Department of History and American Studies
University of Mary Washington

Mary Washington Healthcare Oral History Project

Thomas F. Williams, Jr.

Interview conducted by
Jess Rigelhaupt
in 2013

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

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

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

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Discursive Table of Contents

side was a possible transformation into a regional medical center—Advocates for the new hospital and becoming a regional medical center—Significant debt to build the new hospital—The business plan for the new hospital—Chief Financial Officer created a business plan the board supported—There were solid financial projections—Learning about bonded indebtedness—Municipal bonds issued for the new hospital—Meeting with bond rating agencies

01:00:00-01:15:00
Process of reorganizing MediCorp and combining functions—Leaner, more efficient organization—Planning for board transitions, especially chair of the board—Concerns about losing board leadership at the same time—It was a big transition when the community board ended—Maintaining community input—Leadership projection on the board—Construction on the new hospital, new addition, and atrium—The new hospital felt like a regional medical center—It was a big step into the future—Thought we would never run out of space—Currently running out of space on the campus

01:15:00-01:30:00
Shortly after opening the new hospital there was a sense there would be other centers, like the cancer center—At the time, envisioned all adjunct practices, like rehabilitation, would be part of and owned by MWHC—MWHC tried to develop a rehabilitation center and was competitive with HealthSouth—HCA and HealthSouth are not malicious; they saw an opportunity—MWHC saw value in being a sole provider because volume equals quality—Excitement for new clinical practices such as cardiac surgery—The role of the Medical Affairs Committee on the board—The role of committees (finance, medical affairs, executive compensation) on the board—Confronting areas that have financial loses—Meeting community needs and maintaining medical programs and clinical lines that operate at a loss—Eliminating some of the senior services

01:30:00-01:45:00
Maintaining clinical programs at a loss to meet community needs—Mental health is an example of maintaining a needed service—MWHC now owns primary care practices; twenty years ago it would have caused a physician revolt—Owning physician practices often means loses—Explaining community needs and clinical practices that may show loses to bond rating agencies—Origin of Community Service Fund—MWH Board advocated for half of net profit to be reinvested in community health care projects—Responding to HIV/AIDS—MWH and public health—For-profit hospitals—Challenges of serving the community with small margins, even loses at MWHC

01:45:00-02:00:00
Community needs, public health, mammography screenings, and vaccinations for children—Managed care and insurance companies in the 1990s: "went from day to night"—Increased power and influence of insurance companies—Challenges of negotiating with insurance companies—Role of the board in negotiating with insurance companies—Board and administration dynamics on cutting expenses—MWH MediCorp expanded at the same time the region boomed in the 1990s—Origins of Stafford—Simultaneous approval of COPN for both Stafford Hospital and HCA Spotsylvania Regional Medical Center—Importance of sole community provider for volume and quality

02:00:00-02:11:35
Planning Stafford Hospital—Bill Jacobs resigns—Searching for a new CEO—Seamless transition to Fred Rankin, III as the new CEO—Strategic goals and history of the CEO search—Hiring Fred

Rankin, III—CEO's role in educating the board—Rankin built trust and worked well with physicians—Increase in trust between physicians and MWHC

Interview 1 - October 23, 2103

00:00:00
Rigelhaupt:
It is October 23, 2013. I am in Fredericksburg, Virginia, doing an oral history interview with Thomas F. Williams, Jr. And, to begin, I would like to ask you about how you became involved with the board at Mary Washington Hospital.

00:00:25
Williams:
It was in the mid-'80s, and my partner, Harry Franklin—my boss and partner—was on the MediCorp Properties Board at the time. They had a vacancy, and he recommended me for that job. That's how I first started.

00:00:44
Rigelhaupt:
So you started on the MediCorp Properties Board?

00:00:48
Williams:
Yes. MediCorp, back then, had a lot of subsidiaries. The reason for that is something that happened before my time, but we went from just an acute-care hospital to trying to have income from other sources since we weren't getting reimbursements. I think Medicare was covering about two-thirds of the patient costs. They branched out and went out into different business areas. And the holding company wing or subsidiary of MediCorp was MediCorp Properties. That's where I started. That evolved to being requested to serve on the board, and I did that in 1992. Then in 1993, they elected me chairman of the board.

00:01:51
Rigelhaupt:
Okay. Well, let's stay in the mid-'80s, when you first joined. Could you explain the structure a little bit more? So, MediCorp Properties, and then there was an umbrella—Mary Washington Hospital, MediCorp above—or was it the other way?

00:02:07
Williams:
No. MediCorp was the holding company, and a division of that was Mary Washington Hospital—obviously, the anchor and the biggie. There were a number of other subsidiaries that would take care of various enterprises, such as Chancellor's Village and the Snowden Psychiatric Hospital. The rest of them are escaping me right now. I think MediCorp Services owned a laundry—Sunshine Laundry—at the corner of Sunken Road and William Street. It was unwieldy. [03:00] But in order to

cover all those enterprises, we had a separate entity for each one. I'll tell you a little later what happened to those entities. It began in the early-'80s or '70s. Bill Jacobs was the leader that brought us from being just an acute-care hospital to the need for these other enterprises. It was Jacobs, Pete Hearn, Bill Poole, and the leadership.

00:03:39
Rigelhaupt:
What were you most excited about contributing and working on when you joined MediCorp Properties?

00:03:46
Williams:
The whole idea, from the very beginning, was a learning feast for me. I loved the idea of learning something new. This was vast fields of things that were new to me, health care particularly. I had, pretty much, the properties information and knowledge in hand because that was my practice in law. The idea of coordinating that and merging that with learning more about health care was really the exciting part for me.

00:04:29
Rigelhaupt:
What are some of the first things you remember learning about health care?

00:04:34
Williams:
Back then, it was the start of the transition from fee-for-service to managed-care situations with insurance companies. Everybody had a little bit of health insurance. But that wasn't the driver like it is now, and like it became later on. Basically, it was pretty simple. You obtained medical services, and you paid for it—pretty easy. Then the insurance company was somebody that reimbursed you for those expenses that you had. That changed. The insurance company became the driving force behind all of that. They controlled what services you got, what was paid for, and how much. The patient, then, was kind of pushed to the side. The provider and the insurance company decided, pretty much, what would happen as far as payment is concerned, and then, later on, treatment. That was the dynamic that I saw right from the beginning. But right at the beginning, we were in on what I thought was the ground floor.

00:05:57
Rigelhaupt:
So, if my understanding is correct, [06:00] MediCorp Properties was a for-profit entity—is that right?—under the nonprofit MediCorp holding company?

00:06:08
Williams:
Yes. In order to maintain your tax-free status, you had to carve out those entities such as MediCorp Services and MediCorp Properties that were trying to make a profit and feed the profit back to the parent. That was another reason for having to have separate entities. The thing was that each one of these entities was a community controlled and managed organization. That was an unusual situation. It was not unusual, I guess. It was nice to have community people involved. You were able to get the best and brightest from the community to make your decisions on how these entities would be governed. But I'll tell you later on, it became unwieldy. We had to change it, as you probably know.

00:07:15
Rigelhaupt:
Some, but I'm looking forward to hearing more, in terms of detail. Do you remember some of the first properties that MediCorp Properties sought to either purchase or begin to lease, that you were involved with, in terms of really trying to develop the business side to contribute to the larger mission in terms of the hospital and health care?

000:07:40
Williams:
I remember Sunshine Laundry. We did that acquisition when I was there. The big one I remember—the big, big project and big acquisition—was Chancellor's Village. We had already acquired the land and we were toying with the idea. That was a potential site for the new hospital. We were still at 2300 Fall Hill Avenue. That land out there in Five Mile Forks area on Route 3 was a potential site for the new hospital. It became the site for Chancellor's Village. When we identified the Snowden property as the hospital site, we then went on with Chancellor's Village. That was a big project, and a pretty exciting thing to do. At that time, there wasn't another complex like that in Fredericksburg—it was a senior-oriented center with independent living, assisted living, and complete dining facilities. It was like a hotel, almost, at the beginning. That was what my impression was. I thought that was pretty exciting.

00:08:57
Rigelhaupt:
Did you take the lead in terms of doing the legal work and/or planning, or is that development? [09:00]

00:09:03
Williams:
No, I didn't. I was just a common, ordinary board member giving my input and, as I said before, learning all along. I didn't do any legal work for the health care company.

