HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Robert E. Toomey

ROBERT E. TOOMEY

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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Robert E. Toomey

CHRONOLOGY

1916	Born Cambridge, MA, March 18 son of Daniel and Catherine (Shanley) Toomey
1940	Harvard University, B.S.
1940-1942	Browne and Nichols School, Teacher and Coach
1941	Boston Universtiy, M.Ed.
1942-1946	U.S. Army
1946-1949	Veterans Administration, Detroit, Psychologist
1950-1951	Hospital Council of Greater NY, Administrative Resident
1951	Columbia University, M.S.
1951-1952	Roosevelt Hospital, NYC, Administrative Assistant
1952-1953	North Country Hospital, Gouverneur, NY, Administrator
1953	Greenville (SC) General Hospital, Assistant Director
1954-1978	Greenville (SC) Hospital System, General Director
1978-1979	Greenville (SC) Hospital System, Assistant Secretary, Member Board of Trustees
1978-1979	AHA Center for Multihospital Systems and Shared Services Organization, Consulting Director
1980-	The Toomey Company, Inc., President
1984-1987	MedCorp Health Systems, Inc., President and CEO
1987-present	Toomey Consulting Services, Inc. President and CEO

MEMBERSHIPS AND AFFILIATIONS

Advisory Council for Comprehensive National Planning, Member

American College of Hospital Administrators Council of Regents,
Member, 1964-1970
Education Planning Committee, Area III, Chairman, 1966
Fellow

American Hospital Association, Special Committee for Provision
of Health Care, Member, 1970

American Public Health Association, Member

Appalachian Regional Commission Health Advisory Committee,
Executive Committee

Association of American Medical Colleges
Council of Teaching Hospitals, Board Member

Blue Cross/Blue Shield of South Carolina, Board Member

Boston University National Alumni Committee, Member

Carolinas Hospital & Health Services, Board Member, 1977-

Carolinas-Virginias Hospital Association, President, 1958

Christ Church Episcopal Church, Upper School Planning Committee, Member

Clemson University Adjunct Professor, 1970-1980

Columbia University, Guest Lecturer

Committee for HR1 (National Health Insurance), Member

Committee for Study of Medical School in Greenville, Secretary, 1962-

Cornell University, Hospital Administrators Development Program, 1958, 1967

Cornell University, Guest Lecturer

Duke University, Adjunct Professor

Duke University, Hospital Administrators Management Improvement Program,
Director, 1978-1981

Episcopal Day School, Chairman, Board of Trustees, 1959

Governor's Committee on Nursing, 1963

Governor of State of South Carolina, Special Assistant
(loan from Greenville Hospital System), 1973

Governor's Task Force on Health Care Finance, Member, 1981

Governor's Task Force on Medicaid

Governor's Special Health Services Study Committee, 1972

Greenville Community Council, Member, 1966-

Greenville County Health Planning Council, Member

Greenville County United Fund, Member Board of Trustees, 1963-1966

Holy Cross Health System, South Bend, Member, Board of Directors, 1978-1988

Hospital Bureau, Inc., Board Member, 1981

Hospital Research and Development Institute, Member

Michigan, University of, Guest Lecturer

National Center for Health Services Research and Development,
Publications Advisory Board, Member
Committee on Resolutions

National League for Nursing, Special Committee for Planning and
Implementation, Member, 1964

Northwestern University, Guest Lecturer

Ohio State University, Guest Lecturer

Regional Medical Program, National Advisory Committee, Member

South Carolina Department of Health and Hospitals
Advisory Council Member, 1964

South Carolina Heart Association, Board Member

South Carolina Hospital Association

President 1957-1958, 1970

Trustee 1955-1959, 1961, 1970

South Carolina Hospital Administration Long Range Planning Committee, Member

South Carolina Social Welfare Forum Board Member

South Carolina Study on Alcohol and Drug Addiction, Member, 1963-

South Carolina, University of, Adjunct Professor, 1968

Technical Education Center (Health Careers) Advisory Committee, Member

Veterans Administration Scholars Program

Board of Governors, former Member

Yale University, Guest Lecturer

AWARDS and HONORS

American Association of Hospital Planning

Annual Award of Recognition and Appreciation, 1980

American Hospital Association

Award of Honor, 1971

Clemson University

L.L.D. (honorary), 1968

Columbia University, School of Public Health

Distinguished Alumni Award, 1982

Personalities in the South

Listing

South Carolina Hospital Association

Distinguished Service Award, 1971

Who's Who in America

Listing

Who's Who in the South

Listing

WEEKS:

Mr. Toomey, you have agreed to talk with me about your professional life and the people you have met and the things you have done, so I would like to start out with the beginning. You were born in Cambridge, Massachusetts so it was natural for you to go to Harvard, wasn't it?

TOOMEY:

It was actually less expensive for me to go to Harvard than it was to go other places because I could live at home.

WEEKS:

Did you intend to become a teacher?

TOOMEY:

I intended to become a teacher.

WEEKS:

You received your bachelor's degree from Harvard. Was that in education?

TOOMEY:

No, no. That was in history. I majored -- my specialty was colonial American history. Samuel Eliot Morison was my professor in that department.

WEEKS:

Was he? There were some famous men at Harvard then, weren't there?

TOOMEY:

Yes, there were.

WEEKS:

Did you become interested in naval history like he was?

TOOMEY:

No. His special area still was the colonial American. I chose colonial American history because of my interest in that period. However I was

fortunate in having Dr. Morison as my professor.

WEEKS:

You were in the right spot to study that, right in the right area. You certainly had a very illustrious teacher in Professor Morison.

After you left Harvard in 1940, you taught school for a couple of years?

TOOMEY:

Really, no. I went directly to Boston University. While I was at Boston University I taught at the Browne and Nichols School as well. I got my master's degree in education in 1941. As well as teaching at the Browne and Nichols School, I coached football, crew and wrestling there also.

WEEKS:

I don't picture you as a wrestling coach.

TOOMEY:

One of the interesting things about wrestling is that competition is by weight classification. So you can be a relatively small 115 or 120 pounder and there is a classification which allows you to wrestle people of that size. Even though I am not really tremendously large, by remaining in your weight classification you were able to wrestle with people who were similar in size.

WEEKS:

Agility meant more than size.

You did also serve time in the army during the wartime.

TOOMEY:

Yes. To be specific, I went from Browne and Nichols School and I was a Geographer with the Army Map Service. I was at Browne and Nichols basically in 1941 and 1942. I went to the Army Map Service in 1942. In late 1942 I was drafted into the army. I served from 1942 to 1946 in the army.

WEEKS:

The next note I have is that after the war you were with the Veterans Administration in Detroit as a psychologist. Is that correct?

TOOMEY:

Correct.

WEEKS:

I imagine that is where you met your wife, too, isn't it?

TOOMEY:

No, I met my wife when I was assigned to the Sixth Service Command Headquarters which was in Chicago, and Detroit was part of that Service Command. I came over to Detroit a number of times. My wife had attended the University of Chicago. One of my colleagues in the army had known her. We were introduced while I was on temporary duty in Detroit. Prior to closing out my army career, we married. When I got out of the army I returned to Detroit. I was here in Detroit actually from 1946 to 1949.

WEEKS:

I guess the thing I am looking for here is some indication of how you turned to hospital administration.

TOOMEY:

I can tell you that very quickly. As you might expect, it was an army assignment. Because I had coached football and wrestling and crew, the army saw fit to move me into rehabilitation services -- reconditioning and rehabilitation. So, out of my athletic career I became a worker in rehabilitation. Out of that I generated an interest in hospitals. During that period of time I also took time and studied psychology. When I came to Detroit I went into clinical psychology which put me into a new area of

medical service. I closed out my army career as a medical administrative corps officer. After I had worked as a rehabilitation person and then as a medical administrative corps person and then as a clinical psychologist, these were all very closely allied to the hospital activities. So I made the decision that rather than going on in either education or psychology I would move into the area of hospital management. That's when I made the decision to attend Columbia in their program in hospital administration at the School of Public Health.

In a sense it was all very logical, although it is hard to track unless you ask.

WEEKS:

I was trying to think of the people who might have been on faculty at Columbia back in that period. Was that Clement Clay?

TOOMEY:

No. That was before Clement Clay. It was John Gorrell.

WEEKS:

I don't remember ever meeting him. Columbia turned out a lot of good men.

TOOMEY:

Yes. Actually there are a tremendous number of people who came out of the service from medical administrative corps positions and decided then to stay in the hospital field. A chap, whose name I forget, over here at Harper for twenty-five years was in the class before me. One of my good friends, Charlie Stewart, who was born and brought up in Detroit was a graduate of the Columbia program. There were a lot of us who came out of the service and within several years made the decision to go into hospital work.

WEEKS:

There were a lot of great changes back then in the late forties, weren't there? I was talking just the other day with a retired army officer. We were talking about how many GIs went to college after the war who probably wouldn't have been able to go otherwise.

TOOMEY:

There was a gentleman by the name of Prall who was hired by the Kellogg Foundation to do an original first look at the career of hospital administration. I think his first name was Herbert, but I am not sure.

WEEKS:

I was thinking Charlie. I'll look it up. That was the first big study of hospital administration. I think there have been two more since then.

TOOMEY:

I know of one that was done by the Sloan Foundation, authored by a professor out of the Tuck School of Business at Dartmouth.

WEEKS:

Hamilton?

TOOMEY:

No. Prall recommended programs of hospital administration be based in schools of public health because the vision under Prall was that hospitals were part of the public interest, public health area of concern. When this fellow at the Tuck School of Business came along and did his study under the Sloan Foundation, he made the recommendation that in as much as the trend was toward looking at hospital and health care as strongly needing the kind of input that you get from schools of business, that the schools of business be the locus for programs in hospital administration.

WEEKS:

I think Kellogg supported three different... Was it Olsen?

TOOMEY:

Yes. Herluf Olsen. That was supported by the Sloan Foundation.

WEEKS:

Charles Prall.

TOOMEY:

Yes.

When I began to look at the career of hospital administration as opposed to staying in education and psychology, I began to look around for things to read and I got hold of the Prall report. I was impressed with what I considered to be good potential, much greater than I had anticipated.

WEEKS:

Even in my short acquaintance with hospital administration programs I have seen them grow so much that they have just grown way out of proportion to what you would think.

TOOMEY:

Prall started out looking at need. They have grown out of proportion to need, but we have never made decisions as to careers based on need particularly. There have been our own personal desires and what we considered to be opportunities. You actually can track some of the numbers of people in engineering on the basis of need if you go back to Sputnik when schools of engineering really went crazy. Then they declined, and since then they have come back. But Prall did it on the basis of what he figured were the numbers of people who would be necessary to be responsible for hospital operations. Of course Hill-Burton blew that premise out of the water.

