APPENDIX I
Helms Report: Community Impact Assessment

CRVNA & CNHVNA AFFILIATION
COMMUNITY IMPACT ASSESSMEMT

June 23, 2020

Overview: Concord Regional VNA (CRVNA) has served the greater Capitol Region for over 120 years providing needed home-based care to patients and residents. Central NH VNA & Hospice (CNHVNA) has provided services to southern Carroll County for over 100 years and to the greater Laconia Region for over 45 years. These organizations have been vital components of the fabric of their communities supporting individual care in the home setting. These organizations have proposed a merger to consolidate the resources and services into one home health and hospice organization.

Simione Healthcare Consultants and Helms & Company, Inc. each were engaged to evaluate the potential impact of the proposed merger from both a financial perspective and a community benefit perspective – with focus on access to quality services to meet physical and mental health needs. The Consultants were provided historic information on both organizations and conducted leadership interviews. Drawing on overall industry knowledge, the Consultants provide this assessment of the potential community benefit of the proposed combination.

Covid-19 Impact: The healthcare shut down resulting from the Covid-19 pandemic clearly impacted patient volume, demand, and financial performance of both organizations. While some areas of health care delivery may see permanent change as our country adjusts to the impact of the Covid virus, the home health industry likely will see a return to "pre-Covid" volumes and demand. If anything, the lasting impact of the pandemic may be to increase public interest and acceptance for care delivery in the home setting. Already as NH begins slow re-opening, the two agencies already have returned to patient service demand levels close to those seen before the shutdown. This analysis assumes that the post-Covid home care environment will mirror the "pre-Covid" environment and the merger benefits anticipated before the pandemic will remain valid into the future. Given the recent rise in home health demand we believe this is the appropriate assumption upon which to base our evaluation

EXECUTIVE SUMMARY: The Concord Regional VNA and Central NH VNA propose merging to improve their overall clinical and financial stability at a time of great uncertainty in the health care industry. A critical consideration in the proposed merger is the ongoing melding of the Lakes Region market with the Concord market. Over the past few years more Lakes Region residents have sought care from providers in the Capitol Region Health Care system- in which CRVNA is an integrated member. CNHVNA has seen a significant market share loss to CRVNA. It is more cost-effective for CRVNA to merge with an existing agency- that has similar culture and approach to service delivery- to meet referral demands than to build new capacity. Under current laws, CRVNA cannot share referrals with CNHVNA without organizational integration.

The proposed merger should have many benefits to the patients and providers currently served by CNHVNA. The combined entity will bring greater clinical specialty resources and depth, enhance community education programs, increase community health and wellness program offerings, and reduce clinician travel time through better overall staff deployment to a larger population. CRVNA has many years of experience supporting a health care system with ACO involvement and Total Cost of Care contract performance. These skills can enhance post-acute care services to Lakes Region and southern Carroll County providers as they become involved in Accountable Care relationships.

The Community should benefit by the combined organization having improved opportunity for workforce acquisition and retention. Labor is a huge percentage of overall cost and together the organization should be able to offer enhanced work opportunities, reduce turnover and position vacancies, and provide for greater ongoing education and training. All of this should enhance the overall timeliness of care requested for patients.

Both organizations have been involved with their respective Integrated Delivery Networks which will continue post-merger. Together, they should be better positioned to develop new programs identified to support IDN mission and needs of federal payment reform. They will expand the delivery of the OASIS assessment to include all patients not just those with Medicare coverage. This may help identify behavioral health needs. An immediate benefit will be the support that CRVNA can offer to the CNHVNA nascent Palliative Care Program.

While the goal of the proposed merger is enhanced stability and not cost reduction per se, the combined entity should realize reduce administrative cost that can lower/hold down its overall average cost per visit or cost per episode. Since most home health and hospice reimbursement is on a fixed basis, being able to lower administrative cost per service is critical in maintaining operating funds to invest in needed community services. To achieve this administrative cost improvement, the parties are committed to identifying and implementing a common Electronic Health Record. This will be a cornerstone of the ability to eliminate unnecessary or duplicative administrative costs.

Nationally, there has been ongoing evolution in the home health and hospice industry toward more For-Profit enterprises providing care. While these organizations can offer high quality services they are ultimately driven by financial goals and not by community goals. Creating a combined organization will strengthen and help preserve a critical non-profit resource governed by community members ensuring that meeting community needs are always the primary consideration.

Current Industry Environment: The healthcare environment has become increasingly challenging for smaller non-profit service organizations. Each agency receives over 75% of its revenue from Federal programs (primarily Medicare) and major federal payment reform was instituted at the start of 2020. This has increased the financial uncertainty of both organizations. The New Hampshire market has seen an aging nurse workforce – a critical component of home-based services. Recruitment and retention of quality staff has become a greater challenge for VNAs. The non-profit home care industry has also seen increased competition from For-Profit organizations that enjoy greater access to capital. This environment has created a need for non-profit consolidation to achieve greater economies of scale and resource depth to compete with the burgeoning of profit entities.

A major consideration in home health affiliations is the ongoing provider consolidation that is occurring in health care – especially among hospital providers. Federal payment policy is pushing for total cost of care (TCOC) accountability and Accountable Care Organization (ACO) development. This has pushed hospitals to create both vertical and horizontal integration arrangements to broaden patient population and better manage the entire continuum of care. In the Capitol region, Concord Hospital (CH) is part of NH Cares ACO that includes CRVNA. Commercial insurance products also have introduced elements of total cost of care responsibility and Concord Hospital is one of a few hospital owners in the Tufts Freedom Health Plan. Such arrangements incent hospitals to seek post-acute care relationships that can cover both the full clinical spectrum of post-acute care patients and a bigger geography typically covered under TCOC arrangements. This creates issues for smaller more locally focused home health agencies to remain viable partners for the expanding health care systems.

Merger Rationale: The respective Boards of Trustees have stated the main goal for the proposed merger is the preservation of valued non-profit community resources to continue supporting community and home-based care delivery. An expected outcome of the merger is greater organization stability – both financial and clinical – to meet the shifting needs of referral sources and the communities served. Both organizations currently provide high quality services as evidenced by quality metrics tracked by Medicare Star Ratings, Home Health Compare, and Strategic Health Programs (SHP). By combining, the enhanced stability created should enable the organizations to continue offering good access to their quality services and maintain their high quality outcomes. The organizations should be better positioned together to meet future needs and weather health care changes like Medicare payment reform.

Changing Local Hospital Landscape: A major factor in the decision to seek this affiliation is the change that has been occurring in the Lakes Region. Lakes Region General Healthcare (LRGH) has been undergoing significant financial problems for the past few years. Despite efforts to identify a financial/clinical partner, no organization has emerged. The hospital closed its maternity service and many patients now go to CH for their deliveries. Because of the ongoing financial uncertainty, other elective services have been migrating from the Lakes Region to CH. The Belknap County home health and hospice out migration to the Concord area is shown in ***Table 1***. Over the five-year period from 2013 through 2018, CNHVNA has lost 19% share in home care and 24% share in hospice. Most of this share reduction has gone to CRVNA due to the ongoing exodus of Lakes Region patients to the Concord health care delivery system.

Table 1- Belknap County Market Share Change

Service	Home Health Organization	2013 Share	2018 Share	Share Change
HOME CARE				
	CNHVNA	59%	40%	-19%
	CRVNA	4%	15%	11%
	Franklin VNA	8%	11%	3%
	Lakes Region VNA	13%	17%	4%
	Newfound (Nana)	2%	2%	0%
	All Other	17%	15%	-2%
HOSPICE				
	CNHVNA	67%	43%	-24%
	CRVNA	<5%	17%	>=12%
	Franklin VNA	<5%	7%	>=2%
	Lakes Region VNA	<5%	5%	>=1%
	Compassus	<5%	5%	>=1%
	All Other	<27%	23%	N/A

Source: Home Care Market Atlas

Concord Hospital is highly integrated with its Medical Staff. The CRVNA is a member of Capital Region Health Care and has several programs that are integrated with CH service lines. These include:

- Joint Replacement "Pre-hab" Program;
- Palliative Care Services;
- Baby's First Homecoming;

- NH Cares ACO;
- COPD Collaborative;
- Transitional Care Nursing;
- IDN-2 Capital Region Healthcare.

The migration of patients from Lakes Region to Concord creates issues for both agencies. For CNHVNA, the loss of volume threatens its ability to continue to offer a full array of services cost effectively since the fixed cost administration is spread over a smaller volume thereby raising the average cost of services that are rendered. This reduces the overall resources that CNHVNA can make available to support services that do not cover their cost. Over time as this trend continues, CNHVNA would be forced to reduce or eliminate certain services.

The CH health care system looks to its integrated home care partner – CRVNA – to deliver needed post-acute care to all patients including those coming from the Lakes Region. Current Federal regulations prohibit CRVNA from 'sharing' referrals with CNHVNA. Thus, CRVNA would need to extend its services and hire more staff to cover a greater geography to meet the ongoing referral needs of the CH Medical Staff. This would be much less efficient than bringing the CNHVNA resources under the same organization so that these resources can be legally shared to maximize the effectiveness of providing post-acute care to patients receiving clinical care from Concord Hospital & Concord Medical Staff regardless of their residence. On average, the total cost to recruit, hire, on-board, and provide supplemental training to one new employee is $4,000-$5,000. It also takes an average of 40-60 days from time of position identification to fill the needed position ready to render patient service. Once hired, it takes an average of 3 months for the new hire to attain full productivity because of ramp up learning curve. This is a cost equivalent of nearly $15,000 per position.

Over time, CRVNA might need to hire an additional 5-10 FTEs to meet a continuing demand increase to serve Lakes Region patients seeking clinical care from the Concord Hospital healthcare system. The cost and time delay of building additional capacity can be avoided by combining with an organization already established to provide most of the needed services. But, an integrated organizational relationship – like the proposed merger – is required to legally allow for this coordinated work. Without the proposed merger, it would be difficult for either organization to most cost effectively meet the referral needs of the Concord Hospital Medical Group as more Lakes area patients seek services in Concord.

Both respective Boards of Trustees have considered other affiliation options over the past few years. However, given the ongoing blending of the Lakes Region market with the Concord market, both Boards independently concluded that a merger of these two organizations has greatest potential for overall community benefit. No other affiliation affords the same opportunity to plan for the most effective delivery of home-based services to patients receiving elements of health care from both the CH and LRGH delivery systems. Through numerous discussions, the Boards determined that the organizations have comparable cultures and the proximity of the respective service areas and the comparable approaches to care delivery should allow the organizations to readily integrate without significant disruption.

Clinical Service Stability and Improvement

Specialty Clinical Services Provision: The demands on the home care industry for increasingly complex care delivery has stressed staffing for specialty clinical services such as wound care, home infusion care, special pediatric care, etc. Currently CRVNA has greater resource depth in these specialty areas than CNHVNA. Often CNHVNA has only one clinical specialist available and if that person is away on vacation, out sick, or engaged in a lengthy case, CNHVNA is unable to provide timely care to a referral needing specialty services. By combining with CRVNA, greater clinical specialty resource depth can be shared and deployed to maximize ability to meet patient need. The overall timeliness of care should be enhanced which is highly valued by referring providers.

Table 2 contains a comparison of the Clinical Specialist FTEs for each organization. This shows that together a greater complement of specialty services can be more broadly available. In some cases, CRVNA has certain clinical specialists that CNHVNA lacks. By combining, these specialty services could now be made available to CNHVNA patients, thereby improving overall access to services- especially for patients in the Lakes Region.

Table 2- VNA Clinical Specialty Resources Summary

As of June 2020

Clinical Specialty	CRVNA FTEs	CNHVNA FTEs	Combined FTEs
Wound Care Certified RN	3.00	1.00	4.00
IV Certified RN	2.00	0.00	2.00
Lymphedema – PT	2.00	1.50	3.50

Lymphedema – OT	1.00	2.00	3.00
Vestibular PT	1.00	0.00	1.00
Behavioral Health Coordinators	1.00	0.00	1.00
Community Health Educators	2.00	0.00	2.00
Advanced Illness Management Nurse	1.00	0.00	1.00
Transitional Care Nurse Coordinator	0.25	0.00	0.25
Total Specialty Services	13.25	4.50	17.75
Source: Home Care Market Atlas			

Palliative Care Development: CRVNA has a robust Palliative Care service in collaboration with CH that complements its home hospice and hospice house services as well as its home care services. CNHVNA has recently launched a Palliative Care service to support Belknap and Carroll County patients as part of end of life care continuum. The proposed merger would support this new initiative – currently in its infancy – and CNHVNA can draw on the experience and expertise of CRVNA in developing comparable Palliative Care services. Because many patients receive care from both the Lakes Region and Concord medical communities, having a consistent Palliative Care service across both communities should benefit providers, patients, and families.

Behavioral Health Care Delivery: CRVNA has behavioral health resources that CNHVNA currently lacks. With the support of a Community Services grant, CRVNA was able to expand its behavioral health service to two individuals (1 FTE) who have served a census of 80 clients. These resources helped identify over 240 patients with behavioral health needs leading to 144 referrals to social work services. By combining, the agencies should be better able to continue funding these services that do not always cover their full cost. Additionally, a larger organization should be more attractive to granting agencies looking to provide funds where a larger impact can be made. The organizations have stated their intent to extend behavioral health support services to the Lakes Region after affiliation.

Both organizations have supported the statewide Clear Path initiative launched by the NH Home Care Alliance to provide training on behavioral health for home based services. Both organizations have had staff trained to support behavioral health needs identification in patients. Currently CRVNA conducts an OASIS assessment on all home care patients encountered (not just Medicare). Post-affiliation, the combined organization will conduct this assessment on all patients

including those historically served by CNHVNA. The OASIS assessment can help identify behavioral health issues that may have been missed by hospital health care providers. The merger should strengthen the resources of the combined organization allowing for more ongoing community support of mental health needs detection and social services referrals.

Staff Turnover: An element that impacts both cost of care and access to care is staff turnover. Pre-Covid, both organizations – and the home care industry overall – were facing increased staff turnover and vacancies. Greater turnover increases cost as organizations must recruit, train, and on-board new employees and endure a ramp up period before the new employee can achieve the same productivity as an outgoing employee. In 2019, CRVNA had a turnover rate of 16.5% and CNHVNA had a rate of 10%. Having unfilled positions can reduce patient access as agencies must restrict the number of patients taken under care to ensure that existing staff can provide needed services. Pre-Covid CRVNA had eight unfilled positions while CNHVNA had two. A combined entity is expected to see reductions in both turnover and vacancies.

While staff can leave for a variety of reasons, some can involve a relocation within the state or can result from an employee seeking more overall responsibility where no opportunity exists within the agency. A combined entity should be more flexible to potentially provide ongoing employment after a relocation. More importantly, the larger combined organization could provide more career advancement opportunities because of greater organization scale and breadth. This may help retain some employees seeking more responsibility. Over time, a larger organization may be able to provide more creative options for flexible employment, benefit provision, and continuing education – all of which can positively impact staff acquisition and retention.

Community Education: CRVNA has a robust community education program with commitment of two full time Community Health Educators. These individuals conduct home visits to support education goals as well as supporting wellness and a speakers bureau that has reached over 500 participants. With the merger, the community education program will be expanded to augment the current work of CNHVNA. This will enhance community benefit by sharing and expanding these resources. By combining, the joint financial strength should allow the combined organization to invest in more community education services. The organizations intend to bring the full panoply of community education services to the Lakes Region and southern Carroll County. Education programs anticipated to be extended to more of Belknap and southern Carroll County include:

- "A Matter of Balance"
- “Better Choices, Better Health"
- Powerful Tools for Caregivers
- Aging Mastery Program
- Aging Mastery Program for Caregivers@

Community Program Expansion: CRVNA currently offers many programs that support community health. Post-merger these can be expanded to the Lakes Region and southern Carroll County broadening the array available. Programs targeted for this expansion include:

- -Flu Clinics – both public and private locations;
- -Health Clinics – Foot clinics and Blood Pressure Management clinics;
- -Memory Café;
- -Caregiver Café;
- -Walk-in-Wednesday;
- -Dying to Talk;
- -Community Health Educator – Home Visits;
- -PATHS (Positive Aging Through Home Supports).

New Program Development: Combining the resources of the two organizations could support future new community-based program creation congruent with overall healthcare reform. Already both organizations are part of their respective Integrated Delivery Networks (CRVNA in IDN2 and CNHVNA in IDN5) with representatives serving on the Governance level. If/when the Lakes Region becomes part of an Accountable Care Organization initiative, the experience of CRVNA would be immediately made available to support development efforts and share lessons learned. This should be beneficial since organizations participating in ACOs have found that there is a learning curve to evolve to meet ACO needs. Since many of the new payment and delivery models contain elements of shared economic risk, a larger organization will be better positioned to spread risk over a greater patient base. It should have more patients with common clinical needs to lower the risk associated with new care approaches and programs designed to improve outcomes and reduce hospitalizations.

Financial Stability and Cost Structure Improvement

The proposed merger should enhance the financial strength of the combined organization allowing it to better withstand future reimbursement cuts by federally funded programs and more cost effectively deploy staff in the face of labor shortages and rising employee costs. Labor expense represents 75%-80% of VNA operating revenue. A larger organization can create efficiencies to offset the escalating cost per FTE. Much of the payment for VNA services is fixed – either per visit or per episode of care. Thus, finding ways to manage cost structure – particularly administrative overhead costs – is critical to ongoing viability. Because of current and anticipated future clinical service demand, the purpose of the proposed merger is NOT to reduce clinical FTEs. However, management leadership is confident the merger will allow for reduction of administrative overhead that can be spread over a greater patient base. This is reflected in Years 2 & 3 of the financial pro forma prepared by Simione. Administrative Expense represents 30%-35% of total expenses and a 5% improvement would represent more than a 1% enhancement of overall operating performance.

Integrated Electronic Medical Record (EMR): A cornerstone of the ability to reduce the average cost per visit resulting from the proposed merger is to establish a single common information technology platform for all. Immediately after merger approval, the organization will embark on a comprehensive needs analysis and a thoughtful process for EMR technology evaluation. This will result in identifying the best EMR system to support workflow efficiencies and overall organization needs. As demonstrated in the three-year pro forma financial statements, the parties anticipate creating common policies and procedures in Year 1 while going through the EMR evaluation. An EMR system will be selected and implemented throughout the organization in Year 2. A degradation in financial performance is anticipated in this year while the organization incurs one-time expense and loss of productivity to train users and install the system. However, this will set the stage for realization of improved efficiencies and cost savings that will reduce the overall average cost. This improvement is reflected in Year 3 of the pro forma. This is an ideal time to select a new EMR because Medicare instituted a new prospective payment system – the Patient Driven Groupings Model (PDGM) in January. As the needs for success under this new payment system – which impacts over 70% of the combined revenue – an appropriate EMR can be selected.

Anticipated Administrative Cost Efficiencies: Because so much of the home health and hospice revenue is derived from Federal programs, there is significant administrative burden placed on these agencies. This has made it increasingly difficult for small agencies to survive because the high administrative cost burden cannot be recovered under the fixed payment contracts that exist. Combining these two organizations under one license and Medicare provider number will allow for some administrative economies of scale. This should occur in areas such as;

- Medicare survey readiness;
- Medicare cost reporting;
- Development and maintenance of policy and procedure manuals;
- Preparation and delivery of statistical reporting;
- Participation in Professional Advisory Committees;
- After hours call coverage;
- Accreditation fees;
- Professional and Trade Organization Membership fees;
- Computer Hardware and Software Licensure fees.

There also should be savings from coordination of office space utilization and associated utility costs; office equipment costs; and supply inventory management. CRVNA long term planning has identified the need for more space to support planned program growth and anticipates it will grow beyond its current facility capacity. CNHVNA currently has a surplus of space and by combining the aggregate facility use can be optimized allowing CRVNA to delay, or avoid altogether, the expense of acquiring more facility capacity.

Both CRVNA and CNHVNA have participated in performance benchmarking through the VNA Health System of Northern New England. One measure calculated is average cost per visit associated with overhead as opposed to direct clinical service related costs. For the past few years, CRVNA and CNHVNA have had similar direct costs per visit for both skilled nursing and physical therapy services (the two highest volume services in home care). However, CRVNA has an average overhead cost per visit that is less than half the amount of CNHVNA. This shows the impact that greater scale can have on overall cost per visit. The merger should allow the overhead cost per visit associated with CNHVNA historic volumes to reduce closer to the CRVNA level.

Staff Deployment: Creating a larger combined organization with a common EMR supporting a common service area should support enhanced geographic assignment of clinical resources. This can reduce the travel time between patients which

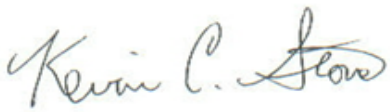
reduces mileage costs and the down time of a clinician engaged in non-patient care activity. Currently the travel time component of a home care visit represents 17%-24% of total visit time. Historically CNHVNA has had greater travel time than has CRVNA in part because of fewer patients and less resource depth. The goal post-merger would be to bring the CNHVNA portion of visit time associated with travel closer to the CRVNA level. More efficient scheduling of staff to cover a larger patient base within the geographic coverage area can reduce this cost and enhance the number of patients per day that can be served.

In aggregate, these various cost improvements should result in a lower overall average cost per visit or cost per episode and improved net margins. This will lead to an increase in the number of patients the combined organization can serve resulting in better patient access and outcomes.

Preservation of Non-Profit Mission Driven Community Organization

The proposed merger is important to ensuring a vibrant non-profit home health service can continue to serve the community. Nationally, for-profit organizations have increased their presence as health care delivery shifts to more of a home and community-based focus. NH has seen growth of organizations such as Compassus, Interim, Bayada, LHC Group, Amedisys, etc. While these organizations can offer quality services, they are driven by the profit motive and not by community service. They do not feature community voices in their governance structure. The VNAs have a long history of providing valuable services driven by community needs – some of which may conflict with maximization of profit. It is critical to preserve and strengthen the non-profit voice during this period of health care stress and consolidation. This merger will ensure ongoing governance input from Merrimack, Belknap, and Carroll County members in guiding the home care and hospice delivery to the communities served.

Respectfully Submitted,



Kevin C. Stone
Senior Consultant

APPENDIX J
LRGHealthcare Community Needs Assessment

LRGHealthcare

care. compassion. community.

Community Health Needs Assessment

2014

Community Responses on Health Issues and Priorities, Selected Service Area Demographics and Health Status Indicators

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LRGHealthcare
2014 Community Health Needs Assessment

EXECUTIVE SUMMARY

During the period April through July, 2014, a Community Health Needs Assessment in the LRGHealthcare service area of New Hampshire was conducted by LRGHealthcare. The purpose of the assessment was to identify community health concerns, priorities and opportunities for community health and health care delivery systems improvement. For the purposes of the assessment, the geographic area of interest was 26 cities and towns in the Lakes and Three Rivers Region of New Hampshire, with a total resident population of 98,249, served by the LRGHealthcare system including Lakes Region General Hospital and Franklin Regional Hospital. Methods employed in the assessment included a survey of area residents made available through direct mail and website links, a series of community discussion groups convened in the Franklin Region and the Laconia Region (the latter conducted in 2013 in collaboration with the Lakes Region Partnership for Public Health), and a review of available population demographics and health status indicators. The table below provides a summary of community health needs and issues identified through the survey of community health needs and priorities, the community health discussion groups, and the collection of indicators of community health status.

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE			
Community Health Issue	**Community Survey**	**Community Discussion Groups**	**Community Health Status Indicators**
Access to Primary/Family Healthcare	Selected as an important community health issue by 51% of survey respondents		About 16% of adults report not having a personal doctor or health care provider, compared with 12.5% of adults in NH overall; Rates of emergency department use for diabetes and asthma in the region exceeds rates for NH overall
Alcohol and Drug Abuse Prevention, Treatment and Recovery	Selected as an important community health issue by 43% of survey respondents	Selected as a top priority for community health improvement by community discussion group participants	Rates of excessive alcohol use among adults in the region are similar to NH overall; the rate of emergency department utilization for substance abuse related mental health conditions is higher than the rate for NH overall

Mental Healthcare	Selected as an important community health issue by 41% of survey respondents	Access to Mental Health/Behavioral Health Care Services selected as a top priority for community health improvement by community discussion group participants	The suicide rate in the region has exceeded the rate for NH overall in recent years; the rate of emergency department utilization for mental health conditions is higher than the rate for NH overall
Jobs; Poverty	Job opportunities selected as a resource supporting a healthy community that needs more attention by 51% of survey respondents	Poverty selected as a top priority for community health improvement by community discussion group participants	Median household income is lower than in NH overall for the majority of communities in the region and the proportion of individuals living near or below the poverty level is higher
Dental Care	Selected as an important community health issue by 24% of survey respondents	Access to Dental Care Services selected as a top priority for community health improvement by community discussion group participants	About 18% of adults report not having seen a dentist within the past 5 years, compared with about 12% of adults in NH overall
Cost of Health Care Services and Access to Affordable Health Insurance	Topic of numerous survey comments	Access to Health Insurance selected as a top priority for community health improvement by community discussion group participants	The uninsurance rate for the region is estimated at 11.7% and exceeds the overall rate for New Hampshire in the majority of communities in the service area
Weight Related Health Issues	Selected as an important community health issue by 36% of survey respondents		The proportion of adults who are overweight or obese is similar to NH overall, but the percentage of adults who are obese has steadily increased in recent years
Transportation	Selected as a resource supporting a healthy community that needs more attention by 34% of survey respondents	Selected as a top priority for community health improvement by community discussion group participants	
Assistance with care coordination and health system navigation	Selected as a resource supporting a healthy community that needs more attention by 29% of survey respondents	Identified as a key strategy for community health improvement by discussion group participants	
Education	Selected as a resource supporting a healthy community that needs more attention by 22% of survey respondents	Selected as a top priority for community health improvement by community discussion group participants	

A. COMMUNITY SURVEY RESULTS WITH SELECTED SERVICE AREA DEMOGRAPHICS

The total population of the combined LRGHealthcare Service area in 2012 (most recent estimate available) was 98,249 according to the United States Census Bureau (American Community Survey, 5 year estimate), which is an increase of about 800 people or 0.9% from the most recent census completed in 2009. The 2014 Healthcare Community Needs Assessment Survey conducted by LRGHealthcare yielded 1,651 individual responses including 1,492 from towns within the service area or approximately 2.0% of the total adult population. (A total of 159 survey respondents were from towns outside the region or did not identify their town of residence). As shown by Table 1, survey respondents from the LRGH service area are represented in close proportion to the total service area population, although residents of Laconia and Gilford are somewhat over-represented in proportion to their total population. Residents of the FRH service area are somewhat under-represented among survey respondents overall. About 25% of total survey responses were from towns in the Franklin region, although the combined population of these towns comprises about 36% of the total service area population. It is also important to note that 2014 survey respondents were older on average than the general population (63% of respondents were 60 or more or years of age) and more likely to be female (66% of respondents).

TABLE 1: Service Area Population by Town and Hospital Service Area;
Comparison to Proportion of 2014 Community Survey Respondents

	2012 Population	% Total Population	% of Respondents	Difference
LRGH Service Area	**63130**	**64.3%**	**65.5%**	**1.2%**
Alton	5240	5.3%	3.4%	-1.9%
Ashland	1653	1.7%	0.7%	-1.0%
Belmont	7345	7.5%	5.9%	-1.5%
Barnstead	4586	4.7%	0.4%	-4.3%
Center Harbor	1034	1.1%	1.7%	0.6%
Gilford	7140	7.3%	11.1%	3.8%
Gilmanton	3761	3.8%	3.8%	-0.1%
Laconia	16062	16.3%	20.8%	4.5%
Meredith	6260	6.4%	7.0%	0.7%
Moultonborough	4078	4.2%	5.0%	0.8%
New Hampton	2234	2.3%	2.0%	-0.3%
Sandwich	1224	1.2%	1.9%	0.6%
Tuftonboro	2513	2.6%	1.8%	-0.7%

TABLE 1 (continued)

FRH Service Area	35119	35.7%	24.9%	-10.9%
Alexandria	1817	1.8%	1.4%	-0.5%
Andover	2503	2.5%	1.0%	-1.6%
Boscawen	3969	4.0%	1.3%	-2.8%
Bridgewater	1268	1.3%	0.7%	-0.6%
Bristol	3060	3.1%	2.7%	-0.4%
Danbury	1218	1.2%	1.2%	-0.1%
Franklin	8499	8.7%	5.9%	-2.8%
Hebron	563	0.6%	0.1%	-0.5%
Hill	1210	1.2%	0.5%	-0.7%
Northfield	4848	4.9%	3.7%	-1.2%
Salisbury	1289	1.3%	0.4%	-0.9%
Sanbornton	1289	1.3%	3.0%	1.7%
Tilton	3586	3.6%	3.1%	-0.5%
Other/Unknown			9.6%	

Table 2 beginning on the next page displays additional demographic information for the towns and cities of the LRGHealthcare Service Area. On this table, municipalities are categorized in lower, middle and higher income categories according to median household income (Note: These categories are only relative within the service area and were created to inform the analysis of survey responses). At the end of the table, service area and sub-regional averages are also provided for these demographic indicators.

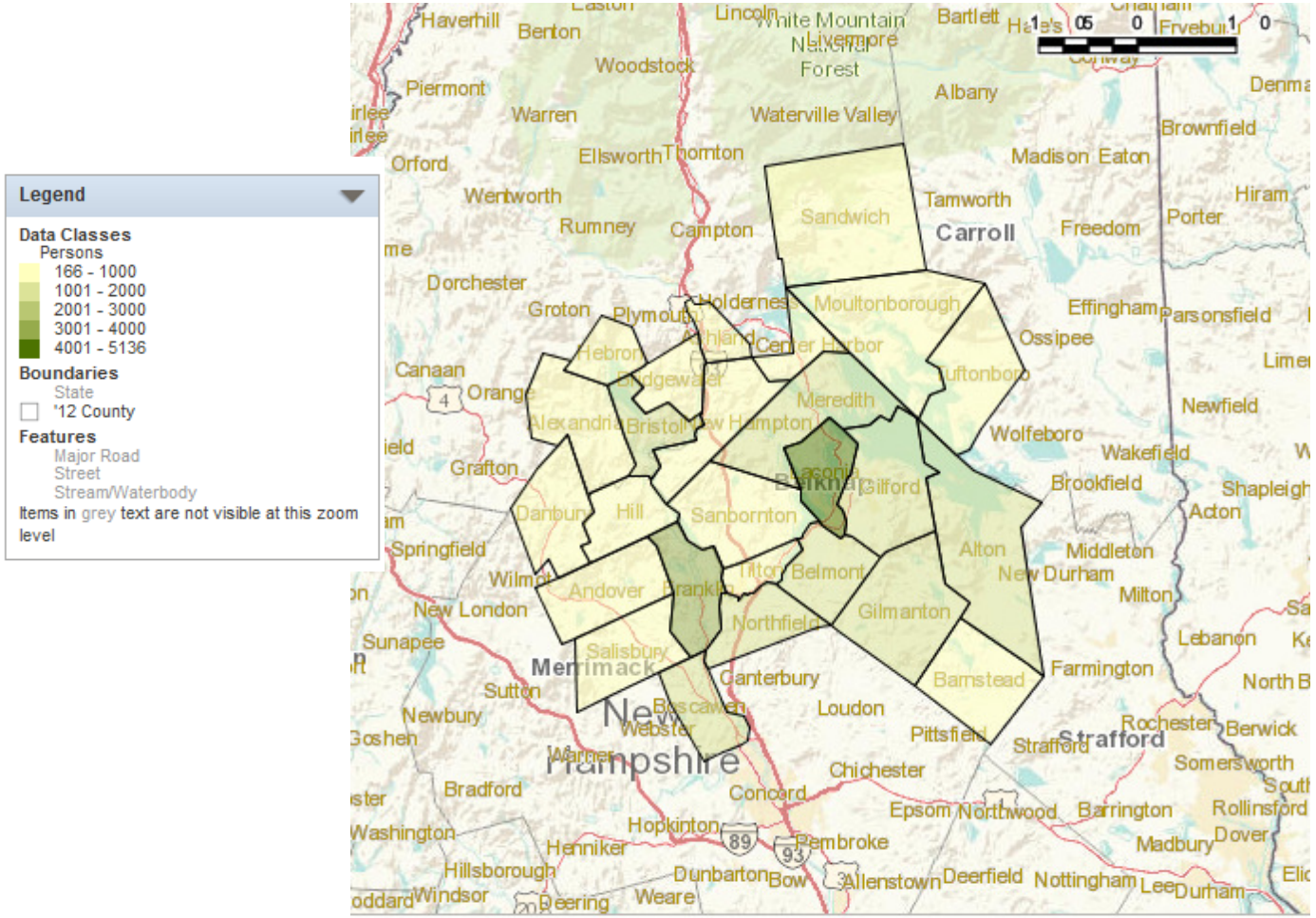
As displayed by the table, the region has a higher proportion of individuals with household incomes at 200% of the federal poverty level or less (28.1%) when compared to the State of New Hampshire overall (22.1%), with the Franklin sub-region in particular having a relatively high rate of residents living in or near poverty (32.4%). The region also has a higher proportion of individuals with Medicaid coverage (14.4% compared with 10.7% for NH) and Medicare coverage (18.4% compared with 15.2% for NH). The latter statistic is related to the higher proportion of elderly in the region compared with the state (17.1% age 65+ compared with 14.1% for NH). Figure 1 following this table displays a map of the service area with shading depicting the number of area residents in each municipality with incomes below 200% of the federal poverty level.