00:09:26
Rigelhaupt:
Okay. Thinking back in those years while you were on the MediCorp Properties board, before you went on the MediCorp board, what do you think some of the most important acquisitions or projects that MediCorp Properties undertook to support the larger mission of MediCorp?

00:09:49
Williams:
Other than those I just mentioned, my memory is fading on that. I can't remember much of what we did. We had Commonwealth Rehabilitation out there in the Massaponax area, and that was an interesting project. We tried to have a primary-care operation in Ladysmith, Caroline County, because we saw a need for that in that area. We had the nursing home in Colonial Beach. Of course, Carriage House Nursing Home, out there in the Chancellor area, was important. All these were opportunities to fill needs. They weren't exactly for profit. That wasn't the primary motive. We saw a need that was not being met by any other institutions, so we stepped up and tried to meet it. And if we happened to make some money, that would be great. But that wasn't the primary motive from the MediCorp board at that time. Those were some of the ones I recall.

00:11:19
Rigelhaupt:
So, it sounds as though the commitment to being not-for-profit and the culture of that, coming from MediCorp and a much longer history at Mary Washington Hospital, even influenced the board of MediCorp Properties, which, in some respects, was a for-profit entity.

00:11:41
Williams:
We took our marching orders from the big board, I guess. They would have the ideas and we would implement what they sent down to us. But you're right. [12:00] Being a not-for-profit community organization, our focus was on whatever the health care needs of the Fredericksburg community were, and whether those needs were going to be met. If they were met by somebody else, great. And, if not, then we stepped up and tried to meet them and not lose too much money in the process.

00:12:21
Rigelhaupt:
You mentioned other organizations or people, perhaps, stepping up to meet health care needs. Do you remember other organizations that MediCorp or MediCorp Properties worked with to meet some of the health care needs?

00:12:36
Williams:
No. I can't think of an example. But if a private, for-profit institution or company would come in and meet a need that we saw as being a need, we probably wouldn't get into the arena. But that was the primary motivator—the health care need.

00:13:03
Rigelhaupt:
Do you remember working with any physicians' practices in this era?

00:13:08
Williams:
The first one I remember was the psychiatrists—Psych Associates. The idea of the hospital owning a physician practice was pretty much of an abomination to physicians back then. Now it's pretty commonplace. But when I first started, that was a no-no. It got people very excited because the physicians would feel the pressure of a hospital competing with them in their field. Later on, that became a necessity, where the hospital would own physician practices and develop it within their corporate structure. But not back then. So any hint that that was going to happen was met with resistance and unease among the physicians.

00:14:19
Rigelhaupt:
This was a psychiatric practice you're talking about?

00:14:21
Williams:
It was called Psych Associates. And we acquired that because we were asked to by the physicians who were running the business. We got the impression, I think, that that was going to be a need that was going to be lost. Mental health—we needed that area. They were not going to continue. That was the indication. Either we stepped up and acquired that practice or we would lose that needed service. [15:00]

00:15:04
Rigelhaupt:
And these physicians worked within Snowden, or was this before? Or am I setting up the era wrong?

00:15:15
Williams:
No, Snowden was there. Then the physicians had a private practice. The need for continuing that service was made apparent and we responded to it. Then, later on, we would have contracts with groups that would be exclusive, such as the radiologists and the anesthetists. Now there's an

emergency-room practice of separate physicians. It just evolved because of the needs. That was a way to implement it: have the physicians get together and develop a practice, and then deal with us. We would deal with that practice on that basis.

00:16:12
Rigelhaupt:
Okay. So, I want to talk both about the new hospital and your joining the "big board," as you called it. But before that, you mentioned the acquisition of the Snowden property. And I'm wondering if you could talk a little bit about your earliest memories of MediCorp thinking about, talking about—kind of the water-cooler discussion—the possibility of acquiring that property.

00:16:43
Williams:
The guys that were really in on it were Joe Wilson, Bill Poole, Joe Rowe, and Rick Johnson. They were the ones that were really on the ground floor doing all the heavy lifting—Bill Jacobs, as well. It was water-cooler conversation for me. I was not really a part of that discussion, but it was pretty exciting when that property became available. I thought that it would be great to keep the hospital in the city of Fredericksburg. When that opportunity came about, I was elated, personally. I really didn't have much to do with the actual acquisition.

00:17:38
Rigelhaupt:
Do you remember if there were other competing interest, in terms of other organizations, people interested in that property? Or was this—

00:17:47
Williams:
I don't. There were other sites that we were looking at for the hospital—I remember that. But the Snowden site just trumped everything, I think. [18:00]

00:18:02
Rigelhaupt:
So, could you talk about the process by which you became a board member?

00:18:10
Williams:
There was a Nominating Committee, and I think Speaker Howell was the one that approached me. I agreed and came on the board. The hospital was under construction then. It was a pretty exciting time to get involved at the top level.

00:18:49
Rigelhaupt:
Thinking about the larger culture and organization of Mary Washington Hospital and MediCorp, what did you learn about the core values of the organization that might have been new, once you joined the board?

00:19:07
Williams:
Because it was a community-controlled, community-run organization, the primary focus was meeting the needs of the community and improving the health care status of the people in Fredericksburg. That was the primary focus. And you certainly wanted to operate in the black. The catchphrase was, "No margin, no mission." You had to turn it around and make sure that you weren't losing money, because you had to keep it going. At some point, there was as much as 5 percent that was all plowed back into the community, which was nice. It wasn't sent to stockholders. It was beneficial to the community. The core values were that. Also, this was a surprise to me. Does someone need to take responsibility for the health status of a community? And, if so, who does that? If you say somebody ought to address those needs, you can't rely on the city council to do that in Fredericksburg, or the boards of supervisors of the outlying counties. They've got enough on their plates. If those needs need to be addressed, who's going to do it? A logical conclusion was a community hospital. That was kind of an awakening to me. [21:00] I didn't really fully appreciate that responsibility when I first started with the organization. That was an interesting revelation to me. It set me off on a different course.

00:21:28
Rigelhaupt:
So, thinking about perhaps the first year you were on the board, are there any decisions that stand out? I imagine a lot of attention was on the new hospital, but beyond that, decisions that the board took that were very much focused on improving the health status?

00:21:50
Williams:
Yes. I'm sorry, but I can't think of anything that was innovative at that time. I remember what I was impressed with—and I didn't really realize that until I got on the board—was that almost half of a net profit that was made by the organization was plowed directly back into the community by community grants for health care projects. That had already been set in place. Mr. Wilson was the driving force behind that and he was the chairman of that Grants Committee, on which I served later. That was something that I thought was a wonderful project and an asset to the community. I can't think of any specifics, but I know that there were almost twenty different projects within that grant-award system that we financed and that people outside the hospital organization ran and operated. We monitored it to make sure it fulfilled the purpose for which it was created and

financed by us. We did it year after year. There were some pretty large dollars involved in being able to do that, when you take half your profit and do that.

00:23:34
Rigelhaupt:
And I'm definitely going to come back there, because the community benefit, I think, is a really important part of the story of Mary Washington Healthcare over the last twenty-five years. Thinking about when you first came on the board, and some of the projects you undertook, [24:00] do you remember where ideas were coming from? Was it board members? Was it board members talking to the community? Did the administration give new ideas for directions? Or perhaps physicians?

00:24:16
Williams:
Physicians are, in my observation from the beginning, stretched pretty thin. Those folks would get up before sunlight and be working into the night, and had their patients to deal with. Meeting community health needs was not part of an organized physician movement. So, I can rule that out. We had health care professionals—very good ones—in the administration. Those folks would be looking at national trends and statewide trends. They would be involved in those organizations. I suspect that very many of the things that we did came from suggestions from the health care professionals that ran the organization—the officers of the organization. We had a lot of good ideas, I think, that came from the community members of the boards. Not always, but overwhelmingly, the majority of projects that we did, I think, were suggested by the officers. It would be interesting to hear what others in that time would say on that. Maybe they would say, "Wait a minute." [laughs]

00:26:14
Rigelhaupt:
If you could also think back on that first year, and your sense of the relationships between the board and the administration and physicians, in the sense that those three entities, ultimately, control the hospital. You know, not-for-profit community hospitals tend to be kind of that three-legged stool between the board, the medical community, and the professional administration. What were the dynamics like between those different interests when you joined the board?