WEEKS:

That really did, didn't it. Now we are coming to a point where many of our people are not going in to running hospitals. They are doing many other things.

TOOMEY:

Oh, yes. Which is why we have changed the terminology from hospital administration to health care administration.

WEEKS:

Yes. This has made a big difference.

What was that, a one or a two year course at Columbia?

TOOMEY:

It was a one-year course. Then I spent a year in residency. I took six months with -- these are maybe names you know or don't know — John Pastore. John was the director of the Hospital Council of Greater New York which was the first really large community planning agency. His number one assistant was a fellow named Herb Klarman. Do you know Herb?

WEEKS:

Oh, yes, I have met him. He is still a very important man.

TOOMEY:

Yes. He is a health economist. He worked with Eli Ginzberg from Columbia University who is the number one health economist. He and Rashi Fein and a few others. I worked with Herb and with Dr. Pastore for the first six months of my residency. Then I took the last six months with Madison Brown at Roosevelt Hospital in New York City. It was there that I first met Pete Terenzio and his brother Joe. The Roosevelt group of people included John Danielson and Jim McGuire. Jim McGuire went to West Penn Hospital just

outside Pittsburgh. We were all together at Roosevelt. It was a very exciting period of time. That ended about 1951 -- 1949-51, those two years were invaluable.

WEEKS:

There was a period there where laymen were becoming administrators, while on the other hand there were people like Madison Brown or Stewart Hamilton who came out of a medical background.

TOOMEY:

They came out of a medical background which was a requirement for the management of army hospitals. When they came out of the army they made the decision to remain in hospital management rather than return to clinical medicine.

WEEKS:

Yes. The war made great changes in that sort of thing and also in what the doctors felt their role was too. It was quite different. They learned to operate in organizations where they previously had maybe not done that.

After you were through at Roosevelt...

TOOMEY:

I stayed at Roosevelt for a while and was hired as an assistant director, along with Pete and Jim McGuire, for a short while. Then I went to the North Country Hospitals. I don't know if you have ever heard of it.

WEEKS:

Is it still called that?

TOOMEY:

It's still called that. I am trying to remember the name of the man for whom they were named. He was a philanthropist and he grew up in Gouverneur,

New York. The name I am searching for is Edward John Noble. One hospital is in Gouverneur and one in Canton and one in Alexandria Bay.

WEEKS:

I looked in the recent AHA Guide Issue and they have it listed under his name.

TOOMEY:

Edward John Noble?

WEEKS:

Yes.

TOOMEY:

He was the founder of the American Broadcasting Company. He owned Lifesaver Corporation, and he wanted to see his money being used in the North Country.

WEEKS:

Some of these philanthropists have really done a great deal for all of us.

How did you happen to go to Greenville?

TOOMEY:

I mentioned Peter Terenzio because Peter was the senior assistant director under Madison Brown. Greenville chose him to come to help them establish a hospital that was going to go from about 250 to 500 beds. They asked Peter if he would be the director of that hospital in Greenville. Peter agreed to go, and then he asked me if I would join him there as his assistant director. I chose to go to Greenville, to leave the North Country and go to Greenville for a number of reasons.

When I got to Greenville, within one year, Peter had been invited to come

back to Roosevelt Hospital when Madison Brown moved to Temple in Philadelphia. So Peter became the director at Roosevelt, and they chose me to succeed Peter. By that time I had developed an affection for living in the South. I felt that it would be challenging in many ways, socially as well as other ways. It really didn't take much to recognize that the South was eager for a resurgence. I felt that it would be exciting to live through that. I stayed in Greenville from 1953 to the present. Actually I started working in January of 1953 at Greenville General Hospital. I stayed there until March of 1978. I really have worked only in two places as far as hospital operations is concerned -- well, three -- Roosevelt, the North Country Hospitals in Gouverneur, Alexandria Bay and Canton, and in Greenville. The last two -- if you want to know how I got interested in multihospital systems it was because my first job as hospital director was in a three hospital, three community operation with hospitals in each community. In a sense I cut my eye teeth on working in that environment. When I got to Greenville, I found that they had a major hospital in Greenville and a satellite in the town of Greer. So I have never operated a stand-alone, individual, autonomous hospital. I became interested in the managerial differences between multis and individual hospital operations.

WEEKS:

Would you like to talk about the development of this through the time you had the building started to the time Pete Terenzio left.

TOOMEY:

By the time Pete left Greenville about the only thing that was initiated was the completion of the expansion of the Greenville General Hospital and the completion of the 25 bed satellite in Greer. I was involved in the opening

of the larger hospital and attempting to find ways to coordinate the large hospital in Greenville and the smaller hospital in Greer administratively and clinically. That was where I began.

As a matter of fact it even went back further than that because I took the eighteen bed hospital in Alexandria Bay, contacted the physicians in both Gouverneur, NY and in Watertown, NY and set up times at which the specialists would come to Alexandria Bay; gave them space in our small hospital and encouraged the few general practitioners in the North Country to send their patients over to our hospital in Alexandria Bay where we had brought in the specialists in order to see their patients. That was the beginning really. Like a lot of things, you do it for pragmatic reasons, very practical. We had no specialists on our staff. There were specialists in the area. We had space available, so one seeks an enticement to bring in the specialists where there was space and where there were prospective patients -- at least in the summertime there were lots of patients available in Alexandria Bay.

WEEKS:

You had a lot of vacationers?

TOOMEY:

Yes. That's the Thousand Island area on the St. Lawrence River.

WEEKS:

So you went to Greenville with...

TOOMEY:

With some background and understanding of a satellite operation.

WEEKS:

When you went to Greenville -- you went there after they had decided to build another 250 beds, wasn't it?

TOOMEY:

Yes, that was the reason why Peter Terenzio and I went to Greenville, to help them finish the construction and begin the initiation of the organization and operation.

WEEKS:

What I was wondering was: who was the moving spirit in Greenville that decided they should do this?

TOOMEY:

There was a gentleman who was a vice president of the J.P. Stevens Company, Gordon McCabe, and another gentleman by the name of P.C. Gregory who was the vice president of Cone Mills and the third man, a Mr. Francis Hipp, who was president of Liberty Life Insurance Company which is a regional life insurance company. Those three people really were the backbone of the board in Greenville and were, in a sense, dedicated to what I said earlier. That is, the resurgence of the South. In this case they wanted to see Greenville grow, they wanted to bring the benefits of enhanced hospital care to the people of Greenville. They felt that one of the ways was to move away from that which was parochial in the South and to bring, through Terenzio and me, some of the benefits and some of the initiative and drive of the northeast into the Greenville area.

WEEKS:

How was this to be financed? Did you have a capital fund drive?

TOOMEY:

The construction of the hospital and its financing had already been accomplished with a basic plan. Basically they raised $5 million on a local bond issue from the local county. General obligation bonds were issued by

Greenville County for the purposes of constructing the new hospital. However, they did something very, very interesting at the same time. They had a study which culminated in an act which moved the hospital from the control of the corporate authorities of the city and county and created an independent, self-perpetuating board. In effect what they did was to create an Authority, what I think we would today call an Authority. They gave the financial and the operating responsibilities to an independent board although the funding for getting the hospital into its desired size was done with public funds.

WEEKS:

At the same time you had this 5ØØ bed hospital you had the small hospital in Greer.

TOOMEY:

Fifteen miles away.

WEEKS:

Did you find that you were getting referrals from Greer to the larger hospital?

TOOMEY:

No, but the physicians who were specialists in Greenville would get the referrals from the physicians who were generalists in Greer.

WEEKS:

Then they would be hospitalized...

TOOMEY:

They would be hospitalized in Greenville. To the degree that the generalists in Greer could take care of the patients, they would admit them into Greer, but into the Allen Bennett Hospital. What this represents is probably one of the first examples of coordinating primary care and secondary

and tertiary care with the physician as the gatekeeper, but clinically as opposed to financially. Clinically, if they can take care of the patients in Greer, they had a facility that would allow them to do that. If they could not or if they felt the condition required services beyond their capability, they referred them to the specialists in Greenville and the specialists used the Greenville General Hospital as their care-giver.

WEEKS:

Maybe I misunderstood you but the local physicians in Greer, were they allowed privileges in the Greenville Hospital?

TOOMEY:

Yes. That's another interesting thing that lasts to this day. That is that all of the physicians who are on the medical staff of the Greenville Hospital System are allowed privileges in all of the hospitals and all of the institutions within their scope of their clinical competence and specialty.

WEEKS:

This is another thing I was wondering: since you are having a common staff, if I can use that word, is the credentialing done with both hospitals in mind?

TOOMEY:

Yes. As a matter of fact, that whole area of hospital, medical staff, organization, as you might guess, is complicated. We eventually established departments of the medical staff. Some were clinical departments and some represented the geographic dispersion of the system. One would receive membership on the Hospital System medical staff and then those privileges would be delineated by the departments.

WEEKS:

I see.

TOOMEY:

It would be possible to be a member of a geographic department, let's say the Greer -- Allen Bennett department -- and as time went on and specialists moved into that area they could receive an additional appointment in a clinical department at the Greenville General Hospital where we had a very active teaching program and they could participate in the teaching program.

WEEKS:

I guess my point was because I was wondering if a small hospital like Greer would have the facilities to investigate the credentials of physicians?

TOOMEY:

No. Investigating credentials was done at the corporate level. Greer eventually grew to 125 beds out of the original 25. They are right now in the process of tearing down the original hospital that was built back in the early '50s, 1952-53, and they are going to replace that. There is not going to be a bed expansion, but there is going to be a general renovation and expansion. There have been three or four building programs out in Greer since the early days.

WEEKS:

Do they have a medical office building too?

TOOMEY:

Well, no, they do not per se because many of the physicians built their own office buildings immediately contiguous to the hospital.

WEEKS:

I see. So they don't have to fulfill any need there. It is becoming so

common today of hospitals building medical office buildings where they are needed. I can see where in this case they wouldn't be needed.

Now I have you in Greenville and now after Terenzio left you are the director. This meant that you were coming into a hospital scene where you had or were going to have about 500 beds in the main building and then a small satellite. What were the problems you faced? How soon did you do more expanding?

TOOMEY:

First of all let me say that the people who were in Greenville who were interested in what I call the resurgence of the area were rather eclectic in a sense. That is, it was all kinds of expansion. Industry was in the process of expanding. Several times the airport has expanded. There just was a continual growth, much more quickly than we had ever anticipated. We achieved a rather full census within the hospital. We then began to look at what we should do in order to accommodate to being in a growing area. When you begin to look around you really have two or three choices. One of them is to continue to expand what you had in the 500 bed hospital and you move to 600, 700, 800, and 900. Or you begin to look and see where the growth was taking place other than in the city of Greenville. It just really was growing in a number of places.