TABLE 2: Selected Demographic, Economic and Insurance Indicators

	Median Household Income	% at 200% Poverty or Less	% with Medicaid	% with Medicare	% Below 5 Years	% 65+
Lower Income Communities (total Population =38,047)						
Ashland	$40,213	36.1%	20.1%	21.8%	10.2%	19.7%
Franklin	$43,856	42.0%	22.3%	14.8%	5.4%	13.0%
Bristol	$46,287	40.8%	16.7%	19.4%	3.6%	19.4%
Danbury	$46,842	36.6%	22.0%	13.7%	2.7%	12.3%
Laconia	$47,817	33.3%	21.5%	19.2%	5.2%	16.6%
Tilton	$51,198	29.0%	10.6%	20.0%	4.4%	19.6%
Boscawen	$52,171	33.6%	21.7%	16.9%	5.5%	19.3%
Middle Income Communities (total Population =25,977)						
Meredith	$56,007	22.3%	11.0%	23.8%	2.7%	23.3%
Sandwich	$56,364	22.5%	8.4%	28.9%	1.6%	27.9%
Alexandria	$58,171	37.4%	15.6%	13.9%	11.1%	11.7%
Hebron	$58,333	29.8%	14.4%	28.2%	4.6%	29.5%
Hill	$58,571	35.2%	20.2%	13.6%	5.2%	9.3%
Alton	$58,883	19.6%	12.9%	21.2%	4.4%	19.9%
Center Harbor	$59,417	20.9%	6.2%	21.9%	4.0%	21.1%
Northfield	$60,029	33.8%	13.8%	13.4%	8.1%	11.9%
Bridgewater	$60,104	17.2%	12.3%	18.7%	2.6%	15.2%
Tuftonboro	$60,143	29.2%	12.8%	23.3%	5.0%	21.8%
Higher Income Communities (total Population =34,225)						
New Hampton	$61,463	27.1%	12.4%	16.8%	3.1%	15.2%
Belmont	$62,767	25.2%	13.8%	14.9%	5.9%	11.9%
Gilford	$63,061	22.2%	9.3%	19.7%	3.5%	18.8%
Gilmanton	$63,977	31.4%	11.0%	14.0%	4.8%	12.8%
Sanbornton	$64,494	18.0%	4.5%	14.1%	18.9%	33.7%
Barnstead	$66,458	19.4%	8.0%	13.7%	8.6%	12.4%
Moultonborough	$68,022	12.9%	5.1%	26.7%	3.1%	23.8%
Salisbury	$68,438	14.7%	6.7%	15.1%	5.0%	11.9%
Andover	$70,583	18.0%	11.8%	21.4%	5.0%	19.2%
New Hampshire	$64,925	**22.1%**	**10.7%**	**15.2%**	**5.1%**	**14.1%**
Service Area Total		28.1%	14.4%	18.4%	5.3%	17.1%
Franklin Sub-Region		32.4%	15.9%	16.3%	6.1%	16.1%
Lakes Sub-Region		25.4%	13.4%	19.5%	4.6%	17.7%

Figure 1 – Number of People Whose Income in the Past 12 months is below 200% of the federal poverty level

2008-2012 American Community Survey; Map source: American Factfinder



Bureau, 2008-2012 American Community Survey

1. Most Important Community Health Issues Identified by Survey Respondents

Table 3 displays the most important health issues as selected by respondents to the 2014 LRGHealthcare Community Needs Assessment Survey. As the table displays, there is a high level of correspondence between the Laconia and Franklin sub-regions with respect to the most important health issues. Chart 1 following this table displays the health issues with the greatest variation between the two sub-regions. For example, a higher proportion of residents in the LRGH service area (45.6%) indicated that "alcohol and drug abuse" was among the most important health issues than in the FRH service area (37.0%; difference=8.6%). The greatest variation in the other direction was for "dental care" where FRH service area residents were somewhat more likely to indicate that as an important health issue (30.2%) compared with LRGH service area residents (21.5%; difference=8.7%).

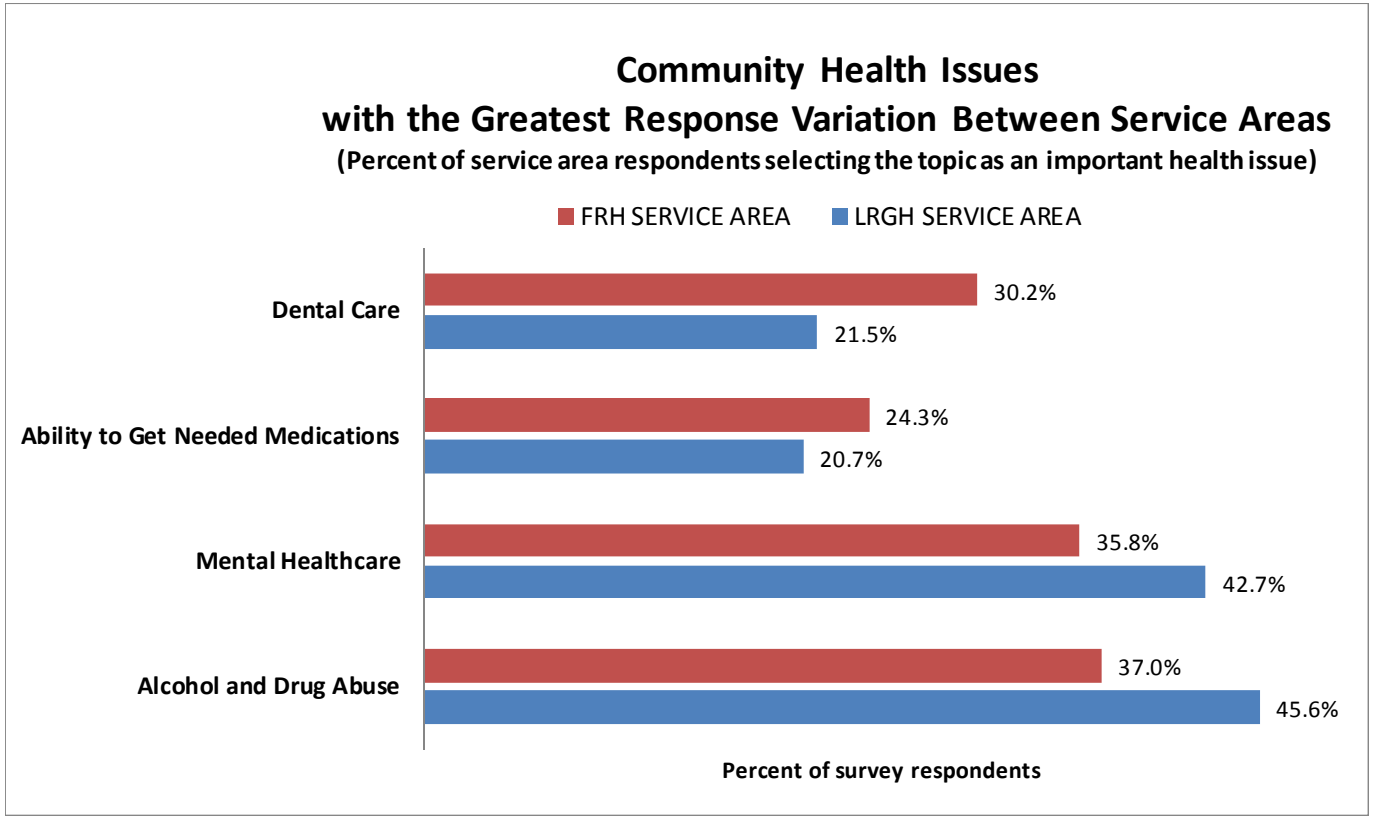
Table 3: Most Important Health Issues in the Community; Overall and by Hospital Service Area

(Survey respondents were asked to select the top 5 most important health issues)

ALL (% of respondents selecting the issue)	n=1651	LRGH SERVICE AREA	n=1081	FRH SERVICE AREA	n=411
Access to Primary/Family Healthcare	51.1%	Access to Primary/Family Healthcare	50.0%	Access to Primary/Family Healthcare	53.0%
Alcohol and Drug Abuse	43.1%	Alcohol and Drug Abuse	46.6%	Alcohol and Drug Abuse	37.0%
Mental Healthcare	40.9%	Mental Healthcare	42.7%	Weight Related Health Issues	36.5%
Weight Related Health Issues	35.8%	Weight Related Health Issues	36.4%	Mental Healthcare	35.8%
Access to Specialty Services	29.3%	Healthcare for Seniors	29.0%	Access to Specialty Services	31.1%
Healthcare for Seniors	28.3%	Access to Specialty Services	28.4%	Dental Care	30.2%
Cancer	27.8%	Cancer	27.2%	Cancer	28.2%
Dental Care	24.2%	Dental Care	21.5%	Healthcare for Seniors	25.8%
Ability to Get Needed Medications	22.0%	Ability to Get Needed Medications	20.7%	Ability to Get Needed Medications	24.3%
Health Education and Wellness	18.4%	Health Education and Wellness	18.2%	Health Education and Wellness	16.1%
Alzheimer's	13.9%	Alzheimer's	13.5%	Diabetes	14.6%
Diabetes	13.7%	Diabetes	13.0%	Alzheimer's	12.9%
Smoking/Smokeless Tobacco Use	12.5%	Smoking/Smokeless Tobacco Use	12.9%	High Blood Pressure/High Cholesterol	12.4%
Nutrition	11.9%	Nutrition	11.8%	Smoking/Smokeless Tobacco Use	11.9%
Heart Disease	10.9%	Heart Disease	10.5%	Nutrition	10.9%
Healthcare Financing Counseling	10.3%	Healthcare Financing Counseling	9.3%	Healthcare Financing Counseling	10.7%

ALL (% of respondents selecting the issue)	n=1651	LRGH SERVICE AREA	n=1081	FRH SERVICE AREA	n=411
High Blood Pressure/High Cholesterol	10.2%	High Blood Pressure/High Cholesterol	9.0%	Heart Disease	10.2%
Emergency Preparedness	8.3%	Emergency Preparedness	8.7%	Emergency Preparedness	8.0%
Prenatal/Pregnancy Care	6.5%	Prenatal/Pregnancy Care	6.0%	Prenatal/Pregnancy Care	7.1%
Chronic Lung Disease	3.8%	Chronic Lung Disease	3.7%	Chronic Lung Disease	4.4%
Osteoporosis	2.2%	Osteoporosis	2.2%	Osteoporosis	2.2%
Asthma	2.0%	Asthma	1.9%	Asthma	1.9%
Lead Poisoning	0.5%	Lead Poisoning	0.4%	Lead Poisoning	0.7%

CHART 1



As displayed by Table 4, there was also similarity in responses to the question of most important health issues when municipalities are grouped by income strata rather than service area. The most notable difference is that lower income communities were more likely to cite "alcohol and drug abuse" as an important issue (50.3% of respondents from lower income communities selecting this as an important issue) than respondents from higher income communities (36.5% of respondents from middle income and 42.1% from higher income communities selected alcohol and drug abuse as an important issue). Variation in the other direction can be noted for "access to primary/family health care" where respondents from lower income communities were somewhat less likely to select this as an important issue compared to respondents from other communities.

Table 4: Most Important Health Issues by Community Income Category (median household income)

Lower Income Communities (% of respondents selecting the issue)	**n=590**	**Middle Income Communities**	**n=367**	**Higher Income Communities**	**n=535**
Alcohol and Drug Abuse	50.3%	Access to Primary/Family Healthcare	54.2%	Access to Primary/Family Healthcare	53.5%
Access to Primary/Family Healthcare	46.4%	Mental Healthcare	39.8%	Mental Healthcare	42.4%
Mental Healthcare	40.0%	Alcohol and Drug Abuse	36.5%	Alcohol and Drug Abuse	42.1%
Weight Related Health Issues	38.3%	Weight Related Health Issues	35.4%	Weight Related Health Issues	35.0%
Healthcare for Seniors	36.1%	Access to Specialty Services	30.5%	Access to Specialty Services	29.5%
Cancer	29.0%	Healthcare for Seniors	30.5%	Healthcare for Seniors	28.6%
Access to Specialty Services	28.0%	Cancer	25.1%	Cancer	27.5%
Dental Care	25.3%	Dental Care	24.5%	Dental Care	21.9%

Table 5 shows responses to the question of most important health issues by age group. While different age groups were more similar than different in their responses overall, 'Mental Healthcare' and 'Alcohol and Drug Abuse' were selected more frequently by respondents in younger age groups as important issues compared to older respondents. Respondents in older age groups were more likely to identify 'Healthcare for Seniors' and 'Cancer' as top health issues in the community.

TABLE 5: Most Important Health Issues by Respondent Age

18-44 years	n=129	45-59 years	n=451	60-74 years	n=763	75+ years	n=243
Mental Healthcare	58.1%	Access to Primary/Family Healthcare	56.3%	Access to Primary/Family Healthcare	52.3%	Access to Primary/Family Healthcare	42.4%
Alcohol and Drug Abuse	57.4%	Mental Healthcare	48.1%	Alcohol and Drug Abuse	40.2%	Healthcare for Seniors	40.3%
Access to Primary/Family Healthcare	44.2%	Alcohol and Drug Abuse	46.3%	Mental Healthcare	37.9%	Alcohol and Drug Abuse	38.3%
Weight Related Health Issues	39.5%	Weight Related Health Issues	38.4%	Weight Related Health Issues	34.9%	Cancer	38.3%
Health and Wellness Education	27.9%	Access to Specialty Services	29.0%	Healthcare for Seniors	33.2%	Weight Related Health Issues	31.7%

Table 6 shows a comparison of the top community health issues identified in the 2014 LRGHealthcare Community Needs Assessment Survey with a similar survey conducted in 2011. In general, the top issues selected by community survey respondents have not changed since 2011 overall. However, it is important to note that the proportion of respondents selecting the issues of "alcohol and drug abuse" and "mental healthcare" each increased substantially in 2014 (8% and 9% increase respectively), while "weight related health issues" and "healthcare for seniors" were each selected by relatively fewer respondents as a percentage of all responses in 2014 compared to 2011.

TABLE 6: Comparison of Most Important Health Issues; 2014 and 2011

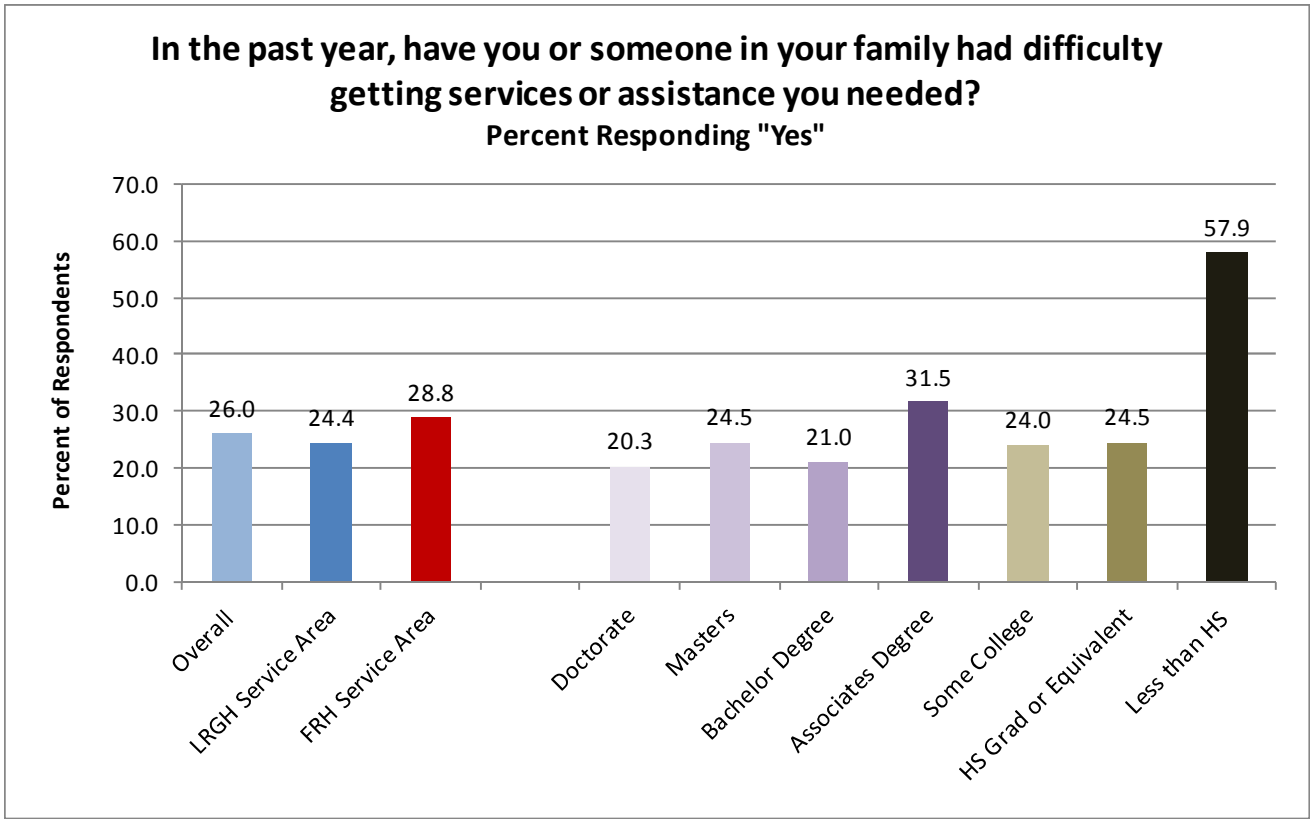
Percent of Community Needs Assessment Survey Respondents Selecting the Issue

2014 Community Needs Survey	n=1651	2011 Community Needs Survey	N=561
Access to Primary/Family Healthcare	51.1%	Access to Primary/Family Healthcare	49.6%
Alcohol and Drug Abuse	43.1%	Weight Related Health Issues	41.0%
Mental Healthcare	40.9%	Alcohol and Drug Abuse	35.1%
Weight Related Health Issues	35.8%	Healthcare for Seniors	33.9%
Access to Specialty Services	29.3%	Mental Healthcare	31.4%
Healthcare for Seniors	28.3%	Cancer	27.5%
Cancer	27.8%	Dental Care	27.5%
Dental Care	24.2%	Access to Specialty Services	26.2%

2. Barriers to Services Identified by Survey Respondents

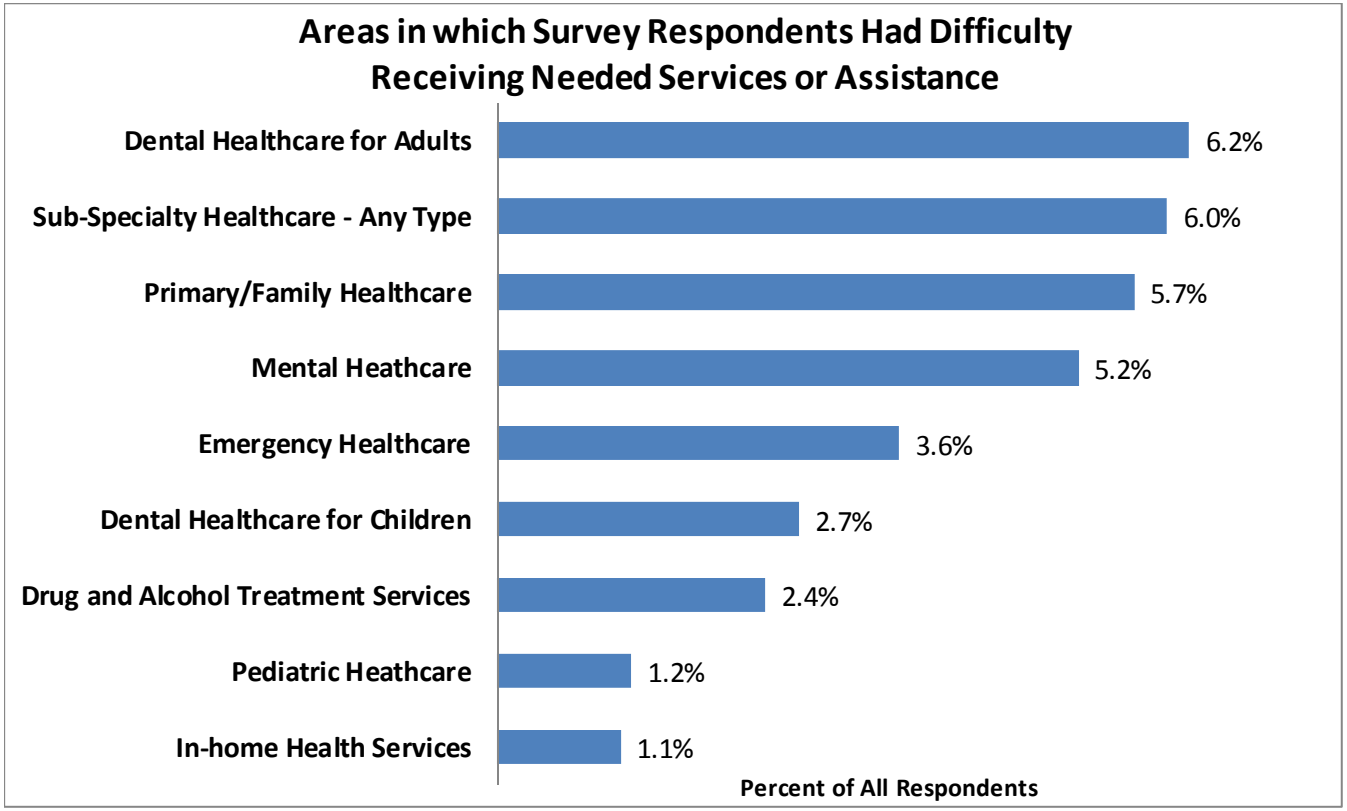
Respondents to the 2014 Community Needs Assessment Survey were asked, “In the past year, have you or someone in your family had difficulty getting services or assistance you needed?” Overall, 26.0% of survey respondents indicated having such difficulty. Chart 2 displays these results overall and by hospital service area. Chart 3 also displays the relationship between education level and likelihood of reporting difficulty accessing services. Respondents with less than a high a school education were substantially more likely to report experiencing difficulty, while those with doctorate degrees were least likely. (It is important to note that these two groups also had the fewest number of respondents; Less than High School=19 respondents, Doctorate=69 respondents). There was no notable difference between community level income categories and the likelihood of respondents indicating difficulty accessing services or assistance they needed.

CHART 2



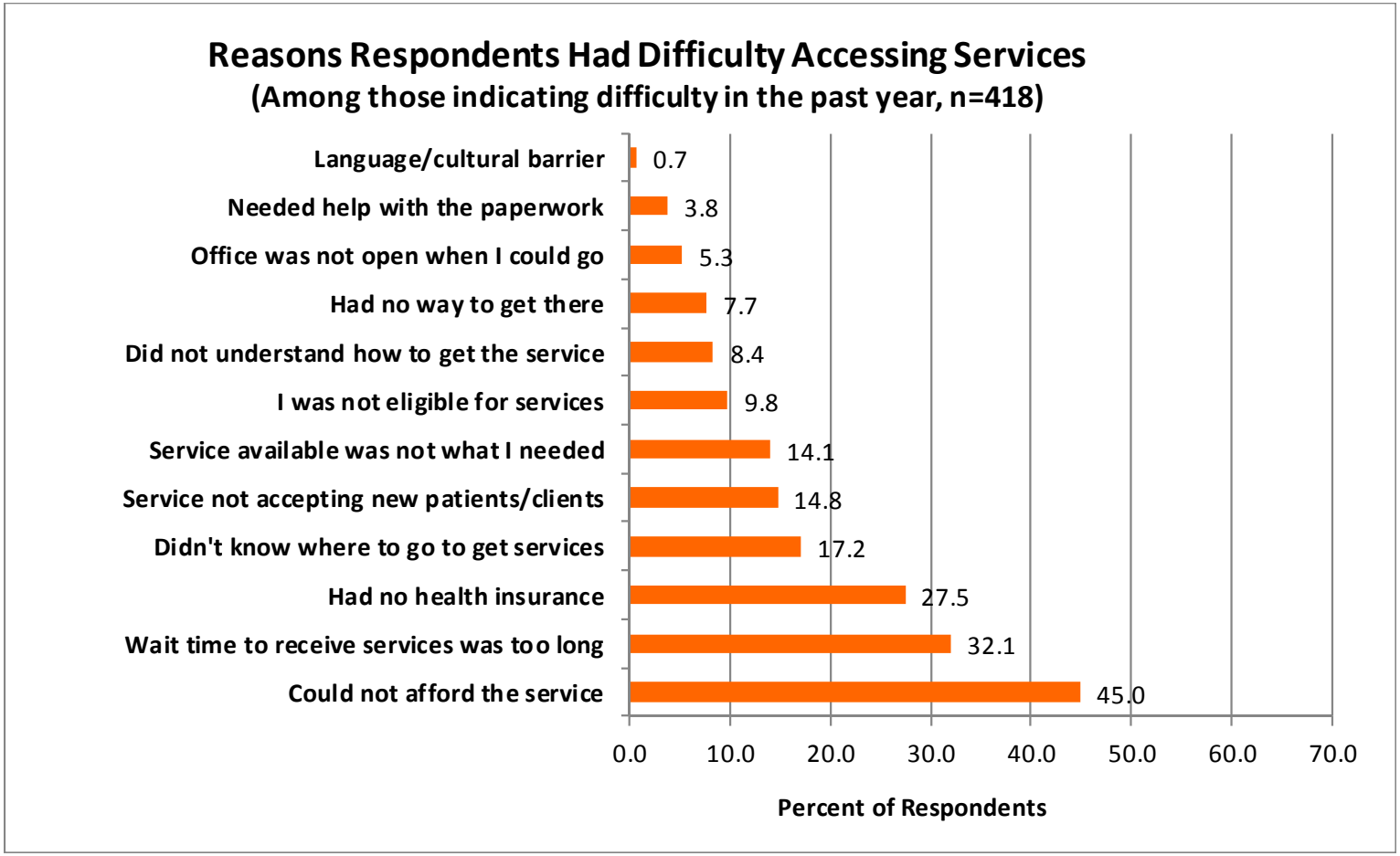
The survey also asked people to indicate the areas in which they had difficulty getting services or assistance. Chart 3 shows that the most common service type that respondents had difficulty accessing was adult dental care (6.2% of all respondents; 8.3% of FRH service area respondents, 5.0% of LRGH service area respondents).

CHART 3



Respondents who reported difficulty accessing services in the past year for themselves or family member were also asked to indicate the reasons why they had difficulty. As shown on Chart 4, the top reasons cited were affordability of the service (45.0%), wait time (32.1%) and lack of insurance (27.5%).

CHART 4



Further analysis of these two questions addressing access to specific types of services is shown by Table 7. Among respondents indicating difficulty accessing adult dental care, about 81% also indicated they had difficulty accessing services in the past year due to affordability of services and 50% indicated difficulty due to lack of insurance. Among respondents indicating difficulty accessing emergency healthcare in the past year, 62.7% also indicated difficulty accessing services because the wait time was too long.

TABLE 7: TOP REASONS RESPONDENTS HAD TROUBLE RECEIVING SERVICES BY TYPE OF SERVICE

(Percentage of respondents who reported trouble receiving a particular type of service)

Dental Healthcare for Adults (n=102, 6.2% of all respondents)	Primary/Family Healthcare (n=94, 5.7% of all respondents)	Mental Healthcare (n=86, 5.1% of all respondents)	Emergency Healthcare (n=59, 3.6% of all respondents)
81.4% of respondents who reported difficulty receiving dental healthcare for adults also reported they *Could not afford services*	**56.4%** of respondents who had trouble receiving primary healthcare also reported they *Could not afford services*	**43%** of respondents who had trouble receiving mental healthcare also reported they *Could not afford services*	**62.7%** of respondents who had trouble receiving emergency healthcare also reported *Wait time to receive service was too long*
Had no Health Insurance, **50.0%**	*Had no Health Insurance*, **43.6%**	*Wait time to receive service was too long*, **33.7%**	*Could not afford services*, **33.9%**
Didn't know where to get services, **17.6%**	*Service not accepting new Patients*, **27.7%**	*Service not accepting new Patients*, **27.9%**	*Had no Health Insurance*, **23.7%**
Wait time to receive service was too long, **17.6%**	*Wait time to receive service was too long*, **24.5%**	*Had no Health Insurance*, **25.4%**	*Service available was not what I needed*, **13.6%**
Service not accepting new Patients, **13.7%**	*Didn't know where to get services*, **16.0%**	*Service available was not what I needed*, **24.4%**	*Didn't know where to get services*, **11.9%**

3. Community Health Resources Needing More Attention As Identified by Survey Respondents

The 2014 LRGHealthcare Community Needs Assessment Survey also asked people to select resources that need more attention in their community from a list of potential resources that support a healthy community. As shown by Chart 5, the top resources identified by survey respondents as needing more attention were job opportunities, support for older adults and transportation.

CHART 5

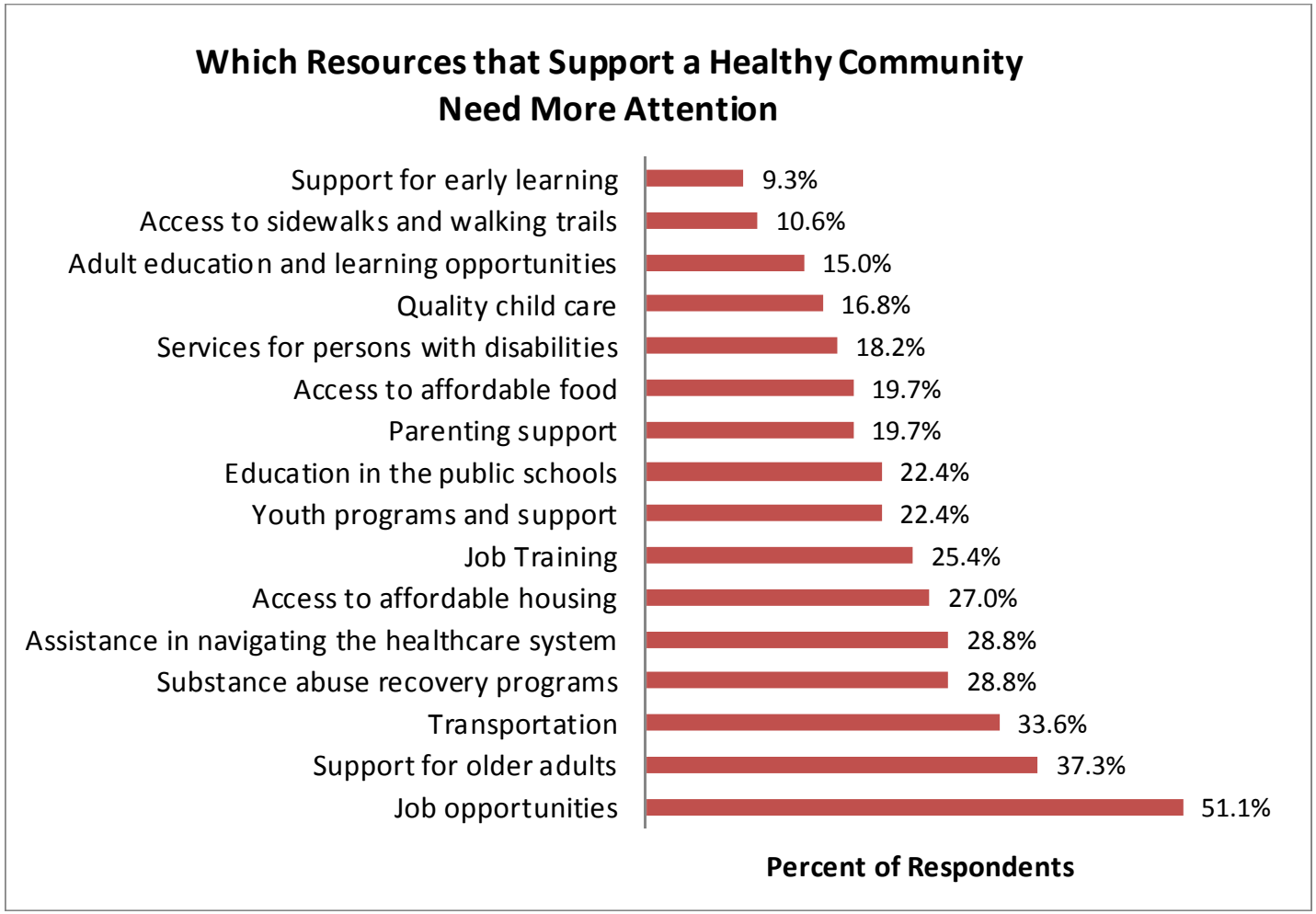


Chart 6 displays a comparison of responses to the question of resources needing more attention by sub-region. The chart displays resources for which there was the greatest variation between sub-regions. For example, a need for more substance abuse recovery programs was identified by about 32% of respondents from the LRGH service area compared to about 22% of those from the FRH service area. A difference in the other direction was observed for the proportion of respondents from the FRH region identifying a need for more attention to education in the public schools (28.2%) compared with respondents from the LRGH region (19.4% selecting this issue).

