out referral programs so that it's a seamless referral. It depends what the specialty is. Sometimes, for example, there was a time when VCU didn't have a cardiac surgeon. I don't know what was going on in the faculty. They shut down the department, or didn't have the person. So you couldn't refer there and you'd have to refer them over to UVA. Most of the time, you'd have standard referral arrangements that fit your community. As long as the center was a good center, and the physicians would do the evaluation of that. The board, as we mentioned earlier, there was a role for the board. There is a Board Committee on Quality Review, quality of care. It reviewed what was going on from the aspect of the physicians and of the paid staff. We reviewed everything in there. One of the things also, when I first came here,

that they didn't have—that was an interesting problem. Every hospital has to be audited, so we would have an external auditor. Well, we didn't have an internal auditor, and they're a totally different person. I had been used to that. An internal auditor gets down into the nitty-gritty, and actually helps management, but does not work for management. But if you have one—and we do, did and do—then they look at all the rules, procedures, quality issues, and report not to management, but to the board. There could be the assurance and we could feel comfortable with the things that were going on. It's a big organization, when you get two, three, four thousand people; it's hard to watch everything that's going on in every system and every service. You would have this person to do that and report to the board. The board could be assured, not only with the big picture issues were being addressed, but also the small issues were being addressed. I don't follow it closely, but I think many hospitals have internal auditors. The board didn't understand that at first. They said, "We have accounting services and we have an external auditor. Why do you want an internal auditor? Isn't that redundancy? Isn't that added cost?" Well, it's an added cost, but it is not redundancy because they're looking at something totally different. "Don't you want some assurance that management's doing its job?" I'd like to say to you the board. "We're doing these things. Don't just take my word for it. What does the internal auditor say?" [01:15:00] Now true, I manage the day to day. But he could always go around me and say, "What you're doing is wrong, and I'm going to go to the board." That was his prerogative, and obligation.

01:15:14

Rigelhaupt:

When you say "external auditor," are you referring to a financial audit? Or is this the—

01:15:18

Jacobs:

Financial audit.

01:15:21

Rigelhaupt:

Okay, so in another part of review of the hospitals from the Joint Commission. Was that another—?

01:15:27

Jacobs:

It's another review.

01:15:29

Rigelhaupt:

What were some of the things that you learned from Joint Commission reviews as you began, and, you know, over that first decade?

01:15:38

Jacobs:

The hospital—a hospital, any hospital—probably has fifty to a hundred organizations looking at it. Some are bigger and more complex. I mean, all the way from the Fire Department coming in, OSHA coming in, IRS coming in, the restaurant organizations coming in, to the Health Department, and all those kind of things. The Joint Commission was started because Medicare wanted some idea that they were paying money to an organization that was worth getting it. That's where it really started. It concentrated on—guess what?—fire and safety. That was the whole thing. They didn't know how to do anything else. The emphasis started primarily, but not totally, with looking at fire safety standards. Then it gradually got into how you elected board members, how you chose physicians, what your hiring procedures were, and to make sure you had quality. Then by the time we got to the '80s, they would come for three or four days and bring a staff of three to five people, and charge you for it. It could be \$15,000, \$20,000 to do a review, which was good. You knew what the standards were, and that's what they were. Standards. They weren't the top; they were what you were supposed to meet. I think it was good for the business. I think it was good for everybody. Was it uniform? No, no. I mean, lots of facilities—not lots, several facilities—would get same accreditation as another hospital. There was no rating. That was the big problem I saw. You either are accredited or not accredited. It seems to me that restaurants were way ahead. Is this a five-star restaurant or a one-star? You can pick. They did not want to scare people and patients can't pick their facility. Well, I'm not so sure about that. Nowadays, we see that's changing too. They're still not changing the rating, but the internet has really made a big difference. Big difference. It should have. [01:18:00]

01:18:06

Rigelhaupt:

So how did the process start, in terms of discussing that you would build the new hospital?

01:18:16

Jacobs:

Let's see. That took a while, because I think we started, broke ground—I know we opened in '93—I think we broke ground in '90, '91. In the late '80s we would have started. Again, all of the things we've already talked about: the major changes that were going on in the business. We were out of space and that building had something like eight additions. There were certain places where a roof would leak more than it should leak. We had a roof leaking problem. We had heating ventilation problems. We had hot water problems. We had traffic problems. We had parking, huge parking issues. During that time, we expanded from the old site on Fall Hill all the way down to Princess Anne, to the old General Washington Executive Center. We expanded our acreage, but it was spread out. We had the main hospital, and still had the old emergency department. The facility was driving it; the need to get modern radiology suites, modern operating room suites, and OB suites. We needed a total upgrade. We said, "What do we do?" You could renovate, but you're still going to put money in an old building. The technology was an issue, as I mentioned. We had some of those

ceilings where you could just barely walk under because we had ceilings now with all these wires in them. We were running wires and pipes in there. God only knows where they were going; and I don't think we did. We started to explore ways to expand at the hospital. The Strategic Planning Committee with the board began to talk about it and discuss it with the management team and others. I went around to various Rotary Clubs, Kiwanis Clubs, and some other clubs, to talk about what was going on. There was a need to build a new hospital. I said I did a lot of farming, planting of seeds, cultivating, and getting things ready to go. There was some discussion about James Monroe High School and whether we could buy the school and the property. That was explored. The school board said, "We'll be happy to sell it, but you got to give us the cost of a replacement building for it." I said, "I don't think that's the way it works. I don't need the building. I'm going to demolish it. We don't want the building." [01:21:00] The school board said, "Then we're not going to sell it." I said, "Okay." We then hired a strategic planning consultant, because something of this magnitude, I think we need to have another set of eyes, another set of ears, another set of brains to take a look at it. The Board Strategic Planning Committee went through a process, including the management team and the physicians. We had the board saying, "What are we looking for? What kind of consultant do we want to bring in?" Now, consultants get a bad name. I think that's undeserved, particularly if you tell them what you want. I don't mean the outcome, but if you say, "What we want you to do is take a comprehensive look at what's good for our community." Be open about it and we said to them, "Should we have one site or two sites?" Two sites; people said I was crazy. I've been called worse. [laughter] Anyhow, we hired this consultant to come in, and he came back with a proposal that said we were not quite ready for a second site. But we needed to be on a different site; we needed a minimum of fifty acres, maybe seventy-five. We started looking around, and narrowed it down to two or three sites. Not all of them were in the city. There was some controversy over that. We heard, "You're going to move the hospital?" Well, nobody had made that decision. We're looking. If you look, then you've made a decision. That was the inference. That's not true. I mean, if I look at a painting, it doesn't mean I'm going to buy it. I can look at it and appreciate it. We looked at these sites, and it got a little tense from time to time. The mayor of the city at that time—and he's still around and is a true gentleman. I got to learn to really like, actually love that guy, Lawrence Davies. Tremendous guy. He came in to see me one time. He always called me "mister." I could not get him to call me Bill. And I'd say to him, "Mr. Davies." He says, "I don't want you to leave the city." I said, "Well, I'm not sure we are." He went through a whole litany of things. He said, "We'll be very supportive. I'll help you get water and sewer, et cetera." We didn't pay property taxes, so it wasn't anything financial. He wanted it because it was a prestige thing. He said, "A lot of your employees are from the city. I don't want them to have to go too far to get work." That made sense; it made a lot of sense. All of the sudden, this piece of property up in what was called Snowden became up for sale. It seemed like it was real natural. [01:24:00] It was still in the city and had good road frontage. It had everything we needed. The first thing we needed was the site, and then the facility itself. We used a different group to help us on the facility design. It was a big architectural engineering firm. The key thing was the new hospital. We finally convinced everybody, and we were convinced, that a new hospital was needed and that we could afford it. We had to have a site because if you're going through the certificate of need process, you have to have zoning. The city

was really cooperative. The mayor said, “We’ll rezone it for the health care services.” That’s why it’s all health care up there. It has been rezoned, and the whole campus is health care. The city got a lot out of it. And rightly so, they deserved it. We had the zoning, we had the finances building, and we were ready to go. Then the rest was kind of history, so to speak. It was a very long process. It took a while. Then moving from the current site up to the hospital site meant that some of the physician’s offices who were nearby the hospital weren’t going to be as accessible to the hospital. Some physicians objected to that. Our analogy was if Interstate 95 is being built bypassing Route 1, those businesses on Route 1 did not get compensated for the new traffic on 95. We can’t compensate you for that. What’s good for the community, we have to look at that. They adapted pretty well.

