Bob St. Peter: Hello, I'm Bob St. Peter. I'm a pediatrician and the former president of the Kansas Health Institute in Topeka. Today is March 6, 2026, and I'm here to interview Maynard Oliverius. Maynard was the president and CEO of Stormont Vail Health here in Topeka for many years. He was also chair of the Kansas Hospital Association board, was on the board of the American Hospital Association, and served in Vietnam in the US Army and the Kansas Army National Guard. Maynard, it's great to have you here.

Maynard Oliverius: Thank you very much. It's a pleasure to be here.

BSP: This interview is part of the Kansas Oral History Project, a series exploring issues in Kansas. The Kansas Oral History Project is a nonprofit corporation that collects and preserves oral histories of Kansans. The series is supported by donations from generous individuals and occasionally grants including one from the United Methodist Health Ministry Fund. Our videographer is Dave Heinemann, former State Representative. Maynard, thank you for being here.

MO: Thank you.

BSP: All right. Well, we had a great conversation just prior to starting this. Tell me a little bit about your background, where you're from, your early career, those sorts of things.

MO: Well, I grew up in central Kansas. I went to high school in La Crosse, grew up on a farm in Rush County. I had an older brother that graduated—I went to Ft. Hays State University, graduated there with a business degree in 1966. During my time in college, as I was telling you earlier, I wanted to be an airline pilot. I needed money to pay for flying lessons. My parents were putting me through school. I got a job at the local hospital, Hadley Memorial Hospital at the time and worked there to begin with because I was only seventeen years old starting college.

BSP: Too young to be on the patient wards.

MO: Too young to be on the patient wards. So, I started in the coffee shop. I did that for a few months. Then later I got a job on the nursing unit, on the surgical unit, and I did that for five years. In the meantime, I was able to get all of the flight ratings all the way to flight instructor, instrument rating, and all the engine, and all of those things. But because of that exposure to health care for all those years, along with my business degree, I decided to go into health care instead of the airlines. So, that led me into my eventual career in health care and here at Stormont Vail.

BSP: That's awesome. I'm partial to the airline industry. I grew up in Wichita, the air capital of the world. My family all worked for the aircraft industry. That's interesting. How long did you keep flying?

MO: Actually I flew all my career and owned a couple of airplanes in partnership with others. I did flight instruction whenever I had time and availability with two others in the partnerships. Really, up to now, I've stopped flying now, but basically sixty years.

BSP: Wow. And you were an instructor for a while?

MO: Exactly, yes. Until last year, I continued to carry a flight instructor rating and use it.

BSP: That's great. Fill that gap in a little bit between serving coffee at the hospital in Hays to being CEO of Stormont Vail. Tell me a little bit of what happened.

MO: When I graduated from college in 1966, of course, at that time, Vietnam was happening. We had a war there going on. When I finished my undergraduate degree, I was working at Hadley as an orderly in the surgical unit during that five-year period of time. I worked for a clinic in Hays, Kansas and did that as well as flight instruction. Again, that kept me in the health care side of things, but at that time, the draft was on, and I joined a National Guard unit. The National Guard unit was eventually federalized as we were building up in Vietnam. So, we were activated. I spent eight months in Vietnam. As I completed my service in Vietnam and completed my service in the National Guard, when I came out of Vietnam, I started looking for a job in health care. There was a lower management position at Stormont Vail open at the time, and so I hired into that job in 1969. So, from 1969 to 2012, I was employed at Stormont and was CEO for sixteen years of that period of time. From 1996 to 2012, I was CEO.

BSP: That's quite a story. You spent the huge majority of your career at one organization.

MO: I did. I was very fortunate. I started in an entry-level management position, and as opportunities came along, I was able to continue growing my career at Stormont Vail. I worked into administration, vice president and executive vice president, and then eventually in 1996, I was appointed as CEO.

BSP: Tell me a little bit about the early history of Stormont Vail. I read a little bit about it and have seen some of the displays at the hospital there. It has an interesting, important history in Topeka.

MO: A fascinating history, yes. Stormont Vail is one of the few large institutions remaining today that's a privately owned, operated, governed, locally owned, 501(c)3. It was started in 1884 as Christ's Hospital, and then in 1894, Jane C. Stormont Hospital and Training School for Nurses was created here in the community. So, you had two hospitals started back in that time. Then they continued to coexist. Then in the 1940s, Christ's Hospital had land and no money to expand. Jane C. had money and no land. So, that brought the two together, and they formed Stormont Vail in the 1940s, and then it just continued to be what it is today.

BSP: That's a great story. I'm going to come back to the name of the Jane C. Stormont Hospital and Training School for Nurses. I'll come back to that in a little bit. So 1949, you came into the organization, twenty years after that, and then you spent forty-three years there. Tell me in your recollection what are some of the important things that happened, big developments at Stormont Vail over the period of time that you were there.

 

MO: When Christ's Hospital and Jane C. merged in 1949, they hired their first professional administrator, and that was Carl Langley. He was there from 1949 to 1966 when he died. His assistant Jerry Jorgensen was then appointed to CEO. Jerry was there when I was hired in 1969. So, just in terms of history, if you think about national health policy, in 1946, the Hospital Survey and Construction Act was passed. Later called the Hill-Burton Act, that funded bricks and mortar for hospitals. So, Stormont Vail was able to access those funds to build what was the south tower at the time.