CHART 6

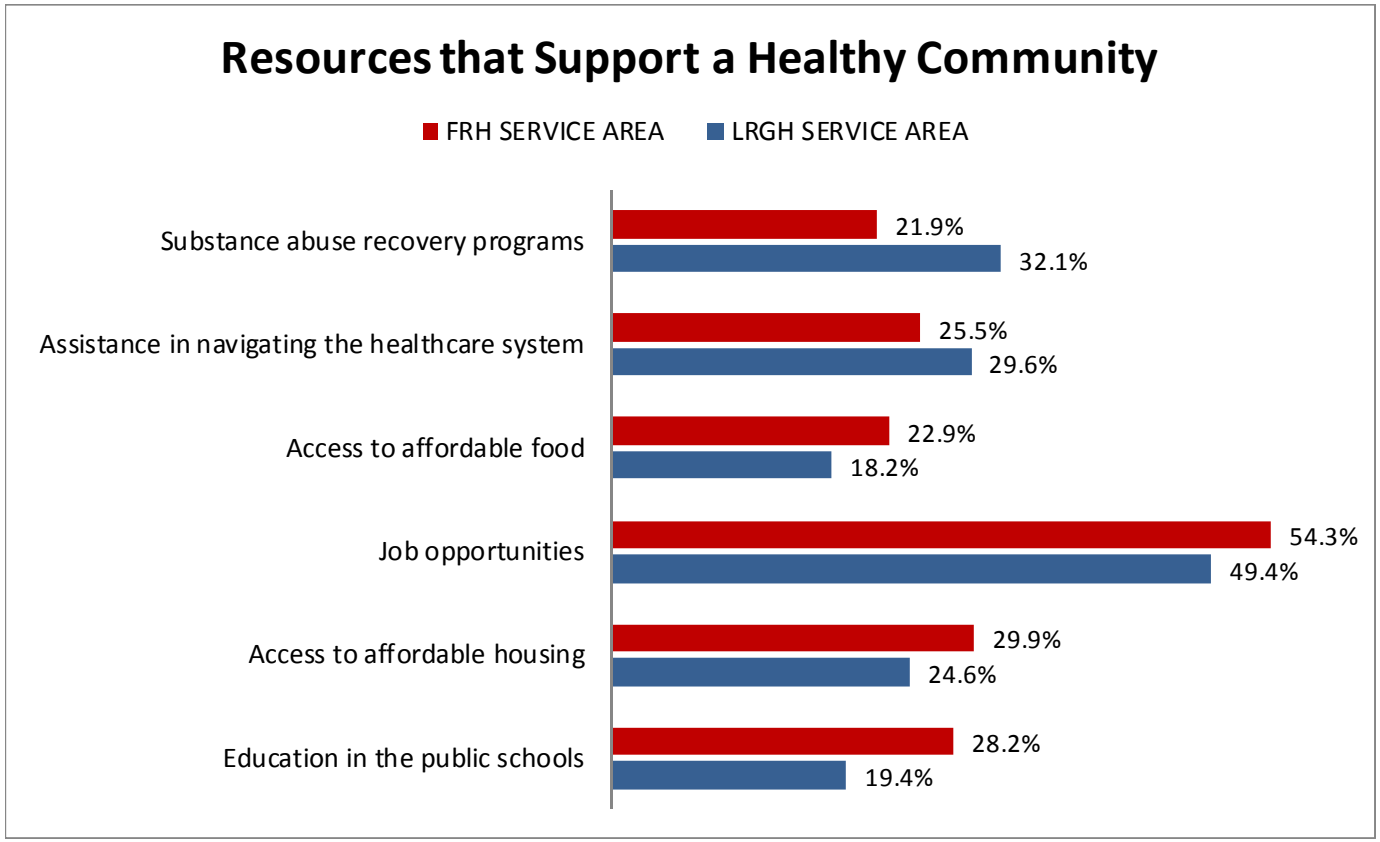


Table 8 shows responses to the question of resources supporting a healthy community that need more attention by age group. The most notable differences are observed in the youngest age group where substance abuse recovery programs topped the list of resources needing more attention, as well as youth programs and parenting support. Support for older adults was selected more frequently by respondents from older age groups, as well as services for persons with disabilities which was selected by 27% of respondents aged 75 years or older.

TABLE 8: Resources Supporting a Healthy Community that Need More Attention by Respondent Age

18-44 years	n=129	45-59 years	n=451	60-74 years	n=763	75+ years	n=243
Substance abuse recovery programs	43.4%	Job opportunities	57.0%	Job opportunities	51.6%	Job opportunities	42.4%
Job opportunities	41.9%	Transportation	33.7%	Support for older adults	42.6%	Support for older adults	42.4%
Youth programs and support	34.9%	Assistance in navigating the healthcare system	33.5%	Transportation	33.7%	Transportation	35.0%
Transportation	32.6%	Support for older adults	31.7%	Access to affordable housing	28.7%	Substance abuse recovery programs	29.2%
Parenting support	31.0%	Substance abuse recovery programs	29.9%	Assistance in navigating the healthcare system	28.0%	Services for persons with disabilities	27.2%

The 2014 LRGHealthcare Community Needs Assessment Survey asked people to provide responses to the question, ***"If you could change one thing that you believe would contribute to better health in your community, what would you change?"*** A total of 1,012 survey respondents (61.3%) provided written responses to this question. The table below provides a summary of the most common responses by topic. The topics are further grouped into categories with similar or related themes. The top seven topics in terms of most frequent responses are shown with text in bold. Substance Abuse Prevention (9.0% of comments) and Affordability of Health Care (6.7%) were the top two most frequent response topics. Appendix C to this report contains the complete text for all 1,012 responses. Survey respondents were also provided an opportunity to share additional comments at the end of the survey. A total of 431 additional comments were made. These comments were also organized by the same general topic framework with the complete text included as Appendix D to this report.

TABLE 9
"If you could change one thing that you believe would contribute to better health in your community, what would you change?"

Substance Abuse Prevention, Treatment; Control	**9.0%**
Accessibility/Availability of Mental Health Services	**4.4%**
Tobacco Prevention and Control	1.4%
Affordability of Health Care/Low Cost or Subsidized Services	**6.7%**
Health Care Reform/Health Policy	**4.0%**
Health Care Provider Availability including certain Specialties; Hours and Wait Time; Access to Care in General	**3.1%**
Accessibility/Affordability of Dental Care	2.6%
Senior Services; Care for Elderly	2.0%
Quality of Care	1.9%

Improved Communication; Care Coordination/System Navigation	1.2%
Emergency Care	1.2%
Affordability/Availability of Health Insurance	1.2%
Access/Affordability of Medications	1.0%
Availability, Improvement of Hospital Services	0.8%
Availability of Walk-In Care	0.6%
Cost Transparency	0.2%
Improved Environment, Programs for Physical Activity, Active Living	**3.5%**
Improved Environment, Programs for Healthy Eating, Nutrition; Food Affordability	**3.3%**
Health Education	2.8%
Preventive Services. Programs, Screening	2.2%
Obesity	1.6%
Employment Opportunities/Benefits; Economy	2.8%
Transportation	1.9%
Misuse of Public Assistance	1.3%
Improve Educational System	1.2%

Affordable Housing	0.8%
Address Homelessness	0.3%
Reduce Taxes	0.3%
Programs for Youth and Families; Parenting Support	1.7%
Community Health; Social Cohesion	1.3%
Healthy Choices/Personal responsibility	1.2%
Community Education/Awareness of Services	0.9%
Faith/Spirituality	0.2%
Satisfied/Complimentary of Services, Community	0.3%
Not Sure/Don't Know	0.4%
Other Comments	1.4%

B. COMMUNITY HEALTH DISCUSSION GROUPS

A set of three discussion groups were convened in the Spring of 2014 as part of an effort by LRGHealthcare to understand the health-related needs of the community and to plan programs and services that address those needs. The three discussion groups were each held in the Franklin Region to supplement a series of six discussion groups held in the Laconia Region in 2013 in collaboration with the Lakes Region for Partnership for Public Health. The purpose of the discussions was to get input on health issues that matter to the community and thoughts and perceptions about the health of the community. Discussion groups were convened representing a variety of important community sectors and perspectives. Including the 2013 discussion groups, more than 100 community members participated in the discussion groups.

In the Franklin Region, discussion groups were held with:

- **Choose Franklin (Community Leadership)**
- **Trip Center (Senior Service Providers)**
- **Head Start Providers**

In the Laconia Region, discussion groups were held with:

- **Seniors**
- **Unemployed, Underemployed Young Parents**
- **Substance Abuse Treatment and Recovery Community (2 groups)**
- **Mental Health Community**
- **Faith Community**
- **Education Community**
- **Refugee (Bhutanese) Community**

1. Franklin Region Discussion Group Themes

The following paragraphs summarize the findings from the Franklin Region discussion groups. See Appendix E for more detailed categorization of the notes from these groups. Overall themes and findings from the Lakes Region discussion groups can be found in a separate report completed in 2013.

In addition, the priority issues identified from the 2013 discussion groups are also combined in Section B.2 below with the Franklin Region priorities to produce overall priority needs for the region from the perspective of discussion group participants. Themes from the Franklin Region discussion groups include:

1. Discussion group participants comprehended and described a comprehensive, holistic perspective on health and well-being. The contributions of health behaviors, the physical environment, programs and services, and underlying determinants of health such as income and education were all discussed with respect to individual and community health outcomes.

2. Participants had mixed feelings about the overall health of the community. Positive factors cited include the perception of increased participation in physical activity and a number of specific community resources that promote health and wellness. However, there was also discussion of different health outcomes between individuals and families with more resources, including income and transportation, compared to those with limited resources. A number of comments also specifically cited substance abuse and barriers to accessing mental health services as significant negative contributors to health in the community.

3. Participants identified a wide variety of community strengths and resources that promote health including specific health and human service organizations, outdoor activities and formal events such as Community Day, and informal social networks.

4. Participants identified a range of barriers to promoting good health in the community including the need for more awareness of available resources, more education, financial pressures on individuals, families, and community service organizations, substance abuse, mental and emotional health, and variability in access to services and health insurance.

5. With respect to what organizations could be doing better to support or improve community health, participants identified needs for enhanced health education, increased awareness of available resources, improved access to and availability of specific services such as mental health care and dental services, increased communication and coordination between agencies, and socio-economic improvements.

2. High Priority Issues from Laconia and Franklin Region Discussion Groups

In each discussion group, a prioritization exercise was conducted to identify the most important or pressing needs for improving community health. The highest priority issues identified by the discussion groups across the region overall were:

1. *Alcohol and Drug Abuse*
2. *Access to Mental Health/Behavioral Health Care Services*

3. *Education*
4. *Poverty*
5. *Access to Dental Care Services*
6. *Access to Health Insurance*
7. *Transportation*

The chart below displays these top 7 overall regional priorities, as well as the priorities identified by each set of discussion groups (Franklin Region; Laconia Region). Alcohol and drug abuse was the top issue in each region, while Access to Mental Health Care was the second most important issue in the Franklin Region and third most important, after Education, in the Laconia Region.

TABLE 10 – DISCUSSION GROUP COMMUNITY HEALTH PRIORITIES

Priority Rank	Overall Region (2014)	Franklin Region (2014)	Laconia Region (2013)	Comparison to 2011 Focus Group Themes
1	Alcohol and Drug Abuse	Alcohol and Drug Abuse	Alcohol and Drug Abuse	Substance abuse and lack of prevention and treatment services identified as a theme in each region
2	Access to Mental Health/Behavioral Health Care Services	Access to Mental Health/Behavioral Health Care Services	Education	2011 themes included access to psychiatry services (Laconia region) and mental health (Franklin region)
3	Education	Poverty	Access to Mental Health/Behavioral Health Care Services	Education not identified as a theme in 2011
4	Poverty	Transportation	Access to Dental Care Services	Poverty not identified as a theme in 2011
5	Access to Dental Care Services	Education	Access to Health Insurance	Oral health care services identified as a theme in the Franklin region in 2011
6	Access to Health Insurance	Obesity	Poverty	Improved care coordination and access to primary care, geriatric care and special medical services for children w/disabilities were themes
7	Transportation	Physical Activity, recreational opportunities, active living	Fragile families, family stress	Transportation not identified as a top priority in 2011 discussions; Obesity and nutrition education was a discussion theme in 2011 (Franklin)

C. COMMUNITY HEALTH STATUS INDICATORS

This section of the 2014 Community Health Assessment report provides information on key indicators and measures of community health status. Some measures that are associated with health status have been included earlier in this report, such as measures of income, poverty, age and public insurance coverage (Medicare and Medicaid). The information included here also supplements a more comprehensive review of health status indicators that can be found in the separate 2013 Regional Health Data Report prepared by the Lakes Region Health Data Collaborative, of which LRGHealthcare is a participating organization. This 2013 report can be found on the LRGHealthcare website with other reports on the Community Benefit Report page.

For some population health indicators described here, the best local data is only available for the Winnipesaukee Public Health Region, which is a geographic subset of 16 communities in the overall LRGHealthcare service area comprised of 26 communities. Where this is the case, the 'Area' is noted in the following tables and charts as the Winnipesaukee Public Health Region.

1. Access to Care

Access to care refers to the ease with which an individual can obtain needed services. Access is influenced by a variety of factors including affordability of services and insurance coverage, provider capacity in relationship to population need and demand for services, and related concepts of availability, proximity and appropriateness of services.

a. Insurance Coverage

Table 11 displays recent estimates of the proportion of residents who do not have any form of health insurance coverage by municipality. The overall uninsurance rate in the LRGHealthcare service area, as well as for the FRH and LRGH sub-regions, was estimated to be 11.7% in 2012. The uninsurance rate in 2012 for the majority of communities in the service area exceeded the overall rate for New Hampshire of 10.5%. (Note: Comparisons to uninsurance rates from prior years are not advisable due to methodological changes).

TABLE 11

Area	Percent of the Total Population without Health Insurance Coverage (American Community Survey; 2008-2012)
Bridgewater	15.8%
Alexandria	15.6%
Ashland	15.2%
Laconia	14.5%
Danbury	14.4%
Alton	14.2%
Franklin	14.1%
Tilton	13.5%
New Hampton	13.4%
Salisbury	13.4%
Barnstead	13.3%
Hebron	12.6%
Bristol	12.2%
Meredith	12.1%
Tuftonboro	11.7%
Gilmanton	11.6%
Hill	11.3%
New Hampshire	**10.5%**
Sandwich	10.5%
Andover	9.4%
Gilford	9.2%
Northfield	9.0%
Center Harbor	8.5%
Boscawen	7.6%
Belmont	7.6%
Sanbornton	7.3%
Moultonborough	5.6%
LRGH	11.7%
FRH	11.7%
LRGHealthcare Service Area	**11.7%**

b. Adults without a Personal Health Care Provider

This indicator reports the percentage of adults aged 18 and older who self-report that they do not have at least one person who they think of as a personal doctor or health care provider. This indicator may highlight insufficient access or availability of medical providers, a lack of awareness or health knowledge or other barriers preventing formation of a relationship with a particular medical care provider.

Area	Percent of adults who report not having a personal doctor or health care provider
Winnipesaukee Public Health Region[1]	16.1%
New Hampshire	12.5%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2012.
Regional rate is not significantly different statistically than the overall NH rate.

c. Behavioral Health Care - Emergency Department Utilization for Mental Health Conditions

Overutilization or dependence on emergency departments for care of individuals with mental health conditions can be an indication of limited access to or capacity of outpatient mental health services. Utilization of emergency departments for mental health conditions was higher overall for LRGHealthcare service area communities and for certain age groups in particular compared to New Hampshire during the period 2008-2009 (most recent data available).

[1] Note: Some population health data is only available for the Winnipesaukee Public Health Region, which is a geographic subset of 16 communities in the overall LRGHealthcare service area including Alton, Barnstead, Belmont, Center Harbor, Danbury, Franklin, Gilford, Gilmanton, Hill, Laconia, Meredith, Moultonborough, New Hampton, Northfield, Sanbornton, and Tilton.

Mental Health Condition ED Visits and Observation Stays (per 100,000 people)				
Area	All Ages	Ages 25-34	Ages 35-44	Ages 65-74
LRGHealthcare service area	**1,594.0***	**2,969.7***	**2,352.9***	**779.2***
New Hampshire	1,495.8	2,674.0	1,861.2	582.4

Data Source: NH DHHS Hospital Discharge Data Collection System, 2008-2009

**Rates are statistically different and higher than the overall NH rate. Other age ranges not displayed do not differ statistically from the state rate.*

d. Suicide

This indicator reports the rate of death due to intentional self-harm (suicide) per 100,000 people. Suicide rates can be an indicator of access to mental health care. During the period 2009 and 2010, the suicide rate in the LRGHealthcare service area was statistically higher than the overall NH state rate of suicide deaths.

Area	Suicide Deaths per 100,000 people; any cause or mechanism; 2009-2010
LRGHealthcare service area	**18.7***
New Hampshire	12.0

Data Source: NH Division of Vital Records death certificate data, 2009-2010

**The rate is statistically different and higher than the overall NH rate*

e. Dental Care Utilization (Adult)

This indicator reports the percentage of adults aged 18 and older who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past five years.

Area	Percent of adults who have not visited a dentist or dental clinic in the past year	Percent of adults who have not visited a dentist or dental clinic in the past 5 years
Winnipesaukee Public Health Region	**37.7%***	18.3%
New Hampshire	26.9%	12.1%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2012.

** Regional rate is significantly different statistically and higher than the overall NH rate.*

f. Poor Dental Health

This indicator reports the percentage of adults age 18 and older who self-report that six or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection. In addition to highlighting needed improvements in preventive oral health care, this indicator can also highlight a lack of access to care, a lack of health knowledge, or social and economic barriers preventing utilization of services.

Area	Percent of adults who report having six or more of their permanent teeth removed
Winnipesaukee Public Health Region	22.7%
New Hampshire	15.3%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2012.

Regional rate is not different statistically than the overall NH rate.

2. Health Promotion and Disease Prevention

Adopting healthy lifestyle practices and behaviors, such as not smoking and limiting alcohol intake, can prevent or control the effects of disease and injury. For example, regular physical activity not only builds fitness, but helps to maintain balance, promotes relaxation, and reduces the risk of disease. Similarly, eating a healthy diet rich in fruits, vegetables and whole grains can reduce risk for diseases like heart disease, certain cancers, diabetes, and osteoporosis.

a. Fruit and Vegetable Consumption (Adults)

This indicator reports the percentage of adults aged 18 and older who self-report consuming less than 5 servings of fruits and vegetables each day. Unhealthy eating habits contribute to significant health issues such as obesity and diabetes.

Area	Percent of Adults Consuming Few Fruits or Vegetables
LRGHealthcare service area	73.9%
New Hampshire	71.5%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2005-2009.
Area estimates from Community Commons; Difference is not statistically significant

b. Physical Inactivity (Adults)

This indicator reports the percentage of adults aged 18 and older who self-report leisure time physical activity, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?". Lack of physical activity can lead to significant health issues such as obesity and poor cardiovascular health. Nearly 1 in 4 adults in the region can be considered physically inactive on a regular basis – a rate similar to the rest of New Hampshire.

Area	Physically inactive in the past 30 days, % of adults
Winnipesaukee Public Health Region	23.3%
New Hampshire	21.2%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2011-2012
Regional rates are not significantly different than the overall NH rates.

c. Pneumonia and Influenza Vaccinations (Adults)

This indicator reports the percentage of adults who self-report that they have ever received a pneumonia vaccine or received influenza vaccine in the past year. In addition to measuring the population proportion receiving preventive vaccines, this indicator can also highlight a lack of access to preventive care, opportunities for health education, or other barriers preventing utilization of services.

Area	Adults who have received a flu shot in past 12 months and those who have ever received a pneumococcal vaccination	
	Influenza Vaccination 18 years of age or older	Pneumococcal Vaccination 65 year of age or older
Belknap County	43.3%	72.2%
New Hampshire	48.0%	71.8%

Data Source: NH DHHS, New Hampshire Immunization Data 2012 Behavioral Risk Factor Surveillance System Update.
Differences are not statistically significant.

d. Adult Substance Abuse

Substance abuse, involving alcohol, illicit drugs, misuse of prescription drugs, or combinations of all of these behaviors, is associated with a complex range of negative consequences for health and wellbeing of individuals, families and communities. In addition to contributing to both acute and chronic disease and injury, substance abuse is associated with destructive social conditions, including family dysfunction, lower prosperity, domestic violence and crime.

Excessive drinking: Excessive alcohol use, either in the form of heavy drinking (drinking more than two drinks per day on average for men or more than one drink per day on average for women), or binge drinking (drinking 5 or more drinks on an occasion for men or 4 or more drinks on an occasion for women), can lead to increased risk of health problems such as liver disease or unintentional injuries.

Area	Engaged in Binge Drinking in Past 30 days, Percent of Adults		
	Male	Female	Total
Winnipesaukee Public Health Region	18.8%	14.0%	16.3%
New Hampshire	23.5%	12.7%	18.0%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2011-2012
Regional rates are not significantly different than the overall NH rates.

Area	Heavy Alcohol Use, Percent of Adults		
	Male	Female	Total
Winnipesaukee Public Health Region	6.2%	6.9%	6.5%
New Hampshire	7.9%	7.1%	7.5%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2011-2012
Regional rates are not significantly different than the overall NH rates.

Substance Abuse-related Emergency Department Use: The rate of utilization of the emergency department for substance abuse-related conditions can indicate a variety of concerns including prevalence of substance abuse in the community, community norms, and limited access to treatment. The rate of emergency department utilization for substance abuse related mental health conditions by residents in the LRGHealthcare service area was significantly higher than the overall New Hampshire rate during the period 2009 and 2010 (most current information available).

Substance Abuse Related Mental Health Condition ED Visits and Observation Stays (per 100,000 people)	
Area	**Overall, Age Adjusted**
LRGHealthcare service area	**984.3***
New Hampshire	892.7

Data Source: NH DHHS Hospital Discharge Data Collection System, 2008-2009

**Rate is statistically different and higher than the overall NH rate*

e. Cigarette Smoking

Tobacco use is a primary contributor to leading causes of death such as lung cancer, respiratory disease and cardiovascular disease. This indicator reports the percentage of adults aged 18 and older who self-report currently smoking cigarettes some days or every day. Nearly 1 in 4 adults in the communities of the Winnipesaukee Public Health Region are estimated to be current smokers, a rate that is significantly higher than the overall State of NH rate.

Area	Percent of Adults who are Current Smokers
Winnipesaukee Public Health Region	**24.2%***
New Hampshire	18.1%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2011-2012
Regional rate is significantly different and higher than the overall NH rate.

f. Teen Birth Rate

Teen pregnancy is closely linked to economic prosperity, educational attainment, and overall infant and child well-being. The teen birth rate in the Lakes Region is higher than the New Hampshire overall rate.

Area	Teen Birth Rate per 1,000 Women Age 15-19
LRGHealthcare service area	**19.7***
New Hampshire	14.8

Data source: NH Division of Vital Records Administration birth certificate data; 2009-2010.
**Rate is statistically different and higher than the overall NH rate*

3. Illness and Injury

Traditional measures of population health status focus on rates of illness or disease (morbidity) and death (mortality) from specific causes. Advances in public health and medicine through the 20th Century have reduced infectious disease and complications of child birth as major contributors to or causes of death and disease. Chronic diseases, such as heart disease, cancer, respiratory disease and diabetes, along with injury and violence, are now the primary burdens on the health and wellbeing of individuals, families and communities. In addition to considering the absolute magnitude of specific disease burdens in a population, examination of disparities in disease rates can help to identify areas of need and opportunities for intervention.

a. Premature Mortality

An overall measure of the burden of disease is premature mortality. The indicator below expresses premature mortality as the rate of death, regardless of cause, where age is less than 65 years at the time of death. During the period 2009 and 2010 (the most current information available), the rate of premature death in the LRGHealthcare service area was similar to the rate for New Hampshire overall.

Area	Premature Mortality (Deaths per 100,000 People Under Age 65)
LRGHealthcare service area	174.8
New Hampshire	159.3

Data source: NH Division of Vital Records Administration death certificate data; 2009-2010.
Rate is not statistically different than the overall NH rate

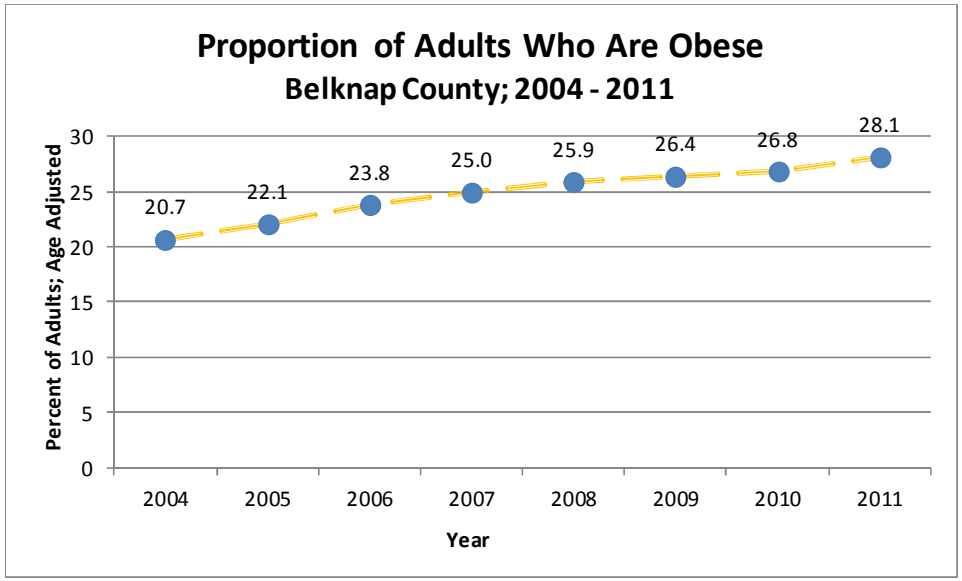
b. Overweight and Obesity

Being overweight or obese can indicate an unhealthy lifestyle that puts individuals at risk for a variety of significant health issues including hypertension, heart disease and diabetes. The indicators below report the percentage of adults aged 18 and older who self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese) or greater than 25.0 (overweight or obese). The chart at the bottom of the page displays the trend in Belknap County since 2004 toward increasing prevalence of obesity in the adult population.

Area	Percent Obese	Percent Overweight or Obese
Winnipesaukee Public Health Region	**32.4%***	64.5%
New Hampshire	27.0%	62.1%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2011-2012

**Regional rate is significantly different and higher than the overall NH rate.*



c. Heart Disease

Heart disease is the second leading cause of death in New Hampshire after all forms of Cancer and is the leading cause of death in the LRGHealthcare service area. Heart disease is closely related to unhealthy weight, high blood pressure, high cholesterol, and substance abuse including tobacco use.

Heart Disease Prevalence: This indicator reports the percentage of adults aged 18 and older who have ever been told by a doctor that they have coronary heart disease or angina.

Area	Percent of Adults with Heart Disease (self-reported)
Winnipesaukee Public Health Region	4.3%
New Hampshire	4.0%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011-2012.
Area estimates from Community Commons. Rate is not statistically different than the overall NH rate

Cholesterol Screening: High levels of total cholesterol and low density lipoprotein-cholesterol (LDL-C) and low levels of high density lipoprotein-cholesterol (HDL-C) are important risk factors for coronary heart disease. Periodic cholesterol screening for adults, particularly those with other risk factors, is a beneficial procedure for early identification of heart disease that can be treated with preventive therapy. The table on the next page displays the proportion of adults who report that they have had their cholesterol levels checked at some point within the past 5 years.

Area	Percent of adults who have had their cholesterol levels checked within the past 5 years
Winnipesaukee Public Health Region	76.3%
New Hampshire	81.0%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2011.
Regional rate is not significantly different than the overall NH rate.

Heart Disease Morbidity and Mortality: The rate of inpatient hospital utilization due to heart disease is lower among Lakes Region residents compared to the New Hampshire population overall, while the rate of emergency department utilization resulting from heart disease is similar. The rate of death due to heart disease among LRGHealthcare service area residents was significantly higher than the overall rate for New Hampshire in the 2009 and 2010 time period.

Heart Disease-Related Emergency Department and Inpatient Utilization (per 100,000 people)		
Area	**Heart Disease Inpatient Discharges, age adjusted**	**Heart Disease ED Visits and Observation Stays, age adjusted**
LRGHealthcare service area	211.5*	54.7
New Hampshire	271.5	49.9

Data Source: NH DHHS Hospital Discharge Data Collection System, 2008-2009.
**Denotes regional rate is significantly different than overall NH rate.*

Heart Disease Deaths (per 100,000 people)	
Area	**Overall, Age adjusted**
LRGHealthcare service area	**178.5***
New Hampshire	140.4

Data Source: NH Division of Vital Records death certificate data, 2009-2010
**The rate is statistically different and higher than the overall NH rate*

d. Diabetes

Diabetes is an increasingly prevalent chronic health condition that puts individuals at risk for further health complications, but is also amenable to control through diet and adequate clinical care.

Diabetes Prevalence: This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. About 9.3% of adults in the Winnipesaukee Public Health Region and 9.1% of New Hampshire adults overall report having been told by a health professional that they have diabetes.

Area	Percent of Adults with Diabetes, age adjusted
Winnipesaukee Public Health Region	9.3%
New Hampshire	9.1%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2011-2012.
Regional rate is not significantly different than the overall NH rate.

Diabetes-related Morbidity and Mortality: The rate of emergency department utilization due to diabetes is higher among Lakes Region residents compared to the New Hampshire population overall. Inpatient utilization resulting from diabetes is higher in the LRGHealthcare service area than for the New Hampshire population overall, including for diabetes related lower extremity amputation. The rate of death due to diabetes among Lakes Region residents is lower than the overall rate for New Hampshire.

Diabetes ED Visits and Observation Stays (per 100,000 people)	
Area	**Overall, age adjusted**
LRGHealthcare service area	**210.8***
New Hampshire	150.2

Data Source: NH DHHS Hospital Discharge Data Collection System, 2008-2009
**Rate is significantly different and higher than overall NH rate*

Diabetes and Diabetes-Related Inpatient Utilization (per 100,000 people), Overall, age-adjusted			
Area	**Diabetes Inpatient Discharges**	**Diabetes Related Inpatient Discharges**	**Diabetes Related Lower Extremity Amputation Inpatient Discharges**
LRGHealthcare service area	**123.7***	**1,442.2***	**26.0***
New Hampshire	99.0	1,380.2	16.4

Data Source: NH DHHS Hospital Discharge Data Collection System, 2008-2009
**Rate is significantly different and higher than overall NH rate*

Deaths due to Diabetes or Diabetes as an Underlying Cause (per 100,000 people, age adjusted)		
Area	**Diabetes Deaths**	**Diabetes Underlying Cause and Related Deaths**
LRGHealthcare service area	16.6	60.6
New Hampshire	16.2	60.5

Data Source: NH DHHS Hospital Discharge Data Collection System, 2009-2010
Rates are not significantly different than overall NH rate

e. Asthma

Asthma is also an increasingly prevalent condition that can be exacerbated by poor environmental conditions.

Asthma Prevalence: This indicator reports the percentage of adults aged 18 and older who self-report that they have ever been told by a doctor, nurse, or other health professional that they had asthma.

Area	Percent Adults with Asthma
LRGHealthcare service area	14.6%
New Hampshire	14.7%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011-2012.
Area estimates from Community Commons. Rate is not statistically different than the overall NH rate

Asthma-related Emergency Department Use: The rate of utilization of the emergency department for asthma care can indicate a variety of concerns including poor environmental conditions, limited access to primary care, and difficulties with asthma self-management skills. The rate of emergency department utilization for asthma care by Lakes Region residents was higher than the overall New Hampshire rate during the period 2008 and 2009 (the most current information available).

Asthma ED Visits and Observation Stays (per 100,000 people)	
Area	**Overall, age adjusted**
LRGHealthcare service area	**594.8***
New Hampshire	493.3

Data Source: NH DHHS Hospital Discharge Data Collection System, 2008-2009
Rate is Significantly Different and higher than the overall NH rate

f. Unintentional Injury

Unintentional injuries causing emergency department visits and observation stays are also significantly higher for LRGHealthcare service area residents overall and for every age category except adults 75 years or older.

Unintentional Injury ED Visits and Observation Stays per 100,000 People by Any Cause/Mechanism	
Area	**Overall, age adjusted**
LRGHealthcare service area	**14,393.7***
New Hampshire	10,451.1

Data Source: NH DHHS Hospital Discharge Data Collection System, 2008-2009
Rate is Significantly Different and higher than the overall NH rate

4. Comparison of Selected Community Health Indicators between 2014 and 2011

The table below displays comparisons of estimated rates for key community health status indicators between the current community health assessment (2014) and the previous assessment conducted in 2011, as well as the most recent statewide statistic for each indicator. This comparison is provided for informational purposes and it is important to note that there are several important caveats to making any conclusions from observed differences. First, the methodology for the Behavioral Risk Factor Surveillance survey was changed in 2011. In particular, a new sampling methodology was applied to reach a greater proportion of people who primarily use cell phones. Consequently, the Centers for Disease Control cautions against making direct comparisons of estimates from years before 2011 with those produced in 2011 and after. Secondly, with respect to results displayed below that are derived from other sources such as the hospital discharge data set and the cancer registry, the differences between the 2011 and 2014 estimates for the local region are not significantly different at a 95% confidence level in all cases. In some instances, there are statistically significant differences between recent estimates for certain health indicators in the LRGHealthcare region and NH statewide estimates. Where this is the case, the indicators are highlighted in bold font.

Community Health Indicator	Geographic Area	2011 Community Health Assessment	2014 Community Health Assessment	NH State Comparison
Access to care				
Percentage of **adult** population (age 18+) without health insurance coverage	Winnipesaukee Public Health Region	13.3%[2]	15.1%[3]	13.0%[3]
Do not having a personal doctor or health care provider, percent of adults	Winnipesaukee Public Health Region	12.4%[2]	16.1%[3]	12.5%[3]
Asthma ED Visits and Observation Stays per 100,000 People	LRGHealthcare service area	554.8[4]	**594.8**[5]	**493.3**[5]
Diabetes ED Visits and Observation Stays per 100,000 People	LRGHealthcare service area	229.5[4]	**210.8**[5]	**150.2**[5]
Mental Health Condition ED Visits and Observation Stays per 100,000 People	LRGHealthcare service area	1,550.1[4]	**1,594.0**[5]	**1495.8**[5]

[2] NH DHHS, Behavioral Risk Factor Surveillance System; 2008-2009

[3] NH DHHS, Behavioral Risk Factor Surveillance System; 2011-2012

[4] NH DHHS Hospital Discharge Data Collection System, 2007; age adjusted (or age specific) rates.

[5] NH DHHS Hospital Discharge Data Collection System, 2008-2009; age adjusted (or age specific) rates.