00:26:52
Williams:
The relationship between the medical staff and the administration was sometimes strained. [27:00] The organization, MediCorp, was, at times, because of its proprietary need to get into profit-making operations, treading on ventures that the physicians were already in. In the view the physicians expressed to me, personally, in my face— we were not playing on a level playing field. If we were going to compete with physicians, then we had resources that they couldn't compete with. That was the initial dynamic that occurs to me. The three-legged stool—the board, the administration, and the medical staff—in that triumvirate, the administration and the board were almost as one. The heat

from that got sent back to the administration. The physicians would say, "The board really doesn't know what's going on. The administration is feeding the board what they want the board to hear." That was what I had heard. That was the only thing, I think. We always had physician leadership on the board—the board was always composed of several physicians. Almost a third of the board at one time was physicians. We had, pretty much, good input. The president of the medical staff was an *ex officio* member of the board of directors. We weren't without input.

00:29:30
Rigelhaupt:
I imagine you saw physicians outside board meetings.

00:29:37
Williams:
Yes. I developed what I referred to later on as a "cocktail-party defense" for when I'd be confronted with certain things. I would almost have to rehearse in front of a mirror before I'd go out to some social function because I knew this was going to come up. [30:00]

00:30:01
Rigelhaupt:
Could you describe what that was like, at a cocktail party?

00:30:05
Williams:
No, I say that facetiously. It was always very friendly. There was never anything that was angry or confrontational. The physicians, if they got angry, they reserved that for whoever happened to be the leader of the staff, not the voluntary member of the board. I always would say, "You know, if you don't like what I'm doing, you can just cut my salary or fire me. That would be all right." They would laugh and then tee off on Mr. Jacobs, Mr. Rankin, or Mr. Kiwall.

00:30:45
Rigelhaupt:
But you can remember instances, even though it was very cordial and very professional at social gatherings, where physicians would communicate to you their responses to directions that—

00:30:59
Williams:
Absolutely. Absolutely.

00:31:00
Rigelhaupt:
Can you remember things or an instance in which a physician said, "You know, this direction doesn't make a lot of sense to me." Is there anything that sticks out in terms of a direction?

00:31:16
Williams:
We had a surgery center, and we had a separate board for that, which was physician-driven. It was all physicians. When that board didn't get everything that it thought it ought to get, or there was a decision made from above that put it on a direction that that surgery-center board didn't agree with, that was something that I heard a lot about. That's because I had good friends. They were good friends and social friends, and guys I played golf with and went skiing with, and things like that. We would hear about that. Sometimes we'd have a group, and the administrator would be in that group. Here we would have the physicians jumping on me. I'd just say, "I defer to the administrator." And I'd throw him to the wolves. [laughs] I thought, "You get paid for this. This is your job."

00:32:21
Rigelhaupt:
On the other side of that were there instances in which you remember physicians at social gatherings speaking to you about things that MediCorp and the hospital was doing well, and that they were very supportive of?

00:32:36
Williams:
Not a one. I wasn't expecting bouquets to be thrown, and not many of these folks threw bouquets. They may have felt that everything was going all right, but anything that's going all right is just not something you generally communicate. [33:00] It's when it's not going all right that you want to be heard.

00:33:11
Rigelhaupt:
Thinking about the board, one of the things that I find particularly fascinating about it is that it's made up of people with an incredible range of professional and work experiences. And I'm wondering if you could talk a little bit about your background as an attorney, and what you were able to contribute to the board with your professional experience?

00:33:37
Williams:
I guess the background is so indirect. With the physicians there is a little difference because day-to-day they are in health care. This is a health care organization, and that's a little different. But when you have a CPA or a rocket scientist from Dahlgren, they're not putting anything into the board that

is a direct reflection or push from their profession. It's more of a community member. Not that I have any particular intellect, but it's nice to get the best and the brightest in the community to be involved with the health care organization. That's, basically what we strived for. When I became chairman, I would not want to go out and seek any board member with a constituency. I did not seek a board member who might say, "I'm from Spotsylvania, and I'm here to represent Spotsylvania." We did have constituencies when we had a physician on the board—the president of the medical staff, for example. He was there for a specific purpose, or she was there for a specific purpose. But we didn't have someone representing communities, for example, someone representing ethnic interests or race interests. It was just the finest people we could find. That was number one. Brightest and willing to commit the time on pure volunteer basis—that's what we were seeking and that was the charge of the nominating committee was back then, in the early '90s.

00:35:58
Rigelhaupt:
Part of the reason I ask is that attorneys [36:00] are so often, in terms of the media, represented in a very adversarial role. And, certainly, that's part of the practice. But there's also a way in which you're a counselor at law. And I'm wondering if some of that background, in terms of counseling and thinking about legal implications, particularly around real estate, came into what you contributed to the board?

00:36:26
Williams:
Yes, yes, you can't help it. You can't help it. You think about potential liabilities. The big dilemma that I had was in medical errors. The law of averages says there are going to be errors. It's just going to happen anywhere. And how do you address that? You've got a dilemma if you're going to step up and tell the patient, "We made a mistake. You may not know it, but we made this mistake." Then, your insurance company is going to just scream bloody murder. You have admitted liability and cost the insurance company money in taking care of this claim. You run the risk of their saying, "We're not going to cover you on this because you put us in an untenable position." On the other side, we've got to address a mistake and go to the root cause of it and try to correct it. Those are some things that would be in the back of my mind as a lawyer. That dilemma presented itself. And you can't help but bring your profession into your thought process and your decision-making when you make decisions. But I never directly had any legal representation that I can remember.

00:38:02
Rigelhaupt:
Can you remember an instance where the board was talking about an issue—maybe liability, maybe a question of what next venture to take—the conversation that the different board members with different background brought to it. You might be an attorney; Mr. Wilson, a small-business owner; a hospital administrator. Where that conversation, you brought your backgrounds to it, and you approached it differently?

00:38:38
Williams:
I'm sorry, I can't respond to that. I can't think of any instances where a direct response was made based on my background. It is an interesting dynamic, and it's one that does work—people from different walks of life. [39:00] You wouldn't want all attorneys on there, obviously. [laughs] Or anywhere. But it's nice to have that dynamic, so that you have that background and perspective—I guess, is what I'm looking for—in making decisions.

00:39:21
Rigelhaupt:
Going back even farther in time, were there things that, ultimately, came out of your legal education that you brought? Or was it more of the professional experience in your years of practice preceding your time on the board?

00:39:39
Williams:
We have legal representation at the corporate level. Decisions would be made. Collections was one thing. We were fee-for-service, and people could get into the hospital, financially, rather swiftly. How we were going to proceed on that? That was viewed a little differently than I would if I were representing a client who was collecting a debt from somebody else. This is a different type of debt and one that needed to be dealt with by understanding the resources of the person involved. If you have a debt you're collecting on behalf of a client, you would pull out all the stops. You'd go after wages, assets, personal property, and real estate. With a hospital debt, you have a counseling situation. That was something that we did, even starting way back in the '90s. We tried not to stomp on people. It's just a little different creditor-debtor relationship. That was part of the way I thought, based on my legal background and my practice. It was a little different than I would do if I were representing a client.

00:41:13
Rigelhaupt:
And so, even at this stage, did the board develop a particular set of policies in terms of trying to collect a percentage? Or was this left to—

00:41:26
Williams:
No, we didn't get that much into the nitty-gritty of it. The overriding policy is that we don't have to lean as hard as a bank or a business owner who is owed a debt. It was a different type of debtor-creditor relationship. That was the general, overriding policy, and that was part of the board development. The board did not go down into percentages, the number of visits, and things like that. [42:00] When was it that you had to garnish a wage? At what point? Things like that. If

someone had an inheritance, and this hospital had a judgment lien against an interest in real estate, you would compromise that a little more liberally than another creditor might.

00:42:33
Rigelhaupt:
Could you tell me a little bit about, and describe, the process by which you became chair of the board?

00:42:40
Williams:
I had only been there one year. I went to lunch with Bill Poole, who was the chairman and wanted to step down, and Bill Jacobs. I was knocked over by the suggestion. As I said, I probably developed a deer-in-the-headlights look for another year after that trying to learn what to do. I can't tell you why they thought I would be the one. I had no idea, but I was very flattered. The idea of the challenge was something that I just couldn't pass up. I agreed to do it, and started a long learning process in that twelve-year trip.

00:43:58
Rigelhaupt:
Well, thinking about what you undertook soon after becoming chair, what sticks out about what you learned, and some of the challenges that you faced?