I go back now to the fact that my first part of my residency was with John Pastore in the Hospital Council of Greater New York which was a community planning agency. I began to look at community planning for Greenville. It's not New York, but the basic elements are the same. That is, what do you do with the growing population, what kind of services are necessary, how do you accommodate to it? You go through that whole question.

I actually brought in a director of planning, a person who had been at Duke. We began to do community planning, hospital planning, and looking at alternatives that we might begin to develop. That really was the way in which we moved from being one hospital into a number of hospitals. At the same time, you will remember, in the '60s — I don't remember whether it was John Gardner when he was with HEW -- we began to talk about comprehensive health care planning. Comprehensive health care began to mean more to me than simply medicine, surgery, pediatrics and obstetrics. It began to mean: what is the market for rehabilitation, for psychiatry, for nursing homes, for large hospitals, for small hospitals? As I, frankly, became more interested in, intrigued with, and conversant with comprehensive health care planning and meeting comprehensive health care needs and looking at the development of a continuum of care, watching my medical staff grow in terms of its specialty capabilities and the fact that you could begin to talk to psychiatrists about should you have a separate facility and what should its relationship be to the acute care institution? Or talk to the orthopedists about the specialty of physiatry and whether they wanted to get into the long-term care of patients and the specialty care of people. We were through the polio epidemic period, thank goodness, but you still had the people with cerebral palsy and all the other kinds of long-term conditions.

We began exploring the potential for doing something with the clinical people. Out of those conversations and out of the growth of the area came the decision, which was really a conscious decision, that we would create a comprehensive institutional health care program. I was careful, if you don't mind my saying, to call it an institutional program rather than a comprehensive medical care program, because I was focused on the development

of institutions and I was not focused on hiring doctors to do psychiatry or rehab. I felt that if I could promote private practitioners into using these facilities that it would allow me greater freedom. During those days of comprehensive health care planning, taking into consideration the amount of antipathy and the fears which the profession of medicine had developed about being taken over by hospitals, I wanted to make sure that there was no question that I was talking about an institutional continuum. Such a continuum would allow us to go from ambulatory care -- which we could do because we had the clinics and we were the second largest medical educational program in the state, and move down the road for acute care to long-term care, psychiatric care, and into nursing home care, and eventually into the hospice. The hospice is of more recent origin.

I started there in Greenville in 1953 and by 1963 we were involved in the construction of other satellite hospitals and the nursing home and the long-term care hospitals and beginning, through the initiation of comprehensive health care planning and the development of a system of care that would allow us to provide specialty services at the hospital level for a variety of conditions, we were already into a medically evolving health care system.

WEEKS:

When you said that you were the second largest medical educational institution, did you mean residencies?

TOOMEY:

Internships and residencies.

WEEKS:

I think the fact that you have explained the spirit of Greenville and of the Carolinas as far as going ahead and expanding and improving and growing --

it must have been nice to have that kind of support behind you.

TOOMEY:

It was great, truly.

WEEKS:

This is a little beside the chronology here but I was wondering what you did in community work to sell them on the ideas that you had and the things you wanted to do.

TOOMEY:

That really was a separate strategy. You had medical care, a strategy for planning and for marketing and working with the physicians to provide those services. On the other hand, we were fortunate in that we were created by an act of the state legislature, not the local government. That act allowed us to operate independently by specifically stating that it was the desire at the state level to remove the hospital from the governmental and political powers of the local group. But it still left us as a 501(c)3 organization with a history of being able to call on the local political funding for our expansion programs.

My own personal strategy was to maintain a very, very close relationship with the county council and the county delegation (the delegation to the state legislature) and to keep them apprised of what we were doing and why we were doing it. We had a very active program of breakfasts, luncheons and dinners for the political decision-makers. I spent time at the state legislature with the people who are in politics. We made them privy to everything we did at the hospital. We responded whenever we could to their needs. Basically, they responded to our needs because I guess it was a successful effort at selling a political/social partnership which would redound, not to my benefit, not to

their benefit particularly, but to the people we both were serving. You achieve that through your political planning. We did this.

We even went one step further in that because, in as much as there was one board for all of these hospitals and it became obvious in time that there was great interest in the System throughout the county. I created a system of advisory boards, which were created to provide advice and counsel to the people in management, as opposed to advising our board. I created them, I put them together. They still do exist. It was an effort carried out in each section of Greenville County. Everywhere that we had an institution, whether it was a specialized institution or whether it be a small acute general hospital, we brought the people of the community in and asked them to participate with us in the decision making that was going on. They advised management and not the board. To me that was rather important. However, because of the planning that we were doing for the comprehensiveness and continuity of care kind of thing, our own board invited the chairman of each advisory council to meet with them at every board meeting and to report on what was going on in their local communities.

We in management began to integrate the whole medical care program and the political services. Our seven man board for the system was made up of the top socio-economic level individuals in the community. This had left all of the blue collar workers, all of the blacks, all the housewives and all of the other people who were being served outside the decision-making process. Through the advisory councils I was able to involve the kind of people I just identified. These advisory boards included blue collar workers, the youngster who went to Greenville Tech and was interested in whatever he was interested in. It included nurses and other interested women. I believe we did a

tremendous amount in the integration of the whole hospital system with the community; medically, sociologically, politically, and in terms of finances in the financial areas.

WEEKS:

You were building up a lot of local pride there.

TOOMEY:

Yes, and it still exists I am happy to say.

WEEKS:

These advisory committees gave all levels of citizenry a feeling that they had a way of input.

TOOMEY:

And they did.

WEEKS:

Did you have these in each community where you had satellites?

TOOMEY:

Yes.

WEEKS:

The seven man board ran all of the operation?

TOOMEY:

Yes.

WEEKS:

How did they listen to these advisory committees?

TOOMEY:

Through the mechanism that I designed by bringing the chairman of the advisory council to the monthly board meetings and asking the chairman of the advisory council to recite whatever he wanted to the seven man board about the

actions and activities of their local citizens.

WEEKS:

Also the chairman could sit in and see what the board was doing on other things.

TOOMEY:

Absolutely. What it did was create a lot of trust.

WEEKS:

Did you have any physicians on your board?

TOOMEY:

Yes. Now on the seven man board I don't believe we ever had a physician but we had the president of the medical staff and the president-elect and the immediate past president invited to attend all of the board meetings.

WEEKS:

As ex-officio?

TOOMEY:

Yes.

WEEKS:

I think that's fine.

TOOMEY:

They didn't mind because they never felt as though they were not welcome. They were always welcome, and they were always given a spot on the agenda. They were always encouraged to discuss whatever was being discussed.

WEEKS:

Could we run down a list of the institutions that I have found? I don't know if I have them all. I don't think I do. Your big hospital is the Greenville Memorial Hospital, right?

TOOMEY:

The original was the Greenville General Hospital.

WEEKS:

That's a small hospital, isn't it?

TOOMEY:

The Greenville General Hospital had as many as 700 beds at one time. In the process of this whole thing we bought 120 acre campus about two miles away from the downtown area. We then began to develop on that campus a series of institutions. On that campus at the present time is Greenville Memorial Hospital, which is an acute general hospital. Also on that campus is the Roger Peace Center for Rehabilitative Medicine.

WEEKS:

Maybe I can run down the list and you can comment: the Allen Bennett Memorial Hospital is the one in Greer.

TOOMEY:

Yes.

WEEKS:

That, now, is about 125 beds?

TOOMEY:

It is down around 100 beds now.

WEEKS:

You have one in Simpsonville called the Hillcrest?

TOOMEY:

Yes.

WEEKS:

Then the Nursing Center. Is that a nursing home?

TOOMEY:

Yes. Roger Huntington Nursing Center. That facility is on the same campus as the Allen Bennett Hospital in Greer.

WEEKS:

Then it is possible to quickly move a patient over if need be for hospital care.

TOOMEY:

Yes.

WEEKS:

Then I have a Family Practice Center.

TOOMEY:

That's a center for family medicine. That basically was a poor person's HMO, although we opened it up to anyone in the community that wanted to join it. But you joined the Center for Family Medicine and the doctors there took care of you. The doctors there were our family practice residents, our other residents, and our full-time faculty.

WEEKS:

That's on the campus?

TOOMEY:

Yes.

WEEKS:

Donald Welch uses the term "clusters," and Henry Ford uses "campus."

TOOMEY:

We actually built a campus with the idea of different buildings doing different things.

WEEKS:

Mr. Welch had a good explanation of how theirs came about. The Seventh Day Adventists historically being concerned with how to live better, through better living comes better health, had their sanitariums out in the country more or less, at least out on the edge of cities. They might have quite a few acres, 40 or whatever. So when the cities started growing out they were in a good location and also were able to build these clusters because they had plenty of room.

TOOMEY:

Our original plan -- this is maybe a digression — but when we bought the 128 acres the thought was that we would start with the acute general hospital and then as demand and opportunity existed, we would spin off specialty hospitals onto this campus. The specialties that we felt sure we would get into were urology and orthopedics and cardiology and cancer, as well as rehabilitation and psychiatry. That has not yet happened, but that is why we bought that property.

WEEKS:

It may happen yet. There seems to be a move toward specialty hospitals now where back fifty years ago...

TOOMEY:

We had to move away from that concept.

WEEKS:

It's hard to tell what is coming next.

We were talking about Mr. Pickens. Is this hospital that you have named after the same man?

TOOMEY:

Yes, our psychiatric hospital is named after Marshall Pickens.

WEEKS:

I'll have to learn more about him.

I have you also with a hospital in North Greenville.

TOOMEY:

Yes, in the town of Travelers' Rest. The North Greenville Hospital is now caring for patients who are alcohol and drug addicts.

WEEKS:

Do you have a cancer treatment center? Is this on the campus also?

TOOMEY:

Yes. It is on the campus also.

WEEKS:

Do you have inpatients there?

TOOMEY:

It is separately constructed, separately operated, but physically connected to the Roger Peace. We have used the second floor of Roger Peace to take the inpatients from the cancer treatment center. It is all well integrated at the moment. It is administratively integrated but it is clinically something separate.

WEEKS:

I was going to ask you when we were talking about the various units that you have: do you have a central accounting system?