Community Health Indicator	Geographic Area	2011 Community Health Assessment	2014 Community Health Assessment	NH State Comparison
Health Promotion and Disease Prevention				
Current smoking, percent of adults	Winnipesaukee Public Health Region	22.7%[2]	**24.2%[3]**	**18.1%[3]**
Physically inactive in the past 30 days, % of adults	Winnipesaukee Public Health Region	22.7%[2]	23.3%[3]	21.2%[3]
Binge drinking, percent of adults	Winnipesaukee Public Health Region	12.9%[2]	16.3[3]	18.0%[3]
Teen Birth Rate (per 1,000 Women Age 15-19)	LRGHealthcare service area	25.1[6]	**19.7[7]**	**14.8[7]**
Teen Birth Rate – LRGH service area	LRGH service area	24.0[6]	19.3[7]	
Teen Birth Rate – FRH service area	FRH service area	26.9[6]	24.0[7]	
Assault Injury ED Visits and Observation Stays per 100,000 People	LRGHealthcare service area	346.2[3]	**315.1[5]**	**261.8[5]**
Illness and Injury				
Obese, percent of adults	Winnipesaukee Public Health Region	25.6%[2]	**32.4%[3]**	**27.0%[3]**
Overweight, percent of adults	Winnipesaukee Public Health Region	38.4%[2]	32.1%[3]	35.1%[3]
Invasive Cancer Incidence per 100,000 People - All Sites	LRGHealthcare service area	448.1[8]	505.3[9]	481.2[9]
Ever told had diabetes, percent of adults	Winnipesaukee Public Health Region	9.3%[2]	9.3%[3]	9.1%[3]

[6] NH DHHS Hospital Discharge Data Collection System, 2006-2007; age adjusted (or age specific) rates.

[7] NH DHHS Hospital Discharge Data Collection System, 2009-2010; age adjusted (or age specific) rates.

[8] NH State Cancer Registry, 2006-2007; age adjusted.

[9] NH State Cancer Registry, 2008; age adjusted.

Community Health Indicator	Geographic Area	2011 Community Health Assessment	2014 Community Health Assessment	NH State Comparison
Ever told blood pressure was high, percent of adults	Winnipesaukee Public Health Region	27.2%[10]	32.5%[11]	30.7%[11]
Current asthma, percent of adults	Winnipesaukee Public Health Region	12.3%[2]	9.9%[3]	10.7%[3]
Health outcomes				
Percent Low Birth Weight Births	LRGHealthcare service area	6.9%[6]	6.7%[7]	6.9%[7]
Cancer Deaths per 100,000 People for All Sites	LRGHealthcare service area	181.9[6]	173.9[7]	158.8[7]
Heart Disease Deaths per 100,000 People	LRGHealthcare service area	183.0[6]	**178.5[7]**	**140.4[7]**
Diabetes Deaths per 100,000 People	LRGHealthcare service area	18.9[6]	16.6[7]	16.2[7]
Diabetes Underlying Cause and Related Deaths per 100,000 People	LRGHealthcare service area	59.7[6]	60.6[7]	60.5[7]
Chronic Liver Disease and Cirrhosis Deaths per 100,000 People	LRGHealthcare service area	7.5[6]	8.0[7]	6.9[7]

[10] NH DHHS, Behavioral Risk Factor Surveillance System; 2007

[11] NH DHHS, Behavioral Risk Factor Surveillance System; 2011

D. SUMMARY OF COMMUNITY HEALTH NEEDS ISSUES

The table below provides a summary of community health needs and issues identified through the 2014 survey of community health needs and priorities, the community health discussion groups, and the collection of indicators of community health status.

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE			
Community Health Issue	**Community Survey**	**Community Discussion Groups**	**Community Health Status Indicators**
Access to Primary/Family Healthcare	Selected as an important community health issue by 51% of survey respondents		About 16% of adults report not having a personal doctor or health care provider, compared with 12.5% of adults in NH overall; Rates of emergency department use for diabetes and asthma in the region exceeds rates for NH overall
Alcohol and Drug Abuse Prevention, Treatment and Recovery	Selected as an important community health issue by 43% of survey respondents	Selected as a top priority for community health improvement by community discussion group participants	Rates of excessive alcohol use among adults in the region are similar to NH overall; the rate of emergency department utilization for substance abuse related mental health conditions is lower than the rate for NH overall
Mental Healthcare	Selected as an important community health issue by 41% of survey respondents	Access to Mental Health/Behavioral Health Care Services selected as a top priority for community health improvement by community discussion group participants	The suicide rate in the region has exceeded the rate for NH overall in recent years; the rate of emergency department utilization for mental health conditions is higher than the rate for NH overall
Jobs; Poverty	Job opportunities selected as a resource supporting a healthy community that needs more attention by 51% of survey respondents	Poverty selected as a top priority for community health improvement by community discussion group participants	Median household income is lower than in NH overall for the majority of communities in the region and the proportion of individuals living near or below the poverty level is higher
Dental Care	Selected as an important community health issue by 24% of survey respondents	Access to Dental Care Services selected as a top priority for community health improvement by community discussion group participants	About 18% of adults report not having seen a dentist within the past 5 years, compared with about 12% of adults in NH overall

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE (continued)			
Community Health Issue	**Community Survey**	**Community Discussion Groups**	**Community Health Status Indicators**
Cost of Health Care Services and Access to Affordable Health Insurance	Topic of numerous survey comments	Access to Health Insurance selected as a top priority for community health improvement by community discussion group participants	The uninsurance rate for the region is estimated at 11.7% and exceeds the overall rate for New Hampshire in the majority of communities in the service area
Weight Related Health Issues	Selected as an important community health issue by 36% of survey respondents		The proportion of adults who are overweight or obese is similar to NH overall, but the percentage of adults who are obese has steadily increased in recent years
Transportation	Selected as a resource supporting a healthy community that needs more attention by 34% of survey respondents	Selected as a top priority for community health improvement by community discussion group participants	
Assistance with care coordination and health system navigation	Selected as a resource supporting a healthy community that needs more attention by 29% of survey respondents	Identified as a key strategy for community health improvement by discussion group participants	
Education	Selected as a resource supporting a healthy community that needs more attention by 22% of survey respondents	Selected as a top priority for community health improvement by community discussion group participants	
Healthcare and Support for Seniors	Healthcare for Seniors Selected as an important community health issue by 28% of survey respondents; Support for Older Adults selected as a resource needing more attention by 37% of survey respondents		
Access to Specialty Services	Selected as an important community health issue by 29% of survey respondents		
Cancer	Selected as an important community health issue by 28% of survey respondents		

APPENDIX K
Huggins Hospital Community Needs Assessment

Huggins Hospital

2016

Huggins Hospital

Community Health Needs Assessment

Carroll County, New Hampshire

Hard copies of this document may be obtained at Huggins Hospital, 240 South Main Street, Wolfeboro, NH 03894
or by phone 603.569.7500 or via the hospital website http://www.hugginshospital.org.

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Perspective/Overview

Creating a culture of health in the community

Sourced from the Robert Wood Johnson Foundation's County Health Rankings website:
http://www.countyhealthrankings.org/roadmaps/action-center

The Huggins Hospital Community Health Needs Assessment defines priorities for health improvement, creates a collaborative community environment to engage stakeholders, and an open and transparent process to listen and truly understand the health needs of Carroll County, New Hampshire. Huggins Hospital (Huggins) conducted a Community Health Needs Assessment (CHNA) in 2013. This 2016 assessment analyzes progress since the last assessment as well as defines new or continued priorities for the next three years.

Huggins Hospital engaged national leaders in CHNA, Stratasan, to assist in the project. Stratasan, a healthcare analytics and facilitation company out of Nashville, Tennessee provided the analysis of community health data and a community telephone survey. Stratasan also presented the data and analysis to the community during Huggins Hospital's Community Health Summit. The event provided an opportunity for community members and local health and safety agencies to determine significant health needs and goals for improvement.

- Huggins Hospital's Board of Trustees will approve and adopt this CHNA and an implementation strategy in 2016.
- Starting on September 1, 2016, this report was made widely available to the community via Huggins Hospital's website, www.hugginshospital.org, and paper copies are available free of charge at Huggins Hospital.

Participants

Over sixty individuals from over forty community and health care organizations collaborated to conduct a comprehensive CHNA process focused on identifying and defining significant health needs, issues, and concerns of Carroll County. The process centered on gathering and analyzing data as well as receiving input from persons who represented the broad interests of the community and who had special knowledge and expertise in public health. The participants helped provide direction for the Hospital to create a plan to improve the health of the community.

Project Goals

1. To implement a formal and comprehensive community health assessment process for the identification and prioritization of significant health needs of the community to allow for resource allocation, informed decision-making and collective action that will improve health.
2. To initiate a collaborative partnership between all stakeholders in the community by seeking input from persons who represent the broad interests of the community.
3. To support the existing infrastructure and utilize resources to instigate health improvement in the community.

"We initiated the Community Health Needs Assessment with the goals to analyze changes in significant health needs and priorities from 2013's Community Health Needs Assessment and collaborate with the community to address those needs," said Jeremy Roberge, President & Chief Executive Officer at Huggins Hospital. "It is our goal to use our findings as a catalyst for community mobilization to improve the health of our residents and visitors."

"We utilized the information we gathered from public health data and community stakeholders to set priorities for significant health issues Huggins Hospital could address through our Implementation Plan. We hope other community organizations will join us," added Monika O'Clair, Senior Director of Communication & Community Relations at Huggins Hospital. "The Community Health Summit was the final step in the assessment process. Now the real work—improving the health of the community and implementing the ideas presented—begins."

Community

Input and Collaboration

Data Collection and Timeline

In February, 2016, Huggins Hospital contracted with Stratasan to assist in conducting a Community Health Needs Assessment for Carroll County, New Hampshire. Huggins Hospital sought input from persons who represent the broad interests of the community using several methods:

- Information gathering, using secondary public health sources, occurred in April and May of 2016.
- 300 community surveys were conducted from April 27 through May 13, 2016. The phone numbers used for dialing were purchased from Marketing Systems Group. The numbers were dialed at random. The completed surveys include 257 landline surveys and 43 cell phone surveys.
- A Community Health Summit was held on May 26, 2016 with 45 community stakeholders attending. The audience consisted of healthcare providers, the Carroll County Coalition for Public Health, businesses, law enforcement, EMS, government representatives, human services, not-for-profit organizations (hospitals, home health, mental health, substance abuse, elderly services) and other community members.

Participation in the Community Health Summit creating the Carroll County Community Health Needs Assessment and Improvement Plan:

Organization	Population Represented (kids, low income, minorities, those w/o access)
Abundant Blessings Homecare	Senior care/ stats affect aging
Brewster Academy	Employees and their families, students
Carroll County Coalition for Public Health	All, substance misuse prevention, emergency preparedness
Central NH VNA & Hospice	Medical social worker - all
Central NH VNA	Pediatrics
Community Members	
Curtis Quality Care, LLC	Elderly/skilled rehab
Doran Independent Insurance	Families, young and old/health, life, LTC
Genesis Healthcare - Wolfeboro Bay	long-term care, rehab, dementia
Huggins Hospital	all
Huggins Hospital board member	All
Memorial Hospital	All, hospital, outpatient practices, homecare, schools
Mountain View Community	Elderly/skilled rehab
Northern Human Services	All ages, genders w/ mental health prevention needs
Service Link Carroll County	Aging, disabled, all populations
Sifonia Family Services, NH	Alcohol & drug treatment
State Representative	
State Representative	
Town of Wolfeboro	Selectmen Board
Tri-County Transit	
Tuftonboro Resident	
UNH Cooperative Extension	low income youth, adults, seniors, nutrition
Wakefield Welfare	
WEDCO	Economic developent
White Horse Addiction Center	Adult addiction/substance use
White Mountain Medical Center	Priary care practice
Wofeboro Bay Center	long-term care, rehab, dementia
Wolfeboro Area Chamber of Commerce	Businesses including non-profits
Wolfeboro Fire Department	Emergency services/town
Wolfeboro Planning Board	
Wolfeboro Police Dept	All
Wolfeboro Welfare	

In many cases, several representatives from each organization participated.

Input of Public Health Officials

At the Summit held on May 26, 2016, Emily Benson, Carroll County Coalition for Public Health Advisory Council Coordinator, presented information and priorities from the Public Health perspective.

The Carroll County Coalition for Public Health is focusing on the following priorities areas in the 2016-

- Early Childhood and Parental Support
- Mentally Healthy Families (including addiction free families)
- Aging with Connection and Purpose, and
- Emergency Preparedness Across the Life Span

Where there are common initiatives between the state, counties, hospitals, and community groups, coordination of efforts would be ideal.

Input of Medically Underserved, Low-Income, and Minority Populations

Input of medically underserved, low-income and minority populations was received during the community survey and Community Health Summit. People representing these population groups were intentionally invited to participate in the process.

Community Engagement and Transparency

We are pleased to share the results of the Community Health Needs Assessment with our community in hopes of attracting more advocates and volunteers to improve the health of the community. The following pages highlight key findings of the assessment. We hope you will take the time to review the health needs of our community as the findings impact each and every citizen in one way or another. We also hope you will join in the improvement efforts. The comprehensive data analysis may be obtained via a PowerPoint on our website at www.hugginshospital.org or by contacting Huggins Hospital.

The Carroll County Coalition for Public Health produced Carroll County 2020: Community Health Improvement Plan 2016-2019. You can access this report online at www.C3PH.org. Huggins Hospital was involved in this assessment and plan.

Additionally, Memorial Hospital in North Conway, NH, also located in Carroll County, produced a Community Health Needs Assessment in 2016.

All three of these assessments had community involvement and contain excellent community health information and improvement plans.

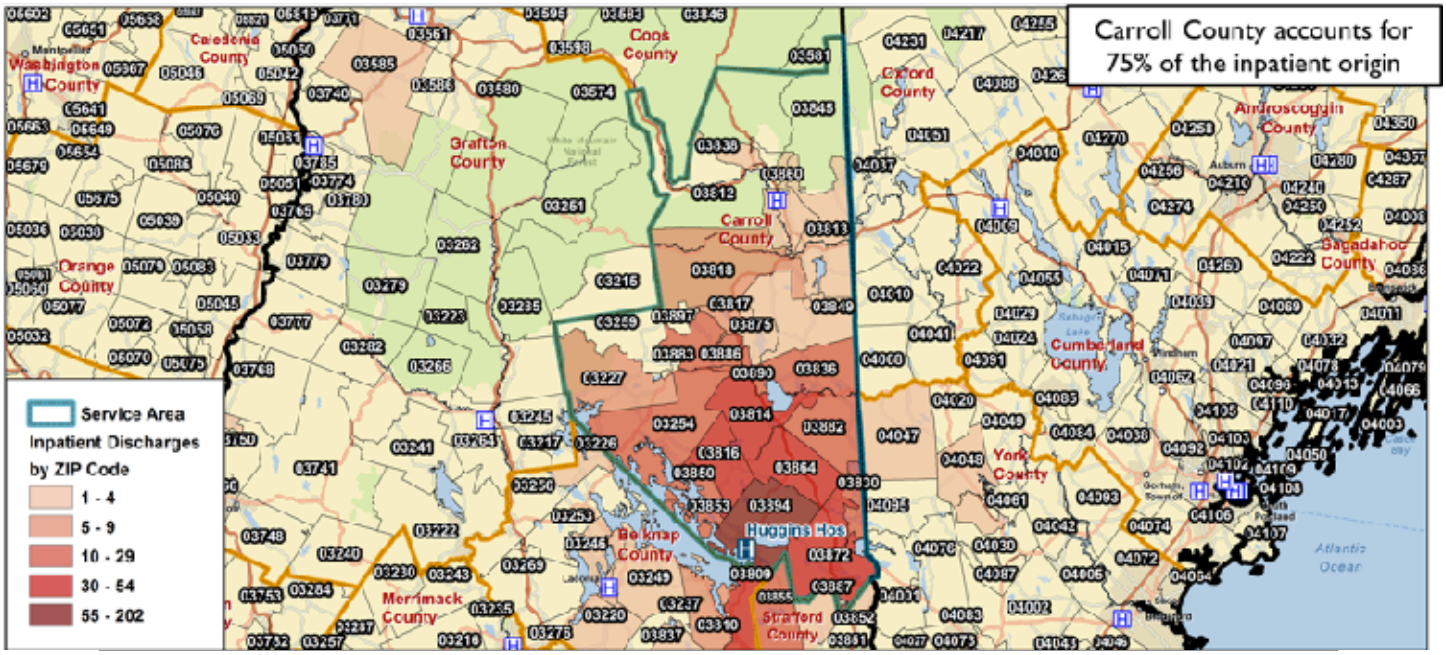
Community

Selected for Assessment

Huggins Hospital's patient information provided the basis for the geographic focus of the CHNA. The map below shows where Huggins Hospital's patients live; most inpatients came from Carroll County (75%). Therefore, it was reasonable to select Carroll County as the primary focus of the CHNA. However, surrounding counties should benefit from efforts to improve health in Carroll County.

The community included medically underserved, low-income or minority populations who live in the geographic areas from which Huggins Hospital draws its patients. All patients were used to determine the service area without regard to insurance coverage or eligibility for financial assistance under Huggins Hospital's Financial Assistance Policy.

Huggins Hospital Patients - 2015



Source: Huggins Hospital, 2015

Key Findings

Community Health Assessment

Information Gaps

While this assessment was quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups (such as the homeless, institutionalized persons, or those who only speak a language other than English) were not represented in the primary data.

Other population groups (for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups) might not be identifiable or might not be represented in numbers sufficient for independent analyses.

Process and Methods

Both primary and secondary data sources were used in the CHNA. Primary methods included:

- Community telephone surveys
- Community Health Summit

Secondary methods included:

- Public health data – death statistics, county health rankings
- Demographics – population, poverty, uninsured
- Psychographics

Carroll County has a large seasonal population with seasonal, part-time homes and vacation populations. Census data includes primary residence information.

Huggins Hospital Community Health Summit 2016

Huggins Hospital Community Health Summit 2016

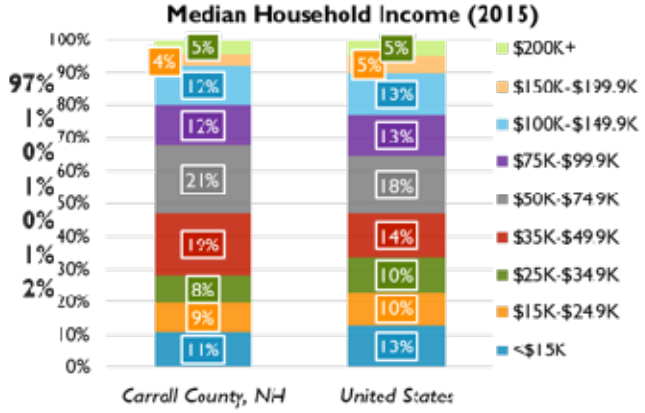
Demographics of the Community

The table below shows the demographic summary of Carroll County compared to New Hampshire and the U.S.

	Carroll County	New Hampshire	USA
Population (2015)	48,935	1,345,926	318,536,439
Median Age (2015)	50.5	42.4	37.9
Median Household Income (2015)	$52,472	$64,044	$53,217
Annual Pop. Growth (2015-20)	0.15%	0.47%	0.75%
Household Population (2015)	21,884	535,613	120,746,349
Dominant Tapestry (2015)	Rural Resort Dwellers (6E)	The Great Outdoors (6C)	Green Acres (6A)
Businesses (2015)	3,400	67,028	13,340,415
Employees (2015)	29,280	750,144	158,567,719
Medical Care Index* (2015)	112	112	100
Average Health Expenditures (2015)	$2,343	$2,349	$2,098
Total Health Expenditures (2015)	$51.3 M	$1.3 B	$253.3 B

Older
Lower HH Inc.
Growing slightly

Racial and Ethnic Make-up	
White	97%
Black	1%
American Indian	0%
Asian/Pacific Islander	1%
Mixed Race	0%
Other	1%
Hispanic Origin	2%

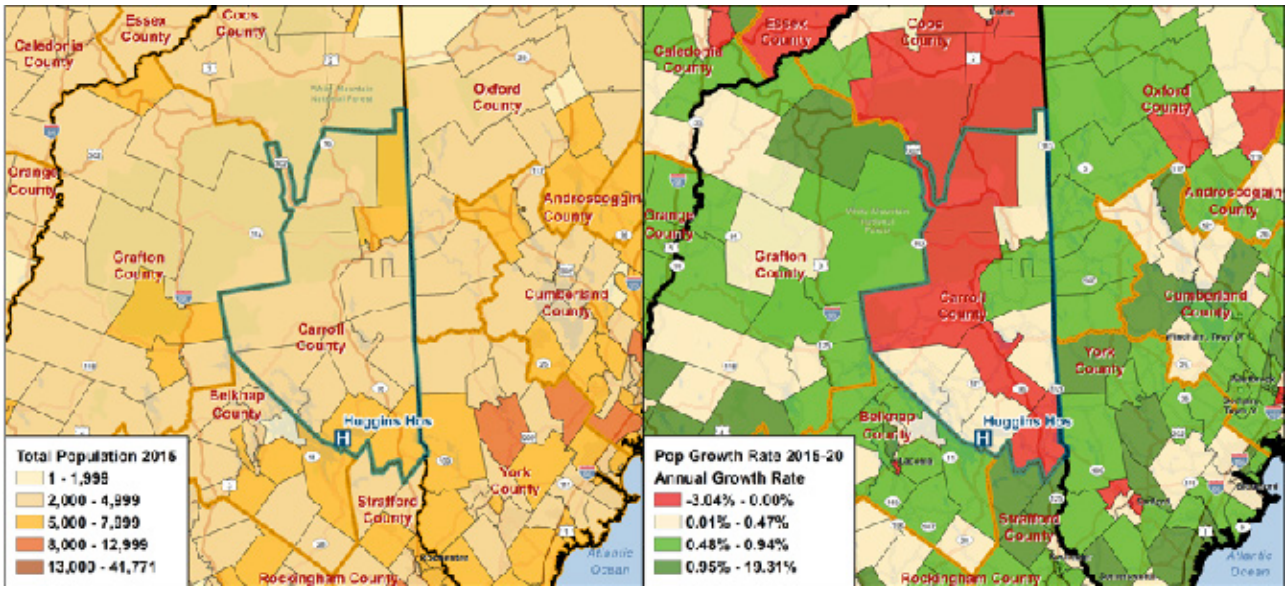


- Source: ESRI

Carroll County, New Hampshire

- The population of Carroll County was projected to increase from 2015 to 2020 (.15% per year), lower than the rate of NH at .47%, the U.S. at .75%.
- Carroll County was older (50.5 median age) than NH and the U.S. and had lower median household income ($52,472) than both NH and the U.S.
- The medical care index measures how much the county spent out of pocket on medical care services. The U.S. index was 100. Carroll County (112 index) spent 12% more than the average U.S. household out-of-pocket on medical care (doctor's office visits, prescriptions, hospital services).
- The racial make-up of Carroll County was 97% white, 1% black, 1% Asian/Pacific Islander, 1% some other race, and 2% Hispanic origin (the total exceeds 100% due to Hispanic being an ethnicity rather than a race).
- The median household income distribution of Carroll County was 21% higher income (over $100,000), 51% middle income and 28% lower income (under $24,999).

2015 Population by Census Tract and Change (2015-2020)

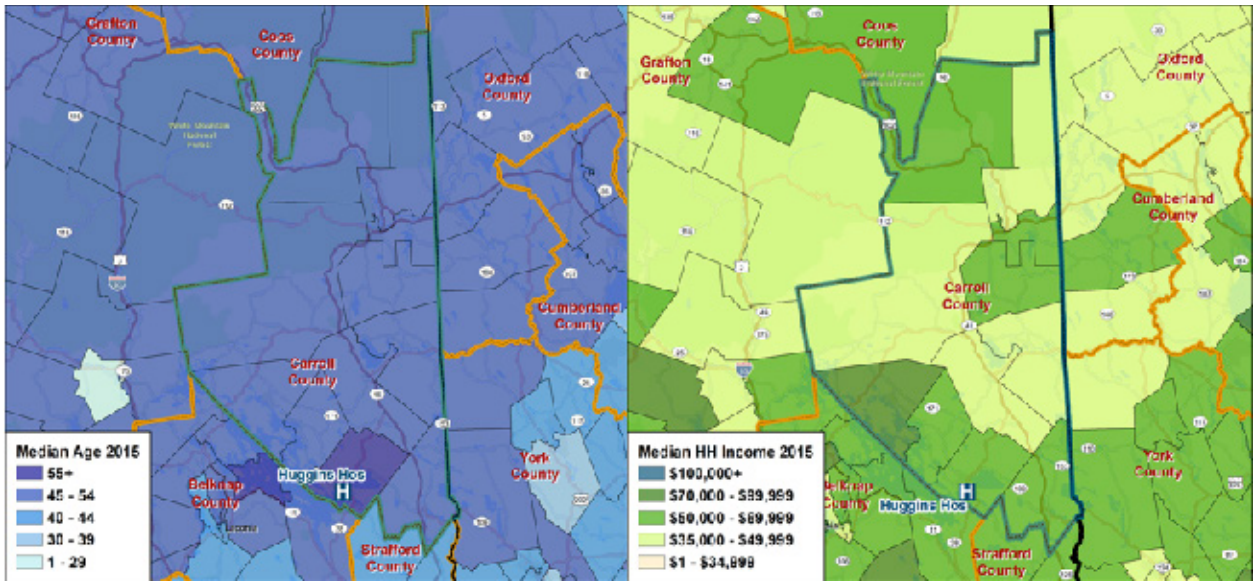


- Source: ESRI

Census tracts generally have a population size between 1,200 and 8,000 people, with an optimum size of 4,000 people. There were higher population census tracts, 5,000-7,999 in the large census tract in the upper northeast section of the county and in the two southernmost tracts, Wolfeboro and Wakefield. The remainder of the county is more rural with tracts containing 2,000 to 4,999 population.

The population was projected to grow in the two census tracts in the east of the county near Eaton, .48 to .94% up to twice the NH growth rate. There are five tracts growing .01% to the growth rate of NH, .47%. These tracts are Wolfeboro, Chatham, Effingham and Moultonborough. The remainder of the county was projected to decline in population.

2015 Median Age & Income



- Source: ESRI

These maps depict median age and median income by census tract. There was a tract with older population (55+ median age) in Wolfeboro. The remainder of the county's tracts had median ages between 45 and 54. There were four tracts with median household income ($35,000 – 49,999) in Chatham, Ferncroft, Sandwich, and Freedom/Effingham. [1] Not all households were at the median in a census tract, but these are indicators of segments of the population that may need focused attention. There is one higher median income ($70,000 - $99,999) tract around Moultonborough. The remainder of the county has a median income of $50,000 to $69,999, which includes Wolfeboro and Jackson.

The rate of poverty in Carroll County was 10.1% (2009-2013 data), which was above NH (8.7%) but below the US (15.4%). The poverty percentage was in the middle of the surrounding counties with the highest being Coos at 13.4% and the lowest being Rockingham at 5.5%.

Carroll County's unemployment was 3.6% compared to 2.9% for New Hampshire and 5.0% for the U.S. Unemployment decreased significantly in the last few years.

[1] *The median is the value at the midpoint of a frequency. There is an equal probability of falling above or below the median.*

Health Status Data

The major causes of death in Carroll County were cancer then heart disease, followed by accidents, chronic lower respiratory disease, stroke, Alzheimer's disease, suicide, diabetes, kidney, and liver disease. *Source: 2014 CDC*

Based on the latest County Health Rankings study performed by the Robert Wood Johnson Foundation and the University of Wisconsin [1], Carroll County ranked 4th healthiest county in New Hampshire out of the 10 counties ranked (1= the healthiest; 10 = unhealthiest). County Health Rankings suggest the areas to explore for improvement in Carroll County were adult smoking, adult obesity, uninsured and injury deaths. The areas of strength were identified as lower physical inactivity, lower excessive drinking, lower sexually transmitted infections and teen births, lower population to primary care physician ratio, low preventable hospital stays, higher mammography screenings, higher graduation and some college percentages, lower unemployment, lower children in poverty and lower income inequality.

When analyzing the health status data, local results were compared to New Hampshire, the U.S. (where available) and the top 10% of counties in the U.S. (the 90th percentile). Where Carroll County's results were worse than the State and U.S., there is an opportunity for group and individual actions that will result in improved community ratings. There are several lifestyle gaps that need to be closed in order to improve health in Carroll County. For additional perspective, New Hampshire was ranked

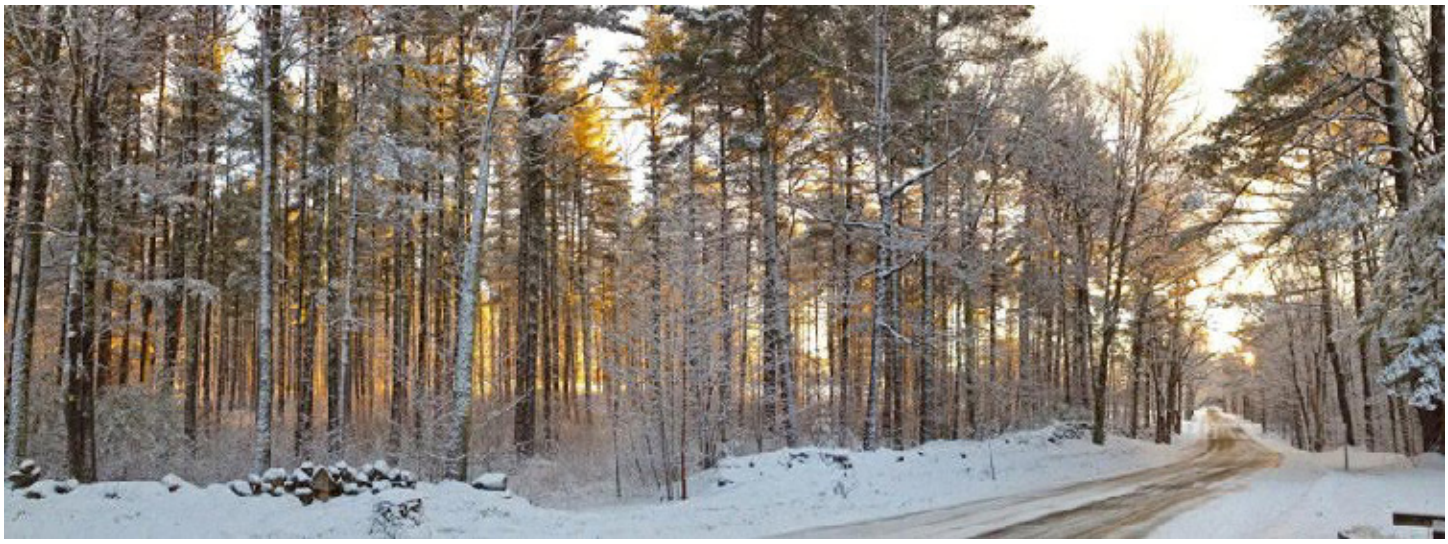


Photo Credit Huggins Hospital

[1] *The Rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play. Building on the work of America's Health Rankings, the University of Wisconsin Population Health Institute has used this model to rank the health of Wisconsin's counties every year since 2003.*

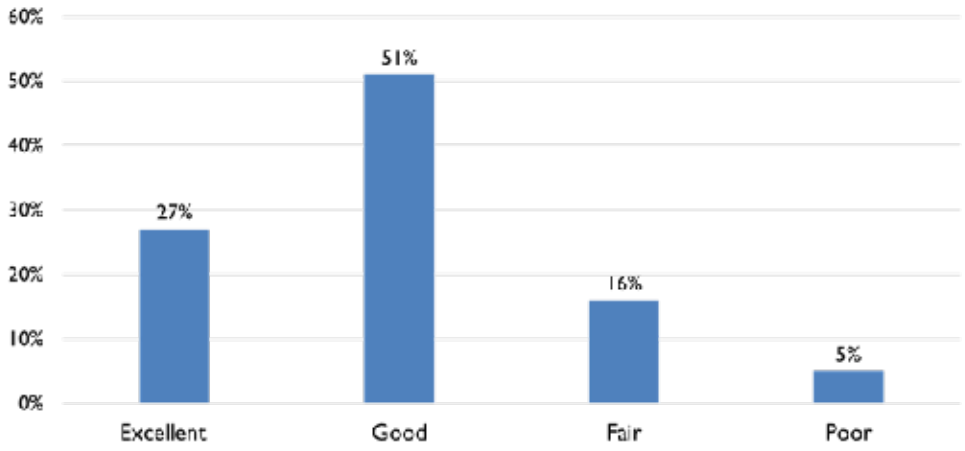
Survey Results, Health Status Comparisons

Survey Results

Three hundred random households were surveyed via telephone and cell phone to obtain input into the health needs of the county. Since the survey was random, it represented the broad interests of the community. Low income, uninsured and minorities were represented. The survey skewed slightly female and older since no quotas were set.

Health Status

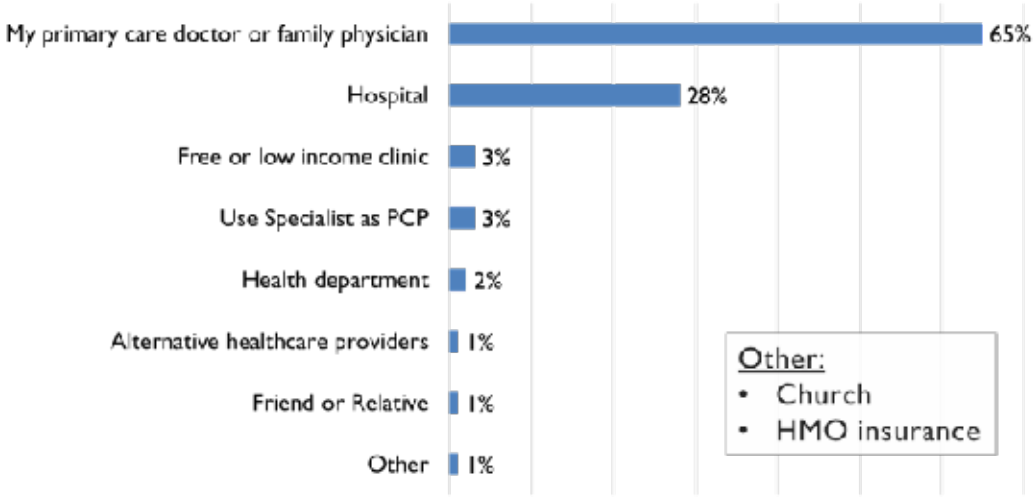
When asked to describe their health, the responses were:



78% responded excellent and good and 21% responded fair or poor.