00:44:09
Williams:
The big one, right at the beginning—and you're looking at 1994 and thereabouts—was my perception, and the perception of many others, that our organization was confusing as hell. It started out way back 110 years ago as an acute-care hospital meeting immediate medical needs of a community. It moved into being required to go out and venture out into other areas to raise money to support the mission of the health care. [45:00] With these subsidiary corporations, all manned by members of the community, it got almost unwieldy and very difficult to explain to people. What is the structure? Well, we've got eight different corporations in there. And that confusion was one thing. The inefficiency was something that just jumped right out at us. When we served on different boards—medical properties or medical services or the foundation—and we heard the same presentation from the same officer three times, we thought, "Gee, that's a waste of that officer's time as a resource and we're paying for his time. He's making this presentation over again to different organizations, but manned by the same type of people." There was overlap and inefficiency that drove us to try to study our structure. Homer Hite was tasked with that commission—the Hite Commission—to delve into the structure. He came back with, pretty much, what was anticipated and that was, it was inefficient. It was a waste of community time and resources. We needed to restructure. A major restructuring then took place with a slimming down. These boards became what they call "operating boards," which were really composed of the administrators. That's all they

were. They were not really decision-making boards. You had one decision-making board at the top, and that board could make decisions on policy by the use of committees. These were necessary boards because of the not-for-profit status and we didn't want to jeopardize that. We, by necessity, have to have separate profit-making entities. The best way to manage that would be by having it staffed with administrators. There is not much sex appeal in restructuring a corporate body, but that's the task that I remember significantly.

00:47:46
Rigelhaupt:
And so, that was an early project? Then the—

00:47:48
Williams:
Yes.

00:47:48
Rigelhaupt:
Because that was—

00:47:52
Williams:
I don't know if I got the dates right, but it seems to me that was 1994, 1995.

00:48:00
Rigelhaupt:
And probably leading into the transition from Mary Washington Hospital and MediCorp to MediCorp Health System? Is that—?

00:48:05
Williams:
That happened afterwards. We tried to become more warm and fuzzy. Instead of calling the people that ran the board directors, we called them trustees. The name change—the name MediCorp was the idea of being a holding company that would protect Mary Washington Hospital. It would keep that as the community organization, the health care and the acute care arm of the organization. It would have an umbrella over it called MediCorp. That sounded kind of lean and mean and like a steely-eyed corporate entity. I think that was the reason for the change to Mary Washington Healthcare—to get rid of that MediCorp business-oriented organization.

00:49:14
Rigelhaupt:
We talked a little bit about the water-cooler talk of acquiring Snowden as a property, and for the potential for the new hospital. But you were on the MediCorp Properties board probably at the time that the new hospital began to really be planned.

00:49:34
Williams:
Correct.

00:49:35
Rigelhaupt:
What do you remember hearing about what it was going to do, why you were going there versus renovating 2300 Fall Hill? Those early conversations about the new direction that was going to go along with the hospital?

00:49:52
Williams:
All right. This is something I've really never said before: 2300, when you talk to people who are health care professionals, was really a dinosaur. We were there as patients. My kids were born there. Everybody was there to see people, but you didn't realize how inefficient it was and how antiquated it was. That was what I learned when I became part of the organization, and this was not part of MediCorp Properties' task. This was water-cooler info. I did witness this. You'd go up on a floor, and the machinery to treat the patient was too big to get through the threshold. You saw pipes and tubes coming from a piece of equipment into a patient's room to treat the patient. [51:00] That was just an anecdotal example of what we needed and what we didn't have. The need for a new hospital was obvious. The limitation in space at 2300 was another reason that we didn't really feel it was the best situation to try to renovate again. We had been building on and renovating since the fifties, I think. We needed to start from scratch. That was the impetus. You needed more land, and you certainly needed another building. To try to make do with what you had was not an efficient use of resources. That's what I recall for the reasoning and the rationale behind wanting to get out of 2300 Fall Hill Avenue.

00:52:19
Rigelhaupt:
And you said the hospital was already under construction by the time you joined the big board. But thinking about those intervening years, was there conversation amongst physicians at cocktail parties, other administrators, other MediCorp Properties board members, where you were talking about what this new building and this new campus might accomplish?

00:52:49
Williams:
Yeah, yeah, yeah. There were people against it. Some physicians were against it. "We don't need a new hospital. The expense is just overwhelming, and just not a good use of community resources." That was one side. The other side—the exciting side—was clearly going from an acute-care hospital to becoming, hopefully, a regional medical center. That was what was thrilling. To be a part of that was really a wonderful vision, and something that I lacked because I didn't have the health care experience. When I heard about it, I said, "My gosh, this is actually possible, given our position in Fredericksburg, and being the sole provider. [54:00] We really have an opportunity to branch out into heart surgery and cancer treatment and women's care." Nursing would be another thing. That was really an exciting vision. Moving from the old 2300 to another location just demonstrated that that was a possibility, and within reach.

00:54:32
Rigelhaupt:
Who do you remember being a strong advocate for the notion of a regional medical center? Do you remember other board members talking about it? Was Mr. Jacobs, the CEO at MediCorp at the time, and other administrators talking about it? Where was that conversation about this possibility of becoming a regional medical center?

00:54:54
Williams:
All I can think of is Pete Hearn and Bill Jacobs. Those are the only two people I can think of that would talk about that vision. Sometimes the things that they said didn't seem like they were possible. That was a moon shot. But I remember, there were some things that I said, "Boy, that would be nice. But that's not going to happen." Those were the two that I think stick out in my mind. They were the visionaries—the people talking about expanding to new heights.

00:55:37
Rigelhaupt:
So, the question of expense has to be, as you mentioned, part of the concern from either physicians or community members. I think it was close to $300 million in bonds for the new hospital?

00:55:51
Williams:
Yes.

00:55:52
Rigelhaupt:
This is a serious venture.

00:55:53
Williams:
Yes.

00:55:55
Rigelhaupt:
Trying to think back, when you first heard about it, with your experience in commercial real estate. And even if you're not necessarily putting together the deals and the financing for a lot of the work, undoubtedly, in your practice, you've come to develop a certain amount of expertise about what projects can really work and what probably shouldn't have worked. What was your recollection about the potential risk for this kind of indebtedness?

00:56:27
Williams:
You had to be comfortable with the business plan. The Finance Committee and the CFO, Les Abernathy, and his staff were tasked with developing a business plan that would make us comfortable and would show realistic projections in the revenue that we could anticipate. [57:00] We knew that we weren't going to go under with a venture like that because that would be the worst thing that could ever happen on your watch. There would always be a hospital here, but you would lose the community hospital if you failed. And there were hospitals failing throughout the Eastern Seaboard. There were examples of hospitals failing. Columbia/HCA—now it's called HCA—was coming in and taking over former community hospitals because those hospitals couldn't meet their expenses and were operating significantly in the red. Even the government won't bail you out if that happens to you. We had to have solid financial projections by way of a business plan and to make sure that we'd be able to do that. Some of those projections were guesses, but educated guesses that we were comfortable with. That was another education for me. It's embarrassing, sometimes, to say we make decisions on things that we don't know about, but I didn't know about bonded indebtedness. I learned a lot about meeting with the big boys from New York City and how they rate organizations. We thought we were pretty hot because we made what we considered a lot of money. We were just at the top tier, but not the hottest of the hot. That was a shock. I thought we were way up there. That was an interesting education for me—the financial part, too, when we did the municipal-bond venture.

00:59:04
Rigelhaupt:
As chair of the board, did you meet with representatives from the bond-rating agencies?

00:59:08
Williams:
Yes.

00:59:11
Rigelhaupt:
What were some of those early conversations like?

00:59:14
Williams:
That's what I was just alluding to. It was really interesting. There was some trepidation on my part because I was venturing into an area that was way over my head. I was always relieved when I got out of those sessions. But I remember the last time we met—John Fick was then the chairman of the Finance Committee. He and I met—me as chairman and he as the chairman of the Finance Committee—with the representatives from New York City to market our municipal bonds from the city of Fredericksburg. [01:00:00] They had a lot of questions on our structure, how we made decisions, and things like that. I thought they were going to just look at the numbers, but they wanted to know a lot more than just numbers. That was a surprise to me. Fortunately, we were able to answer their questions and we felt pretty good about those meetings.

01:00:30
Rigelhaupt:
You just mentioned the structure. And, earlier, you had also mentioned a reorganization in a number of boards. Could you talk about that process, on doing some of the organizations underneath, and trying to become more efficient?