01:25:43

Rigelhaupt:

So who were the board members most in favor of, you know, really pushing forward with the new hospital?

01:25:52

Jacobs:

I have to say, they all were. At that time, who was Chairman of the Board? I think Homer Hite from banking down in King George was one. Mary Katherine Greenlaw, she may have been Chairman of the Board by then. No, Joe Wilson was. Joe Wilson was. MediCorp had to have the final say, and the Chairman of MediCorp was, I believe, Bill Poole. I didn’t prepare myself into looking at all the names. But there was no opposition to going ahead. We showed them what the end result would be as far as the community services, how it would have a financial impact, what we would do with the other facilities, how we went through it, and where we would be set for the next thirty to forty years, I don’t think hospital facilities or any complex facility is good past thirty or forty years. A lot of things are going to change. A lot of things already changed in ten, fifteen years. Where we are in technology today, who would have guessed? [01:27:00] When I started my career—I don’t want to get too far off your question—we didn’t even have such a thing as called “computers.” Now you can’t be without them. Your computer is attached to you in your telephone that you’re walking around with. There’s a lot you can do. My physician sends me notices through my cell phone: “Here’s your lab results.” When I go to my physician’s office, he has my whole electronic chart, he’s seeing anything else that’s going on, and what the lab results are for the last four or five years. We can trend it. The board really wanted to do what was right for the community. The board had a very comprehensive makeup; we had businesspeople, we had some physicians, we had an employee, we had accounting people, we had small businesspeople, real estate people, and people from all walks of life. We had educators who went along. One of my favorite educators who is very involved in the community still today is Marguerite Young. I hope you get a chance to interview her. If you don’t, you should.

01:28:24

Rigelhaupt:

I do.

01:28:24

Jacobs:

Okay. She is fabulous. But she was actually Chairman of the Quality Review Committee. And when I talked to her about chairing that, she said to me, "I don't know anything about quality." I called her Mrs. Young out of respect for who she was. I said, "You know what quality is. You taught all those years and all those students. You knew what to expect and how to measure." She said, "Oh yeah." That was her favorite saying; "Oh yeah." I said, "That's all I want. Same thing. Just stay in the medical field. That's all." She did a great job. She was great.

01:29:05

Rigelhaupt:

Want to come back to some of the functioning of the board. But the new hospital, you buy the site; I imagine the cost of the land was not prohibitive to an organization of your size?

01:29:16

Jacobs:

No.

01:29:17

Rigelhaupt:

But building \$200-plus million facility, were there any board members, any sense of apprehension about taking on that kind of a debt? But also, the Industrial Development Agency. They issue the bonds, right? They're hospital revenue bonds?

01:29:40

Jacobs:

Right, exactly.

01:29:43

Rigelhaupt:

So ultimately, I guess I should ask, I don't know. Where does the risk lie? If the revenue can't pay back the bond. Was there any apprehension about "This is a big investment, can we really afford this?" [01:30:00]

01:30:01

Jacobs:

I don't know about apprehension. There was a fair amount of honest dialogue saying, "Can we afford this? What will go on? How do we know?" Those are good questions to ask, and should be asked by a board. And there's nothing wrong with it. Hopefully we did that as management and we did our due diligence ourselves. We hired outside people, again, to say, "Don't just take our opinion for it. Here's the whole analysis." We did a spread for forty years. We did a projection. We used outside financial consultants to say, "Take into account the new financial picture; take into account this and take into account this." We did all these planning scenarios. What if we get a ten percent reduction in patient care? What if Medicare reduces its rates again? And things like that. So the bottom line was, we went through a very, very exhaustive process to reassure ourselves as management, and the board. The board can say, "That's good." Now legally, the buck stops at the Board of Directors level. They hire CEO, all right? And there's no doubt about that. I served at the whim of the board. I didn't have a contract. And I was offered a contract. I said, "I don't want a contract. If I don't do my job, get a new CEO." That's the way it should be. A contract's not going to help me do what I need to do. The buck stops at the board. The board said, "Okay, we feel comfortable in management's analysis. We feel comfortable with the external analysis." Now let's just say, twenty years from now, something happened. I don't know what it would be. Something dastardly happens. Someone says, "We're going to sue the board because they didn't do their due diligence." They're wrong. First of all, you have a process that's documented. Who were the consultants you used and what were their work papers like? All that is there, archived, so to speak. The board is not paid. They're volunteers. As long as they do their due diligence and as long as they don't just rely upon management, saying, "It's a good idea, let's do it," without any facts or figures or backup, they're fine. There's no responsibility. Now who would pay off the bonds, if that's your next question? You would have the board say, "Well, we're probably going to have to sell this to somebody else who will manage it." Then they would pay off the bonds. The organization is still on the hook for the bonds to pay them off. But I don't think that's a problem. I mean, I really don't. Is it a lot of money? Yes. Now how much money does the organization make a year? [01:33:00] It's a billion dollar a year corporation. So a two million, two hundred million dollar debt is not a big number. The ratios aren't bad, and their profits are probably—I don't know what they are now—maybe \$10 million a year. That's profit after paying bond fees, after paying the interest. It's forty years, and they're already twenty years into it. So it's halfway paid. Hopefully, they've got a reserve; I know they do. They're already getting ready for the next program, whenever that is. The bond covenants probably say you have to have—I know they do—X dollars in reserve at all times. That's another cushion that you have. When you get close to that, you have a review. There's a kick-in that they can say to you, "All right, we want you to either raise your rates," or they bring in a rating agency. And it says, "Whoops! You used to be a number one rating, single A rating, we're going to drop you down to B-minus," which means your cost of borrowing will go up. Then the board is going to say, "What's going on here? Something." They'll get involved. During these are annual checks the auditors will do the same thing. Your external auditors, as I call them in financial, will look at your bond covenants and ask are they adhered to? Your internal auditor will look at it as well

and say, “You’re not following this one, or this one, or this one.” And that’s another thing I’ll share in response to your mentioning of the board. Every year, we have a board meeting. They’re monthly, actually. But every year, the internal auditor would make a report to the board. I would say to the Chairman of the Board, “Here’s your internal auditor, and he’s going to make a report on our bond issues, our finances, and the integrity of the organization. Management is leaving the meeting, and I want the record to show that management’s not in the meeting to influence this discussion. Ask them all you want.” And I did the same thing with the external auditor. I said, “Okay, here’s the external auditor. We will leave, the management team will leave—even though I was a member of the board as president of the organization and I was a voting member of the board—we are leaving so you can question the integrity of what’s going on in the organization.” That is, I think, necessary for the assurance. The board should ask for it if they don’t, and most of the time they do. Some boards do and some don’t. But they should be given that opportunity. Everybody’s doing their job. If something comes up, you say, “Whoops, we looked and we didn’t see that. We missed that.” It’s another set of eyes to help you do a good job. And if that’s the case, there’s nothing to hide.

01:35:47

Rigelhaupt:

Other than the physicians, concerned that their offices were going to be a greater distance from the new hospital, was the general sense from the physician community in Fredericksburg and the region supportive of expanding and building the new facility in Snowden?