Turn for Healthcare Needs

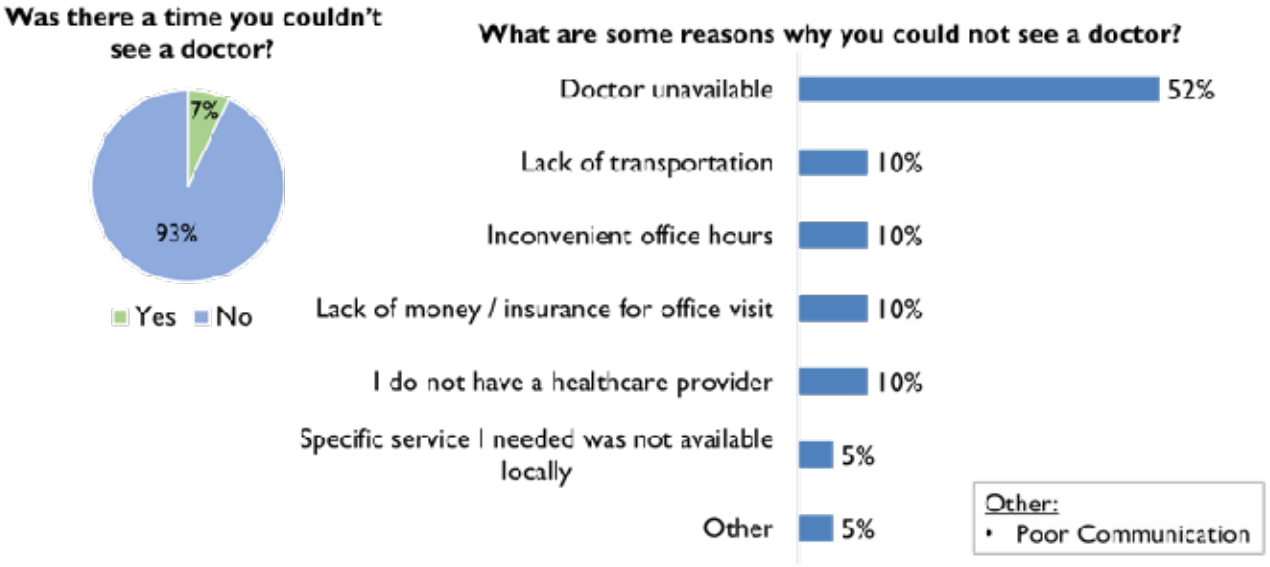
When asked where they turn for your basic healthcare needs, the responses were:



Most turn to primary care physicians for care followed by a hospital.

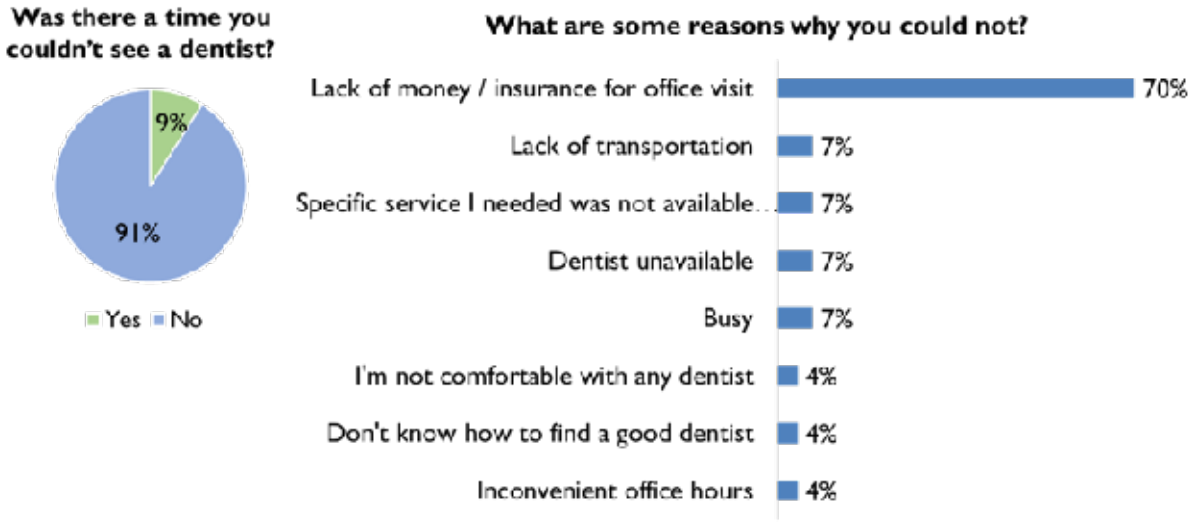
Access

Doctors



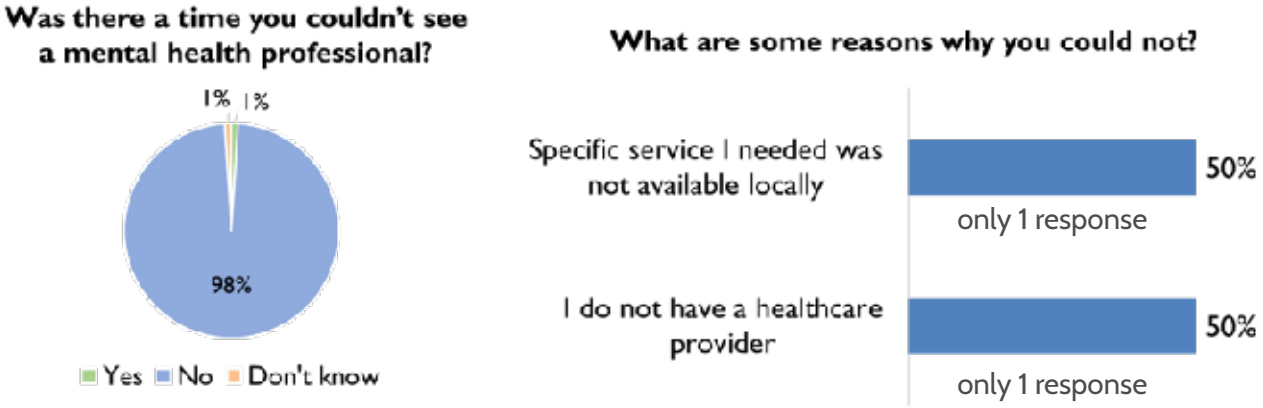
Only 7% indicated there was a time when they could not access a doctor. The primary reason was doctor was unavailable.

Dentists



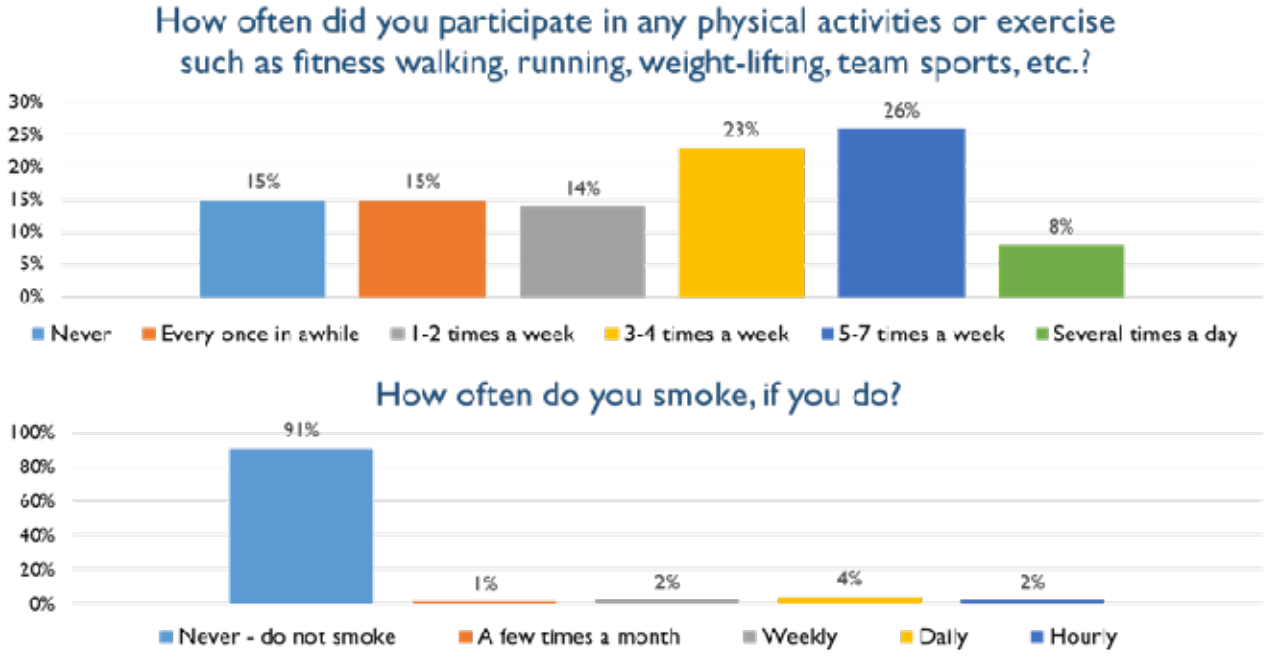
9% (27 responses) indicated there was a time they could not access a dentist.

Mental Health Professionals



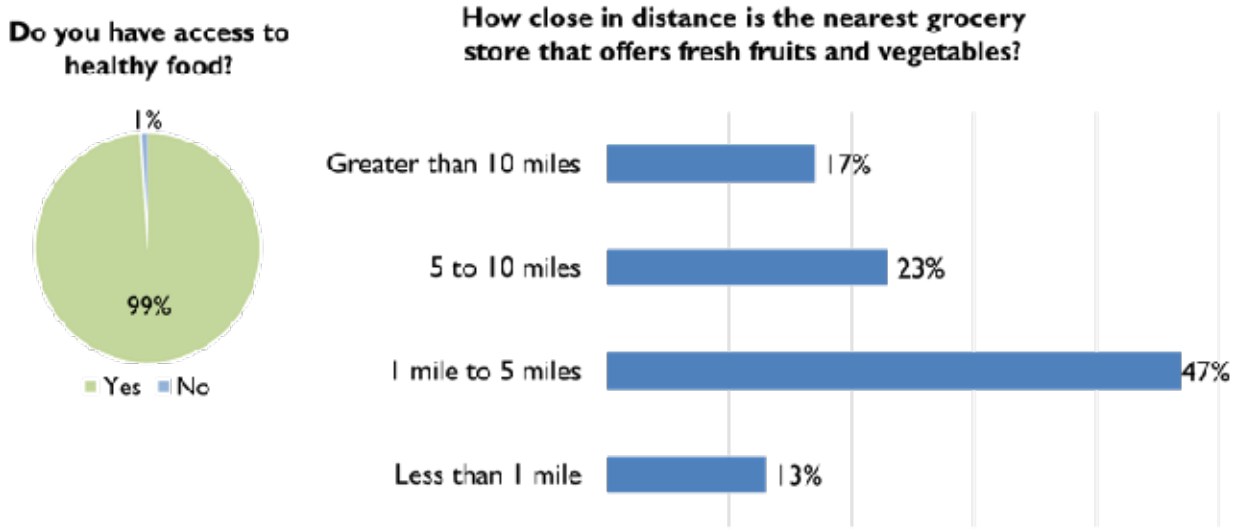
Only 1%, 2 responses, indicated there was a time they could not see a mental health professional.

Physical Activity and Smoking



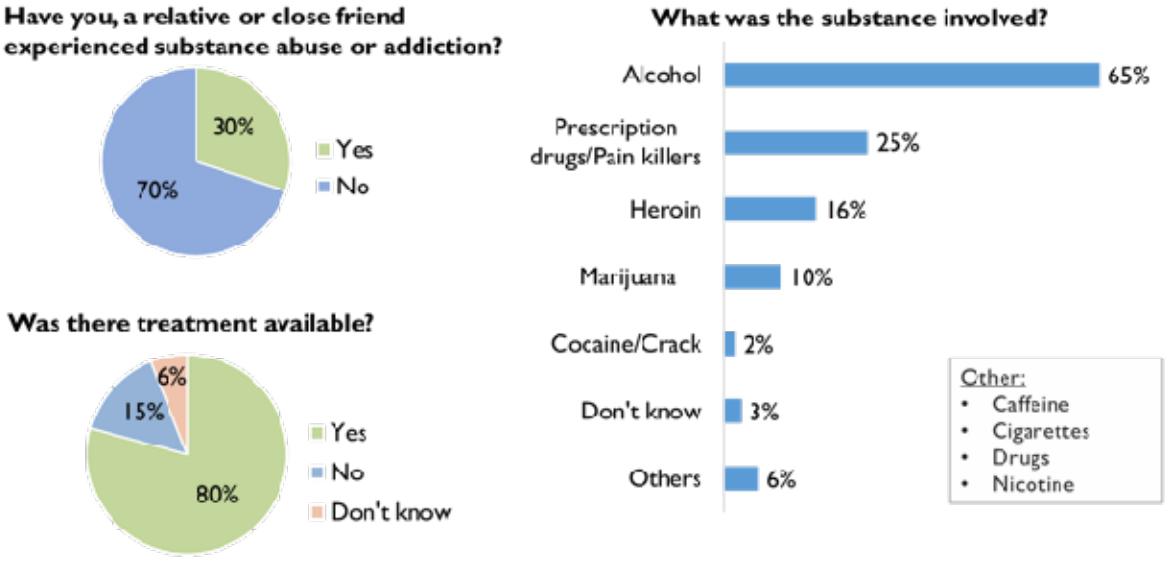
30% of the population does not exercise regularly, and 70% exercises regularly. Only 9% said they smoke.

Access to Healthy Foods



99% have access to healthy foods. 40% travel five miles or more to the grocery store with fresh fruits and vegetables.

Substance Abuse



30% have themselves, or have a close friend or relative that has experienced substance abuse or addiction. 15% responded there was not treatment available. The most common substance involved was alcohol followed by prescription drugs, then heroin.

Top three issues that impact health?

Respondents said the top issues that impact people's health are:

- Substance abuse (24%)
- People taking more responsibility for their own lifestyle/health (17%)
- Affordable healthcare (11%)
- Affordable health insurance (10%)

Top health concerns for children

The top health concerns for children were:

- Healthy diet (33%)
- Substance abuse (15%)
- Physical activity (15%)
- Responsible, involved parents (10%)

Disease prevalence

When asked, have you ever been told by a doctor you have any of these conditions, diseases or challenges, 80% responded affirmatively. The most prevalent issues were:

- High blood pressure/hypertension (46%)
- High cholesterol (34%)
- Arthritis (32%)
- Overweight or obese (24%)
- Cancer (19%)
- Diabetes (17%)
- Heart disease (12%)
- Asthma (11%)

Respondents were also asked if they had everything they needed to manage their health conditions. 93% responded yes and 7% responded no. Of those that responded no, they stated they needed more access to physicians/doctors, financial assistance, affordable healthcare/health insurance and more information/education about their conditions.

Top Health Needs in the Community

The top health needs in the community, identified through the phone survey, were:

- Substance abuse assistance (42%)
- Access to health insurance (33%)
- Access to care (27%)
- Obesity assistance (20%)
- More healthy eating, active living options (18%)
- Mental health assistance (16%)
- Help people to quit smoking (16%)
- More exercise opportunities (13%)

The survey skewed female and older, however the population is older. The other demographics of the survey mirrored the population, 95% white, educated, less educated, higher, middle and lower income.

Health Status Analysis and Comparisons

Information from County Health Rankings and America's Health Rankings was analyzed in Huggins Hospitals Community Health Needs Assessment in addition to the previously reviewed information and other public health data. This additional analyzed data is referenced in the bullets below, such as: causes of death, demographics, socioeconomics, consumer health spending and community surveys. When data was available for New Hampshire, the U.S. or the top 10% of counties (90th percentile), they were used as comparisons. Where the data indicated a strength or an opportunity for improvement, it is called out below. Strengths are important because the community can build on those strengths, and it's important to continue to focus on strengths so they don't become opportunities for improvement. The full data analysis can be seen in the complete CHNA PowerPoint at www.hugginshospital.org. Opportunities were denoted with red stars and strengths were denoted using green stars. The years displayed on the County Health Rankings graphs show the year the data was released. The actual years of the data can be found in the source notes below the graphs.

Leading Causes of Death: Age-adjusted deaths per 100,000

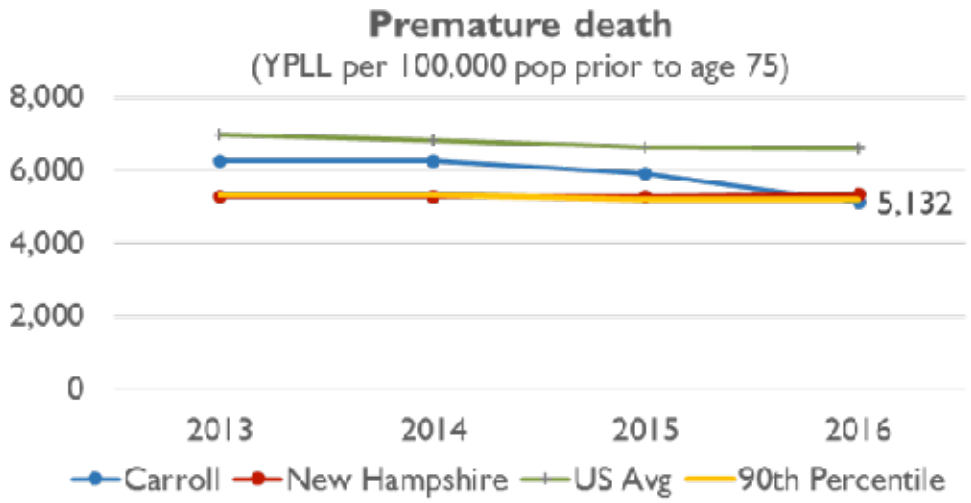
Cause of Death	Carroll Co (1999-2014)	New Hampshire (1999-2014)	US (2013)
Heart Disease	154.1	147.9	169.8
Cancer	175.7	160.4	163.2
Chronic Lower Respiratory Disease	39.8	41.3	42.1
Accidents	48.8	50.5	39.4
Stroke	38.5	28.9	36.2
Alzheimer's Disease	24.5	24.0	23.5
Diabetes	17.5	18.0	21.2
Influenza and Pneumonia	16.1	11.5	15.9
Kidney Disease	9.9	10.2	13.2
Suicide	17.8	17.8	12.6
Liver Disease	7.1	10.2	10.2

Source(s): CDC: 1999-2014 Final Data. In order to get enough data to display county rankings, multiple years must be used.

Red areas had death rates higher than NH. The leading causes of death in Carroll County and New Hampshire were cancer followed by heart disease. In the U.S., heart disease leads cancer. After heart disease and cancer, lagging behind are the other causes of death in Carroll County: accidents, chronic lower respiratory disease, stroke, Alzheimer's disease, suicide, diabetes, influenza and pneumonia, kidney disease and liver disease.

Health Outcomes (Length of Life and Quality of Life)

Health Outcomes are a combination of length of life and quality of life measures. Carroll County ranked 4th in Health Outcomes out of 10 New Hampshire counties. Length of life was measured by years of potential life lost per 100,000 population prior to age 75. Carroll County ranked 3rd in length of life.

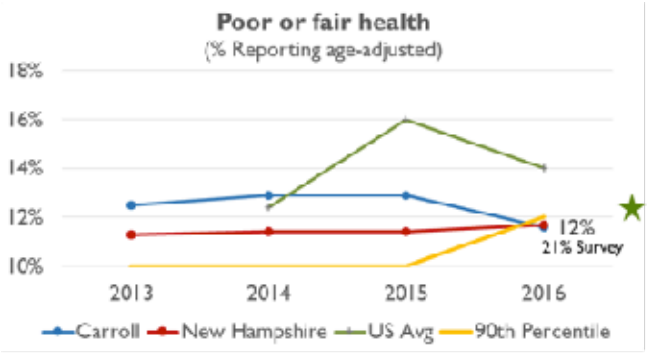


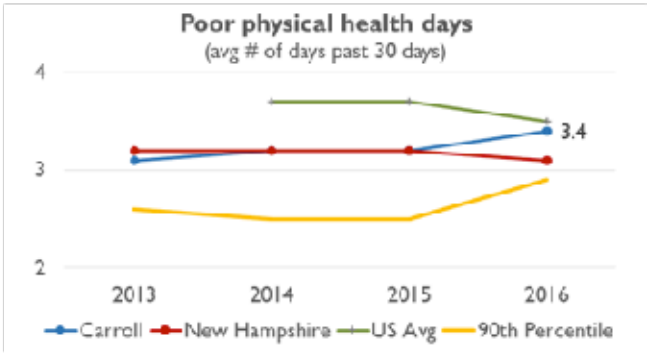
Source: County Health Rankings; National Center for Health Statistics – Mortality File 2011-2013

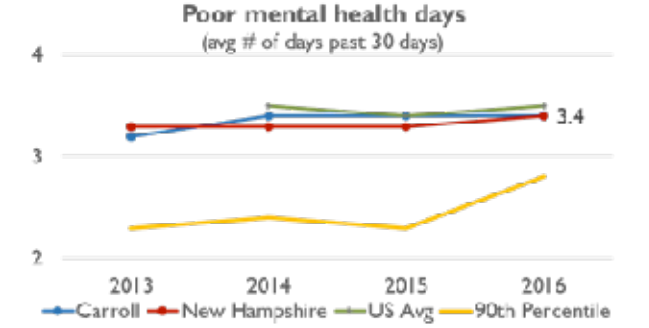
In most of the following graphs, Carroll County will be blue, New Hampshire red, U.S. green and the 90th percentile gold.

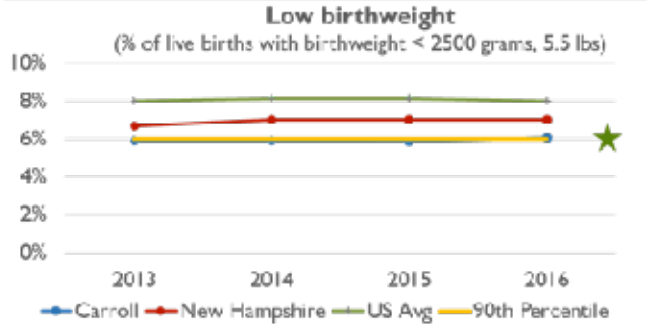
Quality of Life

Quality of life was measured by: % reporting fair or poor health, the average number of poor physical health days and poor mental health days in the past 30 days, and % of live births with birthweight less than 2500 grams (5lbs 8ozs). Carroll County ranked 4th out of 10 counties for quality of life.









Source: Poor or fair health, poor physical and mental health days - County Health Rankings; Behavioral Risk Factor Surveillance System (BRFSS) 2014

Source: County Health Rankings: National Center for Health Statistics – Natality files (2007-2013)

**indicates a change in the Behavioral Risk Factor Surveillance System Survey calculations of results. 2016 cannot be compared to prior year results.*

Quality of Life STRENGTHS

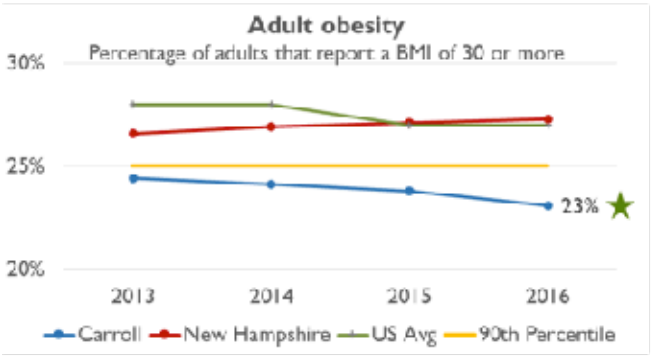
- Years of potential life lost (YPLL) per 100,000 population prior to age 75, was lower in Carroll County, 5,132 years lower, than New Hampshire and the U.S.
- The percent of low birthweight babies, less than 5.5 pounds, was lower in Carroll County than NH and the U.S.

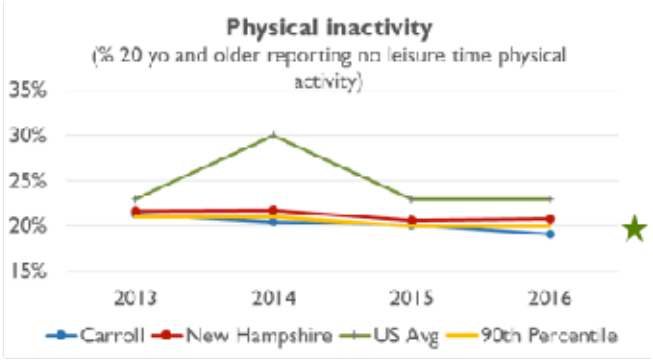
In the other quality of life measures, Carroll County's measures were between NH and the U.S.

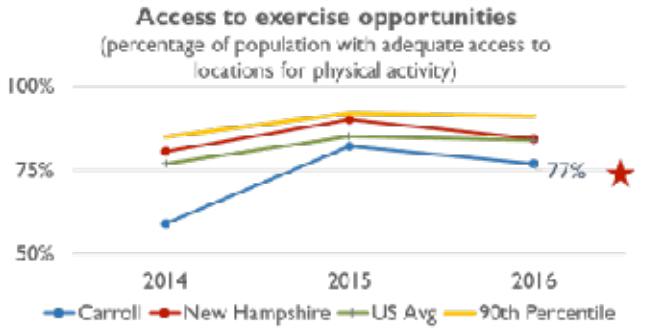
Health Factors or Determinants

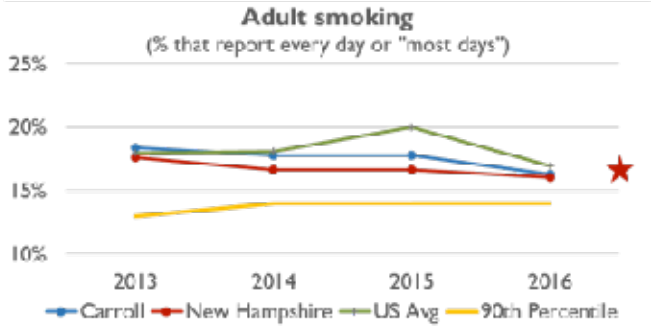
Health factors or determinants were comprised of measures related to health behaviors, clinical care, social and economic factors, and physical environment. Health behaviors are made up of nine measures. Health behaviors account for 30% of the county rankings. Carroll County ranked 1st out of 10 counties in New Hampshire for health factors.

Health Behaviors





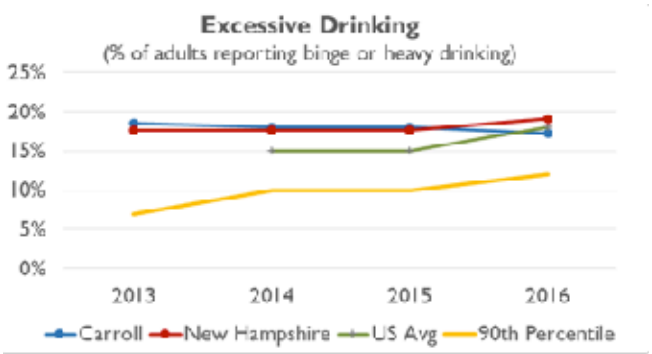


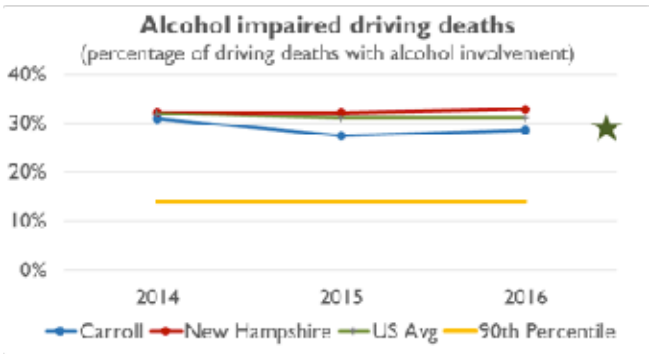


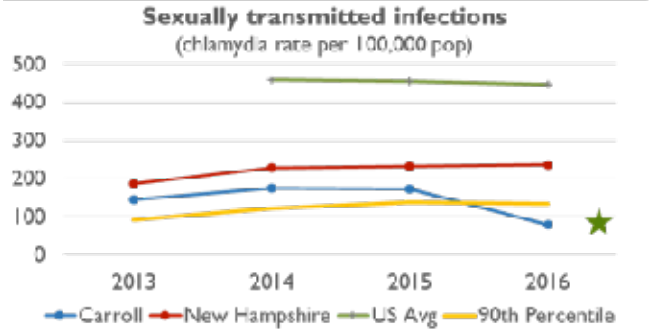
Source: Obesity, physical inactivity - County Health Rankings; CDC Diabetes Interactive Atlas, 2012

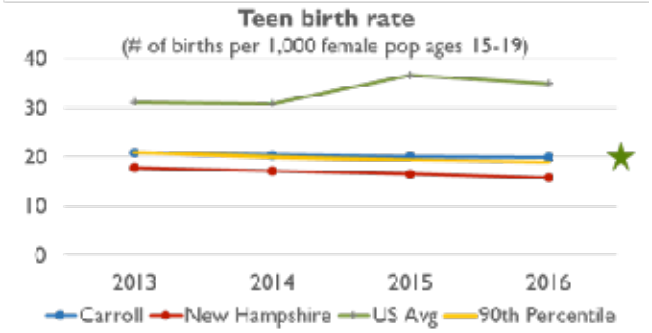
Source: Access to exercise opportunities - County Health Rankings; ArcGIS Business Analyst, Delorme map data, ESRI and US Census Tigerline Files, 2013

Source: Smoking - County Health Rankings; Behavioral Risk Factor Surveillance System (BRFSS)

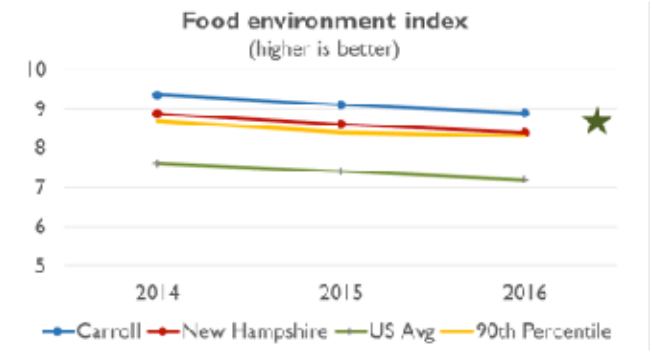


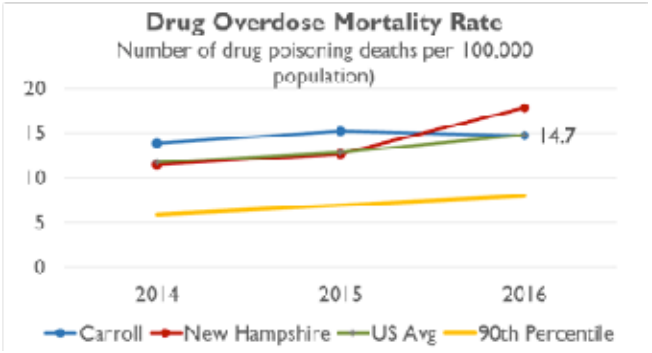






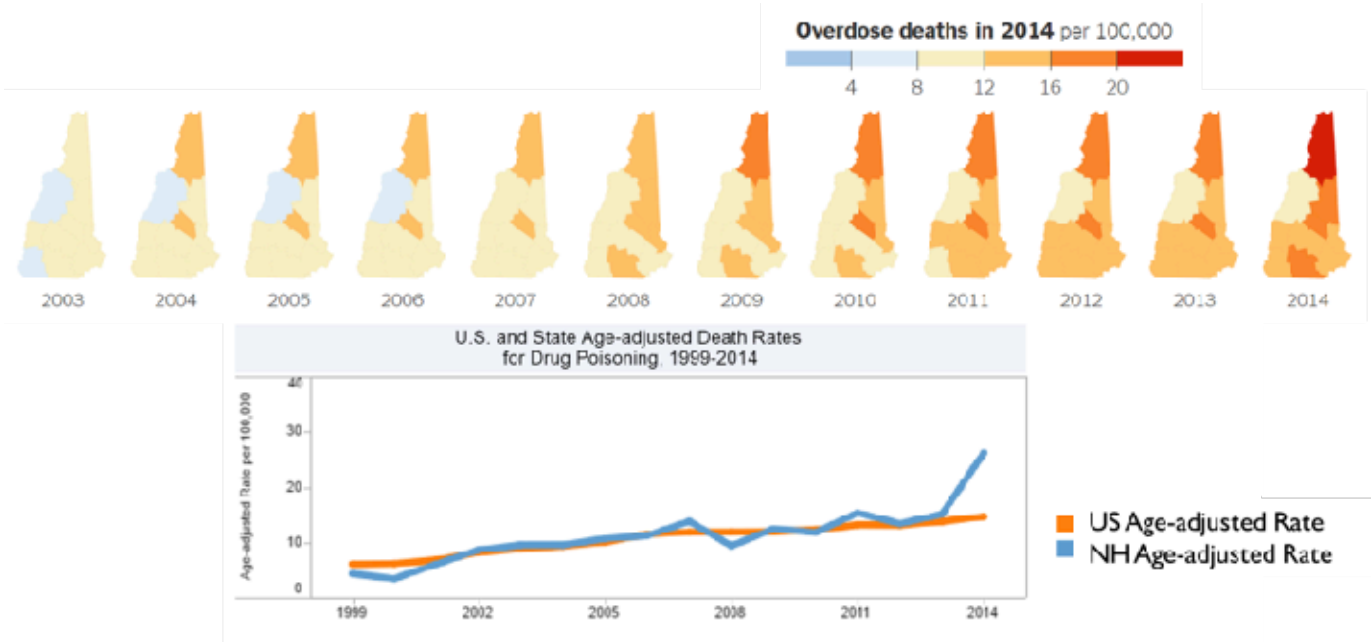
Source: Excessive drinking - County Health Rankings; Behavioral Risk Factor Surveillance System (BRFSS), 2014
Source: Alcohol-impaired driving deaths - County Health Rankings; Fatality Analysis Reporting System, 2010-2014
Source: STDs - County Health Rankings; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2013





The food environment index is comprised of % of the population with limited access to healthy foods and % of the population with food insecurity. Limited access to foods estimates the % of the population who are low income and do not live close to a grocery store. Food insecurity is the % of the population who did not have access to a reliable source of food during the past year.