TOOMEY:

Yes. The other thing is that there are a lot of changes since I left. We also have a children's unit which came to be known as the Children's

Program. It was a separately organized, separately built school for emotionally disturbed children. It was next door to the Marshall Pickens Hospital. It was, as I say, separate. We had dormitory facilities; we had classroom facilities; we had recreation facilities. It was for emotionally disturbed children. It was a separate organization. There always are organizational changes. To me, one of the really, really interesting things was that the school for emotionally disturbed children was approved for Medicaid as well as for insurance. The therapy was actually the educational program and the specially trained special education teachers. We would take in children who could not be controlled at home and for whom an inpatient hospital was really an unacceptable alternative. We provided an acceptable alternative which was counselors and special education teachers and a dormitory life and twenty-four hour a day coverage for these youngsters. It was for ages six through twelve. We would provide that children's program in such a way that it was therapeutical effective. We did have trouble with the insurance companies, particularly Blue Cross. They had to come and see what we were doing before they said it is a part of a medical care facility.

WEEKS:

You really had to gamble a bit to set this program up then.

TOOMEY:

Yes, sir. I got into trouble with some of my board members because after the school program became operable one of them told me that he did not remember ever approving the expenditure of funds to develop that children's program. I assured him that it was all done as part of the total package. The interesting thing to me is that we now have transitioned from the children into the adolescents so the Marshall Pickens Hospital is not only adult and

children but it now is adolescent as well. So the Greenville system currently will take the psychiatric problems for all groups but in specialized programs for each group.

WEEKS:

I see. You will have age limits and that sort of thing.

TOOMEY:

And you have a program that is designed to handle the kinds of problems that each of the age groups brings with them.

WEEKS:

Would you like to say anything about centralization of any of the services and how you handle group purchasing.

TOOMEY:

Before you do that let me also tell you that there was one other institution called the William G. Sirrine Hospital. It was created when we were given a women's hospital that was created for women in the textile mills. It was called the Maternity Shelter. Eventually its significance in the community lessened when insurance became prevalent in the local textile industry and women who worked in the mills had insurance to go to the hospital and didn't have to go to the Maternity Shelter for their care. We started what, in retrospect, was the forerunner of hospitals that were doing outpatient surgery. We started it as a chronic disease hospital. I don't know whether you remember but there used to be under the Hill-Burton program a category of hospitals which was chronic disease. Do you remember that?

WEEKS:

It seems to me I do, yes.

TOOMEY:

We had it licensed as a chronic disease hospital. We took in long-term care patients who were chronically ill, mostly orthopedic, hips and back and that kind of thing. But in addition to which we used the former delivery room as an operating room and began to do one-day surgery. That probably was one of the first. We did cataracts. We did a variety of different kinds of one-day surgeries. Later on, and this is probably going to be part of the story when we get to the capital finances, we gave that hospital up, turned it over to Greenville County because they needed space for some offices. We gave them that hospital. We were in the process of expansion in other places and we felt we could do that.

I mention William G. Sirrine for two reasons. One is that as a chronic disease hospital it later became defunct when the extended care concept was dropped. In the chronic disease hospital, because they had a delivery room that we made into an operating room, we began to do day surgery long before anybody else was doing it. We weren't smart enough to know that we were on the verge of something that was really going to change the whole business as it has since been proven.

You asked about the centralization of our business office. We ended up, Mr. Weeks, in a situation in which there were no business offices in any of our hospitals. There was an admitting office and there was a cashier. So we admitted people, we got financial information, and if they wanted to pay on the way in or the way out or whatever we had the cashier. Other than that we connected everything through computers to a management services center. That was also a separate facility that was geared to doing all of the billing and collecting and all of that kind of business office activity. It was done by a

computer from wherever we had an institution.

WEEKS:

Did you do this yourself or did you contract.

TOOMEY:

No, we did it ourselves.

WEEKS:

How about finances -- did you have a single account for all?

TOOMEY:

Yes. Even today, all of the receivables in our institutions are owned by the Greenville Hospital System.

WEEKS:

Then you probably had one account and little accounts within the big account. What other types of services did you expand into? I am thinking in terms of walk-in clinics or home care.

TOOMEY:

Let me go down the functional specialties that you run into in management operation: material purchasing, receiving and that kind of thing. On the new campus we built a warehouse and we, like everybody else, began to develop specialists who buy special kinds of things like glassware, silverware, textiles. Then we would contract for large amounts to be sent to us and we would distribute them to our separate institutions out of that centralized warehouse. We had, in that warehouse, space for a pharmacy to do that kind of thing, but the pharmacy never moved out of its location in the hospital because you could contract for all pharmaceuticals — you didn't have to have it shipped and stored. They would make shipments often enough directly to each hospital so you didn't have central stores. But materiel was

centralized. The whole purchasing operation was centralized.

You always would allow for your local groups to have somebody who ran the storeroom and the administrator could buy locally if he needed things. We were not so bureaucratic that -- I would say we were 90% centralized.

WEEKS:

If they needed something special they could buy it.

TOOMEY:

Special and small. It wouldn't be worthwhile taking anybody's time.

We tried centralizing food service. We did centralize our dietary and our special dietary. That became centralized. Public relations is specialized except for volunteer services. There is a volunteer service person at each one of the hospitals. The planning was centralized. You asked about the business office, but the whole financial operation was centralized.

WEEKS:

This is much better I think, in most cases. How did you respond to things that came up such as Medicare coming in in the middle '60s and Medicaid? Did you have to make adjustments? Was this a problem?

TOOMEY:

No, because of another one of the strategies that we developed utilizing our very capable group of management people. Let me tell you what I mean. We agreed as a strategy that we would attempt to put ourselves into positions in which we could effect the major decisions that were being made, nationally as well as on a state level, that would affect us. What that strategy has done is to elect our former chief financial person, Jeff Steinert, to the position of president of the Hospital Financial Management Association, HFMA. He was active in that organization when it was the AAHA. As a matter of fact he took

a leading position in changing the name from the American Association of Hospital Accountants to Hospital Financial Management Association. Jack Skarupa who succeeded me as the president of the Hospital System became chairman of the board of AHA three or four years ago. We have, in three clinical specialties, our peer physicians become part of the examination group toward achievement of specialty. That's in orthopedics and pediatrics and, I believe, in neurosurgery. They either became national chairmen of the specialty group or they became examiners, really decision makers at the clinical level.

At the state level I believe practically all of our associate and assistant administrators were president of the state HFMA or the state hospital association, as well as some of our doctors have been presidents of the state medical association. Two of our nurses have been president of the state nursing association.

My point is simply that we were fortunate in that we were large enough to reach out and find people who were very well qualified. Then, on purpose, we tried to move them into the areas where they could participate in the decision making about things that were important.

As for me, I was on the advisory group in Washington. I was with the heart disease, the regional medical program, heart disease cancer and stroke. I worked with Ed Connors in Washington. I worked with John Gardner and Bill Kissick in the days in which they were a factor in HEW. I spent a lot of time doing that.

WEEKS:

You generated a lot of talent there plus your own talent. It certainly made a great reputation.

I'd like to have you talk about your experience at AHA on the Center of Multihospital Systems. How did that come about?

TOOMEY:

That was really a short exposure. It was rewarding to a degree, but not totally. Not as much as the fulfillment that I got in the management of an operation. First of all let me tell you that under Gail Warden and Alex McMahon was developed the concept of constituency centers. These are a variety of identifiable hospitals like governmental hospitals, like small hospitals, like psychiatric and rehabilitation. The constituency that I represented at AHA was that of a multihospital system and shared services organizations. They represent facets of AHA membership which were lumped together with all of the acute general hospitals. This constituency program was an effort to give each of these different types of institutions the opportunity to come together as specialized groups within AHA and develop programs which AHA would then carry wherever they should be carried. Also to give these specialty hospitals representation within AHA.

So if you have the concept of the constituency center I think my part in it was to come to AHA and point out what I knew before I went there. That was there were no records of where the hospital system were located. As a matter of fact the terminology was even new. Hospital systems were scarcely known by that terminology. Here in Detroit you had Grace and its branch out in another part of Detroit. That really was one of the early hospital systems. Then in Youngstown, Ohio -- incidentally, Dr. Barnett was the guy who ran Grace Hospital and the branch. Bob Bachmeyer ran the System in Youngstown. Youngstown had three hospitals. Greenville was the only other one.

Starting somewhere in the middle sixties I began to invite people who I

knew, either through conversations or through word-of-mouth, were developing something. Like Carl Platou with the Fairview-Southdale which became the Fairview hospital system. A fellow out in California who began to develop the Lutheran system. Steve Morris with the Samaritan system. I guess it was in the late fifties and included people like Joe Terenzio who was the commissioner of hospitals in New York, which was the largest system that I knew about. I invited Karl Klicka to come to these meetings because Karl's first big system was Appalachia although he did put together two or three hospitals up in Minneapolis, St. Barnabas and one or two others. We initially met informally at AHA meetings. I began to put on conferences to help explore the idea -- this was in the early sixties -- the idea of how these could be made more effective. To simply explore something that was going on that nobody could yet identify.

The first time that these systems were looked at on a national level was when Ray Brown, at the very first Duke Forum at which Ray Brown and Billy McCall and I were the program development committee. Do you know the title of that first Duke Forum?

WEEKS:

No.

TOOMEY:

Multihospital systems.

WEEKS:

That's how the word was coined?

TOOMEY:

That was the first national recognition that there was something going on. It is interesting, if you can ever get a copy of it -- the forum was

published -- to find that people like Bob Cadmus and Charlie Frenzel were predicting that it would never be successful, just would never take hold. Anyway, it did, as you know.

When I joined AHA we had absolutely no records. As a matter of fact I remember having a meeting out west some place and Bob Cunningham was at the meeting. I told Bob that I had done an informal poll throughout the country and that I had the only listing of hospital systems and that I was going to review some of that when I was scheduled to speak. Cunningham stayed to listen because he was interested in this development.

The first thing I did with AHA was to begin to develop and publish the first directory of hospital systems. It was not the first directory of shared services because a fellow named Elworth Taylor, who still is at AHA, had been assigned as one of AHA's workers to shared services before I came on board and the first thing Elworth did was develop a directory of shared services organizations. Part of the interesting thing is that in many cases they were one and the same. A place like Sun Health, for instance, was doing contract management for a number of hospitals and had developed a hospital system operation. At the same time they were selling shared services, whether it be purchasing or pharmacy or whatever else. So there were a number of systems that were also selling services to other hospitals. There are a number of shared services organizations that would tell their clients we'll take over the management of your hospital or your department. There was a lot of cross fertilization and cross connection.

My point is that publishing a directory was probably the biggest thing that I did in that AHA activity. I had an office in Greenville for the AHA. Scott Mason was our Washington representative. John Hatfield joined us to

take on the base for the Chicago home office. So we had three offices, Chicago, Washington, Greenville, for that constituency program. We had the two parts; Elworth on what he was doing and Scott Mason, John Hatfield and me for the AHA items.