01:00:50
Williams:
The first thing was trying to combine functions. If you had a for-profit entity, could that be combined with another one? We did that, but I can't give you a specific example. But that was the idea—to make it more compact. That was the first step. And, as I said earlier, having thirty or forty people involved was a good thing because it did involve people with the decision-making in the health care system. It was good to bring people in, but at the same time, it was inefficient. We decided we could get by with fewer boards, which means that fewer members of the community were involved. We needed to do that paring down for the sake of efficiency. We felt pretty good at the end. We had a leaner operation and we were much more efficient—just hugely improved efficiency. We were making a better use of our manpower and other resources when we got to the end of that process. I felt pretty good about that. I'd say it doesn't get anybody really excited to hear about that part of it, but that was, I think, a real good step and a good improvement.

01:02:38
Rigelhaupt:
And what you're talking about here, was this in the '90s? Or was this in the early 2000s that the board began to reorganize itself?

01:02:50
Williams:
It was a process that started when Jacobs was here. It kept on going and was always moving toward that goal: how can we become more efficient and less wasteful? [01:03:00] Not only with money, but resources—people's time and energies. With all the duplication, we weren't getting the most out of the people there. They were spending time, and they really weren't accomplishing a whole lot with their time. We were able to take community members, but make better use of their time. That was the goal, and what I think we accomplished. But you're right. It went into the turn of the century.

01:03:45
Rigelhaupt:
The reason I ask is that, in talking with Mr. Fick, that there needed to be some changes in terms of chair transitions—in terms of board members coming off. I think he said that there was the potential that him, you, and Mr. Wilson were all going to rotate off the board at the same time. And you needed to change some bylaws to make sure—

01:04:13
Williams:
We had a three-year term and a three-term limit; so nine years was what you were looking at. Some of the administration felt uneasy about losing the leadership all at one bite. I think that was the fear of the unknown. There were convoluted schemes where we were. I think one was that some of us were grandfathered because we were on the board when the rules were changed. Therefore, it didn't really apply to us and that was a way of keeping people on. Of course, there was no term limit when I became a board member and when I became chairman. Those were all things that we developed. The big thing, and you may have heard it, was a big transition when we got rid of the community board. Mary Washington Hospital had a separate community membership, and that was an anomaly. It was something that didn't exist anywhere that we could find in the United States and it was not accomplishing any purpose whatsoever. Certainly, we didn't get new ideas from the membership. We got a lot of complaints about things that were taking place in the emergency room, and overcrowding here and there. [01:06:00] These were things that really weren't policy matters. They were specific things and gripes that came up. Phasing that out was not a very popular move, but that was part of the restructuring that we just talked about, and eventually we accomplished that. The board has ways—that you've probably seen— to obtain community input, which are a lot more efficient and a lot more productive in finding out what the community and members of the community really think are necessary projects and areas that we should be in—health care areas.

01:06:54
Rigelhaupt:
And was this also an attempt to ensure that a kind of historical memory was always on the board?

01:07:11
Williams:
They're revolving off and you didn't have to reinvent the wheel every three years. That was the idea. You had a leadership projection, I guess it is. It was something where you would try to project at least six, seven, eight, even a whole decade out, as to how you're going to have an evolution of the leadership. It was so that you weren't stuck with starting over from scratch every year or every three years. They were staggered terms. There was some talk about continuing my chairmanship. I thought twelve years was enough, and there was plenty of good help—probably better than I could do. It was kind of embarrassing, too, and kind of like I was hogging the chairmanship. I decided that that was a good time to let somebody else share the wealth.

01:08:35
Rigelhaupt:
Well, let's go back to probably about the first year you were chairing the board. I'm wondering if you could remember, and if you could talk about, the last time you walked through the new hospital, when the construction was done, but there weren't patients in there yet. And you were in there. [01:09:00] What were you thinking about what this was going to change? What this represented to Fredericksburg?

01:09:07
Williams:
All I had were questions. "How in the world is this going to become a hospital?" Then, later, "Okay, now I see. Now it's a regional medical center." But not having a background in any of that, it was really amazing. It was almost unbelievable that something could start from scratch and turn out the way it did. I never lost that wonder. When we did the construction—the major addition that we did where the atrium was built and the whole new wing—I still was awed by how it came to pass. A construction site and a hospital really don't go well together, so that was a chore. Walt Kiwall, I think, pulled it off. He was amazing, but he was probably the busiest man in the universe during that time.

01:10:27
Rigelhaupt:
It didn't quite double in size, but it was pretty—

01:10:31
Williams:
It was huge, yes. A whole new wing. But the futuristic look of it was what I was just overwhelmed with. You would look up and I would say, "Wow, it is nice to be a part of something that looks like this." Because it did look like something from the future—"Starship Enterprise," they called it. It even became more so when the new atrium and the new entrance were finished. It was really, I thought, dazzling.

01:11:12
Rigelhaupt:
So, thinking about this transition. You've been in this finished hospital. All your equipment's there. It's ready for patients, but empty. Tell me about the next time you came in, when there were patients there, and there was a fully functioning hospital. What do you remember about what you saw, what you experienced that first time you came in?

01:11:39
Williams:
I thought the difference was overwhelming. I thought it was going to be the same hospital, just in a different surrounding. But everybody had a different purpose about them, it seemed to me. It wasn't the old hospital that you see in movies, and that we saw at 2300. [01:12:00] It was, I keep saying, a medical center. That's what I seem to recollect. You would go into different compartments and they would see completely separate from the other. Whereas, in the old hospital they seemed all milled together. In the new hospital they seemed to be just operating independently of one another, although they didn't. We knew that they didn't. It was a matter of pride and the efficiency that they were able to combine services. But it did give the impression of being separate, independent units. And maybe everybody says that's what they were at the old hospital. But that wasn't the way I recall it. That was the huge difference to me: to see what I viewed as a big step into the future.

01:13:06
Rigelhaupt:
How many other buildings were on the campus when the new hospital opened?

01:13:13
Williams:
None. I think, later on, we had Kids' Station and Snowden Hospital. Then Tompkins-Martin was the addition right on the back of it. That was little disruption to the operation of the hospital and not like the addition was. I remember that the water-cooler talk was, "Wow. We had about five acres or seven acres downtown in 2300. And this was seventy-three acres. Never, ever, in our lifetime would we ever need any more space. We had all the space that we needed." [laughs] Guess what? We're out of space. That's a shock. Over the years that came about. The surgery center and the rehab—all of those things were added on. I thought, "You've still got plenty of space." Then we went up to the top of the hill and connected to Cowan. "Wow. Here we go. We're out of space."

01:14:22
Rigelhaupt:
Thinking about joining the board and becoming chair, at the time that it was opening, did the board anticipate that all of these entities, in terms of the cancer center, the women's center—the very things you were—

01:14:36
Williams:
The surgery center, yes, and rehab.

01:14:45
Rigelhaupt:
The very things that filled the campus—did you have a sense that this campus was going to house all of these important health care entities?

01:15:00
Williams:
I think I did. I did. I didn't, on day one, in August of 1993. But shortly thereafter, I started seeing that this was really going to happen. It was going to happen here. This was a campus where these separate operations could fit and feed off of one another. I didn't have the vision back then to see what it is now. But I started getting that when the new hospital opened. I started seeing the possibility of that happening, and thinking, as I said before, but now we have all this land. We have the space to do this. I didn't visualize the enormity of it. You include the hospital property. Then the Pratt acquired some property adjacent to it, and different pieces in the area. You can include that as hospital property even though Mary Washington Healthcare doesn't own it, or didn't own it. That's part of the complex, the campus. You add those areas and you're looking at, I suspect it's close to ninety acres. But it's full, including a parking deck and the Park Road office complex.

01:16:54
Rigelhaupt:
Well, the hospital has certainly served as a kind of anchor of a regional medical campus. Did the board have a sense that other health care providers like Kaiser and HealthSouth would also take up a presence on this medical campus?

01:17:20
Williams:
Frankly, to be blunt, I envisioned any sort of adjunct to the hospital such as rehabilitation, a clinic, or primary practice, would be Mary Washington. I thought that, if an enterprise is to be successful in the health care area, and it's because of Mary Washington Hospital and its position. [01:18:00] Being the center of it and the reason for the existence or the necessity of the adjunct, I thought it ought to be Mary Washington Hospital or Mary Washington Healthcare that was the owner of it. That's not greed. That is wanting to support what we have there, and actually make money that can be plowed back into the communities and for the community. I thought the best interests of the community would be for the hospital to have to those adjuncts or those satellite operations as part of the hospital. And not have somebody else come in. An example would be a CVS Pharmacy that happens to be at the foot of the hill. That's a great location for a CVS Pharmacy, and it's a great

location because there's a hospital at the top of the hill. Why can't the hospital be the freestanding CVS Pharmacy? That was my idea. The answer to your question is no. I didn't envision other, outside, private for-profit entities coming in and feeding off of the location of the hospital.