BSP: That was in the early sixties?

MO: That would have been in the 1950s and then continued into the 1960s with expansion. In terms of just major milestones, the hospital really took form as a major hospital at that time with the assistance of the Hill-Burton funds to help build the hospital. All the way back to 1884 to its roots, it started also as a school of nursing and has a school of nursing yet today and hospital based, which is one of the few in the country. But in terms of just major events that shaped the history of Stormont Vail, the Hill-Burton funds that helped build the south tower, and then in 1965 was the passing of Medicare and Medicaid. So, for the first time now, we had public funds available to provide health care, not just the brick-and-mortar side of things but provide health—actual payment for seniors aged sixty-five and made them eligible. That was the requirement. The key words there were "aged sixty-five." They were automatically eligible for Medicare regardless of pre-existing conditions. So, we had Medicare, and we had then for those that needed more help, we had the Medicaid program. That began to help fund the operations of hospitals throughout the United States.

BSP: What an interesting time to be an administrator.

MO: It was because for the first time, there was funding to not only fund health care, but also it funded a lot of the technology and the research that came along that was happening in medical centers at the time. So, as far as major events, in 1965, we had the funding of health care largely for seniors and the needy population through Medicare and Medicaid. In 1975, we became a Stormont Vail Regional Medical Center and created an open-heart surgery program. That was a major, major milestone. Then in the 1980s, we got into high-risk delivery and the neonatal intensive care unit.

As that was all happening, parallel to the growth of Stormont Vail was Bob O'Neil and Bob Cotton were two physicians, general internal medical physicians in Topeka. They started their practices in the downtown area here in Topeka in 1956 out of the Pelletier Building. They wanted to continue expanding their practice. At that time, most doctor groups would grow numbers within their specialty as opposed to multi-specialty group practices. Bob O'Neil had a greater vision than just internal medicine specialties. He started though with Bob Cotton, and then they started adding general internal medicine doctors, and then they added oncology and gastroenterology and all of the specialties and sub-specialties of medicine. They did that through the sixties and the seventies and the eighties and became a very, very prominent physician group in northeast Kansas. While they were smaller, they were modeled after Mayo.

 

All through those years, we talked to them about how we could do more and better service to the community if we were merged into one organization than competing for resources, they in one organization, and we in just a hospital. So, we had discussions for many years about how we could work more closely together, and then eventually in the late eighties and early nineties, we began to see a lot more consolidation of medical practices. We began to see a boom toward the electronic medical record when it was essential and is essential today. Then just the managed care movement that was taking place where more and more health care was being paid for in part with not just government payment systems like Medicare and Medicaid but actually managed care where insurance companies were now moving from mutual to stock, publicly traded companies, and beginning to manage care in a more competitive way.

BSP: So, that integration and cooperation between the hospital side and the physician side became more important.

MO: Important, and in fact, it actually drove the doctors and the hospitals. We would be better as one organization rather than two. It would put us in a better strength of providing care as well as negotiating within that payment system.

BSP: And that happened in—

MO: In 1995. We had the payment system through Medicare, Medicaid in ’65. We had heart surgery that we developed, it was a massive program in 1975, and then neonatal and high-risk delivery, the care of mothers and infants in the 1980s. Then we merged with seventy doctors at the time, Cotton-O’Neil, growing from two in 1956 in 1995.

Then at the time of the merger, it was a very unique structure because most mergers or hospital-physician acquisitions that were occurring in those days, the hospital would acquire the physician group, provide capital and funding and so on for their continued growth, but they would exist in two separate corporations, continuing to compete for resources. Many of those models struggled. Many of them failed. We had the good fortune here in Topeka that we had the visionaries of Cotton-O’Neil who were willing to join with Stormont Vail and place the 500 employees and seventy doctors of Cotton-O’Neil into an organization of 1,700 at Stormont Vail, merge into one organization, one corporation. Everyone was employed by the same corporation, the same employers. We had all the same goals, all the same incentives, the same purpose for how we wanted to serve the community.

But part of that structure was that the doctors wanted to have a say in the governance, wanted to have a say in the management of the hospital. Unlike most other communities where the hospital governance and management would resist that sort of intrusion by doctors in running the hospital, why would we want you to do that? Your doctors let us run things. You take care of the practice of medicine. We and they had a different vision about that. We concluded that the best way to run the combined organization was #1, everyone was employed by Stormont Vail in the same organization. We would continue to exist as Cotton-O’Neil Clinic and Stormont Vail for public purposes and knowledge and so on, but the administration of the hospital would be half doctors and half professionally trained people.

 

So, when we merged in 1995, I was part of the organization and the management team that worked with Cotton-O'Neil and Dr. Kent Palmberg to help create and bring along that merger. Howard Chase was the CEO at the time, and I was executive vice president. So, we put that together, one corporation. Everyone was employed in one organization, but the management team was half doctors and half professionally trained people, and it was a wonderful structure.