Through our Washington office we presented each year a major constituency center program. One of these presentations was published with Scott Mason as the editor. I think you will find, if you look up Scott Mason somewhere, that it is an AHA publication of which he was the editor. Our speakers were McNaughton from HCA; we had Alex McMahon from AHA; we had Ed Connors; outstanding people. We had good sessions.

WEEKS:

I think your operation was sort of a showcase. It always appeared to me -- when I first started becoming interested in multihospitals your name was the first one I remember connecting with it.

TOOMEY:

As you know by now I am loquacious. I was sold on the idea. The only regret that I have is that probably for four years we talked about creating our own organization of multihospital systems and for four years I said, "No, we all belong to AHA. Let's not create another one where additional dues and additional offices will be necessary. Let's take advantage of being with AHA." What actually eventually turned out was that VHA was created. AHS, the Associated Hospital Systems, was created, and a variety of others. The Great Plains Group started one, Western started one, and eventually they all had additional dues and offices. We probably should have, at the very front end, created a representative organization. I thought that when we had the constituency center that would take care of it, but it didn't.

WEEKS:

Kellogg spent quite a lot on grants too, didn't they, to some of these hospital systems?

TOOMEY:

They spent a lot on grants to encourage hospitals to work together. That was where Karl Klicka was doing his primary work, with Kellogg. His work was reviewing the effect and the results of the grant funds that your friend Andy Pattullo gave. Karl was doing the follow-up on all of the Kellogg grants that were done by DeVries and Pattullo to get hospitals to work together. So to the extent and to the degree that Kellogg was pushing, and they were, and Karl was following up, they were participants in that sense. Actually what they were doing was to encourage hospitals that were geographically proximate, sometimes not even proximate but in different communities, and attempting to develop the means and mechanisms for them to work together. Whereas the hospital systems were being developed with corporate offices and really running a group of owned or managed hospitals which was different. Basically, it was quite different from what Kellogg was doing.

WEEKS:

It seems to me that the structure was different.

Going back to Greenville for a minute before I forget about it: what did you do with the HMO situation?

TOOMEY:

Really I haven't done anything with it. I am ten years gone since 1978. While the HMO idea goes back to Kaiser a long time, HMO as an operational activity is basically within the last ten years.

WEEKS:

And it is in a very unsettled state. Do they have HMOs in Greenville?

TOOMEY:

Blue Cross has an HMO in the state. There are moves in Greenville to go HMO. Can I take off for a minute? I want to say that it is my opinion that HMOs and hospitals are antithetic toward each other. The hospital, per se, is interested in having people use its facilities. The HMO is interested in reducing the amount of use and in reducing the kind of use. Because of this I think they are going to find themselves not only the antithesis, antithetical, but in conflict. Hospitals, particularly the big hospitals, are interested in specialized care. The HMO and family practitioners are interested in non-specialized care. As a matter of fact family practice says that 80% of the illnesses that are extant in the country can be cared for in the doctor's office. So you have the family practitioner and the specialist who will be in conflict with each other. The specialist says let's go to the hospital, that's where I have my equipment, that's where I can do the best work, that's where I can be more assured of the quality of my work. The family practitioner and the HMO people say don't go into the hospital. We will take care of you out here. It is less expensive. They are in conflict. I believe it is going to take a long time for these conflicts to be resolved.

WEEKS:

Add another element too. The competitive element. Very few of them are making money. In our county, Washtenaw County, we have four HMOs. One is in the black. The rest, including the University of Michigan, are operating in the red. The very fact that if they come to hospitals and say look, give us a better rate and we will send patients to you and fill up some of your empty

beds. But how many hospitals can they do that to before they begin running out of patients? There are going to be a lot of mergers.

TOOMEY:

To the best of my knowledge Greenville is not looking at HMOs, but they are looking at PPOs. When I say Greenville I mean the Greenville Hospital System.

WEEKS:

One thing that impresses me about multihospital systems is that there are so many different kinds of them.

TOOMEY:

Yes, sir. It's an absolute misconception to think that because you have multi-institutional management that their mission is the same and that their organizational structure is the same and that they were created for the same purposes. The course I teach and have taught since 1980 at Duke -- I taught a course in multi-institutional management -- everyone of the systems is different, they are organized differently, they operate differently, their mission is different. Just this year the first two we looked at were John McDaniel and Medlantic, which is a hospital system built up out of the old Washington Hospital Center in Washington, DC. It now extends out into Maryland and Virginia as well as DC. It has a terrific number of subsidiaries. The second speaker was Stan Tuttle from National Healthcare which is a rurally oriented proprietary health care system made up of thirty-five hospitals in Alabama, Kentucky, Georgia and so on. Not only are the voluntary hospitals of Medlantic system and the new one, National Healthcare System run by Stan Tuttle, different in ownership, but also they are different in operation, they are different in concept, they are different in ambition.

One is oriented to a rural area, the other oriented to an urban area. One is for-profit, the other one is not-for-profit. The second group that I brought in -- I am using them in the form of point and counterpoint to make just exactly this point and that is that they are different. I have had George Caldwell from the Lutheran Health Care System in Park Ridge, Illinois. I had Jack Bovender from HCA, Hospital Corporation of America. He is the group director, group president, for nineteen hospitals in the eastern and southeastern area. I invited Bill Himmelsbach from the Holy Cross Health System. Bill is no longer with Holy Cross, but Jim Lane came and spoke on his behalf. The organizational structures are different. Holy Cross is, interestingly, a horizontally integrated system of vertically integrated clusters. The clusters are in eight states across the country. They are in Anderson, Indiana; in South Bend, Indiana; in Columbus, Ohio; Silver Spring, Maryland; in Fresno and Boise. Each one of these markets is now a vertically integrated system with short-term and long-term care all administered under a single management service. They are clustered around those big markets. That is entirely different from HCA which is a just plain old horizontally integrated hospital system. It is different from what Caldwell has which is a religiously directed, vertically integrated hospital system for Chicago.

You take this horizontally integrated Holy Cross system which is made up of a dozen vertically integrated clusters and it is so different from Bovender at HCA which is nothing but a string of hospitals. Both Holy Cross and Caldwell can affect the delivery of clinical services in their area. HCA cannot affect it because they are covering statewide services. As a system all they can do is say, "We run these hospitals." They can provide administrative services in a way in which you can get economies of scale, but

you can't do a doggone thing from the point of view of centralized clinical services. Incidentally, they knew this. That is why back about five or ten years ago they started to buy the tertiary care hospitals so that they could then begin to cluster small hospitals around the big hospital and begin to get referrals back and forth. They were still limiting themselves to acute care as opposed to what the hospitals today do which is rehabilitation and psychiatry and alcohol and drug abuse. Caldwell even has a program in which he puts a nurse in the various Lutheran parishes, puts her there physically and that is where she provides services. This is marketing. Anybody that needs to go to a hospital after the nurse has seen them they want to go to one of the Lutheran hospitals.

So there is a big difference. I'm glad you brought it up because hospital systems vary as greatly as the old hospitals used to vary.

WEEKS:

Just as an example, I listened to some of the characteristics. There were multiple owners in some cases, consortiums in some cases, management contracts, leases, single ownership both centralized and decentralized.

TOOMEY:

I can give you another one, condominium. You take over in Louisville, the Norton and Childrens Hospital, a children's hospital. It is a condominium. The same way up in Minneapolis. You've got the St. Barnabas Hospital on one corner, the county hospital across the street, as far as their beds are concerned. But they have put together a central core of clinical, diagnostic and therapeutic services. So you have two owners of the bed towers and you have a common ownership for the diagnostic and treatment services. This is simply a condominium.

WEEKS:

You have answered one of my questions because I have run across horizontal versus vertical and I couldn't see but what it could be both. As you have explained, it is.

Going back to the big question: why are we doing this? Is it because we can save money?

TOOMEY:

I think it started out -- I know it did with me -- it started out because you could save money by sharing some of the administrative and functional managing-type services like purchasing and public relations, like marketing, like planning, like just plain management. You could bring some of the benefits of the large hospitals, food services and sometimes social services, you could do a lot to help in sharing. That was the Kellogg point, too, incidentally. You could do a lot by sharing and you could do it at a less expense. I think it would be safe for me to say that it has been found, in addition, to begin to lend itself to clinical types of sharing. This goes back to the heart disease, cancer and stroke kinds of things where you set up a stroke center or diabetic center or heart center. Then you begin to move patients in and out from that. Then they go back to individual hospitals.

It also lends itself to educational effort in the clinical area. I think what has happened is that it started out promoting economies of scale. As we began to get into it further and further, it also allowed for other kinds of economies beyond the financial and the scale. That is the area that really is being exploited now, Mr. Weeks. I feel that we are just beginning to get on the edge of regional and local systems devoted to clinical care.

Maybe somebody else will say it to you but we have been through a period

when prices were flexible but quality was constant. Quality was relatively constant. That is, we thought it was constant. The difference really was where you had the prices flexible for the same quality. I think we are getting into a system now where prices are fixed and constant, through DRGs and whatever, but quality will be flexible. That's where, I believe, the systems are going to be able to make a very rational contribution to keep from getting into a real variation to the quality of care.

WEEKS:

This has been one of the big arguments that has been brought up against HMOs, this question of whether quality of care can be maintained or even increased or bettered. When you were explaining about the HMO's operation through the family practitioner, the gatekeeper, it almost seems that we might be denying the patient some of the sophisticated care, the expensive care.

TOOMEY:

I don't think there is any question that you are. It gets to be a policy question on the part of consumers. Consumers are not organized to resolve policy questions. Do you want to have a voice in the kind of care that you might elect to have? It used to be that the only election we had was whether you would go in a one-bed or two-bed or four-bed or whatever else. You had that social question, but you always assumed that the quality was the same. Now we are getting to the point where there is going to be a recognition that quality is not always the same. But I don't know yet what quality is.

WEEKS:

This is the bad thing. We haven't been able to measure it or describe it or define it. Do you know Avedis Donabedian?

TOOMEY:

Yes, of course.

WEEKS:

Well he has spent most of his life trying to define the quality of care. I don't know if Avedis has come up with the answer yet. These things are so questionable that it may force changes. I often ask people: what is coming after HMOs? What is coming after DRGs, because we are not going to stay with them forever.

TOOMEY:

No. If there is one constant it is change.

WEEKS:

That's a good expression. Or "this too shall pass."

Have you found that your system operation has helped -- you were talking about the people you were able to hire -- your manpower needs?

TOOMEY:

Yes.

WEEKS:

It has helped a great deal, the fact that you have the reputation, the facilities?

TOOMEY:

Yes.

WEEKS:

Your specialists will go out on consultations to the other...

