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## Transcribed Speech of David L. Woodrum

David L. Woodrum  
*Resurge Hospitals*

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## Transcribed Speech of David L. Woodrum

MR. WOODRUM: I want to [discuss] the same subject but from a different perspective and that's a report from the field.

Now, the whole business of physicians and hospitals getting together to work really comes from, or is driven by, the reimbursement system. We find today that the physicians, basically, are in the same position in terms of reimbursement that the hospitals are [in].

When DRGs [(Diagnostic Related Groupings)] were introduced [on] October 1, 1983, hospitals' incentives changed from [a] cost-based to a fixed-based system. [W]e knew from about 1979 that this, a fixed payment system, was coming. We didn't know the type, we didn't know when, but we started devising strategies, and the strategies were in three parts. One was you had to reduce cost. [W]e found out in doing that that the hospitals started doing right-sizing and down-sizing. [Do] you remember all those exercises? [W]e start[ed] talking about developing standardization committees with the medical staff so [that] we could standardize what equipment we [were to] use and what supplies and instruments.

[F]rom that, we also got into some really interesting sorts of problems. [T]hings like gain sharing are really extension[s] of that incentive to try to reduce and control cost. I agree with Dr. Brennan that the whole idea of gain sharing, whereas it goes after a noble objective, which is to reduce and control cost, is a fairly weak attempt [to reach that objective]. We spend a lot of energy and time doing it, but the results probably don't warrant all of the effort that's being made. Should we get rid of it? No, because I think it helps to meet an overall need, which is [that] we have to continually focus on cost reduction in health care.

What we find out, and I am in the business of hospital turnarounds, is that change should be continuous and continue to be made in an incremental fashion. [W]hat happens over time is that the hospitals tend to lose focus on controlling cost, the doctors get very busy in their practices, and so they don't pay attention to the changes in supply cost, equipment, and so forth. [A]s a result, they're always mak[ing] revolutionary changes to try to improve the situation.

As an example, there was a period of time during this call savings period where hospitals, as a strategy, started deferring the replacement of health care facilities, making the needed renovations to stay up to date. [A]s a result, we went through a period of about ten to fifteen years where health

care construction was not a major force in what we were doing. [I]n fact, we now find ourselves with a whole generation of hospital administrators who have no construction experience. [T]hat's a real problem because we suddenly wake up and find out that we need to replace the facilities we have. [For example,] Northwestern [Hospital]. . . just spent \$700 million to replace one facility and now have two others that need to be replaced. [T]he health care system cannot sustain that sort of change.

[C]ost containment is one thing that we have to do but, at the same time, another incentive that the hospitals—and now the doctors, who are also on a fixed payment system—have to do is diversify their revenue. [B]ack in the 1970s, the [hospitals] got into some pretty crazy businesses all in the name of “we're going to make a profit in the for-profit sector.” Things like landscaping and “we're going to own hotels,” and “we're going to get into the restaurant business,” et cetera, et cetera. [These were] things we didn't know anything about, but were going to take the profits and channel them into our not-for-profit to make up for this loss of revenue we perceived.

The same thing applies to doctors today in terms of diversifying their revenue base. They are looking for ways to come up with other sources of income and they view having a piece of what they produce as one legitimate source to get money because, in their perspective, the fixed payment system is not going up in a corresponding rate [to the rate of] inflation. [T]heir perception, whether you agree or not, is that reimbursement is flat and actually going down over time in terms of their payments on a per-case basis. [S]o they're looking for ways to diversify their revenue.

The third thing that you have to do in these situations, whether you're a hospital or a doctor, is you have to “push through put;” that is, you have to get more units of production though using the same resources. [W]e recognized that back in 1979 and 1980 [and] that was to be one of our incentives. [W]e started setting up utilization committees to try to figure out how we could be more efficient in the utilization of our resources. Doctors also have to do that and you even see now that some of the joint-ventures like endoscopy centers are really set up beside the doctor's office so they can move the cases through as fast as they can. A lot of emphasis placed on surgery centers on turning over the room is really to make the doctors more efficient in their practice.