01:36:07

Jacobs:

Yes, they really were. I could see what was going on. We already had an outpatient surgery center over on Fall Hill Avenue, we had some outpatient radiology over there, and things like that. Which are still there, but they’re probably now being brought back in. If there had been a lot of opposition, it may not have happened. But even those who had some question were not opposed to it. They said, “Well, what’s going to happen?” And I said, “Well, it’s not that far for your patients.” That was one of the reason we built the Tompkins-Martin doctors’ office building, to give them an option. The hospital doesn’t own it; they own a small piece of that. The physicians could move their offices if they wanted; so it was an option. They can say, “No, I don’t want it.” Or “The rent’s too high.” The rent was higher because they could just walk. We structured it so there will be units on one floor; the obstetricians and surgeons go on one level, et cetera. That was there. The land was owned around it, as I said earlier. You could have other doctors’ office buildings. [01:39:00] Even those who said, “It’s going to happen,” weren’t really opposed to it. In the bond industry, sometimes it’s what they call a “cram down.” We didn’t cram anything down. Sometimes there are certain contingencies in the bond that they cram it down your throat, and you have to accept them. We said, “No.” We didn’t cram anything down the community, and we didn’t cram anything down the physicians. It wasn’t necessary. If we did our work properly, if the board was 100 percent behind it, and the physicians were behind it, then people would say, “Well, that makes sense, that makes sense.” Then we made a big event out of it, with the groundbreaking ceremonies and the moving

day from the old hospital to the new hospital. We got all those ambulances; it looked like the army coming across the ridge. [laughter] I remember we invited the press. There was a woman laying on the stretcher with a child in her arms, maybe three, or four years old. One of the newspaper people said, "Mr. Jacobs, that's pretty dangerous. What's wrong with the mother?" I said, "Nothing. It's the child who's the patient, but the mother is comforting the child." That's how we moved the child to the new unit; it was with the mother all in the same stretcher. [laughter] I'm going to have a cup of coffee. Am I staying on target? Do I wander too much?

01:38:53

Rigelhaupt:

Not at all.

01:38:54

Jacobs:

Okay. Sometimes I do.

01:38:57

Rigelhaupt:

I have a couple questions about this time period, the early '90s. But let's start with this middle period. Fred Rankin is hired as the President of Mary Washington Hospital in, if my notes are right, 1991.

01:39:15

Jacobs:

That sounds about right.

01:39:17

Rigelhaupt:

So the new hospital is under construction at this point? Or clearly, it's imminent, if not ground-broken?

01:39:27

Jacobs:

I think it's under construction, or just beginning, yes. We opened in '93, and that was a good two and a half year project. I know the ground had been purchased, and the site had been taken care of. We were probably already doing footings. But that's probably where it was.

01:39:50

Rigelhaupt:

What were you looking for in a new President?

01:39:53

Jacobs:

I was looking for someone who was a lot younger than me, even though I was fifty-three or fifty-four at that time. I felt an obligation to the board that if something were to happen to me, for whatever reason—I wasn't thinking about leaving at that point. They need to have at least someone they could fall back on, a succession plan. I thought that was very, very crucial. I was looking for someone who, if the need were there, and the opportunity were there, could succeed me. I wanted somebody who was well qualified, had the training, had the knowledge, had the people skills, had the community interest at heart, and things like that. Obviously they knew how to run a hospital, knew hospital operations, and those kind of things. I wanted some idea, was he well-rounded? Or she. We didn't exclude. We did interview one woman candidate. I don't mean only one, but we used a consultant and narrowed it down to three to five; I think, something like that. And one of the three or five was a woman. We were looking for somebody who was really well-rounded. And, you know, Fred clearly fit that bill. I remember asking him one of my questions, "What have you read lately?" I always ask senior people that because I want to see what they were reading. Were they willing to challenge themselves? I didn't really care what it was necessarily, as long as it wasn't trash, because that doesn't really tell me what—it may tell me something about the person. [laughter] I don't know. I quizzed him on some of his readings and he had read them. I thought, "He's well-read, he's well-rounded, he's well-liked, and he's looking for a community structure." He came out of a large city, he came out of I think Children's Hospital in Pittsburgh—if I recall, but twenty years ago, I don't remember. I think that's where he came from. Fred fit the bill real well. It looked like we could work together well, and we did. [01:42:00] I know one of the interviewers was Mary Katherine Greenlaw.

01:42:20

Rigelhaupt:

Was this about the time you started the Community Service Fund as well?

01:42:26

Jacobs:

Yes. Maybe about '91, '92. It was part-way through the construction project.

01:42:36

Rigelhaupt:

Could you tell me about it?

01:42:38

Jacobs:

It was an interesting situation. I believe, and I can't remember, it might have been a board suggestion. I wish I could say. Maybe it was Fred's suggestion, or a combination of that. We were getting ready to take on this debt of a new hospital; our debt was going to go up. Our plans were we got our operating costs as close as we could get to their lowest, and we had our revenues up; we

made a lot of money. We were making a lot of money. One of the questions was not what do you do with it? You can't tell the community you're just going to pile it away for a rainy day. There's only so much you can pile away, so to speak. We had funded some things for the city on a voluntary basis, which was appropriate because if there's a fire alarm goes off, fire people come up. If there's a need for police, the police come up. We funded some equipment and made contributions to the Fire Department or the Police Department; I don't remember the specifics right now. We also didn't pay property taxes. It was in lieu of some of those kinds of things. Someone raised the issue, could we do something more for the community? How do you do that? And it was really new territory, virgin territory so to speak. We put together a process and a community focus to let people make applications. What does the community think is needed that can improve the health care? We were taking on a role, and Fred was part of that. We were taking on a big role. How to improve the community health care? As I recall, one of the things was there was a community patrol. And they said, "What we need are flashlights and lights." We funded flashlights so that they could do their community patrol. As I recall, it was with bright lights. That made a lot of sense, and it was not a big expense. That can reduce crime in itself. If there's no big crime, there's nobody mugged; if there's nobody mugged, there's nobody into the Emergency Department. It was little things like that. How could you do mammography and increase of visits to the community in mammography? [01:45:00] We had big mobile vans, free vans. It was things like that. What can we do? I think the first year, we may have set aside a million dollars. But that sounds like a lot of money, but some large number; and I don't remember what all the projects were. One of the things we decided was senior management—that's myself—should not be involved in making that decision. That way, on one can say, "You're just directing money back." It was a community decision. And I don't know, is it still going? I think it is. Great. It was another benefit to the community and another way to tie the community in. Then the community has, I believe, a really good attitude, and looks forward to working with Mary Washington Hospital and MediCorp. They've changed it now, now it's MediCorp Health Services?

01:45:50

Rigelhaupt:

I think just Mary Washington Healthcare.

01:45:52

Jacobs:

That's what it is. Things change, and need to change. We all change, so why not the other things?

01:46:01

Rigelhaupt:

One of the first thing you mentioned about the Community Service Fund, mammography, and you mentioned public health?

01:46:14

Jacobs:

And the free health clinic. I forgot about that.

01:46:18

Rigelhaupt:

It sounds like at least from the early '90s in particular, with this idea of the Community Service Fund, Mary Washington Healthcare, and MediCorp was concerned with public health, and really saw it as part of its charge. And I know one of the things I've read about, and from what you've talked about, hospitals pay attention to what other hospitals do. And I've also read that hospitals have not necessarily put public health at the center of their mission. And it sounds like, from what you're saying, that's not what was happening at this moment with Mary Washington Healthcare. And I'm wondering if you could talk a little bit about how public health became a central concern of management and of the board, and I assume physicians, and how you tried to work together?