TOOMEY:

Yes, to the other satellites. Sometimes they will even do rounds. The other thing that has happened is that as the satellites have taken hold in the

community and become literally part of the community, even in the smaller hospitals you will find OB/GYN specialists, you will find urologists, orthopedists. They come to Greenville first, they get exposed to these other hospitals and say, "Hey, it's not so bad out there. I think I'll go move out there and move my practice." They do very well.

WEEKS:

Mr. Welch was telling me that one of the things they found that was quite effective in getting referrals was that they would send their specialists out to the hospitals and hold an educational program, maybe a heart man would show doctors how to put in a pacemaker, or how to repair one, or how to replace one. Then when the time came for repair or replacement they might be able to do it right in that satellite which made them feel good. They could refer but yet there was a referral back also. This has been the big weakness of most regionalized plans. We found that out in Michigan.

Did you find any barriers such as anti-trust laws? I heard you say you were a 501(c)3 so you have evidently got the IRS satisfied.

TOOMEY:

I think there will be problems of unrelated business income as hospitals create for-profit subsidiaries. I don't think there is any question that that is going to be — and it already is — a hot issue.

WEEKS:

Oh, yes. If they have office buildings or they have ambulance services or whatever, or operate a lot of real estate of different kinds. I haven't been to Nashville in three or four years but I notice that HCA is attempting to buy academic health centers like the university health center. Didn't they get the one in Jackson, Mississippi?

TOOMEY:

Yes, they backed off that though.

WEEKS:

Did they?

TOOMEY:

Yes. What they have just done is take a hundred of their less profitable institutions and sold them to their employees.

WEEKS:

I was reading that. I also read that part of that finance was coming from pension funds. I hope that everything works out well for the people whose pensions are in there.

One thing that I have come across in talking about HMOs and other types of delivery systems such as that is the question: where can they find the executives to run these things? It reminds me of the old Blue Cross days when anybody could start a Blue Cross if he was a good salesman. Most of them didn't have much experience.

TOOMEY:

It will take time. However, they will start out with people who have been trained in hospital management and they at least know the language. There will be a certain percentage of them that will make it and an equal percentage, probably, who will drop out.

WEEKS:

What do you see down the road after HMOs?

TOOMEY:

I don't know. Let me put it this way. I don't think HMOs are going to be successful. That's a flat-out statement. If they are, it will be after my

time.

WEEKS:

I've been wondering. Kaiser-Permanente is spreading out a little bit. I was wondering if somebody like that could build a national system. They've got quite a few locations now.

TOOMEY:

It would not be a national system. What it would be would be a national corporation with local "manufacturing" plants.

WEEKS:

Almost like a franchise deal.

TOOMEY:

It would be like a General Motors that builds Buicks in one place and Chevrolets in another place. Maybe that isn't a good example because there is a certain degree of interchangability in General Motors. The interchangability in a Kaiser program would not be in the equipment being used and it would not be in their clientele. It would be in the provider, the doctor. You could move the doctor from the West Coast to the East Coast, but that's about all.

WEEKS:

What do you see as far as fee-for-service disappearing? Do you think that physicians are going to be willing to work for big organizations on a salary basis?

TOOMEY:

No. I do not. OK?

WEEKS:

That's a good way to state it.

TOOMEY:

Once again, let me tell you conditions do change. I've watched the physicians in emergency medicine gradually coming into being and they are accepting a salary. But the salary they accept is beginning to challenge that of the radiologists and the pathologists. In other words, to get a clinician to see a variety of patients and to begin to make decisions about that patient you are going to have to pay rather large sums of money -- to get a clinician. Now, you may be able to get something else.

WEEKS:

Most of the emergency room people, at least in smaller hospitals, have been catch as catch can. It probably isn't too good.

TOOMEY:

We are paying, in some places in the South that I know of, $50 to $75 an hour. That, on a 2,000 hour year, is $100,000 to $150,000. That's what it costs.

WEEKS:

Some of the other men who used to be hired by hospitals, such as the radiologists and the anesthesiologists and so on, some of them today are making much more than that, aren't they?

TOOMEY:

Yes. I believe that to be so but I do not know.

WEEKS:

And the patient is suffering, the insurance company is suffering.

TOOMEY:

You say the patient and the insurance company are suffering. I would tell you that we are no longer looking at three parties. You are looking at

four parties that are involved. I'll give you the four: the patient, the provider, the financing mechanism, and the payer. The payer is usually business and industry in the private sector and government in the public sector. All the insurance industry has ever done is to make a determination as to how much government or the private sector business and industry should pay. Then they have handled the financial administrative activities. There are now third party administrators who allow the industry to be self-insured. What they do is they keep track of who uses what and how much so that they will then tell the business and the industry, "It costs you this much when you pay that provider." So you are by-passing the insurance company. You now have what I call the first party, the second party, no more third party -- I call it the financing mechanism only, an administrative mechanism designed to handle the finances, and the fourth party is the payer. The payer is business and industry in the private sector and government in the public sector.

WEEKS:

A lead in on this question. What is going to happen on mandatory insurance or national health insurance? We are getting a lot of talk about this again.

TOOMEY:

It is my belief that business and industry will develop, through its coalitions, policy mechanisms and they will develop mechanisms that will allow for the policy to be administered. Just the way that government establishes its policy at the legislative section and they have an executive branch to carry it out. I think you will find that business and industry will be looking for a similar mechanism which will simply use the administrative mechanism that we used to call a third party to allow for those funds to be

handled. I do not believe that they will look to government to handle that.

WEEKS:

Looking at a wide picture here, competing against Japan -- we are paying several times the wages that they pay -- the cost of fringe benefits is becoming so great and so noticeable. When are we going to get a revolt by the fourth party?

TOOMEY:

Government is in constant state of revolt. They call it ratcheting down. They continually ratchet down. Business and industry, which is not organized to do this, is finding the mechanism through the coalitions and they will begin to ratchet down. Their mechanism for ratcheting down will be a variety of mechanisms. The most prominent will be called "Managed Care."

WEEKS:

The unions feel greatly threatened now.

TOOMEY:

That's why the unions, at least so far, many of the unions are parts of the coalition. It puts the fourth party and the first party together. The other thing that the fourth party is doing -- John Deere has done it, R.J. Reynolds has done it -- as well as providing the self insurance, they will provide the service. I don't expect that will take hold, but that is another ratcheting down, if you will, and another mechanism. My point is the fourth party, both in the public sector and in the private sector, are looking for ways in which they can develop economies which will make it cost less. Part of it is competitive. That's the PPO. If I were a hospital administrator today the first thing I would do was get a sales department. I would go out and sell services for my doctors and the hospital. I think that that is one

of the things that you will see. The hospitals will begin to compete on price through their salesmen and through the PPO and give you volume discounts. That's the ratcheting down in the fourth party.

WEEKS:

Depending on how it's financed would mean some question about how these services are delivered. Here again quality becomes a question.

TOOMEY:

To show you how volatile this four party concept is: I have already told you that the second party, the hospitals and the doctors -- if you look at Henry Ford where they got together. I can show you where Gail Warden's operation out on the West Coast, the Puget Sound Cooperative, is a consumer -- the first party, deciding that it would get involved in the provision of services. I can show you where insurance companies, Blue Cross, Aetna and some of the other insurance companies are developing HMOs so that they can provide care. So, you find first party, second party and fourth party already working toward providing the service. It is all designed around looking for the most effective mechanism.

So you say, "When will it happen?" My response to you is that it is in the process of happening. The only thing is that they haven't yet come up with that which is the best.

WEEKS:

This is going to be an interesting ten years ahead of us, to see how these things all work out.

I would like to ask you about your consulting companies. You said that after you left the Greenville system you started doing consulting work.

TOOMEY:

Immediately I went to AHA.

WEEKS:

That's when you went to AHA.

TOOMEY:

Then after about two or three years with AHA I opened my own consulting firm called the Toomey Company. Other than the fact that I did a lot of strategic planning for other companies and developed a fourteen hospital consortium in Westchester County, New York, I don't think I did anything that was marvelously different from anybody else in consulting.

WEEKS:

This is an interesting question though. We were talking a few minutes ago about the different kinds of ownership of systems. This consortium of fourteen hospitals, each maintained its own ownership?

TOOMEY:

Yes. This really was a kind of association although we called it a consortium. It still exists and it is still part of an association. It was made up of all of the hospitals in Westchester County. They were beginning to feel the breath of competition. They were beginning to feel that it would be desirable for these individual hospitals from individual communities to work more closely together. They hired me to come on board and to find ways in which to do it. I did get them together. I hired a staff. Then I left. I put it together and I left. They are operating now.

WEEKS:

What do they do together as a consortium?

TOOMEY:

I don't know right now. I know they do educational programs. I know that they have joined with the Northern Westchester Association, I think it is, and that's an organization that does purchasing and the kind of things an association does. They represent the fourteen hospitals in Albany. They watch out and they do public relations for the hospitals. They probably get involved in some politics.

WEEKS:

That was sort of a strength in numbers idea.

TOOMEY:

That's what it would be more than anything else.

WEEKS:

So they could be flexible enough to act together...

TOOMEY:

The other thing is staying apprised of what each one is doing within that confined county.

WEEKS:

Did they exchange talent or do anything of that kind?

TOOMEY:

That's one of the things that they were looking at. That is, where in the area of personnel operation can they be of help to each other?

WEEKS:

How did the medical staff enter into this?

TOOMEY:

Each individual hospital operated with its own medical staff and the medical staff was not pulled together.

WEEKS:

I was wondering if they had some kind of organization where they would meet together on occasion. That was the Toomey Company?

TOOMEY:

That was the Toomey Company, Incorporated.

WEEKS:

The Medical Corporation Health Systems, is that the one you called Medcorp?

TOOMEY:

Yes. That was a very, very interesting organization. The public hospital in Richland County, Columbia, South Carolina, is the largest hospital in Columbia. They, as a governmental operation, cannot participate in joint ventures, cannot participate in proprietary activity. They are government -- enough said. There are some legal reasons. There was created and there was extant, in Columbia, a Richland Memorial Medical Center Foundation. The foundation was an independent foundation which was created to serve the needs of Richland County, the government hospital, to do things that the hospital couldn't do and to raise funds voluntarily so that the hospital could have a source of funds other than through the county council or through their own services to patients.

This foundation in effect said, "Why don't we develop some businesses? If the businesses are successful, the income from those businesses can be used to benefit the Richland Hospital so that we will not only raise money from voluntary gifts but we will raise money from businesses that we initiate. So they created the Medcorp Health Systems, Inc. They incorporated and funded, with some early on capital, an organization that could do joint ventures with

doctors, that could start businesses on their own. These businesses — there are about eight or nine different businesses that they have gotten into -- these can create income which will be used to fund projects or give gifts to Richland. So if you would like to put it in another sense, it is a voluntary, eleemosynary foundation creating a proprietary business operation to benefit a governmental hospital. It is a very, very fascinating use of these three different ownerships to bring them together.