Source: County Health Rankings; USDA Food Environment Atlas, 2012-2013



Source: County Health Rankings; CDC WONDER mortality data, 2012-2014

Health Behaviors STRENGTHS

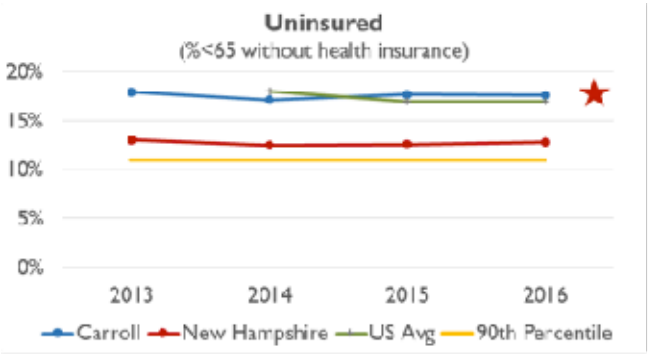
- Adult obesity, lower than both New Hampshire and the U.S., was above 20%. Carroll County was at the top ten percent of counties in the U.S. This measure is a strength for Carroll County, however obesity puts people at increased risk of chronic diseases: diabetes, kidney disease, joint problems, hypertension and heart disease. Obesity can also cause complications in surgery and often leads to metabolic syndrome and type 2 diabetes. It is also a factor in cancers, such as ovarian, endometrial, postmenopausal breast cancer, colorectal, prostate and others.
- Physical inactivity was lower in Carroll County than NH and the U.S. in the top 10% of counties in the U.S.
- The percentage of driving deaths with alcohol involved was lower than NH and the U.S.
- Sexually transmitted diseases as measured by Chlamydia rate per 100,000 population was lower in Carroll County than New Hampshire and the U.S., and decreased since 2013's release.
- The teen birth rate in Carroll County was lower than the U.S. and slightly higher than NH which is below the top 10%.
- Excessive drinking was lower than NH and the U.S.

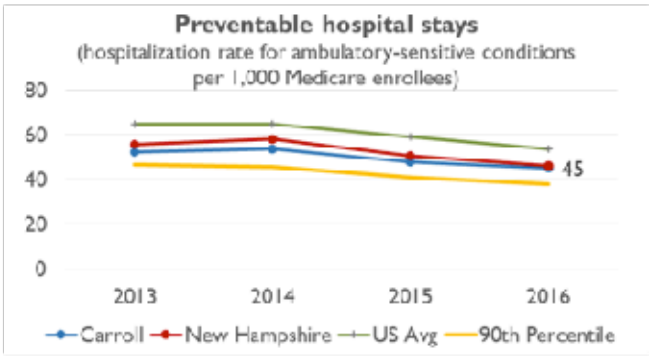
Health Behaviors OPPORTUNITIES

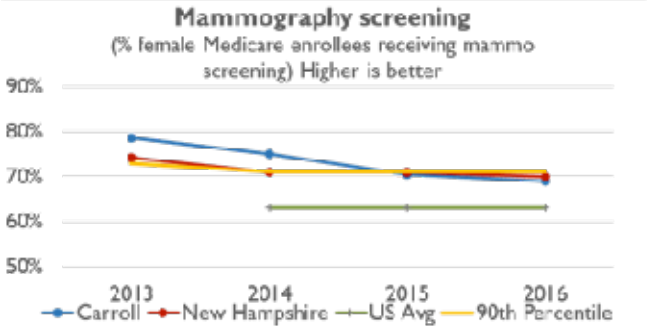
- Adult smoking in Carroll County was lower than the U.S. and similar to NH. Each year approximately 443,000 premature deaths can be attributed to smoking. Cigarette smoking is identified as a cause of various cancers, cardiovascular disease, and respiratory conditions, as well as low birthweight and other adverse health outcomes.
- The percentage of the population with adequate access to locations for physical activity was lower in Carroll County than NH and the U.S.
- The food environment index was lower than NH and the U.S. The index is a blend of access to healthy food and food insecurity.
- Drug overdose deaths increased in Carroll County and NH in recent years to 16-20 per 100,000 of population in 2014.

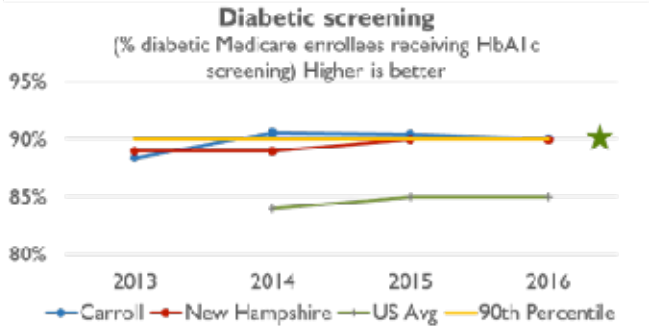
Clinical Care

Clinical care ranking is made up of eight indicators and they account for 20% of the county rankings. Carroll ranked 8th out of 10 New Hampshire counties in clinical care.



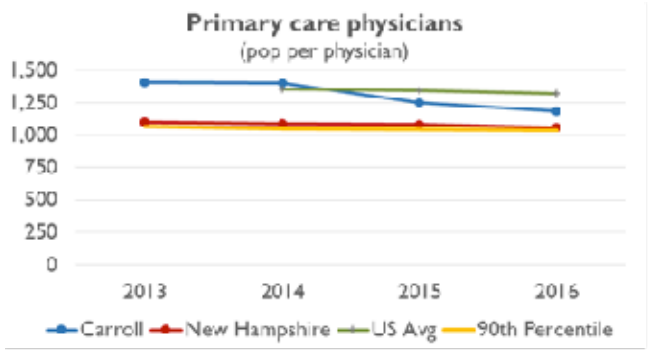


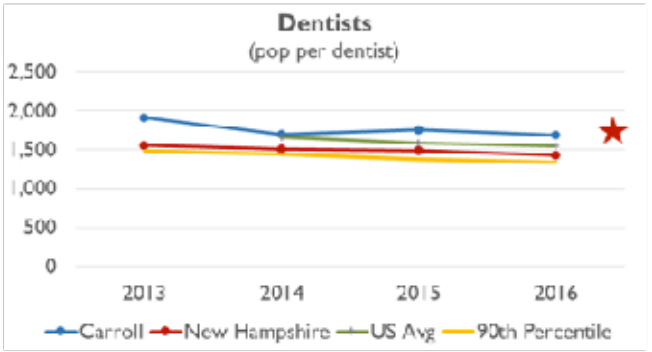


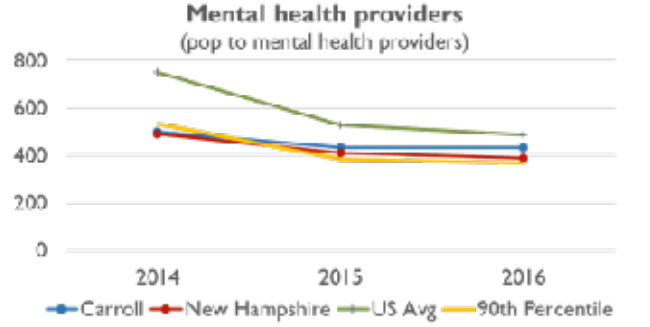


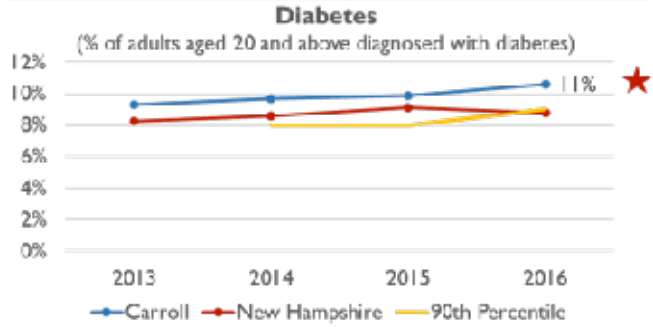
Source: Uninsured - County Health Rankings; Small Area Health Insurance Estimates, 2013

Source: Preventable hospital stays, mammography screening, diabetic screening - County Health Rankings; Dartmouth Atlas of Health Care , 2013









Source: Pop to PCP - County Health Rankings; Area Health Resource File/American Medical Association, 2013
Source: Pop to Dentists - County Health Rankings; Area Health Resource File/National Provider Identification file, 2014
Source: Pop to mental health provider (psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health) County Health Rankings; CMS, National Provider Identification, 2014
Source: Diabetes - County Health Rankings; CDC Diabetes Interactive Atlas, 2013

Clinical Care STRENGTHS

- Preventable hospital stays in Carroll County, measured by hospitalization rate for ambulatory-sensitive conditions per 1,000 Medicare enrollees, was slightly lower than NH and lower than the U.S.
- The percent of diabetic Medicare enrollees receiving screening was higher in Carroll than NH and the U.S. and in the 90th percentile.
- Mammography screening was higher in Carroll than NH and the U.S.

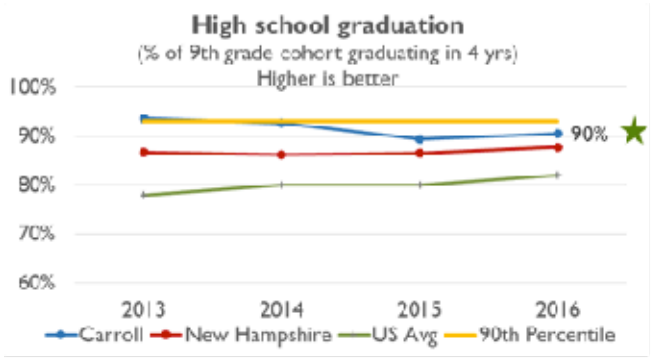
Clinical Care OPPORTUNITIES

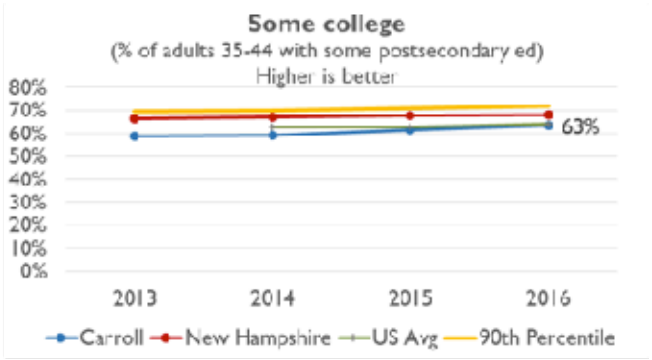
- The percent of population under sixty-five without health insurance was higher in Carroll County than NH and the U.S.
- Eleven percent of Carroll County had diabetes, which was higher than NH.
- The population per dentist was higher than NH and the U.S. The community survey indicated 9% could not find dental care.

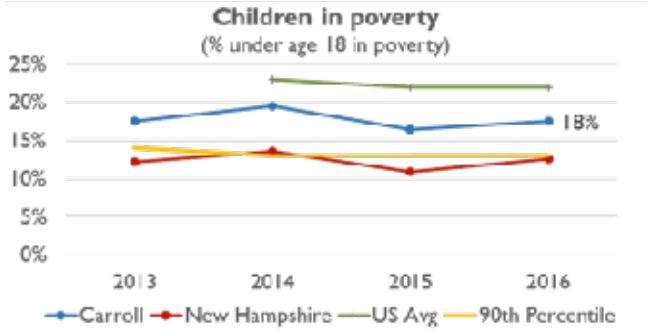
Other indicators in the category were between NH and the U.S.

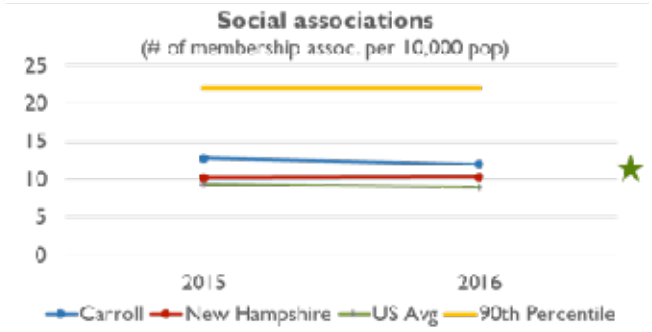
Social & Economic Factors

Social and economic factors account for 40% of the county rankings. There are eight measures in the social and economic factors category. Carroll County ranked 5th out of 10 New Hampshire counties in social and economic factors.







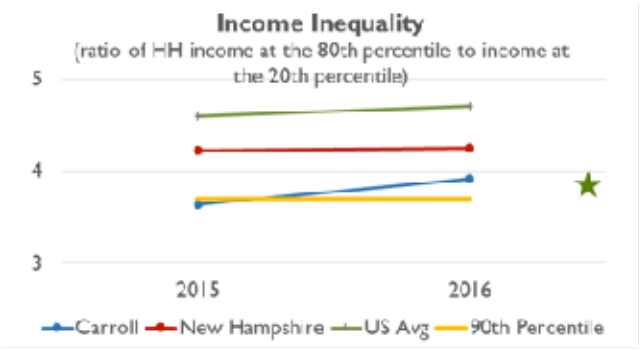


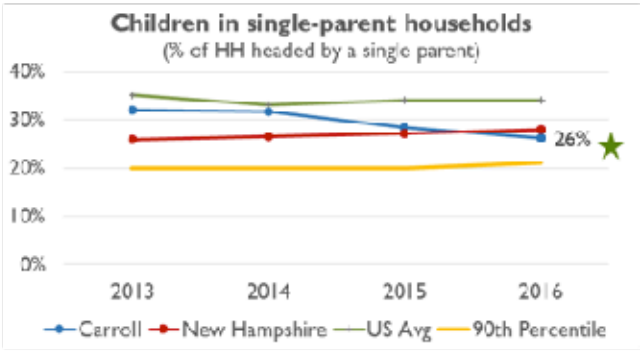
Source: High School graduation – County Health Rankings; States to the Federal Government via EDFacts, 2012-2013

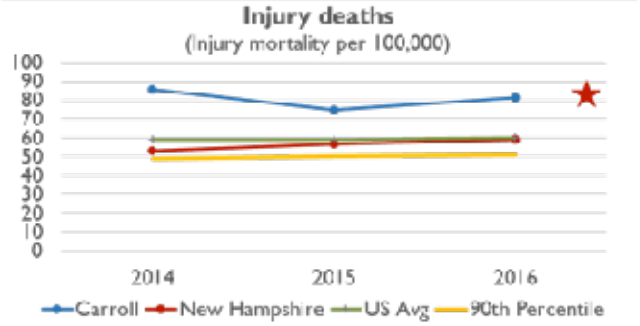
Source: Some college - County Health Rankings; American Community Survey, 5-year estimates, 2010-2014

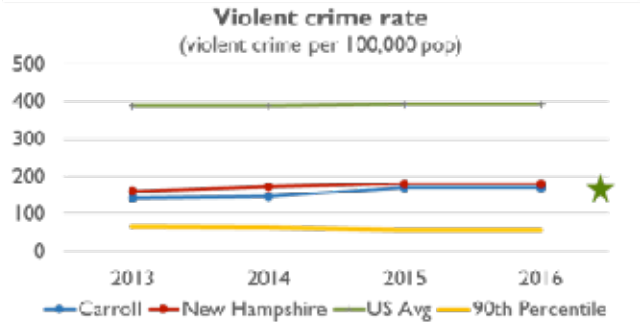
Source: Children in poverty - County Health Rankings; US Census, Small Area Income and Poverty Estimates, 2014

Source: Social associations - County Health Rankings; County Business Patterns, 2013









Source: Income inequality - County Health Rankings; American Community Survey, 5-year estimates 2010-2014

Source: Children in single parent households - County Health Rankings; American Community Survey, 5-year estimates, 2010-2014

Source: Injury deaths – County Health Rankings; CDC WONDER mortality data, 2009-2013

Source: Violent crime - County Health Rankings; Uniform Crime Reporting – FBI, 2011-2013

Social & Economic Factors STRENGTHS

- High school graduation was higher in Carroll County than NH and the U.S.
- Social associations were higher in Carroll County than NH and the U.S. Associations include membership organizations such as civic organizations, bowling centers, golf clubs, fitness centers, sports organizations, religious organizations, political organizations, labor organizations, business organizations, and professional organizations. Poor family support, minimal contact with others, and limited involvement in community life are associated with increased morbidity and early mortality.
- Income inequality, the ratio of household income at the 80th percentile to income at the 20th percentile, was lower in Carroll than NH and the U.S.
- Children in single-parent households declined in the past years and was below NH and the U.S.

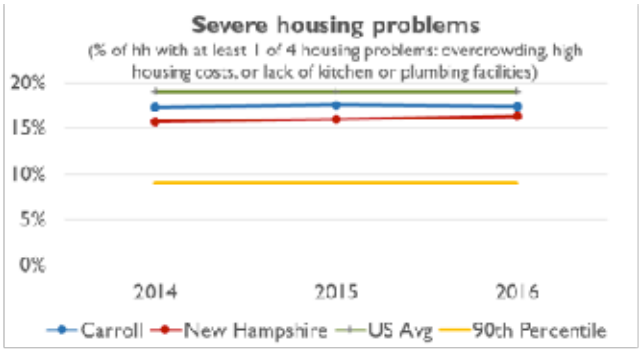
Social & Economic OPPORTUNITIES

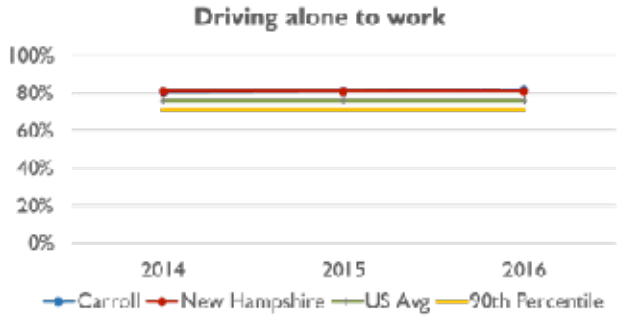
- The percent of adults with some college was lower than NH and similar to the U.S.
- The percentage of children in poverty was 18% in Carroll County, higher than NH but lower than the U.S.
- Injury deaths were higher than NH and the U.S.
- Lower median household income than NH and the U.S.

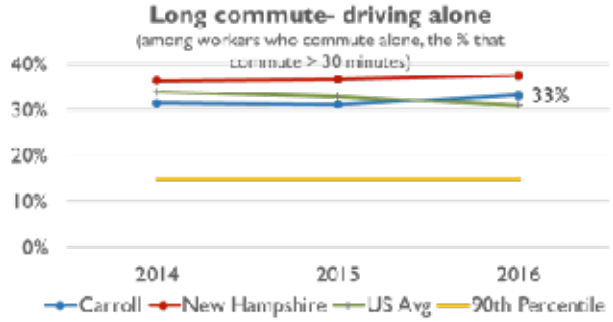
Huggins Hospital Community Health Summit 2016

Physical Environment

Physical environment contains five measures in the category. Physical environment accounts for 10% of the county rankings. Carroll County ranked 5th out of 10 New Hampshire counties in physical environment.



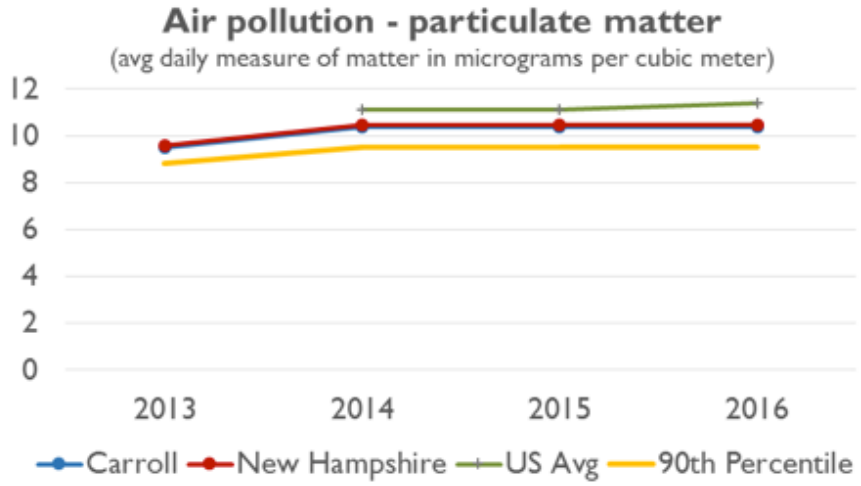




Source: Drinking water violations – County Health Rankings; EPA, FY 2013-2014

Source: Severe housing problems – County Health Rankings; HUD Comprehensive Housing Affordability Strategy data, 2008-2012

Source: Driving alone to work and long commute – County Health Rankings: American Community Survey, 5-year estimates, 2010-2014



Source: Air pollution – County Health Rankings: CDC WONDER environmental data, 2010

Physical Environment STRENGTHS

- Carroll County had fewer air particulate matter in micrograms per cubic meter than NH and the U.S.

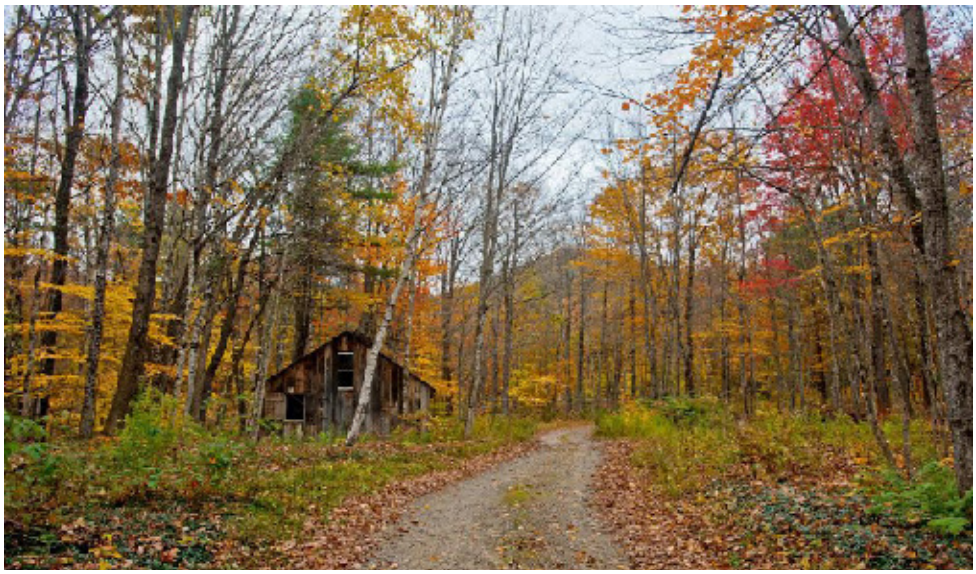
Physical Environment OPPORTUNITES

- There were drinking water violations in Carroll County. These statistics are prior to the Flint, MI water crisis.

In the other metrics, Carroll County was between NH and the U.S.

There were four broad themes that emerged in this process:

- Carroll County needs to create a "Culture of Health" which permeates throughout the towns, businesses, schools, and community organizations to engender total commitment to health improvement for all community members.
- There is a direct relationship between health outcomes and affluence (income and education) - the lower the income, the poorer the health outcomes.
- While any given measure may show an overall good picture of community health, there are significantly challenged subgroups in Carroll County.
- It will take a partnership with a wide range of organizations and citizens pooling resources to meaningfully impact the health of the community. Many assets already exist in the county to improve health.



Results from the Community Health Summit

Huggins Hospital Community Health Summi 2016

Prioritization Criteria

During Huggins Hospital's Community Health Summit, attendees identified and prioritized the most significant health needs in the community to be addressed in the next three-year period. The group used the criteria below to prioritize the health needs.

Magnitude/scale of the problem	How big is the problem? How many people does the problem affect, either actually or potentially? In terms of human impact, how does it compare to other health issues?
Seriousness of Consequences	What degree of disability or premature death occurs because of this problem? What would happen if the issue were not made a priority? What is the level of burden on the community (economic, social or other)?
Feasibility	Is the problem preventable? How much change can be made? What is the community's capacity to address it? Are there available resources to address it sustainably? What's already being done, and is it working? What are the community's intrinsic barriers and how big are they to overcome?

The following needs were prioritized at the Community Health Summit. The groups brainstormed goals and actions to form the foundation of Carroll County's health initiatives. Using a nominal group technique, each attendee posted their ideas of the top three health needs at the front of the room. The group, as a whole, then voted to establish priority. The results of the activity are below with higher numbers indicating the number of "votes" or priority by topic. The bullets below the health need are the actual comments received in writing.

1. Substance abuse (42)
2. Mental Health (25)
3. Chronic diseases/prevention (19)
4. Access (16)
5. Senior/Aging Issues (12)
6. Obesity (12)

1. Substance Abuse (42)

- Substance abuse (4)
- Substance misuse (2)
- Addiction (2)
- Substance abuse cure
- Alcohol/drug addiction
- Alcohol and drug abuse
- Drugs and drug addiction
- Substance misuse – alcohol, drugs
- Alcohol and drug misuse across the lifespan
- Substance abuse services
- Drug abuse
- Drug abuse prevention
- Drug/alcohol issue
- Heroin
- Addiction to prescribed drugs, anti-depressant
- Access to drug abuse/recovery programs
- Drugs – low income
- Acceptance of culture of alcohol misuse
- Physicians' recognition and diagnosing alcohol misuse in patients
- Screening for substance abuse at PCP office by trained person/recovery coach
- Easy accessibility of opioid prescriptions and providers
- Access to mental health and substance abuse treatment
- Excessive drinking, drugs, lack of mental health facilities
- Lack of availability of detox – 1-5 days for heroin Opiates
- Drug treatment recovery
- Drug prevention and education training/ instruction
- Residential treatment availability or long term recovery
- Substance misuse (behavioral health) alcohol, drug, prescription and street
- Substance abuse among young, pregnant moms, causing drug-addiction in newborns
- Substance abuse treatment/education
- Access to drug abuse counseling and medical care
- Health services, such as behavioral health to address smoking, drinking, substance abuse without increasing property tax to support these services/programs
- Drug rehab programs/services
- Substance abuse treatment programs for un/underinsured
- Begin ambulatory detox with PCP assistance to safely detox at home for substances

- Need for recovery coaches – CRSW (licensed recovery support worker) at hospital to screen and coach with overdose/refer to local substance abuse therapy
- Substance abuse – urgent need county-wide, has economic social and financial burden to community, homelessness

2. Mental Health (25)

- Mental health (6)
- Behavioral health/mental health
- Depression/anxiety – mental health, need that afflicts lower income community
- People don't know where to get help – mental health, family services, health insurance
- Lack of mental health services for all issues
- Incorrect contact information for mental health people. Can't find help.
- Mental Health services(3)
- Lack of mental health care
- Mental health services – increase emergency care
- Mental health increase community-based care
- Suicide prevention and awareness
- Access to mental health facilities, Mental health support
- Access to mental health for all ages
- Access to mental health care
- Mental health issues in people living in the community that are unaddressed
- Mental Health – deterioration of mental health services in New Hampshire, upheaval in NH, lack of psychiatrist
- Facilities and care for mental health problems

3. Chronic diseases/prevention (19)

- Individual responsibility
- Promote healthy lifestyles
- Public education
- Faith involvement
- Combining and working together of all community agencies
- Community involvement
- Significant severe disruption/negative consequences for entire family/community
- Heart disease
- Injury prevention
- Accidental death (2)
- Chronic disease/obesity
- It would be nice to have daily walk in centers for treatment
- Health maintenance overall
- Wellness education
- Diabetes (2)
- Chronic health issues/sickness
- Nutrition education for specific diseases and basic health

4. Access (16)

- Lack of shelter (homeless)
- Increase access to care for those uninsured and underinsured through state funded free transportation
- Transportation
- Transportation for the elderly – additional
- Uniform electronic medical record, including prescription drugs to better track/identify population of prescription substance, increase communication among providers about patients
- Clear and concise billing with no secret charges
- Uninsured affects low income, homeless community
- Access to healthcare
- The cost of medical care is prohibitive even for the insured
- Children in poverty lack access to healthcare
- Access to affordable health/dental insurance
- It is important to have adequate cancer treatment in southern Carroll County
- Prenatal health/neonatal care

- Access to medication for patients (insurance companies, auth mandate prior)
- Uninsured and access to health care ability to pay for services they need
- Education about penalty for not having health insurance

5. Senior/Aging issues (12)

- Senior services
- Aging health issues
- Elder support
- Elder care
- Elder services
- Enough facilities to care for and house aging seniors
- Healthy aging
- Aging in place, respect for elders' wishes
- Affordable care for seniors to stay home
- Housing, in-home supports for elderly/ disabled mainly low income
- Current reimbursement for post-acute care has been reduced/eliminated in some cases
- Increasing elders – need more elder services, high population of nursing home patients, healthy aging options

6. Obesity (12)

- Obesity (10)
- Obesity in the young as a start

Community Health Summit Brainstorming

Focus Areas and Goals

Huggins Hospital Community Health Summit 2016

The most significant health needs resulted in six categories. Groups brainstormed goals and actions around the most important health needs listed above. These suggested goals and actions have been organized below.

Substance Abuse

Goal 1 - Establish systematic drug education

Action 1 - Provide effective, age appropriate and systematic education at all levels

Action 2 - Engage medical community in identifying and screening for issue

Resources Needed:

- *Include mental health*
- *Utilize existing resources and expand to schools, church and community*
- *Identify best practice and use a collaborative process*
- *Utilize public health and governor's commission on alcohol/substance abuse*
- *Identify a community physician to champion*

Goal 2 - Prevention

Action 1 – Comprehensive state plan (over the counter drugs) including all aspects of society

Action 2 – Develop a system for the identification of people who are predisposed to drug misuse

Action 3 – Develop a program for pregnant women

Resources Needed:

- *Funding*
- *Trained personnel*
- *Facilities*
- *More professionals trained*

Goal 3 - Recovery

Action 1 – Develop strong community and access to programs that are treatment based

Action 2 – Develop a recovery infrastructure involving treatment centers, counselors, and follow-up care.

Resources Needed:

- *Reimbursement for treatment thru medical insurance*
- *incentives treatment*
- *More extensive treatment facilities with a continuum of care (i.e. inpatient, outpatient follow-up)*

Mental Health

Goal 1 - Increase access to psychiatric services especially acute care

Action 1 – Bring more psychiatrists into Carroll County

Action 2 – Advocate integration of mental health and primary care and pediatric physicians to refer to psych and APRNS.

Action 3 – Use suicide prevention programs that work

Action 4 – Link elderly population to mental health to reduce suicide risks

Resources Needed:

- *Partner with other counties*
- *1115 waiver*
- *Partner with existing programs*
- *Use programs like READ – Referral, Educate, Access to programs*
- *Get buy-in*

Goal 2 - Identify a potential facility to use

Action 1 – Gather a grass roots group to put a clear plan together

Action 2 – Identify possible facilities

Action 3 – Present to legislators

Chronic disease/prevention

Goal 1 – Diabetes/cholesterol/stroke all increase with obesity – more awareness and education needed

Action 1 – Create population change through early childhood/school-based programs with gardens as well as ways to increase outdoor, opportunities and decrease fear of natural environment

Action 2 - Increase activity in kids at school, decrease screen time

Goal 2 - Increase access to healthy foods

Action 1 - Sponsor community health clinic as part of food van

Action 2 - Bring community gardens to schools where people live

Action 3 - Mobile food van w/ SNAP eligibility

Action 4 - Use Carroll County farm property

Goals 3 - Affordable/transitional housing

Action 1 - Families in Transition already in process to address this issue

Action 2 - Increase education and awareness of challenges low income people face, poverty awareness workshops

Access

Goal 1 - Education and access to health insurance

Action 1 - Monthly insurance clinic to educate patients on what's available

Action 2 - Train providers how to bring awareness to patients regarding insurance options

Resources Needed:

- *Media – radio, TV, social media*

Goal 2 - Transportation

Action 1 - Develop regional transportation similar to Maine's RTP options

Action 2 - Transportation between healthcare facilities

Resources Needed:

- *Funding*
- *Cooperation with what is available (expanding) volunteers*

Goal 3 - Improve access to specialized care (prenatal, cancer, dialysis)

Action 1 - Collaboration with facilities that offer specialized care

Action 2 - Telemedicine – video chat with a specialist

Resources Needed:

- *Networking*
- *Transportation*
- *Education for patients*

Senior/Aging Issues

Goal 1 - Attainability of Homecare

Action 1 - Health monitoring in-home

Action 2 - Inform community/seniors about access/options

Resources Needed:

- *Town nurse*
- *Emergency services a.m. call*
- *Community churches or other might be able to fill gaps*
- *Consider surveying this community and service providers*

Goal 2 - Services and supports (meals, housekeeping, transportation)

Action 1 - Increase options/workforce

Action 2 - Agency /organization strategy to assess needs

Action 3 - Transportation – consider surveying this community and service priorities

Action 4 - Increase community engagement through assessment/exploring

Resources Needed:

- *Needs more consideration*
- *ServiceLink*
- *Find gaps*

Goal 3 - Advance Care Planning

Action 1 - Marketing targeting baby boomers

Action 2 - Consider messaging and action to support legislation and funding for sustainable action

Action 3 - Make sure local government and public know about needs/benefits, etc.