01:47:18

Jacobs:

This may sound a little bit personal; I got into the health care business because I had a real concern and a care for helping people. I had a couple small positions before I went in and end of that Fairfax Hospital. But my boss at Fairfax Hospital, Franklin Iams, who was a real mentor for me, was early on interested in public health, and I could see why. We had a relationship with one of the departments within the federal government when they were developing something called HMOs, which put a big emphasis on preventative care. [01:48:00] And preventative care, if you follow it down, is the type of thing that if you really do that job well, people don't need the intensive hospital work; if you follow all the way down. It just seems to me there are some things that go back together. I wanted to be able to stand up in front of community organizations and say things like, "Hey, we are truly a caring organization. We care not just about when you put in a bed, but we care about what's going on in our community. We're going to try to help." A lot of people have accidents. They're already healthy and you're going to do what you can on those. But there are those who don't take care of themselves and end up in the hospital. If you could have done something to prevent that and they still end up in the hospital you're a winner. Can you see instances in the community where you go to the community and you have a fundraiser? You say to the businesses, "We'd like you to donate." "Well," they say to you, "but my employees can't afford your place. Or, "I can't afford health care insurance." It gets back to that balancing in a full, comprehensive work. On a personal note, I had to feel good about the organization I represented. Were we doing the right thing for the right reason? Now, that may sound self-placating, and I don't mean it to be that. It is the management team's prerogative and responsibility to set the framework for it. We had some outreach programs in diabetes. We had a diabetes nurse way back in the '80s to help patients who wouldn't take care of themselves and they end up in the hospital needing an amputation of a foot, a toe, or a leg. That can be prevented, and needs to be prevented. That's full health. You don't want to just be known as the hospital that takes care of wealthy, not-too-sick people. You need to be a

community center. There are some hospitals in Richmond where at one time, they were the place to go. But they focused only on taking care of a small clientele: wealthy people. Where are those hospitals today? They're gone. They are gone, because they didn't meet a need. Hopefully, we're meeting a need. Hopefully, they're still meeting it. I think the campus up here shows that. There's a women's center and the cancer center out in Route 3. [01:51:00] You say what does our community need? It's our responsibility to keep looking, and keep looking, as to who else is going to do it? We're paid to do it, and should do it well if we're paid to do it. Volunteers can be helpful. That's where your board comes in. The board plays a crucial role. Every month, I had to make a report to the board about what we're doing patient-wise and money-wise. What were the issues? What was coming down the pike that they needed to be concerned about, as best I knew, so they could be informed and they could ask questions? There's nothing wrong with a board member saying, "How come we're not doing something about such-and-such?" I said, "Well, I hadn't thought of that." But you would like to be ahead of them, if you can. If I can come back to the mammography unit: it was clear to us that you put together a system to go out to the communities and do breast screenings for early detection. Twenty-five years ago that was an answer. It still is, and it didn't take a rocket scientist, so to speak. In fact, I can share with you an interesting story. We went into the Afro-American part of the community and actually went to the churches with our mobile vans and got almost nobody to come. I went back to Mr. Davies. I said, "Mr. Davies, how come I can't get people to come to our unit? It doesn't cost anything." He said, "Well it's very simple." And I thought about it. He was really smart. He said, "They know lots of people who went to see a doctor and they were diagnosed with cancer and didn't live very long afterwards. They're not going to come see you, Mr. Jacobs, to be diagnosed and think they're not going to live very much longer." So we had to change that attitude because what was happening. It happens a lot of times, but that just happened to be a segment of the community. What happens is that people wait too long for any diagnosis, and then of course, the prognosis is bad. We convinced them, and all of the sudden it just reversed itself. I think we made a positive result in the community. These people were much better off. Everybody was better off. We learned a lot, if we're open. That's another piece I pride myself on: trying to be open. I think the management team was pretty open to try to listen. I think we were.

01:53:46

Rigelhaupt:

It's clear in listening that, you know, this is a community center, not just an acute care hospital. How do you build a culture that self-replicates the concern of the community?

01:54:01

Jacobs:

That, I think, is management's responsibility. I can think of a couple things. Shortly after I arrived in Fredericksburg, I did these community assessments and we did some changes in the emergency department. I hired a gentleman who worked for Disney. And the name will come back to me [Mike Vance]. I said to him, "How do you get that team approach in Disneyworld, where people go there, it's a happening, and they don't mind paying a lot of money to get into Disneyworld? It is not cheap.

You don't hear many people complain about the expense. They talk about the experience. You never have anybody who's offending your customers. How do you build that culture?" Michael Vance was the guy's name. I think he's deceased now. Michael Vance was the gentleman's name. I hired him. He came up for a couple days. We put together a symposium for about one hundred of the top people. We did that on our own campus. We didn't go off-campus because that was frowned upon. People might say, "You're throwing money away." They don't understand that. You have to be careful of those things. We did it on-campus in an old room. And he had us in for two or three days. We developed his concept of a kitchen in the mind. I still remember this. It was thirty years ago. Golly. Kitchen of the mind. You go into someone's kitchen—you go to someone's house where there was a little social, and you generally end up in the kitchen. And what do you see? You see a refrigerator with stickies, magnets with family pictures, lists of things to do, or whatever. Then you may feel something else over here, another sticky. You get a feel for that household by the kitchen of all places. If you see no pictures up there of anybody, or you see off-color remarks, or something like that, that'll tell you something else. So we had this kitchen of the mind. He told us how we do it, why you do it, and what you went through. Physicians participated too, by the way. Board members were invited, and they didn't feel they could give that much time. I think maybe only one or two were there. You show them what that can do for themselves and for their employees. Where management comes into play, is you give them the tools. Then you really, really—and I mean this, and this is hard for a lot of people to do—you got to walk the talk. I would walk around the hospital frequently into various units, unannounced—wasn't my job to do the announcing—and chat with people who are patients. [01:57:00] That was in the '80s before HIPAA, but by the early '90s with HIPAA you had to be very careful of some of that. I generally knew if there was a board member in the hospital, and you shouldn't do that anymore. I would walk around and I would talk to the staff. I didn't care whether the staff was a maintenance guy or gal, or the housekeeping person, or the nurse, or the physician. They knew that they could come to my office if they had an issue. They could come to my office and say, "Mr. Jacobs, we see something going down in this unit, and we don't think it is right. We'd like to tell you about it." No repercussions. If you ever have one repercussion. Now your staff may not be as educated, that doesn't mean they're foolish people; that doesn't mean they're not intelligent. They can see whether you say one thing and do another. If you say one thing and do another, the trust is gone. The other thing we did was I tried to find out what bugged our staff the most and what got in their way. I used to say, "My job is to give you the tools to do your job and get out of the way. Now what's in your way? Besides me, I hope not." [laughter] I remember one instance where I had a nurse come in my office, and she said, "You've asked. Let me tell you what bugs me about my job. Invariably, even though we tell everybody who's coming in for surgery not to bring a piece of jewelry, watch wear, a ring, or their dentures, they do. And they get lost. We don't know where they are. Then the patient is upset with us, and we have to go through this elaborate process to say, 'We don't know where it is. How much is the value? We can reimburse you.' But it takes a while." What we did was we gave the nurses the authority, on the spot, to say, "We don't really know what happened. Tell me what it's worth, and I will reimburse you now." They could go get a check for, I think it was \$300 or \$500. It was used to happen two times a year or three times a year, something like that. They felt empowered all of the

sudden, and they didn't feel like they had to bear the brunt of family complaints. Let me tell you another story like that, and this was at a different hospital. Actually, it was at Fairfax Hospital. I tried to get that empowerment feeling. I had the same thing where the nurses could come see me. One nurse came to see me and said, "Mr. Jacobs, we got this patient who's really gone crazy on us. Just will not behave." I went down to see the patient, and I said, "What's wrong?" And she said, "I want some ice cream and the nurses won't give it to me!" Well, the nurse was following the doctor's orders, written on the chart, for a certain kind of diet, and no ice cream. [02:00:00] I called the doctor and I said, "Doctor, Mrs. So-and-so is just causing fuss down here and making the staff mad, and all she wants is a little ice cream." He said, "Okay, give her some ice cream." There are a couple pieces to that. They felt that they could come to you and there was a culture or a climate where you were really trying to help them to do their job. The other thing that I did—and I don't know how far you want to go with it—once a month, I would pretend I was an orderly or something. I would be an orderly on a shift. I was an ER orderly. I was an operating room assistant. I was a housekeeping assistant. I was from dietary—I did all these things. I put on the garb, and did the whole thing. I didn't do it just during the daytimes; sometimes I did the evening shift or the night shift. I did this so I can get a feel and listen to these people, actually touch, and see what was going on. You have to show them that you're real, that you're human, and that you're not just about numbers and paychecks. You have to do that, too. Everybody wants to be paid. If you can't get paid, then you can't do a good job. If you don't have good nurses and you don't have good care, and on and on and on, then you can't do a good job. Again, it's a balancing act. I mean that and I say that a lot, but it really is a balancing act. I hope that answers your question. Obviously, I got passionate about it. That is one of the things I missed when I left Mary Washington. I did miss that piece.