01:19:36
Rigelhaupt:
Kaiser probably wasn't open when you left the board, but I think the HealthSouth facility was. Did you get the sense that these other providers, for lack of a better term, "played nicely" with Mary Washington Healthcare?

01:19:57
Williams:
Yes. I can't fault any of these. We were the ones that tried to develop rehab, for example. I'll just use HealthSouth as an example, but I think the example follows through on any other venture. We tried to develop, with Sheltering Arms, a rehab facility. We put together a plan and tried to get it approved so that we could capture that market. We were motivated to do that by HealthSouth showing interest in adjoining property. And "not playing not nice" is not the term I'd use. [01:21:00] We were competitive, but I did not think that HealthSouth or HCA at Spotsylvania did anything mean or malicious. They just saw an opportunity, and as entrepreneurial HCA is, they met that opportunity. We opposed it because we thought the best interest of the community would be to have a sole provider and have a lot of volume because volume breeds quality. That was our theory. So, we were not playing not nice, but we were competitive.

01:21:54
Rigelhaupt:
Part of what facilitated the transition of Mary Washington Hospital—MediCorp at the time—to becoming more of a regional medical center were new practices and programs, particularly cardiac surgery and neurosurgery. What do you remember about conversations either with the administration, physicians, about bringing these programs and practices to the hospital?

01:22:27
Williams:
By that time, there had been physicians coming in. They were just a younger breed, I guess. My recollection is that the physician community was pretty excited about being part of a medical community that had these additional services. I was excited for the community. The reaction we got was, "You're never going to have a heart program here because you've got Johns Hopkins and you've got MCV. Nobody is going to want to come to Fredericksburg for that when they have these leaders in the industry." We were assured by the physicians, I think, and by the administration that this could be done. They were right. It was a success.

01:23:36
Rigelhaupt:
What's the process by which the board approves a new program such as cardiology and cardiac surgery, neurosurgery?

01:23:49
Williams:
There was a Medical Affairs Committee that concentrates on that. That committee would receive the presentation. [01:24:00] On new policy like that, they would meet for days, reach a decision, and then present a boiled-down proposal to the board. They would have the input from the professionals in reaching that decision. Part of the demonstration before the board would include a lot of that information, but it was not days. Obviously, we'd get it done in hours, and maybe one hour. By the time the full board is deciding, a lot of input had gone in through the physician-constituted and community-member-constituted Medical Affairs Committee. We relied a lot on those committees. We just didn't have the time to do everything as a board. Committees would get together—Finance Committee, Medical Affairs, the Executive Compensation—and those committees would meet. And Strategic Planning—they would spend hours and hours considering proposals, projects, and policies, boil it down, and then submit it to the board.

01:25:18
Rigelhaupt:
Were there programs or practices you can remember that the board was hesitant to approve, because as you said, "no margin, no mission," to use your phrase. That there are programs that may not be financial viable.

01:25:36
Williams:
Yes. I can't remember, specifically. We got into retail and we had business plans presented. For a lot of reasons—location of the centers and staffing—the business plan wasn't realized. The projections weren't realized, and for financial reasons we had to cut those out. There was a senior services that was a drag. When it starts dragging down other needed areas, you've got to make a decision; and I'm talking about financial drag. You have the need, which I've talked about before, but also it has to stand on its own. If it's operating at a slight loss but meeting a great need, you keep it. If the financial loss becomes a drag on the rest of the organization, then you have to make a decision on what you're going to do to meet the need some other way and cut it. [01:27:00]

01:27:12
Rigelhaupt:
What are some of the programs, particularly aimed at patient-care practices, meeting health needs that you can think of, maybe in the decade after the new hospital opened, that the board and the

administration backed and really worked hard to sustain, that might have been operating at—what you said—"a slight loss"—that you all made a commitment to keeping here?

01:27:44
Williams:
If I had time to think about it, I probably would come up with a number of them because I know there are. We had dilemma after dilemma in believing the projections of some of the plans, but the need was such that we overcame it with a go. And for the life of me I can't pinpoint any specific one. We thought that the senior services was a great idea. We committed resources into that and that turned out not to be. We were able to shift those services over to another area, and eliminate the cost. But that was a plan that didn't exactly work according to the projection. We had reasons for opening nursing homes and rehab center: we needed to get people out of the hospital and there wasn't a place for them. We needed to control that move and for that reason, we had nursing homes. Those nursing homes were a drag. They operated at losses that we had to cut. Those are examples of areas that I can't say were failures because they really did accomplish an immediate need, but they got to be a drag. If a nursing home is up and we sell it, it's still a nursing home. It is still something that we can use. [01:30:00] But we did not control the beds, which is what we needed to do. I gave up, in some instances. As I say, there are things in the clinical area that I just can't pinpoint. I know we started up programs and we maintained them at a loss because the need was so great. We had to do that for the community. Mental health is an example of that—that's a huge example. I don't know what they do now. I've been gone now since the end of 2005. We kept reorganizing and configuring and shifting beds and getting a certificate of need for more beds and less beds and things like that. We would always maintain the service because there was such a need for it. That's one area. And I think the organization now owns primary-care practices, which was absolutely unheard of twenty years ago. It was just not going to happen. You would have had a physician revolt. Now we're doing that because we have to; that's a service that has to happen. You have to take the stress off the emergency room. We need to control that situation. I haven't looked at any of the numbers because I've been gone for so long, but I have a suspicion, and I'll go out on a limb here by saying this, never in the history of delivery of medical care has any money been made by a hospital institution owning a medical practice. That's a break-even situation at best, and a loss, probably, in the overwhelming majority of instances. There you are. You've got a need and you've got to meet it. You have a loss, but you do it because you have to meet the need.

01:32:38
Rigelhaupt:
So, as chair of the board, you're trying to meet community health needs, and you're focused on that. Both with administrators, physicians, you have a group of people that are committed to that. [01:33:00] And you described meeting with representatives from the bond-rating agencies that are interested in the numbers. How do you explain what might be a slight loss but a community need? What's that conversation like? How do you talk to someone about this, in terms of health care, meeting community needs, when they're interested in numbers and margins?

01:33:26
Williams:
You have to sell it. You have to demonstrate the need. I can't tell you what a bond trader or underwriter of a bond thinks when he's sitting on the other side listening to this stuff. All I can do is demonstrate what I've been trying to hear and that is, you have to articulate the need and you have to both qualify it and quantify it. Then you might say, "This is an overwhelming need. Without it, this is what happens. The need is not going to be met unless this organization steps up and meets it because there's no other body who is around to do it. It's incumbent on the community health care organizations to step up and meet the needs. And it's not just something frivolous. It's an absolutely, definite need, and here is how it's a need." We sell it that way, I think. I don't know what they will say. But if they say, "That's not sufficient. You have to make money off it or we're not going to support you." Then so be it. You have to, obviously, show that you're going to be in the black from your other ventures. That's what you have to demonstrate.

01:35:00
Rigelhaupt:
I was going to get to this a little bit later, but this is partially where I wanted to go. I mean, there's a tension between not-for-profit community hospitals meeting community health needs, and also having to operate in the black. And yet, one of the things that Mary Washington Healthcare has been committed to is, also, providing grants to the Community Benefit Fund and the Community Service Fund. And I'm wondering if you could talk about what you remember about how it was started? Why it started? The origin story of the Community Service Fund?