[T]he incentives for doctors and hospitals are perfectly aligned today, with one exception: doctors have one further incentive that they are pursuing and which helps to drive a lot of their actions today and that is personal time or quality time. I've interviewed doctors all over the United States and they all are of the opinion that hospitals do a lousy job of controlling revenue-producing departments and, if given the opportunity,

they could do much better. [T]hey're looking for control in these relationships and control is very important to them.

The hospitals also are thinking that control is important because they feel in the joint ventures that the doctors are not skilled in management and, if not careful, would in fact get themselves in trouble with their tax-exempt status or would run the business into the ground. [A]s a result, control tends to be a common theme in all of the joint ventures that are being set up because the doctors are trying to find additional money.

I just want to talk about two or three things quickly. [T]hen I'll talk about specialty hospitals and give the practical results of what is going on because there is a lot of chit-chat in the literature and on the national health care scene and what we're talking about and what is reality are two separate points.

[I]t really comes down to the fact that [advances in] medical technology and medical technique are increasing very rapidly and because of that we're finding that more and more patients can be treated in ambulatory care, as opposed to hospitals. [P]ublic policy, as reflected in reimbursement by both the government as well as managed care, is to drive the patient even closer to the doctor's office in terms of reimbursement. If you look at the way reimbursement has evolved for GI, for ophthalmology, for pain management — pain management today is basically not a hospital-based practice. A certain amount continues to be in the surgery center, but more and more is being done in the doctor's office [where] there is no facility fee.

[T]hat means that the hospitals and the health systems need to be looking at how they are operating and [question whether] it is appropriate to continue to have monolithic structures that support tertiary and quaternary kinds of care. [A]s a sole community provider in a town of 30,000, is it still [necessary] to have these monstrosities? [A]s we get to the point where we have to replace and provide these facilities, part of turnaround is to reduce these facilities, strip off a lot of the services that are needed but cannot be supported, and try to set up regional networks. [T]hat's part of the integrated healthcare delivery system that [Ms. Conard] talked about that Intermountain [Health Care] has tried to establish. That, unfortunately, is not what is being done in the rest of the country and so I think that what will happen is that we are going to have more joint ventures — clusters, if you will — and more of a regional health network which will support the hospital.

[H]ospitals are desperate for money. We are, right now, being approached by health systems and individual hospitals to be capital partners with them because they do not have the money to support this. For example, Health South, National Surgical, and others are putting together packages where they become the capital partner with the hospital and the

doctors to help support some of these systems.

I really think that when we use the phrase “disaggregate the health care system,” [it] is a reflection of a trend that we’re clearly going towards and is something not to fear. However, the hospitals need to get out in front and start preparing the way. They need capital. [T]he doctors are willing to provide a small part of the capital, but they need to form partnerships or alliances within the community.

Control seems to be a big issue in all of this and the interesting thing is when you interview the doctors nationally about what control means, they do not think about the governance issues that we are really talking about: mission and vision, for example. When they say control, they want to know [if] they are going to turn that operating room over quickly; do they get that same nurse every single time, and the supplies, and equipment – that is, those things that affect service – but that’s not what I mean by control. Those are what I call management issues.

[P]art of the compromise that we’re trying to effect in these joint ventures is to get an understanding [between] both parties [so] that there can be a blending of interest between governance and control that will meet everyone’s overall interest.

Surgery centers are pretty well criticized and I think you are all fairly clear with what is occurring in surgery centers; it is pretty well established from the law and a regulatory point of view. I think the real growth in the next five years will be in the imaging centers. Dr. Brennan talked about cardiovascular imaging. Suddenly, there is a real interest in the bigger hospitals. Within about three to five years, we will see more of that in the individual community hospital level. That is a real growth area in joint ventures.