BSP: My next question was going to be: You mentioned the pressures that made this not terribly uncommon around the country, but it was pretty unusual in this part of the country. What Stormont and Cotton-O'Neil did at the time was very innovative. I was going to ask what made it successful, and it continues to this day. But you hit on a lot of the points that made it successful.

MO: It was that. Most other organizations, and some of them failed, and they actually moved apart. We came together as one organization, everyone employed in the same organization, and the management team, we still had our governance and we had doctors on the governing board as well, but we had one team that was the management of the organization. That was the strength. That was the chemistry that made it work.

BSP: You mentioned that long name, electronic medical record. But another thing that Stormont did in partnership with Cotton-O'Neil and as part of the integration was to introduce this concept of an electronic medical record. Tell me why that was important and how that contributed to the success.

MO: There were many companies at the time that provided electronic medical records. Or instead of having paper medical records that doctors in hospitals had for years and years and years, that was all history, we were moving to an electronic format, not only to make it easier to retain those records, but also to transfer them. Just like you can use a telephone to make a phone call rather than using the mail.

BSP: A lot of organizations developed one for the clinic and the outpatient and one for the inpatient hospital side.

MO: Exactly. That's what I was going to say. Most of the companies that were developing electronic medical records, they created a hospital record, or they would specialize in creating a doctor medical record. But few had the ability and knowledge and capital to actually create one record that served doctors and hospitals. And one organization that we went with called Epic, which is based out of Madison, Wisconsin, still exists today, still is probably the leader in electronic medical records. They were one that had a consolidated medical record. They were totally integrated; the hospital and the clinic record are all one. They keep separate data, but they're all one record. They're truly a merged record.

BSP: Stormont had to be one of the earliest organizations that had that integrated inpatient/outpatient medical record.

MO: We were one of the first to have a truly integrated organization. There were others that had adopted the Epic electronic medical record system, and we brought that into the organization after we had merged the corporations together. It took us about ten years, from 1995 until about

 

2007 or ‘8 in order to do that. But in the meantime, from 1995 until that was occurring, we continued to grow the doctor side of the clinic, adding specialty and subspecialty medicine to the Topeka community, serving a larger geographic area. We moved from being a Level 2 to a Level 3 neonatal intensive care unit. We became a Level 3 and then a Level 2 trauma center and began to incorporate surgeons into what was originally only a medicine group. Instead of medicine and surgery, they specialized in all the subspecialties of medicine. We added surgeons to that, and close to the time I retired, we had grown from seventy or seventy-one doctors in the Cotton-O’Neil Clinic to about 140.

BSP: That’s a great recap of the history of Stormont but also of medicine in Topeka in a lot of ways over that period of time. You mentioned a couple of points where the role that federal health policy played in motivating and accelerating some of these changes and innovations. Can you reflect a little bit on how those major federal policy innovations and even around electronic medical records, there’s a lot of federal regulation and money that came around for that but talk a little bit about the role of federal or state health policy and the health care industry and hospitals in particular.

MO: If we think about the last—let’s just talk about an eighty-year period of time. We’re in 2026. In 1946, World War II had ended. We had soldiers coming back from fighting a war. Many of the doctors that were in our communities at that time had been in the war and the hospital administrators. All the doctors and the soldiers were coming back. We were beginning to have families and have children. But we were coming back to communities where we didn’t have doctors because they were in the war. We didn’t have hospitals because they were never built. We didn’t have a funding mechanism to build the brick and mortar, let alone operate the hospitals.

Harry Truman had a vision. He wanted a universal health care plan. He wanted a one-payer system, all the way back to the 1940s. Congress would not give him that, but they said—a member of Congress by the name of Hill and one by Burton—one of each party—said, “We won’t go with universal health care, but what we will do is we will fund the brick-and-mortar so we can start putting hospitals in the communities where we haven’t had them before. We again have this large population of soldiers coming back. They’re growing families. They’re starting businesses and so on.

BSP: There were more things that could be done for people. That field of medicine was evolving with innovation and opportunities to take advantage of the bricks and mortar and procedures.

MO: So what happened at that time in 1946, they passed the Hospital Survey and Construction Act that basically said, “We will fund the brick and mortar for communities,” small communities like my hometown in LaCrosse, “We will fund the brick and mortar for our communities if the community will then assume responsibility for the day-to-day operations of the hospital. In trade for that, what the government also required was that if we provide the brick and mortar, we want assurance that you will provide care to all comers regardless of race, color, creed, religion, or ability to pay. This was 1946.

 

So, now we had in place about 375 million dollars at that time that ended up over a period of time building about 70,000 beds across the United States. So, that provided the structure. As we think about the history of Stormont Vail 1949 merging and building the south tower of Stormont Vail, so now in 1946, we had the hospitals having a way of being built, the funding of those, and a few years later, 1965, Cotton-O'Neil again was starting their practice in 1956. In 1965, we had Medicare. Medicare was for the first time a major payment system for providing the services. The brick and mortar was partially paid for out of bonding, private bonding, as well as Hill-Burton Act money. But the payment for services in health care was largely up to Medicare and Medicaid in 1965. Private insurance didn't exist. We had a little bit of Blue Cross. We didn't have employer-based insurances at that time. It was mostly private pay, and people didn't have enough money to pay for it.