01:35:48
Williams:
One of the entities was Mary Washington Hospital, a pretty significant subsidiary of MediCorp. That had its own board. [01:36:00] That board, I think I remember under the leadership of Joe Wilson, developed that plan. Our profits were great. I mean, they were substantial: five percent, six percent—over five percent anyway. The hospital board said, "Let's take half of that. Although we do it plow it back in the community when we expand the services of the hospital by using those sources. Let's do it in a situation where we can show actual dollars going to specific projects. Here's $20,000 toward a bike-helmet and bike-safety program. Or here's $15,000 towards a Meals on Wheels to keep the elderly healthy and sustained." The impetus came from the hospital board. I thought it was great because it was something we could brag about and say, "Look at what we've done." The resistance was, "If I want to contribute money to Shiloh Old South Baptist Church I don't need to contribute money to the hospital foundation and have the hospital foundation then channel money to another charity." We combated that by saying and demonstrating that these are specific health care related projects that we can either do ourselves or we can use community resources such as a Kiwanis club or a church or another civic organization, and get that organization's leadership under our monitoring. We have to have a plan, and then we have a follow

up to make sure it's met. And if it didn't, then next year, you won't get the grant. But most of the time they did very good jobs. That's a very successful project in terms of plan and policy. And I can say that because I had nothing to do with it, other than serving on the committee that awarded the grants for a period of time. There were areas such as AIDS, for example, where that was not very popular health care projects. We were able to meet those needs, I think, by using community grants and I think that was a wonderful use of it. I'm very proud of that, to be in the organization that did that. I'm very proud of the people that made it happen, among whom I was not in their number.

01:38:49
Rigelhaupt:
You mentioned something like HIV/AIDS, and it's certainly probably one of the most well-known public health epidemics in the last thirty-plus years. [01:39:00] How did Mary Washington Hospital respond to the HIV/AIDS crisis that was emerging?

01:39:14
Williams:
That was a clinical issue that, to my knowledge, and it never reached the board, other than to provide the half-way house that we did. We were always supportive of the needs of people who have any kind of malady, including the not-popular maladies. You know, there are popular illnesses and unpopular illnesses, and this was something that we stepped up and supported on a policy basis. I can't tell you what happened clinically, but I think there was something done. I just don't know what those policies were, in the clinical areas.

01:40:03
Rigelhaupt:
Well, part of the reason I ask is that not-for-profit hospitals, over a long history in the US, haven't necessarily been at the forefront of public health issues for a large number of reasons. And I'm wondering—

01:40:23
Williams:
A large number of reasons? I think it's one reason and that is the bottom line. You answer to stockholders. You don't answer to members of the community. That's the simplistic explanation for that. Health care and the health status of the community are not primary in a for-profit vision. It's delivering health care for a profit. That's my understanding. To do that, you've got to cut costs. Your provider/patient ratio has got to be pared down. You're dictated to have efficiencies, and some of them are very efficient. HCA, for example, in my experience—my granddaughter was delivered at an HCA hospital. Of course when I went there I was all eyes and observed what was happening. It was a very efficient delivery of health care. But the ratio of providers to patient was a lot less than it was at Mary Washington. You could see that. It is tougher when you're trying to cut

costs. It's a fine line: deliver quality health care at a reasonable cost. That's not easy because it means cutting the hands-on providers. [01:42:00]

01:42:05
Rigelhaupt:
And the question of the bottom line—it's interesting, in the sense that Mary Washington Hospital, MediCorp, all the way to Mary Washington Healthcare now, has maintained its commitment to the Community Service and the Community Benefit Fund. There's a certain amount of revenue above the expenses that's going to go back out, in terms of grants. And yet, you do have to make the bottom line. You have to speak to bond holders and bond-rating agencies, and maintain the margins. I know this is a long question. But it would have been perfectly reasonable to reinvest that revenue over expenses back into the hospital. It provides a community benefit—the fact that it's there, that it provides acute care, and all the other programs and services that have been developed. How has the organization—when margins and health care are not huge, ever—maintained this commitment to a certain amount of revenue going back out to the community when it's difficult for the own organization to really keep an eye on the margins?

01:43:41
Williams:
You're asking a guy who's very sympathetic to the people who have to make that call—very sympathetic. When I left in 2005, there was a profit. We had the luxury of being able to do a lot of things that we still do, as you point out, but not without some stress on the system. Quite frankly, I don't know how they do it now because I read the paper. I'm tangentially involved in some other hospital projects. I hear that it's very challenging, trying to operate two acute-care hospitals and have any kind of a black bottom line. I can't answer that. I don't know how they do it. If you were taking those same dollars that we were granting out and plow them back in the system, you are still meeting health care needs either way. This is a more demonstrable targeting of specific projects related to health care. [01:45:00] I think it's a practice that I hope they will never stop, but they may have to. I can't answer how they do it now, and how they balance that dilemma of wanting to specifically make grants to the community for health care related projects and being strained on the resources to be able to do that.

01:45:29
Rigelhaupt:
Thinking about your years as chair of the board, what are some of the grants that were given out? And I know this is coming from the foundation, but I imagine the board—there was some conversation across that—in meeting public health needs, that Mary Washington Healthcare was able to undertake and lead.

01:45:56
Williams:
Mammography screenings. Those were substantial expenses, I think. Vaccinations for kids. I can't specifically think of anything. Those are the larger ones, I think, that I was proud to say the initiative came from the health care organization—Mary Washington—and may not have come from any other source if we had not done it.

01:46:48
Rigelhaupt:
Switching gears for a bit, going back to your early years chairing the board, as the new hospital opens in 1993. In these years, there was a kind of managed-care revolution. The HMOs became much bigger players in health care. What do you remember about how insurance companies, with managed care, affected the projections or the directions that Mary Washington Hospital and MediCorp was going to undertake?

01:47:30
Williams:
We went from day to night. I am, as I say, a layman. I was looking at it from the outside, when we were having to deal with it on the board level. We had contracts with Anthem and Aetna and US Health. I'm using a statistic that may not be right. [01:48:00] It seemed like, back twenty years ago, only twenty percent of workers and people and patients had substantial health care coverage. Most of it was either co-pay, large co-pay, or strictly fee for service. We went from that to where everybody had health care coverage. You went from an indemnification contract: where I go out and incur health care costs and I pay for it and I've got an insurance company that indemnifies me for that and reimburses me. It went from that to where the tail was wagging the dog. The provider of insurance dollars was making the decisions, and having a direct relationship with the provider, be it a hospital or a physician. And the patient is left out of it. The dollar person—the insurance company or the HMO—has the ability to say, "We're not going to pay a certain amount of money for certain procedures. I don't care what your costs are. If your costs are a hundred dollars, we're only going to pay you seventy, and you figure out how to deliver the service for seventy." That was the stress and that all happened when I was on the board. It went from, as I say, sunshine to night to darkness because we had to have a special staff of people whose job it was to negotiate contracts with health care insurance companies. We had some very tense moments, as you probably know in your history, where we had to say, "We don't have a contract with Aetna." You've got 10,000 people in the Fredericksburg area who want to come to Mary Washington Hospital and they're not covered. We charged the patient and the patient then makes the claim with his company. The reimbursement is not the same as what the cost was. That was pretty stressful. Those contracts last for three years. I'm talking about the provider and the insurer contracts. Then you go through it again, the sleepless nights and the stress of not being able to cover people who should be covered for the health care services. [01:51:00]

01:51:06
Rigelhaupt:
Does the board play an active role in negotiating with those companies? Or is that from the administration?

01:51:14
Williams:
What the board has got to do is make sure that it makes sense, financially. You can't really approve something that is pushing us over a cliff. It would be general policy on that. Largely, we received recommendations from the administration and we'd approve them for a contract with an insurance company. But you're faced with the dilemma of having to cut your own costs. I mentioned the luxury that we had was a high ratio of providing hands, providers to patients. That's got to fall if you've got to get your costs down. That's a chore, to be able to do that constant fight.

01:52:31
Rigelhaupt:
And so, is that a question of staffing, or are there other ways that the board has tried to work with the administration to cut expenses in other ways?

01:52:46
Williams:
You start looking at services, and whether they're accomplishing everything that you want. If not, it might mean combining those and making everything a lot more lean so that you can meet your service obligations and commitments.

01:53:12
Rigelhaupt:
And yet, in this environment of dealing with powerful outside organizations such as third-party payers and insurance companies and managed care the decade after the hospital opened is a period of expansion. What are some of the things that you think, in term of adding wings, surgery centers, that made that kind of growth possible for Mary Washington Healthcare?

01:53:53
Williams:
It was boom times. The number the houses and the number of rooftops that spread out through the Fredericksburg area—the population doubled. [01:54:00] You had more potential. The fact that we were the only provider back then played a large part in that. We were the only provider from Culpepper or north to Woodbridge or south to Richmond. The vision of being a community health center was actually realized. We could see this is going to happen. It's coming about. And, as I said, the business was there. The health care business, the people, and the population expanded. We were just tracking that. We were staying in tune with that. Our census continued to be stable. We added

more beds and we continued to fill them. That's why we were able to do it. That was the motivator, I guess, because it worked.