02:01:47

Rigelhaupt:

It sounds like you had a good working relationship with the city, at the city government level. What was it like working with the state government, or the Commonwealth?

02:01:58

Jacobs:

I understand. I know what you mean. There was a time when—and maybe that's what you're referring to—we had a major expansion in the early '80s. I don't remember the dollar amount, but it was a pretty big expansion. It was one of our last major expansions. It probably was \$25 million, or something like that. There's a process in the state. You have to apply for a certificate of public need; and then they approve it or disapprove it. We went through the approval process. I'm sorry, that is the process, but it was the tail end. Construction ended in '81 or '82, or something like that. I think that was the \$15 million expansion. [02:03:00] We went through a certificate of need process, which notified the Medicaid office and notified the architectural review so it meets fire codes. We notified all the state agencies and went through the certificate of need process. All the state agencies went, "Yes, yes, yes, yes." The project met all the standards. Shortly after, I don't know when exactly, whenever Doug Wilder was governor. During that reign, I remember that. We got notice from the

state Medicaid office that they were not going to reimburse us for the depreciation on this building. Arbitrarily, they just said “We’re not going to do that, because we don’t approve anything after 1981 or ’82.” But our project was approved before that and they just said, “Nah.” And I’m simplifying, okay? I appealed to the Director of Medicaid, whom I remember very well, and I appealed to the Secretary, a guy named Joe Fisher. Joe Fisher? I think it was Joe Fisher. He seemed to sympathize. And Pete Hearn was with me—Pete Hearn was the Chairman. He seemed to sympathize and sent me back to the guy that refused to deal with me. That was a concern I had. I followed through and I was denied again. Then I got a letter saying that you’re not going to get paid and there’s no appeal. “That’s ridiculous.” There’s a local attorney named Bill Sokol, who’s the hospital attorney. He is a great guy, and still in practice, too. He said, “Everything has an appeal. This is America. This isn’t a foreign country. [laughter] There’s an appeal for everything.” But he said, “This is outside my area of expertise.” We got some kind of hotshot attorney, who we interviewed, and what have you. We actually had to sue the Commonwealth of Virginia, and we did. It was a four-day trial, by judge, Judge Merhige, who just died a couple years ago. He was tremendous and actually took the state to task. At the end of that time, they found in our favor and said the state has to pay us for this, which they did. There was about a million, million and a half dollars per year that they were not going to pay us. This was thirty years ago; that’s a large number and about half of our bottom line. They were obligated to pay, just didn’t want to pay. During the lawsuit, Doug Wilder sent a piece to the newspaper, to the *Free Lance-Star*. I got upset with, not only the letter, but the fact that it was printed in the *Free Lance-Star*. It said that “Mr. Jacobs’ income is underreported.” [02:06:00] Yes, in the newspaper. He said, “Mr. Jacobs is hiding money in these other corporations, in MediCorp. His salary from the hospital is not his total salary.” This was false, dead false. I was furious. This was during the trial. And we also had an unannounced audit by the Medicaid Department over something else. I took this information back down to Richmond to the federal court the next day. To Judge Merhige, the people of Medicaid and the state Attorney General who was representing them tried to say this was a coincidence. The judge said, “I don’t think so.” He slapped their hand. Then he called the Director of Medicaid onto the stand and said, “I have a letter here that says, “Dear Mr. Jacobs.” I’m going to summarize to the bottom line: “There is no appeal to this decision. Sincerely.” The judge said, “I have a letter here from the Regional Office of Health and Human Services that says, ‘Here is our Medicaid appeal process.’” He said, “Which way is it?” To which the Director of Medicaid said, “Well, maybe my grammar wasn’t too good.” To which Judge Merhige said—I still remember this—he said, “You know, I’m first-generation immigrant here. My parents didn’t speak very good English, but they taught me English well. We’re not talking about grammar.” The state lost all credibility at that point, and the Commissioner of the Medicaid program was sent away for a year for further study. My relationship, other than incident, pretty much was pretty good. That was a personal issue, I’m convinced. Not so much of the Governor, he just signed a letter that someone put under his nose. He didn’t know me from Adam. Well, maybe he did. I was President of the Hospital Association, which was a voluntary position. That’s when he wanted a sick tax. He wanted to tax hospitals under profit, which I had the pleasure of saying, “No, we’re not going to do it.” I know it was after the lawsuit, so I’m not worried about that. But that was pretty nasty and I wanted to sue the governor. Bill Sokol said, “No, probably not a good idea.” I said, “Can I write the

letter?” He said, “Yes.” So I wrote him the letter, gave it to Bill, and he tore it up and threw it away. I got a lot of good advice from him. He is a good attorney and a great guy. [02:09:00] But we had great relationship with the counties. I knew County Administrators. I knew the City Administrator. We tried to try to keep them informed when we were doing things, when we wanted to build a cancer center out on Route 3, way out there. The county wanted to know why, what we were going to do, and what was going to go on. Rightfully so, you know. We met several times with them. We didn’t have much in Stafford County. We saw a lot of their indigent patients, or non-paying patients; we kept that relationship. We built the place up in North Stafford, which was part of Stafford County. We had a relationship with King George, where we had a nursing home down there. Other than that one incident, I think our relationships were good.

02:09:53

Rigelhaupt:

Part of the reason I ask is it seems as though hospitals are a relatively unique organization in terms of the amount of regulation at different levels. And you have to work with local state and federal government in a way that a lot of other organizations don’t have to. And what you remember about those working relationships. Other than this incident, it sounds like was cordial, good?

02:10:28

Jacobs:

I think so. I mean, sometimes there are certain issues—and I can’t think of any right off the top of my head—that may come up. You try not to do your discussions in the press. Occasionally, that would happen. People get set; you try to not let that happen and try to have a good relationship. I used to go to the counties and report how much free care we gave them each year. Once in a while, I’d send them a bill, tongue in cheek, saying, “Last year, Spotsylvania County, your free care bill was two million six hundred-some thousand dollars. Please send check care of.” That was always tongue in cheek. But that would give me an entrée if I had to go back and say to them something like, “Remember I did send you a request for some payment on free care.” And they’d just chuckle, and we’d move on. But hospitals are sometimes targets. If you know that, don’t make it worse than it is. Don’t try to play the bully role. There’s no need to, if you’re a community service. People come to a hospital. Most of the time when I stand up in front of a group and say, “I don’t know you folks in this community, in this room, but I know either you or one of your relatives got a good chance of visiting me this year.” Emergency departments see 50,000, 60,000 people; that’s a lot of people. [02:12:00] I did a lot of work with the community, with civic clubs, and community organizations. We tried to stay involved. We worked with the rescue squads, and it even went to the point where we would say—I think we created the rescue squad. We tried to help with that. Then a room where the state police and the city police, county police, could do their reports with a cup of coffee and some donuts, so to speak. They can get in and out and get their job done. Because if I needed them, I knew they would respond. I think these organizations try to work together. One of the things people don’t like to know is what goes on after midnight in the Emergency Department; you see a whole different part of your community. I mean, it is very, very different. And you won’t see them