So, the Medicare/Medicaid program allowed millions of people literally overnight have coverage for the payment of health care, for the payment of services by hospitals and doctors. They now had a funding mechanism to run their day-to-day operation. That helped also with the technology side, things like cat scanners and MRIs and all of those things.

BSP: Open-heart surgery.

MO: All of that technology, now there was a funding source to help pay for that once we developed the ability to do it.

BSP: You're describing a period of time—we both know that at the time that some of those innovations were going on, there was a lot of resistance from doctors and hospitals both, but in retrospect, you're describing a very rosy picture where federal policy really supported the development of hospitals and providing of health care across the country. Give me a little bit of your perspective on where we are now related to federal policy.

MO: Let's just continue down that path.

BSP: This is a history project after all.

MO: Because in 1946, of course, we had the Hill-Burton Act, and then in 1965, we had Medicare and Medicaid come into existence. Now for the first time, millions of people had some additional federal funding. And this was members of both parties that put this legislation into effect. You had Harry Truman who signed into law of the Hill-Burton Act. We had Johnson who signed the Medicare and Medicaid, and then Ronald Reagan became president and we began looking at—not only did we want to make sure that we had health care for all comers regardless of race, color, creed, religion, and ability to pay, and also now we covered the seniors under the Medicare program because of age sixty-five and above, everybody had coverage.

We also began to look at were we turning people away from our hospitals, and that was happening in our country in the 1970s and so on. So, under Reagan, we had the Emergency Medical Treatment and Labor Act was passed.

BSP: They called that EMTALA.

 

MO: EMTALA. For the first time, we are now assuring that not only all comers regardless of race, color, creed, religion, and ability to pay, but also expectant mothers would be taken care of in our hospitals. They would be assured that they would get care. So, that law said if you're managing a hospital, running a hospital, that anyone who comes to you for care, mothers or anyone else, you have the responsibility of evaluating, stabilizing, treat the patient if you have the ability. If you don't have the ability, find a hospital and doctors who do have the ability.

That was the 1970s. So, talk about history and changes and things, so for fifty or sixty years, those kinds of laws have been in place. And it also included not only coverage for what I just mentioned about race, color, creed, and ability to pay, and so on, but regardless of country of origin. So, even folks who were coming here from other countries, we were required to provide health care for them.

BSP: That initial assessment and stabilization.

MO: All of that back in the 1970s under Ronald Reagan. That continued. Ford made some changes in that that were very, very positive, and then in 2003 and 2004, we expanded not only health coverage, and hospital coverage and doctor coverage for Medicare and Medicaid, but also now we put the prescription drug law was passed into law by George W. Bush in 2003 and '4. Now, that's again, bipartisan continued expansion and growth of health policy and health services.

BSP: So, as important as Medicare had been all those years, it wasn't providing good coverage for prescription drugs.

MO: So, that came into effect—

BSP: As more and more drugs became available, they became more and more expensive. People spent more and more money on it.

MO: Exactly. That was in 2003 and 2004. But even at that time, as far as health insurance, we were still and are today the only industrialized nation in the world where all of our population does not have health coverage. Even at that time in the nineties and when we merged with Cotton-O'Neil, we had 47 million people and a population of 300 million people in this country, but about 47 million did not have health insurance. So, we had Medicare. We had Medicaid. We had private pay. We had employer-based insurance, and, of course, government and military and so on were covered, but we still had about 15 percent of our population that did not have coverage. So, access became a continued issue over time, access to providers and payment.

BSP: And during that period of time, there were also some incremental expansions to children's coverage, allowing children in families with slightly increasing incomes to be able to still get Medicaid coverage.

MO: That's right.

 

BSP: You're describing very sort of piecemeal groups of people focused opportunities to try to provide access to services. So, you've gotten us up to the early 2000s, maybe in the 2010s.

MO: So, we have all of those various forms of payment that I just mentioned. We now have prescription drug coverage. In 2010, President Obama signed the Affordable Care Act. Of the 47 million that did not have coverage of any of those other categories—Medicare, Medicaid, employer-based coverage and so on, many of those folks were working—obviously, they had jobs. They were the working poor. They didn't have the ability to pay for all of their rent and their groceries and also health care because it was expensive.

The Affordable Care Act was an attempt to cover that additional 47 million with some type of insurance. While that was the goal, they didn't quite get it achieved. Even though it provided additional payment system and support to cover more people that met certain poverty guidelines, it didn't cover 100 percent of the population.

There was a provision in the Affordable Care Act that allowed states to take the Medicaid program—it's important to point out here while Medicare was a totally federally funded program, Medicaid was passed at the same time. It was the same kind of coverage, but it was funded differently. It was funded partially by federal government and partially by the states, the partnership. So, it would be a matching dollar for dollar.

BSP: Each state had the ability to design the program with certain federal constraints.

MO: That's right.

BSP: A lot of differences emerged among states over that period of time.

MO: Exactly. So, the Medicare program was fundamentally the same across all fifty states. The Medicaid program was matching dollars. The federal government would guarantee putting up a dollar if it would be matched by the state. Many times states individually could decide, "Well, we won't totally fund it." That cut back on the amount of federal funding. So, you had a lot of disparities going on from state to state to state.