01:55:02
Rigelhaupt:
Well, probably, one of the last things you worked on, in terms of a big expansion, was Stafford Hospital. And I wonder if you could tell me about, again, the water-cooler conversations—the early times board members, administrators are just bouncing ideas around, not necessarily formal planning about the possibility of a Stafford Hospital.

01:55:29
Williams:
Mary Washington, as big as it is, we had to add a parking deck. It still was kind of overwhelming at times. People had to walk for long distances to get to the building. We were very busy. We started thinking whether we should expand. If you look 360 degrees around, you had all sorts of opportunity going toward the Northern Neck or south before HCA was there. We concluded, after a lot of thought and brainstorming, that going north would be the most advantageous. That's where the greatest need was and the greatest potential for population growth. We started along that track and started identifying potential sites. We ended up with a site at the Stafford Courthouse. Again, we thought that the need was there. I don't know that we really anticipated competition from the south, then. I think we may have always had that in mind. As a matter of fact, ever since I've been on the board, I had Bill Jacobs drill it into me what could happen if we had competition. [01:57:00] Our lovely comfort level would be rocked. We always had that in mind. We figured we'd better expand because somebody else was going to come in if we didn't. That was probably part of it, and we did see the need. We had pretty hard evidence on the demographics and the likelihood of population growth.

01:57:39
Rigelhaupt:
Were you surprised that the state approved both the COPNs for Stafford Hospital and Spotsylvania Regional Medical Center?

01:57:48
Williams:
No. I wanted to fight it because there were lots of reasons that I think a sole provider is the best thing health care-wise for the community. I'm just convinced of it. I was really sorry to see it happen. But my cynical view was that the state health board that approves COPNs didn't see it that way. They didn't see it as a benefit. You have more volume, you have better quality—I mean, it's irrefutable. That's exactly what happens. They thought it wasn't fair. That's what the commissioner said, at one point: "Competition is good, and that will help drive down health care costs." I don't

believe that, and that hasn't happened anywhere. But that was what she—I think it was she at the time—said in making that decision to approve a certificate of public need for Spotsylvania.

01:59:05
Rigelhaupt:
The planning process, in terms of Stafford, and really from the COPN in 2006 to when it opened in 2010, after you left the board and—

01:59:24
Williams:
Yes, but it was in place when I was there. That was part of my exit.

01:59:34
Rigelhaupt:
The plans were?

01:59:35
Williams:
Yes. And the identification of the site. That was done.

01:59:40
Rigelhaupt:
Thinking about the site, and thinking about the plans, and all the work that the board and the administration put into planning Stafford Hospital, what are some of the things that you can remember you learned from opening the new Mary Washington Hospital, [02:00:00] that the board and the administration applied to the planning and opening of Stafford?

02:00:13
Williams:
I'm sorry. I'm blank on that. I can't tell you. I can't take any specific item and speed it forward to Stafford. The guy that was responsible for overseeing it had a lot of experience from the expansion at Sam Perry, on the Snowden Campus. That was a benefit. He had learned a lot, and probably didn't make any mistakes. I don't know if he made any mistakes to begin with, but if he had, he probably learned a lot from those mistakes and applied them to the Stafford construction.

02:01:10
Rigelhaupt:
Is this Mr. Kiwall?

02:01:11
Williams:
Yes.

02:01:11
Rigelhaupt:
Okay. So, this is a little bit out of order, and I know we've been going here for a good time. But going back to when Mr. Jacobs left, what do you remember about what that meant for the organization when he—I don't know if he retired?

02:01:40
Williams:
No. He resigned to take a better job with an insurance company, Virginia Insurance Reciprocal, which is an insurer of hospitals, physicians, and lawyers and offers professional liability coverage. He became the CEO of the company and dealt very fairly with Mary Washington. He gave us plenty of notice. That was my second deer-in-the-headlight visage. I had to give that a lot of thought. What we did was take the Executive Committee, which I didn't think had enough to do, and constitute that committee as a search committee for a new CEO. That was populated by physicians and lay people. Then, we brought in one or two other people with the Executive Committee of the board, to undertake that job and find a new CEO. We were able to identify a new CEO, Mr. Rankin, through a process we went through before Mr. Jacobs left. [02:03:00] It was, in that sense, seamless. It wasn't that difficult. It's just that it was something that I had never been through before. I was a member of a search committee for a new minister of my church on two occasions, but those occasions were nothing like this. I thought I was faced with running an operation without a CEO, and that was scary. That never happened. Looking back on it, it was a rewarding experience, as a matter of fact.

02:03:40
Rigelhaupt:
Well, tell me about the experience, both when you're faced with the deer-in-the-headlights moment—you're going to have to locate a new CEO. What did you, as chair, and the Executive Committee—which, it sounds like, functioned as a kind of search committee.

02:03:57
Williams:
Yes.

02:03:59
Rigelhaupt:
What did you want to accomplish? What were some of the strategic goals?

02:04:04
Williams:
What you have to do is recognize the changes that you've been through, and what you anticipate. Then you have to identify skill sets to do that. That was something we had to do to begin with. We had a list of criteria that had to be met in both what we needed, and then in the skill sets of the potential candidate. I guess the people we had to begin with, Mr. Jacobs included, came on board when we were an acute-care facility, primarily. Mr. Jacobs brought us into the next century. We had to make sure we didn't revert to the old way. We had to make sure we continued forward. That was a good exercise. We had a strategic plan that told us where we ought to be, and then we had to identify somebody that could take us there. I thought we did that well.

02:05:24
Rigelhaupt:
Well, what were some of the things that you, as chair of the board, and your committee identified about Mr. Rankin that led the board to offer him the position as CEO?

02:05:39
Williams:
He had a background in Pennsylvania that was both hospital administrator and, at the same time, he had the skill sets and financial wherewithal. [02:06:00] He was active in health care executive organizations that gave him the ability to meet all the needs—financial and the visionary needs that we talked about. Plus, he was enthusiastic. He had some different ideas that we thought were exciting and went even beyond what we were addressing. Trade association is what I was trying to think—he was active in those. He had kind of a global view of things that we were impressed with. Although we hired from within, we almost tried to resist doing that because we didn't want to take the easy way out. We looked at all possibilities. I think we had a consultant or two that helped us out on that.

02:07:16
Rigelhaupt:
One last question about that transition: you mentioned earlier that Mr. Jacobs played an important role in educating the board about health care trends. What are some of the things that Mr. Rankin has done similarly, differently, and you would see as being very beneficial to the organization in terms of working with and educating the board?

02:07:54
Williams:
Mr. Rankin, I think, was a continuation, for me. What he brought was a sense of ease on behalf of the physician community. I don't know if it's misplaced or not, but there was certain mistrust of the Jacobs-run organization because I think the physicians felt that they may be in competition with the hospital. You have to have physicians. Even the president of the world can't admit somebody to the

hospital unless he's a member of the hospital staff. It was almost a necessary evil with Bill [Jacobs]; he had these ideas and was met with resistance because of fear on behalf of the physicians. [02:09:00] Some of the fear may have been founded or mis-founded. When Fred [Rankin] came along, all of a sudden everybody relaxed. It was like the physician community said, "Okay, we're going to be okay now. Here's a good man. We've been working with him. Now we're going to be able to continue to work with him." And Fred did have lots of policies that he had to continue with, and new policies—I can't think of one, but I know this came up—where he got physician resistance. But he was able to deal with it very diplomatically. At the end of the day, the physicians came away not despising the health care organization, but feeling like he or she had been heard—had his day in court—and was okay with whatever the resolution was. That was a big observation that I had: internally, things seemed to become more relaxed and worked better. Fred has had some tough decisions. He's let some people go who were popular in the clinical area and the physician community. He has done well with it. Whereas they would almost be forming a lynching mob with one CEO, the physicians accept it with another. They feel confident that he had made the best call: "I disagree with it, but it's the best call, in his mind, for the organization. So, I'll respect that." I don't know if that's responsive to your question, but that was one observation I had in the transition.

02:11:09
Rigelhaupt:
There was an increase in trust between the administration and the physician community?

02:11:15
Williams:
Yes, that's my observation. People may say, "That's all wet. We still hated the hospital no matter who was in charge." But that was my observation. And I think you'll hear that from the lay leadership at the time. [02:11:35]

[End of Interview]