the next day. I remember when the AIDS epidemic first came out. And I remember being asked by a community member, “How come we don’t get AIDS patients at Mary Washington?” And I said, “How do you know we don’t?” They just looked at me. We took care of whoever was admitted to the hospital. They said, “You mean, they really do?” I said, “You know how AIDS is spread?” You know, it’s not a contact sport. We take care of whatever is needed in the community, or should. We can’t pass moral judgment. It’s not our role. It’s not my role. You have to cooperate with these agencies, state and federal. I remember one time I got a visit to my office by our security person, who said that in this package, which came through the mail, they thought were drugs. I said, “What makes you think there are drugs in this package?” They said, “Well, because we had a patient who was a drug addict.” They were pretty sure he was being sent some drugs to use while he was in the hospital. Obviously, not the drugs we want him to use. I said, “Open it.” They said, “We can’t, it’s US mail.” I said, “Well, it looks like it’s open to me.” And inside were drugs. I called the police. The police came out and said, “Yes, those are drugs. Who opened it?” We said, “That’s the way it came through the mail.” They said, “Okay. What we’re going to do now is look at the return address that is probably fake. We’re going to contact that address.” It wasn’t a fake return address. It was a real address. So we did both ends. They were very cooperative about it, and we didn’t have to worry. Because our concern, again, was the patient. You don’t want them getting drugs that they’re not authorized to have. Cooperation is essential, but you have to earn it. [02:15:00] Respect is essential, but you have to earn it. It’s not given to you. It’s a two-way street, a two-way street.

02:15:10

Rigelhaupt:

Did the AIDS epidemic, as it was, you know, first happening in the 1980s, have an impact on Mary Washington Hospital?

02:15:20

Jacobs:

The impact was more cultural than anything. We had to put together educational programs. We had a disease specialist, an infectious disease specialist. We had a nurse assigned to it. We just put together an educational program for the staff to realize how to handle these people. It’s not contagious, Okay? A needle stick—we’d have to get into that. A needle stick would be another issue, because it’s obviously transferred by fluids. Other than that, I don’t think so. Did we have a lot? I don’t have any idea. I didn’t think about it, but I don’t know. Other than the education piece, we just had to do it.

02:16:09

Rigelhaupt:

Well, one of the things I was going to ask specifically about in terms of the federal government were the DRGs, which you talked a little bit about. Were there other changes in terms of health care policy, or hospital-based legislation that you can recall from the federal level that had a big impact on the Mary Washington hospital?

02:16:35

Jacobs:

I don't know. I'm trying to think. There were regulations passed. I don't know if they had a big impact. You get regulations all the time. One was called, I remember, the Emergency Medical Transfer Act, or something like that. That was a federal piece that was passed, and was also pulled in through the Joint Commission. We did create a position with the responsibility to help us through those regulations. There were a lot of regulatory pieces we had to be aware of. We had somebody, believe it or not, who would read the federal registry every day, or at least pieces of it, to see if there are some regulations that are being proposed that we should know about. You usually get a time period to comment. Then they also, if it's a big piece of legislation, might look at what the congressional intent was. There was some extra staff time. We didn't have anybody just full time on that, but we had some people who were assigned that as a responsibility, in addition to the other things. [02:18:00] On the new hospital, there were a lot of regulatory pieces. And I remember one; it was kind of funny. It's a federal program through the state, and it has to do with the handicap laws. We had handicap parking in all public facilities and private facilities for people to have visitors coming in, and that was appropriate. If you read the law, it tells you what the rules are. A piece of the rules states the size of the restrooms, which is where I'm going. We had a restroom on the second or third floor of the new building that was three inches too narrow to meet the code. The building's built, and we're thirty days from opening, and this inspector says, "You got to do something." What am I going to do? He didn't have a clue, other than here it says it's got to be X-Y, and there's no X. And I said, "Hold on a second. Does the law require me to have a handicap restroom and public access to the handicap toilet on every floor?" "Well, I don't know. [skipping pages noise]. No." I said, "Okay." I went up to the door, took the sign off, and I said, "It's no longer a handicap door. There's one down on the first floor." We met that. We put it back up after he left, of course. If somebody's on that floor, three inches isn't going to bother them. I want them to know where the restrooms are. That was just an overly zealous individual. You learn to live with that. I think we were a couple days from opening and we found some curbs that had to be cut or painted, or something. That's part of the process, just part of the process. The biggest problem we had was the Chesapeake Bay Act. If you notice down below the Mary Washington Hospital, there's an area that I think has Dominion Power. There's a flood plain there that's a conservatory, a natural area that we had to keep. That wasn't the problem. But there was a piece on the other side that, when we started, didn't have any water in it. Shortly after we opened the hospital, there was water there, but not much. I may not have the pieces all put together exactly. We got a letter from the state—not the federal government—from the bureau of natural sciences, or, I don't know, whoever controls ponds and things like that. It said that we had illegally dammed up this little backwater piece. "I went out there with the engineer." I said, "What?" [02:21:00] He said, "But Jacobs, come over here." And he said, "They're half right. It is dammed up." A beaver had come up from out of the other piece and built a dam. We now had sixteen inches of water where we had muck before. We wrote back and said, "You're right. And here's the person who's dammed it up. Do what you like, put him in jail, but here it is." [laughter] We never heard back. Somebody told him there was water,

but the person didn't inspect it. He's sitting in Richmond and he writes a letter. Sometimes you just have to laugh about it, but most regulations have a reasonable intent, if they're reasonably interpreted. And that's a problem. Whose reason? If it's your job to enforce it, and somebody does get hurt, they'll say, "Didn't you follow the rules?" "Well, I gave Mr. Jacobs a little bit of latitude." It's a tough one.

02:22:06

Rigelhaupt:

In terms of the federal government, in '93 and '94, there was pretty major debate about health care in the US, with potential for reforms in the Clinton Administration. And obviously, they didn't pass, but do you recall discussions among hospital staff, the board, senior administrators, about what potential impact that health care legislation might have on the hospital?

02:22:40

Jacobs:

To be honest with you, it was so complicated what was being proposed; it was so complex. Of course, we have a very similar thing, although for a smaller piece of the population. I think that's the biggest difference that I see. It wasn't a major one. I had been in the business long enough. You go back in the '70s, when some guy named Nixon put a freeze on certain things, including all hospital rates, but not their expenses. Your income is frozen, but not your expenses. I used to have a philosophy, and I said this with the board: "We will always be one step ahead of the regulators. Trust me. Whatever they put together, we'll figure out how to live with. Okay?" It's the way it is. Whatever they come up with, we'll figure out a way. It's the same way with Obamacare, the Affordable Care Act. Interesting names Congress puts on things. That's not Obama's name, that's what Congress put on it, "Affordable Care Act." I guarantee there's going to be nothing affordable about this care. It primarily has to do with Medicaid and uninsured. That's where we're going. That makes sense. The process we use or the solutions probably are not going to work, and I don't know where that's going to lead us. [02:24:00] I think we're going to be redoing it. I don't think we're going to do away with it—personal opinion—but I do think that there are some aspects that just are going to collapse on their face. I think the states are right to kind of be cautious because they're going to be stuck with a bill in four or five years that they can't pay, and nobody else is going to pay. I'm not sure that you could make the federal government pay. I always felt that the regulatory aspects were something that we could deal with, just like DRGs, just like freezing. I remember my famous saying at Fairfax Hospital was, "Show me how I can raise my income without raising my rates." People look at you like you're crazy, and they'll think about that. That's all I'm asking you to do; think about it. How can you raise income without raising rates? And there are ways of doing that legitimately, because you have to rethink what you're doing. Look at the regulations, what's really set in there? Like the new Affordable Care Act, have you read it? Probably not all 2,200 pages. Have I read it? No. But I have a person that I work with who has read it, all 2,200 pages. The problem is, you can't read twenty-two hundred pages and be done. Therein lies our problem. You get to page twelve, and it refers you to section such-and-such of HHS. And all told, there are probably about

30,000 pages of material you would have to read if you wanted to understand what's in the Affordable Care Act. What did Nancy Pelosi say? "Pass the damn bill so we can see what's in it." That's ridiculous. No end.