Obesity

Goal 1 - Raise awareness about obesity

Action 1 - Comprehensive list of community resources

Action 2 - Promote and market the list of resources

Resources Needed:

- *Hospitals*
- *Public health*
- *Chamber*
- *Newspaper*
- *Schools*
- *Internet*

Goal 2 - Reduce barriers to resources (time/cost/access)

Action 1 - Affordability – food, exercise

Action 2 - Use existing community services

Resources Needed:

- *Dietician*

Goal 3 - Education

Action 1 - Develop a strategy based on risk level of obesity

Action 2 - Social/emotional motivation

Huggins Hospital's Selected Initiatives and Implementation Plan 2016

Implementation Plan 2016

To successfully make our community healthier, it was necessary to have a collaborative venture which brought together care providers, citizens, government, schools, non-profit organizations and businesses around an effective plan of action. Huggins Hospital will now select key elements of the assessment and develop strategies and initatives to address those elements.

Based on the results of this CHNA, Huggins Hospital selected three (3) of the identified significant health needs to address.

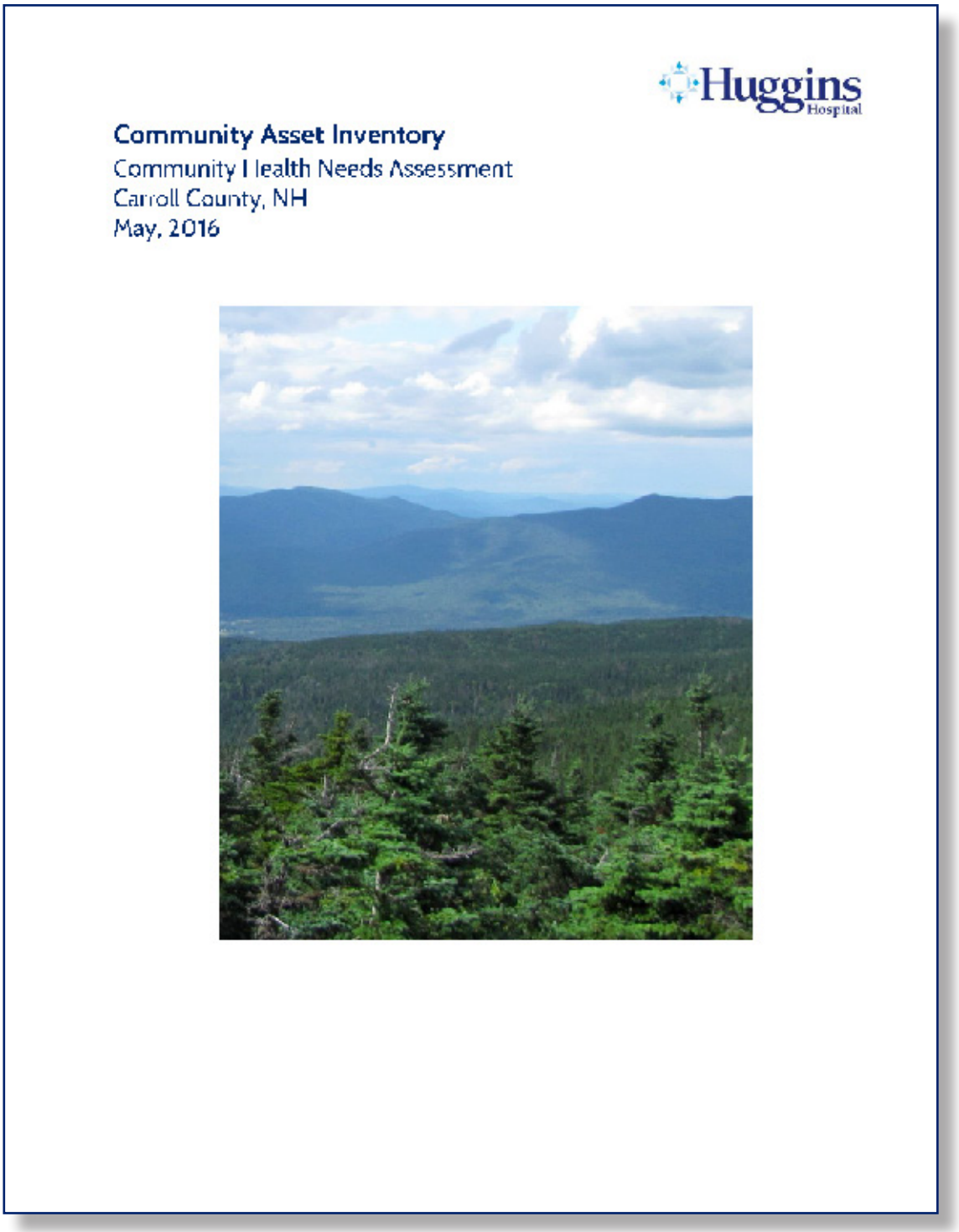
1. **Chronic disease and obesity treatment and prevention**
2. **Healthy aging**
3. **Mental Health and Behavioral Health**

Chronic Desease and Obesity Treatment and Prevention	Healthy Aging	Mental Health and Behavioral Health
Strategy to address needs: • Increase specialty and primary care services and access • Develop Coordinated Care program in Primary Care offices • Expand community education • Expand programming through Rehabilitation team and services • Support healthy activity initiatives in community **Anticipated impact:** • More chronic disease patients accessing the care they need • Increase in coordinated care for those with chronic disease **Resources proposed or needed:** • RN Care Coordinator for Primary Care • Increase in care providers • Funding for community initiatives • Community Education Campaign **Collaborations anticipated:** • Public Health • Community organizations • GraniteOne Health affiliation	**Strategy to address needs:** • Create Senior Wellness Group through Huggins Hospital to offer specific health information and social interaction for those 55+ • Provide activities for seniors in community (ie: line dancing, etc.) • Develop program to educate seniors about how to age at home safely and about Advanced Care Planning • Begin Falls Program - Tai Ji Quan **Anticipated impact:** • Decrease in EMS calls for falls (seniors) • Increase relationship building for seniors in the community **Resources proposed or needed:** • Senior Wellness Group program managed through Huggins Hospital • Senior health and wellness education • Staff to provide activities to seniors • Staff to provide Tai Ji Quan **Collaborations anticipated:** • Public Health • Senior Groups in community	**Strategy to address needs:** • Participate in multiple groups of the Medicaid 1115 Waiver from CMS • Advocate for patients through participation in community forums and groups addressing mental health and behavioral health as well as substance misuse • Develop continuum of care process within Primary Care offices • Support other organizations who focus in this area **Anticipated impact:** • Reduce ED visits and length of visits • Increase in coordinated care for those with mental health, behavioral health and substance misuse issues **Resources proposed or needed:** • Social Worker in Primary Care offices • **Funding for collaboration and support** **Collaborations anticipated:** • Public Health • Integrated Delivery Network (IDN) 7 participants • Local substance misues organization

Community Assets and Resources

Community Asset Inventory

A separate document that includes lists of community assets and resources that can help improve the health of the community can be found on the hospital's website at http://www.hugginshospital.org/assets/pdf/Huggins_Community_Asset_Inventory_2016.pdf or can be printed by request to the hospital's Communication & Community Relations Department.



2013 Huggins Hospital Implementation Plan/Impact Evaluation

Huggins Hospital adopted an implementation plan in 2013. The results of this plan were reviewed at the Community Health Summit.

The top health issues were:

- *Behavioral/Mental Health*
- *Dental Care*
- *Obesity/Nutrition*
- *Diabetes*
- *Unintentional injury*
- *Elder Care*
- *Substance Abuse/Domestic Violence*
- *Access to Care*
- *Heart Disease*

The Implementation Plan from 2013 was:

- *Address gap in Health Insurance Coverage*
- *Improve access to Primary Care Providers*
- *Offer services to improve activity levels*
- *Offer services to improve heart health*
- *Offer services to for diabetes prevention and management*
- *Provide education for safety to prevent unintentional injury*
- *Provide access to domestic violence support in Wolfeboro area*
- *Support other organizations offering public transportation*

With This Implementation Plan, Huggins Hospital:

- *Employed Financial Assistance Counselors to help patients access health insurance and guide them through their options.*
- *Hired more primary care providers resulting in an improvement to the primary care provider and patient ratio.*
- *Built a new Primary Care facility in Alton, NH to make more patient appointment availability.*
- *Continued exercise programs and weight management education for the community.*
- *Continued to offer specialty services in cardiac care through a clinical relationship with Catholic Medical Center of Manchester, NH.*
- *Developed a new evidence-based diabetes program through the CDC.*
- *Educated the community about injury prevention through Falls Prevention programs.*
- *Provided space for Starting Point, a domestic and sexual violence support organization, within the hospital.*
- *Financially supported local transportation.*

2013 Huggins Hospital CHNA and Implementation Plan Written Comments

At the community health summit, a worksheet asking for written comments was distributed to all participants. Written comments received were:

- *Glad it included unintentional injury as a focus area*
- *The 2013 Plan, as I understand it, at both hospitals indicated need for increased mental health/behavioral health a priority. Neither hospital addressed it as a priority action because of lack of resources.*
- *Always ambitious, seems difficult to get a handle on it all.*
- *Should be measured (i.e. success or failure by year)*
- *More Community "follow-up" i.e. does our community know about the plan?*

Photo Credit Stratasan

Community Health Needs Assessment

completed by Huggins Hospital in partnership with:

APPENDIX L
Accounting of Central VNA Donor-Restricted Funds

CENTRAL NEW HAMPSHIRE VNA & HOSPICE
PERMANENTLY RESTRICTED FUNDS
DECEMBER 31, 2019

		Muriel Devens Bond Fund	Fernald-Gilman-Leavit Education Fund
Beginning Balance	**1/1/2017**	**78,435.36**	**60,012.46**
Contribution		0.00	0.00
Net Investment Return		10,700.41	8,187.11
Grant Distributions & Program Expenses		(3,220.29)	(2,463.91)
Foundation Fees		(541.33)	(414.18)
Ending Balance	**12/31/2017**	**85,374.15**	**65,321.48**
Beginning Balance	**1/1/2018**	**85,374.15**	**65,321.48**
Contribution		1,000.00	0.00
Net Investment Return		(2,935.34)	(2,245.89)
Grant Distributions & Program Expenses		(3,145.58)	(2,406.75)
Foundation Fees		(555.00)	(424.64)
Ending Balance	**12/31/2018**	**79,738.23**	**60,244.20**
Beginning Balance	**1/1/2019**	**79,738.23**	**60,244.20**
Contribution		0.00	0.00
Net Investment Return		10,188.26	7,697.49
Grant Distributions & Program Expenses		(3,231.46)	(2,441.45)
Foundation Fees		(565.47)	(427.23)
Ending Balance	**12/31/2019**	**86,129.56**	**65,073.01**

NEW HAMPSHIRE
CHARITABLE FOUNDATION

Margaret A. Franckhauser\Central NH VNA & Hospice, Inc
780 North Main Street
Laconia, NH 03246-2756

Muriel Devens Bond Fund (3629-3)

	Current Quarter 10/1/2017 - 12/31/2017	Year to Date 1/1/2017 - 12/31/2017
Activity Summary		
Beginning Balance	$82,642.01	$78,435.36
Contributions	$0.00	$0.00
Net Investment Return	$2,868.77	$10,700.41
Grant Distributions & Program Expenses	$0.00	($3,220.29)
Foundation Fees	($136.63)	($541.33)
Ending Balance	$85,374.15	$85,374.15

Itemized Contributions

Itemized Grant Distributions & Program Expenses

02/13/17	Central NH VNA & Hospice, Inc-GE-D17-106073-1 The purpose of this fund is to support the Visitin	$3,220.29

Message from the Foundation

If you have questions or comments on this report, please contact (603) 225-6641 and select Donor Services option, or email at donorservices@nhcf.org.

[1] Donor advised fund advisors may recommend grant distributions above and beyond the charitable disbursement rate.

NEW HAMPSHIRE
CHARITABLE FOUNDATION

David Emberley/Central NH VNA & Hospice
780 North Main Street
Laconia, NH 03246-2756

Muriel Devens Bond Fund (3629-3)

	Current Quarter 10/1/2018 - 12/31/2018	Year to Date 1/1/2018 - 12/31/2018
Activity Summary		
Beginning Balance	$84,631.42	$85,374.15
Contributions	$1,000.00	$1,000.00
Net Investment Return	($5,753.39)	($2,935.34)
Grant Distributions & Program Expenses	$0.00	($3,145.58)
Foundation Fees	($139.80)	($555.00)
Ending Balance	$79,738.23	$79,738.23

Itemized Contributions

12/14/18	Shirley A. Bentley Rev Tr -9144	$1,000.00

Itemized Grant Distributions & Program Expenses

02/10/18	Central NH VNA & Hospice, Inc-GE-D18-111988-1 The purpose of this fund is to support the Visitin	$3,145.58

Message from the Foundation

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NEW HAMPSHIRE
CHARITABLE FOUNDATION

David Emberley/Central NH VNA & Hospice
780 North Main Street
Laconia, NH 03246-2756

Muriel Devens Bond Fund (3629-3)

	Current Quarter 10/1/2019 - 12/31/2019	Year to Date 1/1/2019 - 12/31/2019
Activity Summary		
Beginning Balance	$81,545.75	$79,738.23
Contributions	$0.00	$0.00
Net Investment Return	$4,725.05	$10,188.26
Grant Distributions & Program Expenses	$0.00	($3,231.46)
Foundation Fees	($141.24)	($565.47)
Ending Balance	$86,129.56	$86,129.56

Itemized Contributions

Itemized Grant Distributions & Program Expenses

02/10/19	Central NH VNA & Hospice, Inc-GE-D19-118198-1 The purpose of this fund is to support the Visitin	$3,231.46

Message from the Foundation

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NEW HAMPSHIRE
CHARITABLE FOUNDATION

David Emberley/Central NH VNA & Hospice
780 North Main Street
Laconia, NH 03246-2756

Muriel Devens Bond Fund (3629-3)

	Current Quarter 1/1/2020 - 3/31/2020	Year to Date 1/1/2020 - 3/31/2020
Activity Summary		
Beginning Balance	$86,129.56	$86,129.56
Contributions	$0.00	$0.00
Net Investment Return	($11,368.61)	($11,368.61)
Grant Distributions & Program Expenses	($3,234.66)	($3,234.66)
Foundation Fees	($141.52)	($141.52)
Ending Balance	$71,384.77	$71,384.77

Itemized Contributions

Itemized Grant Distributions & Program Expenses

02/14/20	Central NH VNA & Hospice, Inc-GE-D20-125342-1 The purpose of this fund is to support the Visitin	$3,234.66

Message from the Foundation

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NEW HAMPSHIRE
CHARITABLE FOUNDATION

Margaret A. Franckhauser\Central NH VNA & Hospice, Inc
780 North Main Street
Laconia, NH 03246-2756

Fernald-Gilman-Leavitt VNA Hospice Continuing Education Fund (3824-1)

	Current Quarter 10/1/2017 - 12/31/2017	Year to Date 1/1/2017 - 12/31/2017
Activity Summary		
Beginning Balance	$63,231.08	$60,012.46
Contributions	$0.00	$0.00
Net Investment Return	$2,194.94	$8,187.11
Grant Distributions & Program Expenses	$0.00	($2,463.91)
Foundation Fees	($104.54)	($414.18)
Ending Balance	$65,321.48	$65,321.48

Itemized Contributions

Itemized Grant Distributions & Program Expenses

02/13/17	Central NH VNA & Hospice, Inc-GE-D17-106007-1 The purpose of the Fund is to support continuing e	$2,463.91

Message from the Foundation

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NEW HAMPSHIRE
CHARITABLE FOUNDATION

RECEIVED

FEB 06 2019

Central New Hampshire
VNA & Hospice

David Emberley/Central NH VNA & Hospice
780 North Main Street
Laconia, NH 03246-2756

Fernald-Gilman-Leavitt VNA Hospice Continuing Education Fund (3824-1)

	Current Quarter 10/1/2018 - 12/31/2018	Year to Date 1/1/2018 - 12/31/2018
Activity Summary		
Beginning Balance	$64,753.19	$65,321.48
Contributions	$0.00	$0.00
Net Investment Return	($4,402.03)	($2,245.89)
Grant Distributions & Program Expenses	$0.00	($2,406.75)
Foundation Fees	($106.96)	($424.64)
Ending Balance	$60,244.20	$60,244.20

Itemized Contributions

Itemized Grant Distributions & Program Expenses

02/10/18	Central NH VNA & Hospice, Inc-GE-D18-111895-1 The purpose of the Fund is to support continuing e	$2,406.75

Message from the Foundation

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NEW HAMPSHIRE
CHARITABLE FOUNDATION

David Emberley/Central NH VNA & Hospice
780 North Main Street
Laconia, NH 03246-2756

Fernald-Gilman-Leavitt VNA Hospice Continuing Education Fund (3824-1)

	Current Quarter 10/1/2019 - 12/31/2019	Year to Date 1/1/2019 - 12/31/2019
Activity Summary		
Beginning Balance	$61,609.81	$60,244.20
Contributions	$0.00	$0.00
Net Investment Return	$3,569.91	$7,697.49
Grant Distributions & Program Expenses	$0.00	($2,441.45)
Foundation Fees	($106.71)	($427.23)
Ending Balance	$65,073.01	$65,073.01

Itemized Contributions

Itemized Grant Distributions & Program Expenses

02/10/19	Central NH VNA & Hospice, Inc-GE-D19-118104-1 The purpose of the Fund is to support continuing e	$2,441.45

Message from the Foundation

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NEW HAMPSHIRE
CHARITABLE FOUNDATION

David Emberley/Central NH VNA & Hospice
780 North Main Street
Laconia, NH 03246-2756

Fernald-Gilman-Leavitt VNA Hospice Continuing Education Fund (3824-1)

	Current Quarter 1/1/2020 - 3/31/2020	Year to Date 1/1/2020 - 3/31/2020
Activity Summary		
Beginning Balance	$65,073.01	$65,073.01
Contributions	$0.00	$0.00
Net Investment Return	($8,589.27)	($8,589.27)
Grant Distributions & Program Expenses	($2,443.87)	($2,443.87)
Foundation Fees	($106.92)	($106.92)
Ending Balance	$53,932.95	$53,932.95

Itemized Contributions

Itemized Grant Distributions & Program Expenses

02/14/20	Central NH VNA & Hospice, Inc-GE-D20-125280-1 The purpose of the Fund is to support continuing e	$2,443.87

Message from the Foundation

If you have questions or comments on this report, please contact (603) 225-6641 and select Donor Services option, or email at donorservices@nhcf.org.

[1] Donor advised fund advisors may recommend grant distributions above and beyond the charitable disbursement rate.

N·H·C·F

New Hampshire Charitable Foundation
37 Pleasant Street
Concord, NH 03301
(603) 225-6641

AGREEMENT TO ESTABLISH A FUND

I/We agree to establish the **Leo & Marguerite LaFrance Fund** (hereinafter referred to as the "Fund") as a component fund of the **Lakes Region Charitable Foundation** (hereinafter referred to as the "Foundation").

PURPOSE. The purpose of the Fund is to support the programs of the Community Health & Hospice, Inc. that benefit the needs of low-income residents in ~~the~~ Laconia ~~area.~~

PERMANENT NATURE OF GIFT. The IRS requires that gifts to the Foundation be permanent and irrevocable. The Foundation is the legal owner of all assets contributed to any of its component funds, which are not separate trusts. For accounting purposes, the assets of each fund are reported on the Foundation's financial statements. It is intended that the Fund hereby established shall be continued as long as the need therefore exists, and money or property is available in the Fund for its purposes. If the Fund is terminated by the Board of Directors of the Foundation for any reason, then any money or property remaining in the Fund shall be devoted by the Board for the purposes of the Foundation that, in the opinion of the Board, most nearly approximate the Purpose outlined in this Agreement.

VARIANCE POWER. As required by the United States Treasury Regulations, the Foundation has the right to modify the terms of this Agreement to Establish a Fund if, in the judgment of the Foundation's Board of Directors, the restrictions and conditions of the Fund's Purpose become unnecessary, incapable of fulfillment or inconsistent with the charitable needs of the State of New Hampshire or elsewhere.

FEES. The Foundation shall charge an annual fee for administering and managing the assets of the Fund. The current administration fee is 1.1% (1.2% for scholarship funds) applied to a 20-quarter rolling average of the market value of the Fund. There is also an investment management fee that varies depending on the investment managers selected. All fees are subject to change.

DISTRIBUTIONS FROM THE FUND. Grant distributions from the Fund will be made based on a spending allocation, which is a percentage of the assets set by the Foundation and reviewed annually. The current spending percentage is 5.0% of the market value (using a 20-quarter average) of the Fund. Market value of the Fund includes, without limitation, both realized and unrealized net appreciation/depreciation in the fair value of assets. This spending rate is subject to change at the discretion of the Foundation. Earnings in excess of the spending rate and fees are reinvested in the Fund's principal. The Foundation's spending policy permits the application of the spending percentage to a Fund even if it results in a Fund's balance falling below its historic dollar value. Thus, depending upon the market value of the Fund, distributions may be made from the Fund's principal. The Foundation's spending policy is applicable to all individual funds; however, donor advised funds may recommend grants up to the full value of the Fund.

Fund Establishment Initials

M.R.L.
I.A.F.

The Foundation shall honor the Fund Establisher's restrictions as to the use and/or investment of income or principal set forth at the time of the establishment of the Fund. This is subject to the authority of the Board of Directors of the Foundation to determine that conditions or circumstances are such or have so changed that such restriction or condition is unnecessary, incapable of fulfillment or inconsistent with the charitable needs of New Hampshire or elsewhere. In that case the Board may, in accordance with the Bylaws of the Foundation, order a variance from the restriction or condition as, in the judgement of the Board, is then necessary to serve more effectively the charitable purposes of the Fund.

INVESTMENT OF FUNDS. Funds are pooled for investment purposes. An independent investment committee makes investment decisions for all assets of the Foundation. IRS and Treasury regulations prevent Fund Establishers from making specific investment decisions.

MINIMUM FUND SIZE. The current minimum to establish a fund is $10,000 ($25,000 for donor advised funds). Funds that do not reach minimum size may be dissolved, in the discretion of the Foundation, according to one of the following options:

- π Transfer all principal and interest to an unrestricted fund
- π Transfer all principal and interest to an existing field of interest fund
- π Distribute all principal and interest for the Fund's Purpose as described in this agreement

INTERPRETATION OF AGREEMENT. Nothing in this Agreement to Establish a Fund shall affect the status of the Foundation as a community foundation as governed by the Internal Revenue Service Code and any subsequent regulations issued which may be applicable to that status. This Agreement to Establish a Fund, and all contributions made to this Fund, now or in the future shall be subject to the Policies, Bylaws and Articles of Agreement of the Foundation as currently written or as amended in future.

This Agreement to Establish a Fund is made and effective as of the next regularly scheduled meeting of the New Hampshire Charitable Foundation's Board of Directors:

Date: Jan 5, 2004 By: Marguerite K. LaFrance
Fund Establisher

Joseph A. LaFrance
Fund Establisher

The Foundation accepts the foregoing Fund and the conditions thereof.

Date: Jan 5, 2004 By: Linda Gray
Foundation Representative

Date: 1/14/04 By: Shirley Mullen
Foundation Officer

APPENDIX M
Simione Report: Combined Entity Financial Projections

The Information Contained in This Appendix is Confidential, and Excluded from Public Disclosure Under NH RSA 91-A:5(IV)

APPENDIX N
March 19, 2020 Joint Press Release

Concord Regional Visiting Nurse Association and Central New Hampshire VNA and Hospice Announce Intention to Merge

Concord and Laconia, NH (March 19, 2020) – Concord Regional Visiting Nurse Association (Concord Regional VNA) and Central New Hampshire VNA & Hospice (Central VNA) today announced that they have signed a non-binding letter of intent (LOI) to merge their two organizations to better serve the home and community based health care needs of residents of the Greater Capital Region and Central New Hampshire.

The non-binding LOI is the first step in a process that involves further due diligence, negotiation of final terms, opportunities for public input, approval by each organization's Board of Trustees and review by federal and state regulators. The unified agency would:

- Improve access to high-quality home-based care for individuals and families in 82 communities served
- Respond to growing demand for specialty home-based clinical services, including intravenous therapy, wound care and pediatrics
- Enhance and expand community wellness programming
- Attract, retain and develop a highly-skilled workforce

"Agencies that deliver home health and hospice services face challenges that are making it more difficult to deliver care, including complexities in technology, licensing and administrative requirements, and demand for services that require a higher level of expertise," said Beth Slepian, President and CEO, Concord Regional VNA. "Our number one priority is the health, safety and well-being of our patients, staff and communities as we all grapple with this serious public health emergency, however, we must also look to the future. Merging our agencies would allow us to maintain a high level of care, and scale to expand services throughout the New Hampshire communities we serve."

"Concord Regional VNA and Central New Hampshire VNA & Hospice have a longstanding history of working closely together," said Lisa Dupuis, CEO, Central New Hampshire VNA & Hospice. "With the healthcare landscape continually changing, we need to focus on the future in order to guarantee that we can continue to deliver the highest level of home-based health care, and I am excited about the possibilities affiliating with Concord Regional VNA would offer to our communities, our patients and our staff."

This LOI represents a high-level agreement about why a proposed merger of the two agencies would better meet the growing demand for home and community based healthcare, including nursing services, physical rehabilitation, occupational therapy, homemaking services, end-of-life care, and wellness programming. Merging would bolster the agencies' future sustainability.

Formed through the merger of Community Health & Hospice in Laconia and the VNA & Hospice of Southern Carroll County in Wolfeboro, Central VNA provides in-home healthcare services to

47 Lakes Region communities, including home care, rehabilitation services, pediatric care, palliative care, and a comprehensive, team-based home hospice program.

Incorporated in 1899, Concord Regional VNA is a not-for-profit licensed and certified home health and hospice care provider. The agency serves people of all ages in more than 44 communities in central New Hampshire by providing home care, hospice care, palliative care, personal home services, pediatric and maternal child health services, and wellness programming. Concord Regional VNA opened New Hampshire's first hospice house in 1994. In fiscal year 2019, Concord Regional VNA provided more than $5.1 million in community benefits.

APPENDIX O
Summary of Transaction Terms

Summary of Proposed Merger Agreement between Concord Regional VNA and Central New Hampshire VNA & Hospice

Concord and Laconia, NH (June 1, 2020) - CONCORD REGIONAL VISITING NURSE ASSOCIATION, INC. CENTRAL NEW HAMPSHIRE VNA & HOSPICE

Summary of Proposed Merger Agreement

The purpose of this summary is to inform the parties' respective constituents about the major elements of the transaction that they are negotiating. The definitive agreement has not yet been finalized, and the board of trustees of each organization is soliciting input from its communities to inform the board's deliberations and negotiations. Therefore, the terms of the final agreement may vary from this summary.

I. WHO:

Concord Regional Visiting Nursing Association, Inc. ("CRVNA") and **Central New Hampshire VNA & Hospice** ("CNHVNAH") are New Hampshire tax-exempt entities with charitable missions to provide home health care, and community wellness and hospice services. CRVNA is based in Concord and CNHVNAH is located in Laconia and Wolfeboro, and they have adjacent and slightly-overlapping service areas.

II. WHY:

Given (i) the current economic and regulatory challenges to the fulfillment of their charitable missions, (ii) the evolution of home health care delivery models, services and reimbursement, and (iii) the compatibility of their missions and adjacency of their service areas, CRNVA and CNHVNAH have explored various collaborative arrangements through which they can maintain and potentially increase their ability to meet the community health care needs of their respective service areas, and enhance the quality and sustainability of their charitable services. They believe that the transaction described below will result in innovative models of care, improve quality, reduce duplicative services and the expense of delivering and accessing care, and enhance their workforce recruitment and development.

III. WHAT:

A. Combination. The parties have determined that they will be best able to fulfill their missions by combining their organizations into a single entity (the "*Combined Entity*"). By integrating the assets, liabilities, and services of each organization into a single management, financial and operational structure, the parties expect that the Combined Entity will be more efficient and

viable in the long-term. Although a 2-year integration period is contemplated (discussed below), the parties envision that the Combined Entity, while respectful of its heritage, will have evolved into a unified entity pursuing its charitable mission without the need to maintain separate powers or protections for its founders. This is not a merger by which one organization subsumes and extinguishes another, but instead is the combination of two non-profit organizations with compatible missions to create a new, integrated and stronger organization with the same charitable pursuits.

B. Operations and Existing Assets. The Combined Entity will continue to offer current CRVNA and CNHVNAH services and to maintain principal offices in Concord, Laconia and Wolfeboro for as long as such services and locations are feasible and in furtherance of the Combined Entity's charitable mission. The Combined Entity will respect all donor-restricted funds and the programmatic purposes for which certain historical fundraising activities of the parties have been conducted. The parties also expect to commit to using all operating reserves existing at closing for the needs of the service area of the organization which accumulated such reserves.

C. Governance and Management. The Combined Entity will be governed by a Board of Trustees, the initial size of which is proposed to be 21 members. The Combined Entity Chief Executive Officer will serve on the Board ex officio with full voting rights. The parties have agreed that Beth Slepian (current CRVNA CEO) will serve as the initial Chief Executive Officer of the Combined Entity, and Lisa Dupuis (current CNHVNAH CEO) will serve as the initial Chief Operating Officer of the Combined Entity. The following decisions are expected to require a vote of 2/3 of the trustees of the Combined Entity Board (a "supermajority vote"): (i) unbudgeted capital expenditures or debt in excess of $100,000; (ii) material changes in clinical services or programs; (iii) relocation or closure of any principal office or the expansion or contraction of the current combined service are of the parties; (iv) a corporate reorganization; (v) a proposed dissolution; or (iv) an amendment to the supermajority provisions of the Combined Entity bylaws.

IV. HOW:

A. Merger. CNHVNAH is expected to be merged into CRVNA, with CRVNA being the legal surviving entity. To capture the identity and heritage of each party and integrate their clinical operations and charitable missions, the articles of agreement and bylaws of CRVNA will be amended at closing to combine the parties' charitable mission statements, establish a new governance structure and incorporate other terms of the merger agreement between the parties.

B. Integration Period. To ensure that the Combined Entity is established and integrated as contemplated by the parties, the definitive agreement will establish a 2-year integration period (the "Integration Period"). During the Integration Period, the Combined Entity Board of Trustees will have representatives nominated by CRVNA (60%) and by CNHVNAH (40%). To protect the interests of CNHVNAH under the merger terms, the following decisions of the Combined Entity Board will require a supermajority vote of all Trustees during the Integration Period: (i) hiring or termination of the chief executive officer; (ii) approval of operating and capital budgets; and (iii) any material change in endowment or investment policies. Additionally, the merger agreement

will describe an un-winding procedure if the Combined Entity Board, by a supermajority vote, decides during the Integration Period that the parties' mutual vision and goals cannot be fulfilled.

V. WHEN:

It is expected that the boards of trustees of CRVNA and CNHVNAH will meet in late June and/or early July, 2020 to vote on the merger agreement. If the merger agreement is approved by the boards, the parties will seek regulatory approval from the New Hampshire Director of Charitable Trusts under RSA 7:19-b (the "Change of Control" statute) and review by the New Hampshire Attorney General, Consumer Protection and Antitrust Bureau. Following receipt of regulatory approvals and the completion of any remaining due diligence, the parties' boards will reconvene either to confirm the merger agreement, make modifications based on the public testimony or diligence results, or conclude that the conditions to the agreement (satisfactory due diligence and regulatory approvals) cannot be met. The parties hope that all conditions can be satisfied and the merger consummated by December 31, 2020.

Summary Date: June 1, 2020

APPENDIX P
May 27, 2020 Joint Press Release

Concord Regional Visiting Nurse Association and Central New Hampshire VNA and Hospice Will Host Virtual Listening Session Wednesday, June 3

Concord and Laconia, NH (May 27, 2020) – Concord Regional Visiting Nurse Association (Concord Regional VNA) and Central New Hampshire VNA & Hospice (Central VNA) will hold a virtual public listening session on Wednesday, June 3, 2020, from 4:30 to 6:00 p.m. to share information about their proposed merger and gather feedback from the public through a question and answer session.

The online listening session follows the organizations' announcement on March 19, 2020, of their signing of a non-binding letter of intent (LOI) to merge. The non-binding LOI is the first step in a process that involves further due diligence, negotiation of final terms, opportunities for public input, approval by each organization's Board of Trustees and review by federal and state regulators.

The listening session will include a presentation by Beth Slepian, President and CEO of Concord Regional VNA and Lisa Dupuis, CEO of Central VNA outlining the organizations' plans for the merger and its role in sustaining the home and community based health care needs of residents of the Greater Capital Region and Central New Hampshire. Following the presentation, Slepian and Dupuis will be joined by Concord Regional VNA Board of Trustees Chair Melvin J. Severance and Central VNA Board of Trustees President Kristen Gardiner for a live question and answer period in which they will take questions from attendees.

Formed through the merger of Community Health & Hospice in Laconia and the VNA & Hospice of Southern Carroll County in Wolfeboro, Central VNA provides in-home healthcare services to 47 Lakes Region communities, including home care, rehabilitation services, pediatric care, palliative care, and a comprehensive, team-based home hospice program.