But in the Affordable Care Act, there was a provision that allowed not only for the Medicaid program to continue as it had been for years, but also to do Medicaid expansion where if the state would put up a little bit more funding—instead of using the traditional dollar-for-dollar match, if the states would put up something like 10 percent, the government would put up 90 percent and try to pick up more of that uninsured population.

That law got passed in 2010. Over time, it started with a handful of states that participated in the expansion opportunity. Over time, that grew from a handful of states to about forty of our fifty states that participated in that expansion opportunity.

BSP: There was a Supreme Court case in between that as the states were deciding whether or not to expand Medicaid.

 

MO: That's right. And while that case was going on, but it did say they could do that.

BSP: It allowed them to do them, but it didn't allow the federal government to pressure them by withholding other Medicaid dollars.

MO: That's right.

BSP: So, the states had total freedom of whether or not to implement that part of the ACA.

MO: Of expansion, yes. So, over time, about thirty-nine or forty states did adopt that. Kansas continued, and as of today, has continued to not participate in that expansion opportunity.

BSP: Right.

MO: So, what we had is over a period of Truman, Johnson, Reagan, Ford, Bush, Obama, six presidents, fundamentally three Republicans, three Democrats, shaped along with the Congresses that they had, shaped the health care policy of this nation for the last eighty years. And now we're at a time when a lot of that is under review and in some cases, we're now moving towards dismantling some of that.

BSP: We're going to get to some of the challenges facing hospitals now. Let me ask, in that period of time, that's a great overview of federal health policy. What about state level policy? How has that had an important impact in Kansas over that period of time?

MO: I think that across that entire history of health care, millions and millions of people, we still have even today about twelve, thirteen, fifteen million people that fall in the category of uninsured. As I mentioned earlier at the turn of the century, that was about forty-seven million, and then the Affordable Care Act covered a lot more. So we reduced that number. We still have about fifteen million or so that are not covered.

In terms of state health policy, and one of the things that Kansas is facing is that it has lost pace or is losing ground with how it compares in health, general health of the population.

BSP: The ranking of health in Kansas compared to other states. We'll talk about that.

MO: I think part of that is playing out, and I'll just say the word "access." Access to providers and access to a payment system to pay the providers brought about over time because we have not participated in the Medicaid expansion program. I think that's a major component of it.

BSP: Before we move on, I want to just mention this concept that people may have heard about—underinsurance. You talked about being uninsured, having no insurance coverage to pay for your health care. Over the last twenty years, there's been a real increase and a focus on this issue of being underinsured. You may have insurance, but the premiums and the co-pays and deductibles may be so high that a lot of working families are still not able to get the access that you're talking about. So, I think we have to now be thinking about uninsured as well as this group of underinsured persons.

 

MO: That is true. If we could talk just a little bit about current legislation that has been recently passed in 2025, the concept of not funding some major components of the Affordable Care Act, and even impacting on Medicare is bringing about a philosophy of "Well, instead of providing insurance, whether it be government or a subsidized private insurance system, we might just think about giving people a check, and they can buy their own insurance."

For those of us who've been in health care all of our careers, it's a very complicated area. To go shop for my own insurance would be—even with knowledge is a complex issue. So, underinsured, the phenomenon of underinsured is even potentially greater risk because if the public—instead of given coverage, you pay a certain premium based upon your income and so on, you're just given a check, and you go shop for your own insurance, it means that you have to have the knowledge and ability to select the coverage.

BSP: Buy the right one.

MO: When you buy car insurance, you buy comprehensive or you buy liability. You don't buy for the fender or for the taillight or the headlight or whatever. In health care, if you are underinsured, you might be underinsured because the coverage you're buying doesn't cover some of the important components of health care that you didn't realize were not going to be covered.

BSP: You talked about the improvement, but still there's a considerable number of people that don't have insurance or maybe have insurance but can't pay their share of the bill. How does that impact hospitals?

MO: The systems that we have in place, Medicare and Medicaid, they're substantial sources of revenue for the hospital. Patients that come to the hospital that have employer-based coverage or if they're in the service, they have the government payment system, or if they're working in municipal government, county governments, they probably have coverage. All of those payment systems are there to provide coverage and payment for the people that they're insuring. What the hospitals have to try to do is to generate enough additional profit or revenue from those sources of payment to pay for those who come to their facilities and again are required to provide care regardless of race, color, creed, and religion, or ability to pay. To meet those requirements, we have to generate enough revenue from either of those other payers by how we contract with them or how efficient we are, or a combination of both so that we have enough additional funds to cover those patients who arrive at our emergency rooms who didn't expect to come to the hospital or maybe they—but they needed care, and we have a requirement to provide that care. So, it becomes free care to them unless they have some ability to pay. We try to charge them obviously charges, but if they don't have the ability, then it becomes charity care.

BSP: So, that burden gets picked up by the hospitals, and in some ways is partially paid for by the population that are payers. That was again a great review of the health policy in our state, in our country over the last eighty years you went back.