02:25:56

Rigelhaupt:

The other thing happening, or that did happen nearly simultaneous to the Clinton-era health care debates was a real rise in managed care and HMOs. Did they have a significant impact on Mary Washington Hospital?

02:26:13

Jacobs:

Yes, I think they did. It was more the managed care than the HMOs. HMO is a form of managed care. The impact they had was how to live with the restructuring of the payment systems. Again, it's a matter of how. When you look at managed care, it is trying to figure out how to reduce the cost of the non-Medicare side; that's strictly on the private side. Managed care doesn't really get in there. Some of those made sense and some of those didn't make sense. That is what we were talking about earlier. To say to the hospital, who doesn't admit, treat, or discharge—the physician does—you're going to be responsible for controlling what gets done to the patient and how long they stay. [02:27:00] That's totally impractical. What you can do, and what we did do at Mary Washington, is sit down with the physicians to understand what was going on, and what did they need to help us. What did we need to give them so that we could live within that environment? That's what you have to do, but you just can't do it. It was about that time when you began to see some hospital mergers begin to take off because controlling costs were an issue. How do you put together programs that address lengths of stay and treatment? How do you educate physicians? That's costly. Physicians are brilliant people. They wouldn't get through medical school if they weren't. You have to give them data. You have to give them data that says, "Okay, here's what happens if you do this or don't do this for the patients." And they'll look at the data and go, "Wow." Okay. You mean if I do that, my patient's going to do well or better, and still save a lot of money?" Of course they'll do it. They'll do that. All of the sudden, you began to see at that point in the early '80s, it just started to creep in. That's when you saw HCAs and some of the others begin to develop; and there were spinoffs of HCA. A lot of the facilities today, like community health systems, are spinoffs. They developed these huge databases, central billing systems; here's how to interpret the rules, here's how to work with the rules. We're helping you out. All of the sudden now, the merger mania, so to speak, starts up. It's necessary. At that time, Mary Washington had strategic alliances and relationships with facilities, but we didn't really formally explore a merger because it didn't make sense for us at that time. It may make sense today and probably you'll see some more formal relationships. I'm not privy to inside information, so I'm not suggesting that. But just look at what's going on around. The little hospital in Warrenton signed an arrangement with a for-profit hospital system just recently. I think there are now three or four independent hospitals left in the state. In Winchester, it's four or five in a system and you got have the Inova system. I don't even remember who the others are who are not

in a system. And again, it is to cut your operating costs and it is access to capital. If you're going to lend me \$50 million or \$100 million, you want to know I can pay you back. If I'm one facility, and something happened to that one facility, your risk is greater. [02:30:00] If I'm ten facilities and something happens to one, your risk isn't that great. You're willing to take a little bit less interest since you have less risk. That's what the capital piece is about. I do some work with Sentara and they have put together various protocols for how to take care of patients. It's a way that you can reduce the amount of resources you put into them, and increase the outcome. That's good. That's good. You can do that when you centralize data, and things like that. Medicare is trying to do this too, using their databanks and putting out information. They don't have the control, except through their financed. Whereas the hospital systems have the control through the finance and the management, and that's the difference. I think you're going to see more of that, but I think that this is really kicking up now. In fact, I read just recently—trying to think where it was—some publication that goes out; an insurance publication, maybe? A hospital president in North Carolina—it's a freestanding hospital—was quoted as saying, “We will have to entertain a merger, because if we don't, it'll be management malpractice not to at least consider and entertain it.” That's quite a bit. I think you're going to see consolidation even greater than we've had in the past. It depends on where the Justice Department's going to come down. There's some places they've ignored antitrust, and in other places they've used it. You go to Lynchburg; all the hospitals in Lynchburg are in one system. All the hospitals in Roanoke are in one system. How did that get by the Justice Department? I don't know. In other places, they're holding it up. There's a hospital up where I'm from in Williamsport, Pennsylvania, that merged, and it's the only hospital for thirty, forty miles around. They merged with a Catholic hospital about fifteen years ago. What they said to the Justice Department was “We will guarantee, in writing, to save X dollars for the next ten or fifteen years.” It was a lot of money. “And if not—and you'll hear the measurement standards—then we'll undo it.” It was accepted, and they saved that and then some. The whole issue from the IRS or of the Justice Department is if you have an advantage, then you're going to raise the rate. They said, “Well take that off the table. We're not raising rates.” Interesting approach. That's how you live with regulations. What can the Justice Department say? [02:33:00] Our role is to make sure there is not unfair advantage. Is there any unfair advantage in that? And now they're building a new hospital up in that area; they needed it.

02:33:16

Rigelhaupt:

When you first started talking about having to educate physicians, is that one piece or similar to a lot of the discussion we're hearing now about integrated care, that hospitals and physicians beginning to communicate more around the question—you know, with managed care is coming in—to think about patients' outcome. Is that an example of some kind of integrated care happening earlier? Or was that happening throughout your career?

02:33:59

Jacobs:

I think it was happening throughout. I think you're seeing more of it, but more of it now is in the area of medical records and information flowing back and forth on a real time basis that wasn't there before. In those times, physicians talked to physicians. Physician A would send me to physician B. Either I took my chart with me, or they sent the chart, or they called and said, "I'm sending you Bill Jacobs for such-and-such." They would have that. Now, it's instantaneous, and it's any place in a system. A lot of hospitals have hired physicians; they have all those folks. There's a group of hospitals in Richmond that spent \$45 million for a common electronic medical record. That's a lot of money. They couldn't do that alone, except there were four hospitals in that organization to share that cost. They have about three or four hundred salaried physicians, and another three or four hundred kind who are affiliated. They can do that. Then their lab work is all done through that and what have you. It's getting more and more into the clinical side. Before, it was more on trying to understand what the trends were financially and how that might impact everybody. My concern would have been the hospital. The physician's concern would have been the physician. There was a bit of a natural kind of misunderstanding; whose interests are you representing? Hopefully you're representing both, but you got to work through that as well. And it depends on where you stood on that particular day, whether you could do that or not. Those things, I think, have always been there. But I think now there's just a lot more pressure. Managed care has been around long time. [02:36:00] These contracts are out there, but it is how you manage them and how you get paid. The managed care companies would send you a check. I started my own business about thirteen years ago. One of the companies I represented was going in and doing an audit of how managed care paid the hospital. About half the records were wrong. They underpaid hospitals because the hospitals didn't have the wherewithal—that's my point. They would have fifteen, twenty managed care contracts. You've heard about the infamous charge-master, that has 10,000 charges on it. Holy cow. How do you keep a record of that? My job was to pick out a company—that's how I worked for years—that only did one little sliver of the health care business and was very efficient. It had the database, it had the system to go through, analyze, and give you a report that says, "Here, Mr. Jacobs. Here's Aetna, here's Blue Cross, and here's what they should have paid you. Here's what they paid you, and they owe you this." You send them a bill and you show them where they made the mistakes. If the mistake was in their favor, you have got to show them that too. You have got to show them both sides of the coin, but ninety percent of it was always on the other side. For whatever reason, I don't know. Does that answer your question? I think we've switched to more clinical integration, as opposed to where we were talking about the financial before. That's where it's going to be. As I said, it is how you're going to manage. The hospital doesn't treat, the physicians do. You have got to integrate that material. The hospitals have paid for the clinical integration in Richmond. They're paying for it in other places, and that's going to benefit them. As you probably know, that didn't happen in 1983 or during my term in Mary Washington. But in January of this year, we had something called sequestration. That two percent cut. You know who else is cut two percent? Medicare. Every hospital has got their Medicare bills cut two percent. Do you think they had planned for that a year ago? No, I don't think they did. So there's another federal government hit.