They hired me as the first president of the Medcorp Health Systems Corporation. I worked at it for two or two and a half years. In that period of time we have a billing operation. We do billing for doctors and for anesthesiologists. We do billing for anybody who wants billing. We also started two urgent care centers, an imaging center, a treatment center that is called the Hyperbaric Oxygen (HBO) Center. There are others.

We will contract with individual hospitals to provide the emergency services for them. We will initially provide the emergency physician, then secondly, if they want us to, we will take over and run their emergency rooms, all the administrative aspects. At the present time the operation is a positive one. It is $100,000 in the black this past year. It probably will go up from that. So the idea has been successful in its implementation.

There is no question we pay taxes. No matter what we are in we are a proprietary, investor-owned operation. The investor, of course, being the foundation.

WEEKS:

This must have been a great delight for the attorneys just to set it up.

TOOMEY:

It was. It was a great learning experience for me because I found that

running a hospital necessitates a lot of balancing the needs and the desires and the wishes and the aspirations and the prejudices of the people you work with, employees, doctors, the community. You had to balance them and compromise them and work with them. When you run a business you don't balance anything except the books. And you don't compromise anything unless there is some overriding reason. You do what is right, and you insist on doing what is right, and that's it. If somebody else doesn't like it that's his tough luck. It requires an entirely different mind set from what I had as a hospital operator. It was initially very difficult for me, but as time went on I became more and more proficient at it.

WEEKS:

Is this the project in which your son was associated?

TOOMEY:

No. My son was associated with me in the Toomey Company. At one time I probably had a half a dozen people working for me, clerical and other planners.

WEEKS:

What is your third? You said you had three.

TOOMEY:

The Duke one. I am still teaching.

WEEKS:

That keeps you busy then.

TOOMEY:

Yes.

WEEKS:

It keeps you up-to-date too.

I made a list of some of the things you are doing. One thing, I was surprised at how many schools at which you have been a lecturer or professor.

TOOMEY:

That is something I am proud of. There for a while in my last ten to fifteen years in Greenville I was constantly on the road talking to a variety of students. I've talked to your group at Michigan several times. Zuckerman and Steve Loebs are colleagues of mine.

WEEKS:

I'll read the schools to you and see if you want to add anything. Columbia, of course. You were on the faculty at Clemson. Cornell; you helped establish some kind of program at Cornell, didn't you?

TOOMEY:

No, I don't think I want to take any credit for that. The Sloan Foundation started the program and it was called the Sloan School of Hospital Administration. My oldest son attended that school. That school was one of the early schools to be located in the school of business, and depending on the courses that you took you could get an M.B.A. or you could get an M.H.A. My son took not only the M.H.A., but he had enough M.B.A. so that he chose the degree of M.B.A. That's my oldest son.

WEEKS:

I didn't know you had two sons.

TOOMEY:

The only other thing I had to do with Cornell was a constant member in the summer of their summer session. It used to be HADP, now it is HEDP. Doug Brown, Roger Battistella and Teddy Chester from England were the guys who put that together.

WEEKS:

Is Battistella still there?

TOOMEY:

Yes, to the best of my knowledge. He is, I believe, tenured.

WEEKS:

Wasn't he a Michigan graduate?

TOOMEY:

I believe so.

WEEKS:

Then I also have you down for Northwestern and Ohio State.

TOOMEY:

Northwestern was particularly true when Monty Brown was running the program and Ray Brown.

WEEKS:

I didn't realize Monty Brown had run it. He has been in many things, hasn't he?

TOOMEY:

Yes, he has.

WEEKS:

I like him. He got his law degree, didn't he?

TOOMEY:

Yes.

WEEKS:

I haven't seen him since then. His wife is still active, I guess, in the field. I like her too.

Somewhere I ran across a note something about a medical school for

Greenville. Did you work on that project?

TOOMEY:

Yes. I worked on it for Greenville and used Tony Rourke as the advisor and consultant on that, but eventually, the other thing that you might have run across is that under Governor John West I was given a leave of absence from the Greenville System to go to Columbia to work with West on the development of the second medical school in the state of South Carolina. The second medical school was initiated in Columbia. The first one is down in Charleston and is one of those few freestanding medical schools, and always has been. The second medical school is a school within the University of South Carolina which is located in Columbia and which uses Richland as its teaching hospital. I was Governor West's personal assistant through the determination of the need and the desirability and the political appropriateness of the second medical school.

WEEKS:

It's very hard to fight the state capitol, isn't it?

TOOMEY:

Oh, yes. I tried. That is one of the reasons you don't see more about it, because in my report I said that we don't need a second medical school in South Carolina. The governor said, "Well, maybe we don't need one, but I want it." Naturally he won. Logic does not always prevail.

WEEKS:

No, no. You can't really fight city hall, as they used to say.

TOOMEY:

I felt it got to a question of honesty and principles. Every way I looked at I could see that they needed a change, they needed to bring the

medical school in Charleston under a university umbrella. I also had some recommendations as to using other really first class hospitals and universities like Clemson as the first two years in the new program designed to create a medical school system. The system would embrace two years at Clemson, or two years at the University of South Carolina and then into the medical university and through the state for clinical training. Such a system would use Greenville, Richland and the hospitals in Charleston for the clinical training. It would have been administratively more difficult to do, but it would have taken advantage of Clemson which was a first class university. It would have taken advantage of some of the resources of the state. It would have taken a capable administrator to pull it all together, but it is a lot less expensive to get a capable administrator than it is to build another medical school.

WEEKS:

You were just fighting a losing battle.

I have quite a few little notations here of work that you have done on the Governor's committees. The one that interested me most, and I would like to talk with you a bit about it, is nursing. I see you were on a committee for nursing and that you have been active in the National League for Nursing. Have you expressed any opinions on nurses' education and what it should be?

TOOMEY:

Once again within the state itself. When Senator Hollings was governor of the state he became interested, and the state became interested, in developing a system of technical education. These are basically junior college two-year schools and basically designed for vocational purposes as opposed to liberal arts college programs. At the same time hospitals were

finding it increasingly difficult to gather together the resources necessary to have three-year accredited hospital schools of nursing diploma programs. We were beginning to lose accreditation of the hospital schools. We were beginning to turn out three-year graduates who were unable to successfully pass the licensing examinations. So I became involved, once again with Governor West -- it was after Hollings -- and with Governor Russell as a matter of fact — in the development of four-year schools. The first one was at Clemson. That's a four-year school of nursing. It is a degree granting program. They had a four-year program at the University of South Carolina at Columbia, but they had no graduate program. We recommended a graduate program there at the University of South Carolina.

Those two recommendations were agreed to. At the same time we recommended that there be established two-year programs for nurses in the technical schools. There are three or four in the state now that have accredited programs in the technical college. They are turning out an equivalent number to what we used to have with our three-year diploma programs, or more. They are doing well on their licensing examinations. At least they were the last time I was involved. I really can't tell you right today how they are doing. Those were things that we did in the state of South Carolina which created for us an opportunity to continue to provide at least a reasonable quality of RNs at the technical school level and a high level of capability at Clemson and in the four-year degree granting program and at the University of South Carolina with a master's and a Ph.D. program.

WEEKS:

I don't know whether you mentioned it or not but do you have any hospital schools anymore?

TOOMEY:

There is one left.

WEEKS:

One thing that has been coming up many times in these talks is the nurse's role or her self-respect estimate, her professional competence reputation.

TOOMEY:

Probably I am going to do the same thing everybody else does. We have opinions. I don't have any knowledge, I have opinions.

WEEKS:

This, in itself, is valuable.

TOOMEY:

It is my opinion that the nurse is the most exploited and least appreciated person in the hospital operation in terms of their contributions to the clinical care of patients. She is exploited, she is pushed around. They are not given the kind of consideration and honor that I think they should get. I have tried to make some suggestions as to treating them differently. What I have suggested that they do is to become private practicing nurses just like private practicing physicians. That they work with the doctor and each patient will choose his RN. That RN will then work with the doctor in planning the treatment program and in doing what nurses do of a professional nature. Then the people the hospital has working will be those people who do the baths, keep the temperature, pulse and respiration. The kinds of things that you don't need a professional nurse for. The nurse can go on a fee-for-service arrangement. You don't need a professional nurse at the bedside twenty-four hours a day. But each patient needs the kind of

nursing care he needs. It will be up to the doctor and the private practicing nurse to see that he gets it.

WEEKS:

Do you think the doctors could accept this idea?

TOOMEY:

If it gives him the kind of care that he wants for his patient he will. I don't think they would feel professionally threatened because the nurse does what a nurse does. What a nurse does a doctor doesn't do.

WEEKS:

So many of the nurses that I have talked with, from the top down, hope that the day will come when the doctor will say, "This is a case of so-and-so, nurse. You know what to do and how to give this patient nursing care. I turn this patient over to you."

TOOMEY:

You've got to do more than that. When I say you've got to do more than that I am a firm believer that if you don't hitch that change to money it's not going to happen.

WEEKS:

I can understand that, both ways, both parties. How about nurse midwives? Are they an item in South Carolina?

TOOMEY:

No, not really. I know of only one birthing center in South Carolina and I know that they use nurse midwives. I know that there are some hospitals that have nurse midwives but that is mostly for the care of hospital-sponsored patients as opposed to private patients.

WEEKS:

I can see how that would work out. Did I ask you if you have licensed practical nurses?

TOOMEY:

Yes, we have LPNs.

WEEKS:

They can take a big share of the work at the bedside.

TOOMEY:

They also are trained at the technical schools, one year.

WEEKS:

That's as it is in Michigan.

I see that you worked on the Governor's Task Force on Health Care Financing. Did you come up with any conclusions that would be good to share with others.