The other thing that seems to be hot right now is the neurosurgeons suddenly saying they want to do joint ventures. This is an area that hospitals are very interested in because neurosurgeons at this point cannot joint venture too much in terms of surgery, which is a big revenue area for hospitals. But there is a lot of talk about spine centers and you have to ask “What is a spine center?” [I]n the case of the neurosurgeons right now, most [say] they want a one-room operating room because very little neurosurgery can be done in a surgery center. They also want an imaging center and they want physical therapy and occupational therapy all put together, and there are some other variations. But when you hear the words “spine center,” that is what the neurosurgeons are talking about. [W]e are going to see a bunch of that in the next two to three years.

Let’s talk about specialty hospitals just for a second. I am in the specialty hospital business and I have to tell you up front, I do not really care if the Grassley Amendments to the Omnibus Reconciliation Act pass

or not. What Senator Grassley's Amendment is trying to do piecemeal is to put a permanent ban on specialty hospitals.

The practicality of specialty hospitals is [twofold]. One, there are very few opportunities in the United States for [specialty hospitals]. It just does not happen. You have to have a certain mask to build a hospital. Now, a specialty hospital is very akin to a surgery center with beds if you look at it from an acute point of view. We are talking, by definition, an average length of stay of three days or less. [T]his is what the hospitals see as cherry picking although, I have to tell you, most of the hospitals in the United States have an average length of stay of three days or less and the more tertiary and quaternary consultations are being done in the regular acute care hospital.

Doctors, in their minds, take that as an extension and say, "Well, we are going to capitalize it the same way." [However], the amount of capital for a specialty hospital versus an ambulatory surgery center is a great difference. [T]o [build] a three-operating room surgery center, you need about a million to a million and a half dollars in cash to properly capitalize and launch it, and then you borrow the rest. In a specialty hospital that has three to four rooms, you probably need more like four to five million [dollars] in cash to be able to properly capitalize it. [T]o say it another way, the cost of a surgery center is in the four to six million [dollar] range. A specialty hospital costs \$40 to \$50 million. Some will try to do it cheaper, but really to do it properly, that is the amount of money [needed].

The land [needed] for a surgery center is an acre and a half. Land [needed] for a hospital is eight acres. This is a big difference and doctors hate to spend money. They will take on debt [and] they hate personal guarantees. [I]t is very difficult to get doctors to put up cash. There is an old saying that doctors have money, they just do not have cash; [i]t is all tied up in their pension funds. [A]s a result, it is very difficult to get physicians to come up with sufficient capital to be able to do this on their own. They need a capital partner; and because of that, the real opportunities for the health systems are to reach in and joint venture with the doctors to create an environment. In the process of doing that, they also can reconfigure the way they are delivering health care [services].

In Carson City, Nevada, we just opened a hospital last March. [I]t is the brand new Carson Tahoe Hospital and right beside it is Sierra Surgery and Imaging. [Surgical care, over the first three days, is performed] in the specialty hospital, but if you require a longer stay than that, or more acute care, [the patient may] go to Carson Tahoe [Hospital].

Interestingly, the doctors had a surgery center that was very well capitalized and very valuable, but in the process of using that as their equity, they could only pick up 30% ownership in the specialty hospital.

They needed Carson Tahoe Hospital to put up 70%. We are doing a joint venture in Akron, Ohio, between a group of 32 orthopods and the SUMA health system there. [A]gain, the doctors wanted to do it on their own but, frankly, needed a capital partner to do it.

I worry that the American Hospital Association is spending a lot of political capital trying to eliminate something that probably is not practical and is not going to be much of a factor in the United States. There just are not that many groups around that have much of a bolus of physicians that they, in fact, can support. Maybe, we are going to be guilty of making much ado about nothing.

The only other thing I think I wanted to say about specialty hospitals is that there is a need for capital. I think that the Proprietary Hospital Association is lobbying hard against the specialty hospitals and they are refusing to work with the doctors to do this. I am predicting that there will be a rise of companies that are willing to take the model of joint venturing with physicians providing capital who will then, in fact, be providing [care]. [E]ven if it is not a specialty hospital, it can be a focused community hospital to provide emergency rooms. [A]s a result, we are going to see a whole new industry rising and there will be more and more of these focused community hospitals.

Thank you for your time.