I'll share with you one thing now. Have you heard of hospitals saying they're upset and they're going out of business? It will be a driving force financially accelerating where hospitals will look for appropriate merger partners, or acquisitions, as the case may be. When I'm saying Mary Washington may do a merger, they may acquire a hospital. [02:39:00] I'm not saying they'll be merged, but they're going to find out that they're probably better off to expand their base somehow. There aren't many freestanding hospitals. There's one in Northern Virginia that I'm aware of in Arlington. That's the only one. It is called Virginia Center and it's the only one up in Northern Virginia. There are none over to the valley.

02:39:26

Rigelhaupt:

Well, one of the things you mentioned ties into with one of my last questions about the internet and consumers becoming informed. One of the things that happened in 1990, *US News and World Report* launches its "America's Best Hospitals." And there's a kind of ranking. And it seems clear that doctors and physicians are playing a large role in the clinical side. So what does it mean when a magazine is creating a kind of consumer-driven ranking system, more than a clinical system? And was that something that a community hospital such as Mary Washington at that time would have taken notice of?

02:40:26

Jacobs:

We probably didn't take as much notice as maybe we should have. The reason or rationale would be, in some of those rankings, if you dug into them, really had to do—some of them, not all of them now—with the finances. If you kept your charges low and they appeared to be low in your ranking, that would push you up real high. You see billboards from time to time say "Top fifty hospital." What it really gets back to is what they're charging Medicare or Medicaid or something like that. On the consumer piece, I don't think it played a lot in our decision making, only because we're a community hospital. Our community doesn't have much choice. We did periodic surveys in our community to see what people thought about us and how they felt about us. We also surveyed where people were going for health care as best we could. We felt pretty comfortable we had a handle on that. But on the long run, the more the consumer knows, the better off we're all going to be. And I think one of our concerns would have been—and I don't know if we specifically discussed it—is do you have to publish your rate, and how to people evaluate that? That would have been a concern, and I think that's what they're still wrestling with today, okay? Is a gall bladder this much, and what does that mean? [02:42:00] That'll be an issue, although we may find out there are going to be specialty hospitals. I picked gall bladder because I think there's a hospital up in Toronto, Canada, that does only gall bladders. No. They do only hernia repair, and they have the cheapest rates, the shortest length of stay, low infection rates, and less complications than anybody. That's all they do. There's clearly an issue that the more you do in the right environments, the better you are. How do you get people to buy into that? And who publishes that information? I've been in this business a long time. There used to be a rule of thumb that if you did less than 500 deliveries a year,

complications in OB were sky high. There were hospitals, up until a couple years ago, small ones in this state, who were doing less than 500 deliveries. Were the complications high? No. What happened? We had better-trained physicians, better-trained nurses, monitoring equipment, and better transportation. So how does the public judge that? Yes, they need to have tools. I think the reason we've not gone real far yet is how do you educate the public to interpret? I don't know. I wish I had that one I have some feel. I go into hospitals, to visit relatives and friends—I'm probably not a good one to let go in a hospital. I can tell you, there are lots of hospitals I can get into. I don't even have to sign in. If you wear a suit and a tie, they think you belong there, if you don't ask questions. I can tell you where administration is all the time. I can tell you where the lab is without even having been in there. Hospitals are the same. They think they're different, but they're not. We thought we were different, we weren't. The people were. The people were. I can also tell you when I walk in a hospital—and you'll see it in the new Mary Washington hospital—you can get a sense for what kind of a program it is as soon as you get in there. How do the people greet you or don't greet you? Cleanliness, noisiness, directions, helpfulness, smells, all those things—you can get a feel for it real quickly. If I go to administration and I see carpet, wooden panel, glass, and what have you, but most of the hospital is kind of drab, I can't help but think, "That's kind of interesting. That's kind of interesting." [02:45:00]

02:45:02

Rigelhaupt:

Was that something you worked on a lot directly in terms of working with architects, industrial engineers? And what were some of the priorities you wanted in the new hospital?

02:45:13

Jacobs:

I say somewhat facetiously, but I was really serious about it—a lot of times facetiousness is meant with deeper meaning, you don't know quite how to say it. The lobby was an example. It's been changed a little bit, but that's progress, I guess. I wanted the lobby to show openness, welcomeness, and security. When somebody walked in there, they would say, "This is where my relative and loved one is." They must know what they are doing. Why do you think a lot of the old banks used to have these beautiful lobbies? With art and what have you? They wanted you to feel your money was secure. I wanted people to come there and say, "Hey, my family or my loved one who works here, they're working in a secure, good place." That was one. You'll see, there's artwork throughout. In fact, we had a board committee headed up by Dori Iglerski, Dr. Iglerski's wife. She helped to make that kind of a non-institutional setting. The other area was in the cafeteria. We wanted the cafeteria to be open. I wanted everybody to be able to go there, and we had a little patio outside. If you're visiting someone who's very ill, I wanted you to have an opportunity to get away to have a cup of coffee, get a break, see the sun, or see the moon, whatever time of the day. I also wanted a place for the staff to get away from their routine and their pressure to say, "Whew, isn't this a nice place to relax, have a cup of coffee, and have my lunch?" That kind of stuff. The layout of the food and having good food were important. Those were two of my key areas, but also the aesthetics

throughout the place. I haven't been in there a couple years, in the pace unit. There were sitting areas up in the floors. They're open, they're nice, and they get windows. The nursing stations are where they can do their business without interfering with the families. The architectural group had an interior designer as part of their program. I think it worked out well. I was proud of it. I think the community is. I hope they are.

02:47:43

Rigelhaupt:

Well, those are largely my questions. And I think we've gone over some of the time you allotted, so—

02:47:53

Jacobs:

I don't even know what time it is.

02:46:56

Rigelhaupt:

It's 1:15.

02:47:57

Jacobs:

You're kidding.

02:47:59

Rigelhaupt:

We've gone two hours and forty-eight minutes.

02:48:00

Jacobs:

Well, that's a lot. 1:15. I thought we started at 10:00.

02:48:06

Rigelhaupt:

I think we started a little late—it took a few minutes to set up.

02:48:08

Jacobs:

Okay. I told my daughter I'd see her later this afternoon. Okay.

02:48:11

Rigelhaupt:

Now that we've talked about time, this is probably moot, but one of the things I try to do to wrap up is to ask is there anything you'd like to add? And second, is there anything I should have asked that I didn't?

02:48:29

Jacobs:

The only thing I think I'd like to add is why I left. I left Fredericksburg and Mary Washington Hospital for one reason and one reason only. I like the organization, I like the people, and I like the community. There are lots of good folks there. It was kind of hard. But I was age fifty-five, and I thought, "We just built a new hospital, and we've done all these things. What do I do now? Should I do something different? What do I do different?" While I was thinking—I wasn't looking, I was thinking—I was asked to become President and CEO of a hospital and physician malpractice company out of Richmond. They wanted to expand their program. They were in four states. I interviewed and talked to them. I knew some of the people. I said, "Wow, that's a whole new challenge. It's like building a new hospital." I talked to my wife about it. I said, "Would you be willing to move again, and move to Richmond or near Richmond?" She was very supportive. She is a psychotherapist and had an office here in the community. She said, "I would." I said, "Okay." I went because I thought, "Well, I'll do this for another ten or fifteen years." That's why I left. I want to make sure everybody knows that. I have kind of a heavy heart, so to speak, because I left some good people behind that I wouldn't be working with I had a lot of good friends, many I've retained. I came back for the roast of the Mayor a couple weeks ago to benefit the homeless program, the Thurman Brisben Center. Mary Washington supports that a little bit too. So as far as questions you didn't ask: you didn't ask me how many kids I have, how many grandchildren I have. [laughter]

02:50:35

Rigelhaupt:

Well, as I said, you know, some of the life history was where if time allowed.

02:50:39

Jacobs:

Yeah.

[End of Interview]