TOOMEY:

South Carolina is one state in which they have increased the amount of money for care of Medicaid patients and they have set up an organizational entity out of the governor's office to provide funds for the Medicaid patient. I'm sorry I can't give you the details but I could get it for you. The other thing that I was most interested in was that organizationally I felt that you could create an HMO for poor people. You know how many there are and you know who they are, because you have to enroll in Medicaid in order to be eligible to get any benefits. So you have the enrollment feature. Secondly, you could work out a system, it seems to me, of a panel of doctors that would take care of these patients in the various communities through the state. Third is you know ahead of time how much money you have so you know what you can pay for,

how many days you can pay in the hospital, and, most particularly if it really is an HMO, you reduce admissions, secondly you reduce days. That's what an HMO does. So by having that HMO and that panel of doctors and those patient clients registered with them, you have the beginnings of a system of care which is designed to keep them out of the hospital. Then if you want to go further, it is entirely feasible -- it's been done, I just haven't done it -- to take the DRGs and to make a determination for every hospital the number of days of care for primary care that you need versus days of care for secondary and tertiary so you actually can budget for primary care outside the hospital, secondary and tertiary care in the hospital. The last part of my proposal in this has to do with something like the VA. The Veterans Administration hospitals are all created, developed and operated on the campuses of a university and teaching hospital. Part of my proposal simply was that the four, maybe five, hospitals that do residency training programs in the state of South Carolina would be the locus for the HMO for poor people so you could begin to integrate your residency into the whole program. But you would do it within the context of a teaching hospital rather than willy-nilly through any hospital and any doctor.

WEEKS:

This would be a separate HMO?

TOOMEY:

Yes.

WEEKS:

Some of the HMOs have accepted a few Medicaid and Medicare patients, haven't they?

TOOMEY:

The only one I know of that has tried what I am talking about is in Chicago.

WEEKS:

What you are talking about is much more extensive than what some of them are doing.

TOOMEY:

It is an organized approach to the care of poor people, utilizing the premise of an HMO and a panel of approved physicians, family practitioners and participating hospitals.

WEEKS:

This would eliminate some of the things that are evils of Medicaid such as going to four or five doctors and getting medication prescriptions and that kind of thing.

TOOMEY:

I think so. It would also reduce the days of care in the hospital -- until you control that there is nothing you can do about the hospital expense. Basically it is an organizational problem for the care of a segment of the population and I made a proposal that I felt would be suitable.

WEEKS:

It wasn't put into practice?

TOOMEY:

No.

WEEKS:

That is the unfortunate thing about it.

TOOMEY:

Managerial sophistication is necessary. What everybody is looking for is more money and a quick fix. So you come up and tell them there are other ways of doing it...

WEEKS:

That's the unfortunate part of it.

I see you are listed as part of the Greenville Community Council. Was this part of your general...

TOOMEY:

Participation in their activities.

WEEKS:

The Greenville County Health Planning Council. Did this change before or after the system was founded?

TOOMEY:

Greenville County Health Planning Council is an offshoot of the state comprehensive health planning agency... Actually, it doesn't show any place but the Greenville Hospital System -- talk about having to gamble -- when the Appalachian Regional Commission was established we were part of that geographic region of the Appalachian Mountains. There are six counties in northwestern South Carolina. Under the ARC, Appalachian Regional Commission, I gave the initial funding out of Greenville Hospital System for starting a planning agency. That planning agency was later folded into the Comprehensive Health Planning Agency, either that or vice-versa. In any event, a chap named Bob Johnson and Jim Keasler ran it. They were the staff, but I was always a member of the council. The council was later used to do the initial CON development and CON review. It is just a community health planning agency.

I am proud of the fact that I was instrumental in the development of the Appalachian Regional Commission's health planning section. As a matter of fact I was on the ARC commission in Washington, Appalachian Regional Commission. I was part of that commission and on their health planning section.

WEEKS:

I see a couple of terms here that I am not familiar with. One is Hospital Research and Development Institute.

TOOMEY:

HRDI?

WEEKS:

Is that local?

TOOMEY:

No. That is the forerunner of VHA. It still exists.

WEEKS:

I didn't realize that. VHA in itself, were you a member of that?

TOOMEY:

No. I was a member of HRDI. I dropped out. HRDI was designed by Dick Loughery from Washington Hospital Center. Don Carner from Memorial Hospital at Long Beach, CA and Mac McLin from Community Hospital in Indianapolis, Don Cordes from Iowa Methodist, and Pat Groner from Pensecola. The initial group was called the Group for Hospital Efficiency. That then became Hospital Research and Development Institute. The Institute then sold services to those businesses and industries that were interested in the development of new articles for care that they wanted the hospitals to buy. The clients were Eli Lilly and American Hospital Supply and other similar organizations. They all

had items of equipment that they wanted to check out and they had no places to provide the product research.

WEEKS:

That's where the research came in?

TOOMEY:

Yes. So, what this group of hospitals, including me, said we would let them try their products in the surgery, try it in the pharmacy, try it wherever it might be desirable. We would keep track of it then they would pay us for it. Well, they paid HRDI, but HRDI did not pay the hospital. I felt that was basically unethical, so I dropped out of the group. I got out of that business of using my hospital to prove the desirability of new items coming on the market. Pat Groner, for instance, gave all of his income back to the hospital. There was another guy from out in Las Vegas that was part of this group. The newspapers picked up what he was doing and they gave him a bad time. I didn't want to go through that. HRDI still exists. It brought on people like Zack Thomas and Terenzio and Stan Nelson and a whole group of really terrifically outstanding folks. Then they began to get into doing other things. They put on a yearly seminar for the business people in the health field. They say you come and listen to us and pay us so much money and we will tell you what is going to happen, so you then can adjust your businesses and industries to things we are telling you.

WEEKS:

That has become a big business, hasn't it, seminars in exotic places?

There is another one, Hospital Bureau Incorporated.

TOOMEY:

There used to be a place in New York that existed from the time that I

was starting in the business in the late '40s. They would do group purchasing. What you would get back would be credit. It was like a co-op. You would get credit for your next year. You hopefully got a better price, but you would get credit for what you bought from them. It finally folded about 1980. It probably had a good forty years. It was never able to adjust to the changes in the configuration of the industry.

WEEKS:

You said something a few minutes ago about your being a member of the board of Holy Cross. One thing I neglected to ask you: how many institutions do they have in their group?

TOOMEY:

They have ten major hospitals. Now they have a variety of long-term care and ambulatory care and other businesses that are located in each community, but there are ten acute care hospitals.

WEEKS:

You have been president of your state hospital association a couple of times and trustee for a number of years. What is the Board of Health and Hospitals Advisory Council?

TOOMEY:

I don't know where you got that.

WEEKS:

You have been in several of these state organizations. You mentioned the Heart Association.

TOOMEY:

Oh listen, at one point I belonged to everything. It wasn't that I am a joiner it was the fact that I ran a hospital that was involved in one way or

another in a tremendous variety of activities. I always felt an obligation to represent the hospital to these organizations that were important to us and we were important to them.

WEEKS:

If you were a member of it then you should have some representation.

I see another term that I am not familiar with, Technical Education Center.

TOOMEY:

That is the technical education center that I was talking about, Greenville Tech.

WEEKS:

After I came to it I assumed it must be. I also wanted to ask you about the VA Scholars Program.

TOOMEY:

That was another thing of which I was proud but I think in terms of the budgetary activities it has been eliminated. The VA used to choose, out of its Washington operation, a group of young people and would allow them to go to school and work at the VA, some job within the health field, within VA in Washington. This scholars thing was initially choosing them, secondly meeting periodically with them and advising them and third, monitoring their activities while they were involved in this scholarship. It was a total scholarship including a cost of living and the whole bit.

WEEKS:

I wondered if it was any part, connected in any way with George Bugbee's forum. Do you remember when he had the VA forum?

TOOMEY:

No, it was not. There was a fellow named Dr. Jack Chase who was the medical director for the Veterans Administration. This program, when I was involved, was being directed out of his office as medical director of the VA at the time that I was part of the program.

WEEKS:

Did you know or meet Al Gavazzi when you were interested in the VA at all?

TOOMEY:

I'm sure I did because I know the name.

WEEKS:

He was at one time number two man on the hospital side of the Washington administration. As I understood it they were parallel authorities. There was the medical authority and there was the hospital authority. They didn't always agree, as you might expect. Al is now retired. I enjoyed a talk with him a few months ago.

I think we should say something about the honors that you have received. You have your LLD from Clemson. You received the AHA Award of Honor which is a pretty good thing to have.

TOOMEY:

That for work that was done... Are you familiar with the Perloff Committee?

WEEKS:

Yes, I talked with Perloff just before he died.

TOOMEY:

That was awarded for work that I did with Perloff.

WEEKS:

Oh, you served on that committee? Then you worked with Ed Connors there too, didn't you? What do you think of that idea?

TOOMEY:

I thought it was terrific.

WEEKS:

The corporations...

TOOMEY:

It was to be a health care corporation.

WEEKS:

And you retained competition.

TOOMEY:

Yes.

WEEKS:

They were, in a sense, community based.

TOOMEY:

Yes.

WEEKS:

I wonder why it didn't take off. Maybe the ideas were too good.

TOOMEY:

Have you ever read it?

WEEKS:

Yes, I have. That yellow booklet.

TOOMEY:

Ed was one of the primary writers of that.

WEEKS:

It's going to be interesting to see what he does as chairman, isn't it? I dropped him a note of congratulations. He answered and said that he was looking forward to it and that he was going to depend on his colleagues to help him out. This is Ed, of course.

The Columbia University Distinguished Alumnus Award.

TOOMEY:

I got two of them. I got one from the Program in Hospital Administration and one from the School of Public Health. When I did that resume it was before I got the School of Public Health award.

WEEKS:

You also got the South Carolina Hospital Association Distinguished Service Award, didn't you?

You have had quite a career.

TOOMEY:

I got one from Duke also. The Duke University National Honorary Award. I have been very fortunate because, many of them are local. I received a Service to Mankind Award.

WEEKS:

I don't see how you can avoid it.

TOOMEY:

When you are in a leadership position there are people out there who are being lead who, if they approve of where you are going, they will let you know.

WEEKS:

That's nice.

Have you been active in the American College?

TOOMEY:

Yes. I was a member of the House of Delegates. I chose, because there were so many things going on in my life that what I felt I had to do was to choose between serving the hospital and AHA or to serve the administrators and their needs. Frankly, I got a bigger kick out of working with the hospital and the AHA than I did out of ACHE. So I chose to go in that direction. While I think I was the state representative for ACHE for years, but I really was never terribly involved in it.

WEEKS:

Until Dick Stull and Stu Wesbury got into it. They have sort of cut things up.

TOOMEY:

They did. Dick was a close friend of mine. Dick was a Duke alumnus.

WEEKS:

That's right he was.

TOOMEY:

Before he died we had two years of team teaching.

WEEKS:

You knew that he was one of the first in the program of on-the-job training.

TOOMEY:

At Duke, oh yes.

As a matter of fact I go back even a little bit further than that. Dick had a football scholarship to Duke.

WEEKS:

He was injured, wasn't he?

This has been a very interesting discussion. Thank you for coming.

Interview with Robert Toomey

November 4, 1987

Hilton Hotel, Detroit Metro Airport

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