 

I want to switch a little to talk about rural Kansas and the parts of the state where you come from and my family originally homesteaded, some of the unique challenges facing small rural hospitals. I want you to touch on another really important federal program that was implemented in the 1990s designed specifically to help communities in small rural hospitals called the Each Peach program. Before I ask you to get on to that topic, I just want to acknowledge a mutual friend of ours who worked with you and others at that time, Don Stewart, to really help Kansas be a national leader in that area of supporting rural hospitals, through the Each Peach program. And your ties with Don, you told me earlier that when you were working in that coffee shop back at the hospital in Hays, Don was the administrator there, and you used to serve him coffee. So, your relationship with him goes back a long way.

MO: Right. Don is a great leader, a great administrator, a mentor of mine, and friend. In the 1960s when I was in Fort Hays, I worked at Hadley Hospital. At that time when I started, Austin Evans was the administrator. He was there for a few months while I was starting in my job in a coffee shop. When Austin took another job in another state, they hired Don Stewart. Don grew up in Abilene. I think he's a Northwestern graduate, and he was doing his residency in Dallas in health care administration. The board hired him to come to Hadley Hospital in Hays. Don, as many administrators do, worked late into the evening, and I'm working an evening shift in the coffee shop. Don would come. I really never got to know him at that time because of the difference in our positions, but he would come and drink coffee, and we'd chat a little bit.

I got to know him then over time, and he actually served as a preceptor of mine when I worked on my master's degree in health care administration. As I grew in career, we had a lot of interactions. Don was just an enormous wealth of knowledge and skill for the entire health care industry and field.

BSP: What was your role, and how did Kansas get involved in the Each Peach program? Explain a little bit of what Each Peach is.

MO: It was a mechanism to recognize hospitals that were under twenty-five beds to qualify them for an additional payment system in order to ensure their existence and availability to patients in small rural communities. In the towns of LaCrosse and Wamego and Colby and Ness City and so on so that those hospitals would be able to survive by having additional resources again through the Medicare program to assure their existence to provide services to those communities.

BSP: It was a program the hospitals had to apply for and be qualified for it. Kansas had a very high success rate in that.

MO: It did, and I think at its peak, there might have been about 145 hospitals in the state of Kansas, even though we have 105 counties, all but five of those counties had hospitals and, in some cases, more than one, obviously, like Shawnee County. But many of them were the small rural hospitals. Their ability to continue to survive and thrive, and again as those populations got older in those rural communities, and farmers had more mechanization and automation and so on, they didn't need as much farm labor. So, the population not only was getting older, but it was getting smaller. So, if you're going to have a hospital available to provide care and service to the

 

population that exists, they need to have some additional payment system for the patients that they're serving, and that's what the Each Peach Program fundamentally did.

BSP: My understanding is Kansas had more hospitals to gain that designation than any state in the country, not on an adjusted basis for the population, just as an absolute number.

MO: That's right.

BSP: And I think we still have in the low eighties the number of hospitals in Kansas that qualify under that supplemental sort of support for small rural hospitals.

MO: The role that Don played while those were legislative decisions that were made, Don's leadership, along with others at the time, helped encourage that sort of health policy to be developed.

BSP: Yes.

MO: But then Don through Hadley where he was the CEO began to do outreach, taking services that he had available and used in his hospital to begin sharing those services with smaller hospitals that couldn't afford to have a department of physical therapy or occupational therapy or whatever. He would work with hospitals around him, network with them, and provide resources, staff resources with those hospitals, and they would network services together.

BSP: I know that's something that Stormont has continued to do even to this day.

MO: Right.

BSP: I want to go back for a minute to something that you mentioned in talking about the history of Stormont and the training school for nurses, back with the original hospital in the 1800s. Tell me why that was and has continued to be an important part of Stormont Vail.

MO: In 1884, when Christ's Hospital started—

BSP: You took me literally when I said, "Take me back to"—1884, okay.

MO: Yes. 1884, when Christ's Hospital was created, it had its roots in the Episcopalian Church here in the community, and Bishop Vail—and that's how the name came about—Bishop Vail and his wife had either through the church or somehow had access to land. So, they granted the land if the community would build a hospital. That's how Christ's Hospital was started.

In those days, if you were going to start an open hospital, universities were not in the business of training nurses. Each hospital had to train and educate their own people. We grew our nurses from within, and we had diploma programs at that time. So, someone would come to work for Christ's Hospital, and they wanted to be a nurse, we would provide the training and the education, and at the end of a couple of years, we would grant them a diploma. So, they might be a Christ's Hospital diploma nurse.

 

And when Jane C. Stormont Hospital opened over at Third and Greenwood in Potwin, they had their own school of nursing. The same way, they had to home grow their staff. Every hospital, Hadley and St. Anthony and Wesley and St. Francis, every hospital in the state of any size at all, they would create their own schools, and they would grant diplomas to those graduates.

Over time, starting in really the 1970s, universities, colleges, began to say, "Well, like we train people in the business school or engineering and law, we will move into the field of health care." So, Washburn and others began to create their own baccalaureate nursing programs. We were transitioning now from a diploma program, a diploma granted by the hospital where they worked and got their training to a university-based program where they could earn a Bachelor of Science degree in nursing. Many hospitals in those times endorsed that, and they said, "We would love to have the universities provide more of other programs, a rounded education in addition to the training in nursing education. We will still provide the clinical experience, but we'd like the universities because that's what they do. They're educators. We want them to take on that role."

Most of the hospitals across the United States elected to move out of their hospital-based programs and let the universities take them over. Stormont Vail was one of the organizations that said, "We would prefer to continue participating." So we linked with eventually Baker University and said, "We don't want to become a university. It's Stormont Vail. We want to provide the clinical experience and training, but we would like to still have our diploma program transition from an associate"—they had two-year programs as well. From a diploma to an associate degree, we'd like them to have a bachelor's degree, but we'd like to have a university grant that degree. So, in the 1980s, we continued to say, "We want to have a school of nursing based at Stormont Vail because Topeka is—it's hard to recruit nurses to some communities and given our growth strategy and need for more and more nurses, we wanted to be a clinical side for Washburn, but also have our own school of nursing linked with Baker. So, even today, we have two programs where we provide the clinical, but it was because we didn't feel we could build the staff and the size of nursing employment base that we wanted by just relying on the universities across the entire region to supply us nursing. So, we continue to grow our own program.

BSP: Great. The work force, not just nurses, but a lot of health professionals, is going to continue to be a challenge.

MO: It is a given. We went through COVID, which was very, very difficult in terms of retaining, retention and training of nurses, doctors, and so on. So, having our own program has been very, very powerful and important.

BSP: You mentioned in describing Stormont that it's a nonprofit organization that is tax-exempt from federal income tax. Talk a little bit about what hospitals, the role that they play in communities, the organization, but also the leadership of the hospitals. My impression is that in many communities, the hospital is tightly linked with the identity of the community, especially in smaller communities, and it's a large employer. It's an economic engine in those communities. Talk a little bit about the relationship between a hospital, its executives, obviously the providers that are providing health care, but in the community at large.

 

MO: Historically, again, most hospitals in the country, whether they be large or small, were all community-based. Most were not-for-profit, tax exempt, so they were community-governed, community-owned, and community-operated. Over time, many large organizations like we were talking about doctors and hospitals merging together, we also saw a consolidation of hospitals joining together, forming corporations and systems instead of freestanding. Most of those systems were faith-based, or some of them like HCA became corporate-based and publicly traded companies like Hospital Corporation of America. So, you had the consolidation of hospitals in the system. Stormont Vail has continued to be—even though it's one of the larger hospitals across the nation as you look at the 5,000 hospitals roughly, it would be in the top 10 percent in terms of size. Most of those other hospitals of large size are in systems. They're governmental, faith-based, or they're in for-profit systems. Stormont Vail is still one of the few that is locally owned, locally operated, locally governed, still tax exempt.

Now it doesn't mean that we don't need profit to replace our assets in buildings and so on. It just means that we don't distribute—not-for-profit in our case means we don't distribute any of our revenues or profits to shareholders. We put them back in the community, and that's the key thing about a Stormont Vail in how it functions in a community like Topeka. All of our staff, now over 5,000 employees of Stormont Vail, probably the largest nongovernmental employer in northeast Kansas, many of those people live in the communities surrounding area. The resources that we generate in terms of profits and so on, we put back in the organization, put back in the community. So, the dollars generated create employment. They also create wealth that stays in the community as opposed to distributing it out.

The other thing that happens is when you have the leadership, the governance, and the management team of the organization, if you're consolidated, that management might be in another community, and you'll have maybe a small staff running the local hospital. Here, the entire administrative team is here.

BSP: Local.

MO: So, they're part of the community. They're part of the fabric in the community.

BSP: I want to say right now, I'm currently on the board of directors of Stormont Vail. I feel like I should disclose that, given the conversation.

MO: Thank you for your service.

BSP: You were not the CEO when I came on the board, but we've known each other a long time. I just wanted to put that out there. Talk about in a small community, what commitment, what obligation—those are largely either—they're nonprofits. Some of them are run by the government or at least funded and subsidized by the government. What sort of a relationship exists there? I want to go back to the ACA a little bit. The Affordable Care Act implemented a requirement that nonprofit hospitals submit an annual report sort of justifying their tax-exempt status. That's kind of what I want to get at. What is the commitment, the relationship between hospitals and a community? How does that shape how hospitals are governed and operated?

 

MO: I think again the key is that most of the hospitals—I'll use Stormont Vail again—it's not-for-profit, which means that we do not distribute our profits to shareholders. So, those dollars that are generated in terms of revenue over expense, profit stay local. They're put back in the organization to provide services and programs and technology and so on for the community we serve. And the fact that it's locally owned, locally governed, and locally operated, so there's a relationship because it is the fabric of the community. Does that get at the question you're asking?

BSP: I'm heading somewhere. Let me just go there a little more directly. You mentioned the rankings earlier. At one point in time in the early nineties, Kansas ranked as the 8th healthiest state in the country, and our current ranking is somewhere around 27th. So, over the last 30-some years, the relative ranking of health and well-being in Kansas compared to other states has decreased. And hospitals, especially over the last twenty years, have become much more involved, engaged in community health and participating in community health assessments, developing health improvement plans, that sort of thing. That can be a stretch for hospitals that have specialized and developed the ability to provide high technology, high touch specialized medical services are now getting pulled into that sort of broader community and public health sort of a role. Talk to me about that, how you think hospitals are responding to that. Is that a good thing? What are ways that we can use that to our advantage to try to improve health and well-being in our state?

MO: The role of the hospital has—we've always been involved in the public health side of things. We're always working towards developing programs or working with the state, the health and human services, and the state or even federal on how we can provide additional services or support things that are going on in the community. But again I come back to the point I made a while ago about access. The difficulty that many of the rural hospitals have is that they have an increasingly elderly population but a shrinking population.

BSP: Yes.

MO: Their ability to continue to provide access, access of doctors and hospital services to a shrinking and a more targeted population, the elderly, is becoming more and more difficult. You also have difficulty keeping the providers. Many of the communities that we have in western Kansas do not have primary care doctors.

BSP: And ob gyn in particular.

MO: I think there are only two ophthalmologists-- three west of Highway 81. So, you have access to providers and access to funding to pay the providers to be out there. Unless there is some mechanism to do that, then I think that hospitals have a very, very difficult time trying to provide the level of care and service that's needed to support the health needs of the community. I don't know if that's getting at the question you're trying to ask.

BSP: Can you look in your crystal ball? It's a challenge for many communities, many hospitals in our state, and rural communities across the country, where do we go? What are the kinds of things—you lived through a period of time with major innovations and development of new

 

programs. What do you think the next wave of those needs to be to address some of these challenges?

MO: Again, when we go back to the history of health care over the last eighty years, we have through various administrations, both parties have developed significant programs for the population that we have. Now, as I mentioned earlier, we are the only industrialized nation in the world that doesn't provide health care for all comers, for our entire population. We've come from a time when the insurance coverages were done by mutual insurance companies. So, all of the policy holders were the owners. Properties were not distributed. So, we're the only industrialized nation in the world that doesn't have 100 percent coverage for all of our folks. Yet we are the most expensive health care delivery system in the world.

That's in part because of the fragmentation of the way we're structured. We have Medicare. We have Medicaid. We have lots of employer-based insurance products, lots of insurance companies, and lots of things going on that are adding costs that aren't necessarily leading us to spending dollars on health care. Where we're going, I think we are at a place where we should be moving frankly to a single payer system, or we should be allowing the under-sixty-five population to buy Medicare. We know that Medicare, which now covers about seventy million people, Medicaid covers seventy-two million. So, a huge, huge portion of our population is covered by two programs, and the Medicare program operates at a cost of about 2 to 3 percent. There's not private insurance, and I'm not critical of private insurance, but they're structured differently. They have shareholders. They have marketing. They have a lot of things that they do that the Medicare doesn't have to do that costs money that doesn't go to pay for health care. It goes to pay for the premium, the cost of the premium, but it doesn't drive health care.

So, ideally, we would move toward a payment system where we'd have maybe one payer or at least allow more and more people to access the Medicare for all. It's an easy structure because we already know how that system works. We know exactly how to rate the population and so on. That's where I think the future should take us, toward a Medicare for all or a type of a single payer system. The commercial insurance companies could still be used as the third-party intermediary to process claims and do all of that. That's my thought about where we should go.

We are not moving in that direction. The current legislation that has been passed is basically taking us out of the World Health Organization. It's taking us away from funding research in universities. The NIH is not being funded properly or as much as it used to. So, we're moving away from public health policy and vaccine coverage and use of vaccines across our population in children. We're in a time when we're re-evaluating where do we want to go. I think that's a difficult time we're in, a very difficult time.

BSP: Yes. It's a challenging time for more and more hospitals, too, just to stay in the black and relying more and more on support from their communities and the tax base to support many of the smaller hospitals that we've been talking about. So, it's a challenging time.

MO: It is. As we change what is covered or what we support in terms of the way health is delivered from Health and Human Services now, let me just say this. In all of my career, everyone that has been in charge of Health and Human Services, the United States Health and

 

Human Services program, every leader of that organization has built upon their predecessor, added value, added service, added programs, added quality, and added safety. We are now at a time when we are re-evaluating that whole structure, and we're no longer endorsing certain kinds of vaccine coverage. All of those things are going to add to the complexity, the cost of health care. It's going to increase the number—we have measles outbreaks in this country today that we forgot about measles years ago because it didn't exist anymore. Polio could come back.

We could have lots of things coming at us that we're not prepared to handle at the hospital and at public health and the community level because we went through that, and we dealt with that, and now we're being challenged by many of those things coming back that will impact on our health. It will impact on our costs, and it's going to come back again to access, access to providers to care for the increasing needs of the population that many doctors are going to have to be retrained on how to take care of diseases that we—

BSP: I was just reading a medical journal over the weekend about showing pictures of kids with measles because most doctors younger than me have never seen measles before.

MO: We've had outbreaks in Texas, southwest Kansas.

BSP: This has been fascinating to me just to hear your perspective and this great review of things in our state and federally. Are there things we haven't touched on that I should have touched on?

MO: I think we've covered it all.

BSP: That gave you a chance to say what you had to say.

MO: It's been a pleasure.

BSP: Thank you so much for joining this project and participating today, Maynard. I really enjoyed it.

MO: A pleasure. Thank you.

[End of File 1]

 