Incorporated in 1899, Concord Regional VNA is a not-for-profit licensed and certified home health and hospice care provider. The agency serves people of all ages in more than 44 communities in central New Hampshire by providing home care, hospice care, palliative care, personal home services, pediatric and maternal child health services, and wellness programming. Concord Regional VNA opened New Hampshire's first hospice house in 1994. In fiscal year 2019, Concord Regional VNA provided more than $5.1 million in community benefits.

The public listening session will be hosted on Zoom, and those who wish to participate must register at www.vnaforthefuturenh.com by 2:00 p.m., Wednesday, June 3. The event will begin promptly at 4:30 p.m. and will conclude immediately following the question and answer period.

APPENDIX Q-1
Listening Session Presentation Slides

The Journey to Partnership

CENTRAL NEW HAMPSHIRE VNA & HOSPICE (CNHVNAH)
LISA DUPUIS, CEO

CONCORD REGIONAL VNA (CRVNA)
BETH SLEPIAN, CEO

WWW.VNAFORTHEFUTURENH.COM

CNHVNAH

- Serving 43 towns around Lake Winnipesaukee
- Operating Budget of $8.4 million
- $981,000 in community benefit this past year
- Net assets of $13,768,251
- Two offices - parent in Laconia; branch in Wolfeboro

CNHVNAH

- Home Health, Hospice and Pediatric and Maternal Child Health programs
- Home Health Census ≈ 280-300; Hospice census ≈ 55
- 75-80 % of revenue is Medicare
- Approximately 100 employees

CRVNA

- Serving 44 towns in Central New Hampshire
- Operating Budget of $36 million
- Over $5.1 M in community benefit
- Net assets of $38,210,358
- CRVNA owns its Concord administrative building, and has a 20-year lease with Concord Hospital for the Hospice House

CRVNA

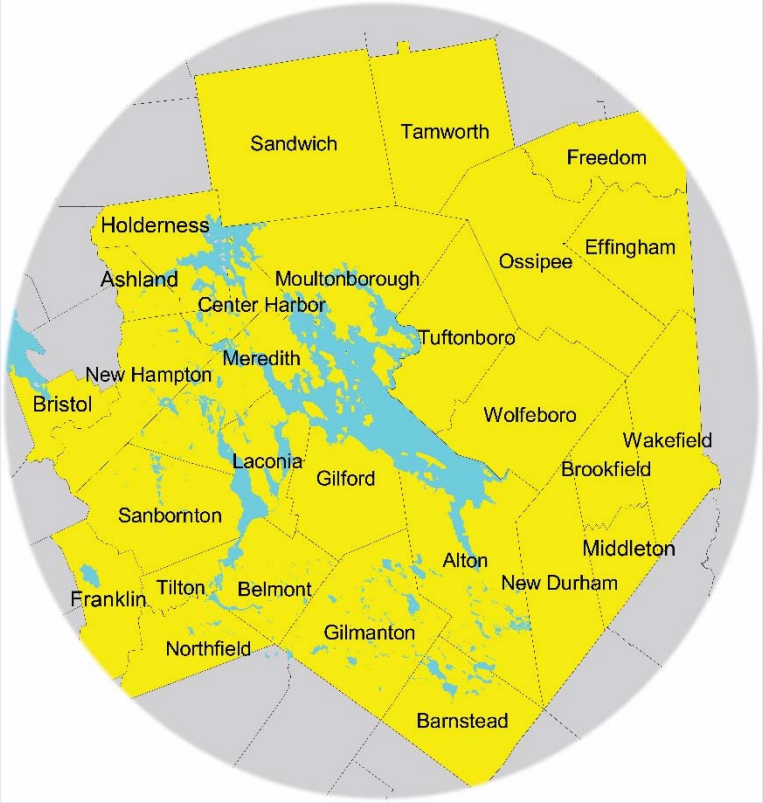
- Home Health Census is approximately 1,100 patients, Community Hospice is approximately 120, and the Hospice House is 10 beds with 96% occupancy
- 71 % of revenue is Medicare
- Approximately 400 employees

CRVNA

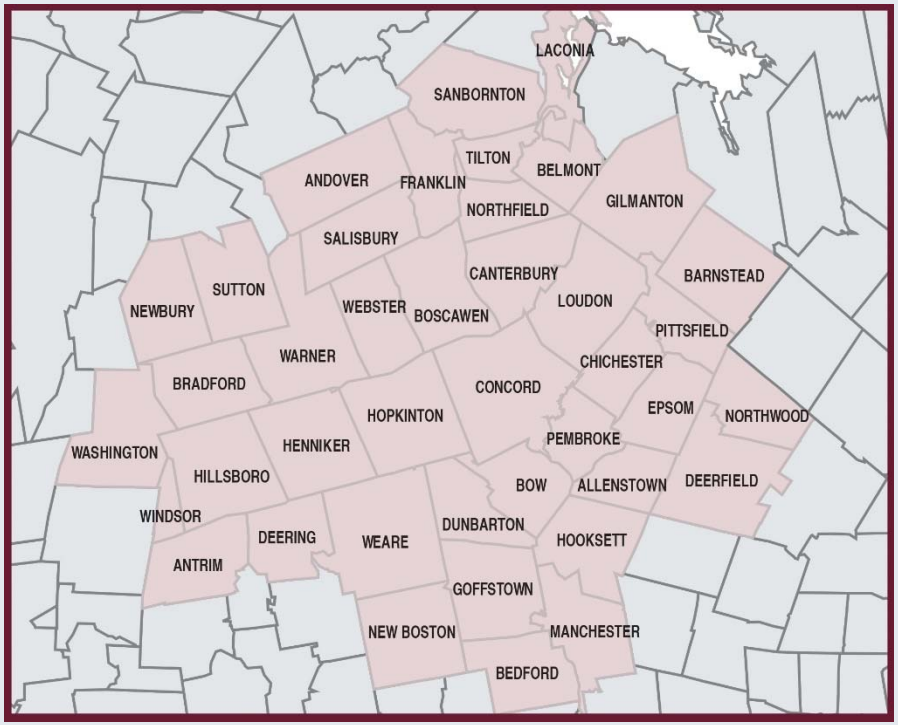
- Member of Capital Region Health Care
- Home Health, Hospice and Pediatric and Maternal/Child Health, Private Duty and Community Health Services. Palliative Care is a joint program with Concord Hospital

SERVICE AREAS

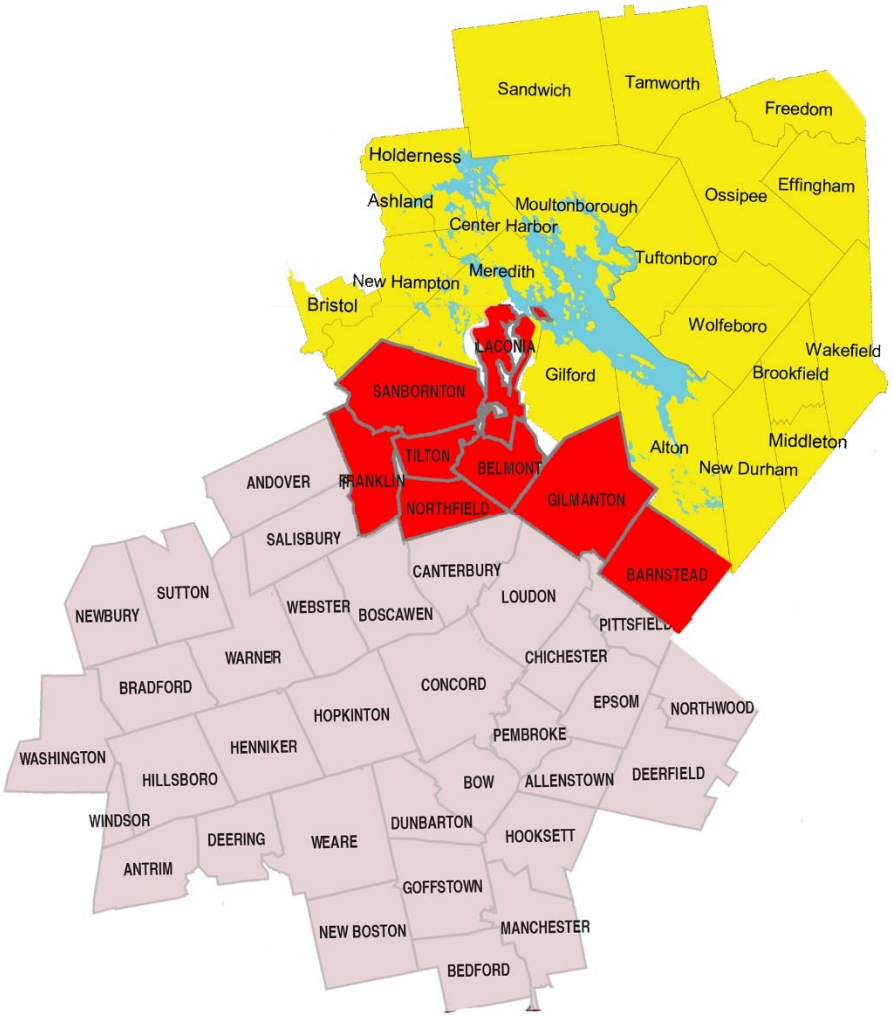
CNHVNAH



CRVNA



Combined Service Area



THE CONVERSATION

What?

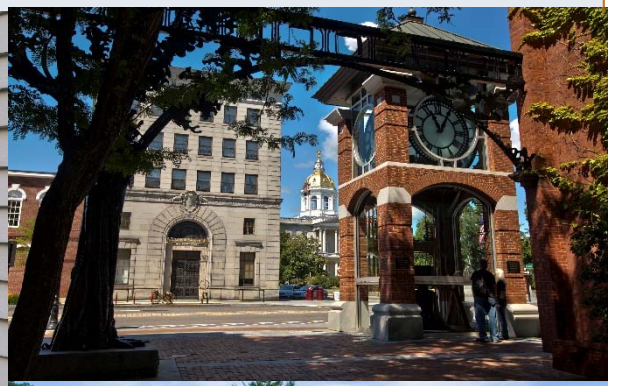
- One single entity by merging CRVNA and CNHVNA
- The combined entity will change governance documents which will reflect the heritage of both parties and terms of the merger agreement
- Donor restrictions will continue to be honored
- Existing operating reserves as of closing date will be used in the service area they were generated

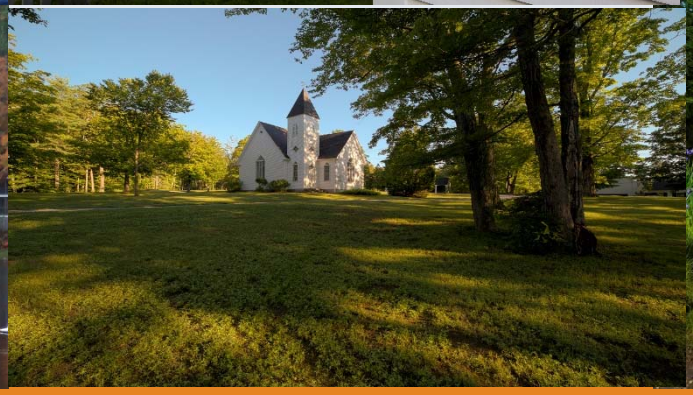
THE CONVERSATION

Why?

- Enhance the provision of the Mission and services to the communities








THE CONVERSATION

How will this transaction improve access to quality and affordable health care services?

- Resource depth
- Fill some clinical gaps or shore up services
- Workforce retention and recruitment
- Improve service cost/visit
- Expand services & access to Hospice House
- Strengthen referral relationships
- Sustainability

Governance Integration

Guiding Principles

- Board composition
- Diversity in Board member skill set
- Gender, ethnic, and age diversity
- 3-year terms
- The Board can/should use non-Board members to serve on select Board Committees

Governance Integration

Guiding Principles, continued

- The initial composition of the Board will be an agreed-upon portion of the new board selected by each entity
- Major decisions require supermajority vote

Management Integration

- Leadership- proposed
  - CEO - Beth Slepian
  - COO - Lisa Dupuis
- Executive Leadership team
  - Beth and Lisa would develop the team and structure collaboratively

We now invite your questions & comments.

CONCORD REGIONAL VISITING NURSE ASSOCIATION | YOUR CHOICE FOR 120 YEARS

COMMITTED • CARING • COMMUNITY
Central NH
VNA & HOSPICE

APPENDIX Q-2
Listening Session Summary Report

Concord Regional VNA / Central New Hampshire VNA & Hospice
Proposed Merger Virtual Public Listening Session
REPORT

June 16, 2020

Overview

On Thursday, March 19, Concord Regional Visiting Nurse Association (Concord Regional VNA) and Central New Hampshire VNA & Hospice (Central VNA) announced that they had signed a non-binding letter of intent (LOI) to merge their two organizations to better serve the home and community-based health care needs of residents of the Greater Capital Region and Central New Hampshire.

The non-binding LOI was the first step in a process that involves further due diligence, negotiation of final terms, opportunities for public input, approval by each organization's Board of Trustees, and review by federal and state regulators. The plan was for the announcement to be followed by a public listening session. Jointly-hosted by both organizations, the session would afford the public an opportunity to learn more about the proposed merger, to ask questions and share feedback, which would in turn inform the ongoing merger preparations.

While the merger process was well underway prior to early March, the announcement of the LOI came amidst the escalation of the COVID-19 pandemic. Concurrently, federal and state rules and guidelines were being implemented to help stop the spread of the virus, including rules governing gatherings of groups of people, social distancing recommendations, and eventually, a 'Stay at Home' order from NH Governor Chris Sununu.

With social distancing orders preventing in-person gatherings, the organizations, in agreement with the NH Attorney General's office, opted to forge ahead and hold a virtual public listening session to share information about the proposed merger and to gather feedback in real-time through a question and answer and comment period.

The organizations chose to use the Zoom Webinar platform based on its user-friendly technology for meeting hosts and attendees alike, including simple log-in access by computer, mobile device or phone; screen sharing for the PowerPoint presentation portion of the program; and easy management of the question, answer and comment period to ensure that all attendees who wished to speak had the opportunity to do so. Zoom also enabled the meeting host to record the session and save it as an MP4 file for later viewing.

Overall, the session was well received by attendees and ran smoothly with the Zoom technology and processes (outlined in the schedule).

Of the 146 people who pre-registered for the listening session, 131 attended.

Planning

Advertising/Publicity:

- Updated microsite – vnaforthefuturenh.com – to include information about the listening session and link to registration details
    - Listening session announcement and registration link placed prominently on homepage
    - Listening session press release posted on 'Updates' page with link to registration details

- Drafted & distributed press release announcing listening session, registration details (one week before session)
    - Posted press release and registration on merger website
    - Shared press release with key stakeholders by email

- Developed and placed print ad announcing listening session and registration details one week prior to session in newspapers within both organizations' service areas:
    - Concord Monitor
    - Laconia Daily Sun
    - Salmon Press Weeklies:
        - Newfound Landing
        - Meredith News
        - Alton Baysider
        - Granite State News
        - Gilford Steamer
        - Winnisquam Echo
        - Carroll County Independent

- Created social media posts announcing listening session with link to microsite (ongoing starting one week before session)

Attendees:

- Invited both agencies' board members, employees, partners and other stakeholders to attend

Session Materials & Guides:

- Script for panelists (including Zoom features, queues and participant roles)
- PowerPoint presentation – overview of proposed merger
- Run-of-Show (including Zoom tips)

Logistics:

- Internal test of technology
- Registration page setup
  - https://us02web.zoom.us/webinar/register/WN_AtBwo8ntRHWsDZJZFQntXw
  - (Participants pre-registered for the session via the link provided on the "vnaforthefuturenh.com" website. Upon registration, Zoom automatically prompted registrants to add the event to their calendar. Additionally, registrants were able to submit questions/comments ahead of time if preferred.)
- Walk-through session (recorded for participant review) one day prior to live session
  - Tested technology and participant's hardware
  - Adjusted participants' screen views and backgrounds
  - Adjusted script

Post-Session Communications/Actions:

- Recording was posted to the microsite and shared on social media (next day)
- Email to all registrants thanking them for their interest and providing a link to the website to view the session and submit additional questions and feedback if desired, particularly for those who registered and were unable to attend (pending)

Listening Session Format/Schedule

Panelists:

- Montagne Communications (technology host & controller)
- Martha Tecca, Community Care of Lyme/M&M Strategies (moderator)
- Beth Slepian, President and CEO of Concord Regional VNA (primary panelists)
- Lisa Dupuis, CEO of Central New Hampshire VNA & Hospice (primary panelist)

- Melvin J. Severance, Concord Regional VNA Board of Trustees Chair
- Kristen Gardiner, Central New Hampshire VNA & Hospice Board of Trustees President

4:00 PM – Montagne opened session and settings (closed to attendees)

4:15 PM – Panelists joined and tested/confirmed settings

4:30 PM – Montagne opened session to attendees and began recording shortly after, allowing a few minutes for people to join late

4:35 PM – Martha welcomed attendees to the session to kick things off:
- Introduction of herself
- Overview of the schedule and format
- Introduction for each panelist

*Attendees were able see and hear panelists but were automatically muted with cameras disabled for the entire session, unless permitted during Q&A portion

4:40 PM – Presentation
- Martha turned the session over to Beth and Lisa
- Montagne screen shared presentation while Beth and Lisa talked through slides

Presentation concluded

4:50 PM – Q&A session
- Martha provided an overview of how attendees could ask a question or share a comment:
    - Click raise hand feature on web browser or app – attendee name is added to the queue
    - Press *9 to activate raise hand feature for phone-only attendees – phone number is added to the queue
    - Chat feature – attendees have the ability to communicate with the panelists, but not with each other
- Martha fielded questions from attendees (working with Montagne to enable attendee microphones once called on)
    - Beth and Lisa rotated answering questions
    - Melvin and Kristen added commentary as appropriate

5:35 PM – Wrap-up
- With no additional attendees in the queue, Martha indicated the end of the session was nearing and offered all panelists an opportunity to share last thoughts

5:40 PM – Session concluded

Notes & Tips

- Test technology extensively ahead of time to understand features, including dress rehearsal to make note of position of camera, volume, processes.

- To avoid feedback and background noise, all panelists should mute their audio when they are not speaking. Any added background noise will compromise the quality of the audio in the recording playback.

- To make session as engaging and interactive as possible, panelists should be encouraged to "react" to what other panelists are saying (nodding, agreeing, elaborating on someone else's point, etc.).

- Ensure panelist names/titles are properly displayed in their respective Zoom windows. Montagne hosted off-camera, but displayed the logos of both organizations and the microsite URL in place of their Zoom image while the camera was disabled.

APPENDIX Q-3
Listening Session Transcript of Questions, Answers and Comments

Concord Regional VNA / Central New Hampshire VNA & Hospice
Proposed Merger Virtual Public Listening Session – June 3, 2020
Question, Answer & Comment Transcript

Following is a transcript of the question, answer and comment portion of the virtual public listening session. The session was moderated by Martha Tecca, who managed the incoming questions and comments from attendees. This transcript does not include the introductions and presentation portions of the program, or the closing remarks. The full video recording of this session can be viewed at www.vnaforthefuturenh.com.

Michelline Dufort, Concord: We look forward to hearing from community members on this.

BJ Entwisle, Canterbury (Capital Region Health Care Board): You talked about the two leaders figuring out the executive teams, leadership teams. What would the process be for figuring out the two executive teams and would there be full retention of jobs in both organizations?

Beth Slepian (CEO and President, Concord Regional VNA): We are committed to our workforce and we do not have plans to reduce our workforce. We both feel that we have very talented leadership and management teams and we are committed to making sure that the talent is utilized and retained to the best manner. I think that everybody will be pleased and relieved when they see the structure and the organization roll out.

Headley (Lee) White: What do you both, as leaders, see as the cultures of your organizations? I think that is critical to the future of any merger.

Lisa Dupuis (President, Central NH VNA & Hospice): Looking at the culture of our two organizations, we feel that there are a lot of similarities in the cultures. Concord and Central have worked together over the years and are members of an organization where we come together and we do a lot of processes together, quality, IT, and work groups. We collaborate on a lot of levels already, our cultures are already well aligned for this type of arrangement.

Beth Slepian: I would also add that we are both very mission-driven, committed to the communities, and want to see both organizations come together so that we are sustainable and will continue to be able to serve the communities. We are aligned in how we deliver care in many respects, and our staff have worked together in the past. We feel through the board discussions and the board groups that a lot of the synergies have been identified already. We feel as though we can work on that and continue that.

Margaret Franckhauser, New Hampton (Former director of Central VNA): I fully understand the reason for a merger. I think this is a very challenging business in the world of health care and I think these are two wonderful organizations that have been working very closely together for a number of years, so I'm very much in support of the merger. How would a merger possibly benefit people in the community?

Lisa Dupuis: We really feel that as one organization, and being sustainable for the future coming together, that we have a lot to continue to offer the community. It would be sustainability as well as services. There are some differences in our services, and by coming together we would meld those services and they would be available to all of the communities that we both service, as one entity.

Beth Slepian: We are looking forward to bringing our community benefit programs for the community up into the Lake's Region. I think that is an asset that we bring, and we also do have some specialized clinical programs that the lakes region would also benefit from as we come together.

Donna Davey, Concord: I'd be concerned that opening up the Hospice House to the Central area would mean that there will not be enough room to accommodate the Concord regional area, which keeps it at 96% capacity now.

Beth Slepian: I want to clarify the Hospice House and eligibility. Currently, we do have patients come from a large service area and are able to accept patients from Central New Hampshire if they chose to come to the Hospice House for their care. So, we are not concerned about access. That is certainly something that we will continue to look at but our patients do come from outside our initial region as well. There are only two hospice houses in the state and so it is a benefit, really, to everybody. We will continue to look at and monitor access and ensure people can benefit from those services.

Rosemary Heard (President/CEO of Catch Housing): On the outset I would like to commend both organizations for pursuing a merger here. We are much stronger together and obviously see footprints of services greatly enhanced by this. We happen to have an incredible partnership with Concord Regional VNA on a program called PATHS, which is "Positive Aging through Home Supports." This is a pilot program that we have at our only age-restricted property. The impact of this has been incredible for our residents. I hope to see other programs like this throughout the new footprints together. It is something that is so valuable and can replicated in other places. I think that with a stronger new entity, perhaps that would be possible. How will this new entity be identified? Will Lakes Region still have its own name, or will there be a new entity for this going forward? Thank you all for the

work, I know that this is an enormous undertaking to get to where you are today, so thank you.

Beth Slepian: The name remains to be determined. We are extremely sensitive to the heritage and the history of both organizations. As we move forward over the next few months, we will understand greater how we can best represent the new entity both in name and how we create a brand in the new area.

Lisa Dupuis: We do not want to jump to a name, we want to really work on it together as the two entities come together and make it meaningful – both organizations have set that in our first step in moving together.

Lisa Gloddy, Franklin (Dartmouth-Hitchcock Concord Surgical Specialties Manager): How will the leveraging of resources help us with coverage for patients with post-operative care? As well as the ability for expansion for community-based clinics?

Beth Slepian: We feel that coming together will really allow us to better support the communities. What we are seeing in Concord is that many patients are coming to Concord Hospital for their care and we are receiving referrals to service an expanded area. We are challenged as everybody else is with the workforce, and by coming together we can really leverage our workforce and be efficient in making sure all of the programs can be brought into the surrounding area. We're eager to be partners, we're looking forward to that, but we do think that with the scale that the organization will create, that we will be able to better serve specialty clinics, the surgical needs, and can move forward with innovative programs.

Betsey Rhynhart, Hopkinton (Concord Hospital): Thank you for the helpful overview. How will the community and New Hampshire as a whole benefit from the merger?

Beth Slepian: I think we are all well aware of the aging population in New Hampshire and we are dealing with a future that will require significant investments into population health and the infrastructure that will allow us to deliver care to people in their homes. It is not just the care though. It is the wellness programs and the community health education, and it is also the programming that we can put in place together to make sure that we can meet those needs. I think we could also be a model for New Hampshire as a whole in health care, where home health care and hospice can look towards the future in a positive way of coming together and being sustainable so that organizations can continue to provide the necessary care for the community. We know it's cost effective, we know people want to be at home, we hope that this sets an example for care across the state.

Lisa Dupuis: As a larger organization, we'll be able to better service the community and the rapid changing of the industry. There is a lot of other changes within the healthcare industry, there's regulatory changes, payment changes. As a stronger organization with more support and resources, we'll be able to make those changes to then be able to continue to be around long into the future.

Kevin Donovan (President/CEO of LRGHealthcare): Central VNA is an important partner to LRGH and to the entire Lakes Region. Expand upon how Central VNA and the joint communities will benefit from the transaction?

Lisa Dupuis: Together as one organization with a broader depth we'd be able to… People from the Lakes Region are leaving to go to get health care other places and we want to be here in the community for when they come back to their home and be able to get that care. And I think that this type of partnership will allow that.

Jessica Barker, North Sandwich: I'm moving to Laconia in June. What is the new name and what contact number should be used?

Lisa Dupuis: First, as we go through his process someone can always visit the website we are giving, www.VNAforthefuturenh.com. As we go through this process, updates, questions, answers, and comments, everything will be posted there so everyone has one place to go so they can see where we are in the process. At this point we are still two entities so if you need to reach out to one of us you can find us on the web, you can reach out to either one of us if you need services or if you have any questions, you can call either Central's main number or Concord's. To stay educated on where we are in the process the best thing to do is go to the website.

James (Jay) Mullins, Hopkinton (CRVNA Board of Trustees): I believe this merger has a strong business rationale. As the delivery of care becomes more complex with ever-increasing technology and regulatory demand, this combined organization will be in a better position to meet these demands.

Margaret Pritchard (CEO of Lakes Region Mental Health Center): Could we or should we expect some of the programing with partners in the Lakes Region to expand? I think both organizations have worked hard to collaborate and integrate services. Can we expect more of the same with the new entity?

Beth Slepian: We are approaching this partnership as coming together for sustainability, we are not coming together as a growth opportunity. If that is the question, should we expect more expansion? That is not in our plan. Certainly not at the moment. We are committed,

both Lisa and I, to creating relationships both new and making sure the old relationships that both organizations have are well cared for and to understand what the opportunities are, and again move forward in how we deliver care. We know how we deliver care today is very different from how we delivered care in February of this year, which we all can appreciate. So I think our first step is really to understand what the ongoing needs are and how can we best meet them while creating new opportunities.

Headley (Lee) White: I am generally a very positive person, are there any disadvantages to this merger?

Lisa Dupuis: I have not come across any yet, to be honest. I am not saying there isn't something that exists. We have not come across that, but everyone we have talked to about it has been very positive, has said positive things – haven't come across anything negative at this point. We continue to remain in all three offices and we'll be continuing to serve all of the communities we service just in a stronger way. So I'm not sure I found any negative in that yet.

Beth Slepian: We don't think it's going to be easy. We know there will be challenges. We have found this to be a very positive experience between both Boards, between both organizations and also the community support we have seen. I think our negative is *not* doing something and really taking the future and doing this in positions of strength not in a position that we need to. I think there are absolutely more positives, although, like I've said, we don't expect it to be easy.

Rosemary Heard: Going back to one of Lee's earlier comments about culture and corporate culture as it relates to a merger. Having been through three mergers in the private sector and one merge function in the nonprofit sector, one of the things that we found incredibly valuable, albeit that we thought we had two cultures that would naturally come together, when we really got down to brass tacks we found that that was not necessarily the case, and so we brought in a corporate phycologist to work with the two groups. We found that it was incredibly valuable, money really well spent, and I think that's the one area in which mergers do fail and are challenged going forward, because one group or another changes them some way. So, if there is money in your budget to consider doing that, I would highly recommend that moving forward. I think it's a great way to give everyone a voice at the table and dispel any myths and get everybody rowing in the same direction.

Brian Winslow (Central VNA): I want to comment on Lee White's question about disadvantages. In all my discussions with supporters and community members, there hasn't been really anyone talking about the disadvantages, except for the disadvantages if this doesn't happen. I wanted to point out that out, that there are certainly disadvantages if this

doesn't happen for both agencies, and even if we start and can't finish there are disadvantages. When it comes to actually accomplishing this there are no real disadvantages that I've identified.

Melissa Reep (CRVNA): How will this change my day-to-day work life? I have a hard time imagining how this will affect me.

Beth Slepian: I think you will continue to deliver care in the manner in which you always have. I would not expect that your day-to-day life will be changed. Certainly, there will be opportunities in this, we would like to bring our certified services into the Central New Hampshire catchment area, and I think it will create opportunities for our employees and Central NH's employees for growth and development. But in day-to-day work life, you're caring for the community and we would not expect that to change.

BJ Entwisle: I was part of an organization once where the Boards couldn't get along. It was a big merger and so it's a similar question about the two boards of the organization. It's easy to think the two parts of New Hampshire are very different, but probably are not as different as we think, and I loved Rosemary's comment about get some help if you need it because it helps to keep talking and take advantage of what sounds like a terrific opportunity. My questions is about the two boards, as opposed to the institution themselves.

Melvin Severance (Chair, CRVNA Board of Trustees): The Boards have worked together now for several months in terms of discussion about what will be the normal operational elements, technology. We've spent a great deal of time together talking about the people in the community and the people in the organizations. One of our main concerns, originally, was that we wanted to do this with doing no harm to anybody or any program, and we spent a great deal of time at the Board level making sure of that. We have been unbelievably lucky to have Beth, Lisa, and a great Board from Central to work with and have a discussion, although we could probably use all the psychological help on the planet. But part of that, if we get that opportunity it would probably be great, but at this point, we've been comfortable working with each other and we're coming down to working on branding, and we'll see how that goes but everybody has really seen value in this process.

Kristen Gardiner (President, Central NH VNA & Hospice Board of Trustees): I think the Boards do have very similar missions and both Boards are very committed to this project. We have anticipated and talked about some issues and we've done a great job at giving each Board their say and their ability to provide input. We're not being swallowed up, Central is not going to be swallowed up by Concord. I feel that they've been really receptive to us and I think we've worked really well together.

Christopher Parkinson (Former CRVNA Trustee): Could you address competitive aspects of Lakes Region Visiting Nurse Association? My understanding is that the Lakes Region Visiting Nurse Association has grown quite a bit in the last couple of years. Will they be a threat to us in the Lakes Region? How will we compete against them? What differentiates us versus them?

Beth Slepian: Both of our organizations have really focused on the strength of what we bring. Our strength and ability to be successful in the region is to bring high quality care and programing to the Lakes Region. Through our partnerships with referral sources and talented staff, I think we will be able to do that. One thing that does differentiate Concord at the moment, and hopefully together, are the community benefits that we bring to the regions we serve. I think that really does differentiate us from many of our colleagues and competitors and we will continue to be committed to that. Certainly, we deal with competitors all the time, both in the for-profit and nonprofit world. We have to deliver the best care and understand our communities. I think our commitment will lead us forward. This is about being stronger together from positions of strength, not a growth transaction. As we move forward and create those relationships, I think we will be identified as the leader of care in the community.

Lisa Dupuis: Competition is good. It's not a bad thing to have competition. It keeps you on your toes and there's a lot of positive things to having competition.

Susan Houghton, Alton Bay (Central VNA): Many of the towns on both sides of the lake are rural and/or summer resort communities, how will this area be incorporated into a new, larger "big city" VNA?

Beth Slepian: Our service area includes very rural areas both in Washington and Hillsboro, so although we do service Concord, we do consider ourselves as serving the rural community. These are things that we need to work together to understand our community, but it is important that our care will remain local. We have the same staff that are living in the communities we're serving, so the care will still be delivered. We hope as we come together, and develop our culture together, that we learn to appreciate the differences and address those in our programing. So it's an opportunity for us to be able to come together in that manner, but I would say that our staff at Concord, who were in Washington today, would not feel that they are working in the city, but that they are treating rural New Hampshire. Just to give you also an understanding, our staff last year traveled 1.5 million miles to care for our community. So if we were caring in a city environment, I would not expect us to cover that much ground.

Lisa Dupuis: Our staff are remaining and will continue to be in those communities. It's not that Concord staff is going to come up and work in Wolfeboro or Ossipee - the workers that are living in those areas are going to continue to service those patients and the cultures of those communities will remain.

Rosemary Heard: I live down the street from Jessica Barker in Sandwich, New Hampshire, be it that I run an organization in Concord, so I'm very familiar with the Lakes Region and the challenges up here. We are seasonal communities and residencies have been slow. So, I wonder if it's appropriate to say that this merger will also help with some of that ebb and flow we see from summer to winter. We're a very aging community up here so I would think that this would also bring some stability to the Lakes Region because of that. Working together may really help in that instance as well.

Beth Slepian: We too have gaps in our staffing and we see the advantages of not overlapping but sharing those staff to serve the community.

Jessica Barker: Who proposed this merger, did Concord Regional VNA approach Central or vice versa?

Lisa Dupuis: Beth and I are colleagues, we sit together on a lot of different organizations and the Alliance, and earlier we had mentioned that we do things together. We started having a conversation, what if? It was a mutual discussion, as challenges are happening and as we had a major change in the way we're reimbursed in January of 2020. We talked about if we were to become one organization, what would that look like and how would that work? So, it was a mutual coming together.

Norma and Ron Daviault, Allenstown: What effects would it have on coverage?

(Asked via moderator, already covered)

Susan Houghton: The Central New Hampshire VNA currently has a community presence in Laconia and in Wolfeboro and addresses the specific needs and reflects the cultures of those two very different communities. How will this be affected by a merger with a much larger VNA that is focused on the Capital Region? Will the merger bring a culture shift? Will the service stay the same or improve, in what ways can we expect?

(Asked via moderator, already covered)

Kristen Hayes, Concord: Will there be any changes in employee positions?

(Asked via moderator, already covered)

Rosemary Heard: Timing moving forward, where do you see the next steps and the timing of a formal kind of operating merger going forward?

Lisa Dupuis: We're right now working on the definitive agreement. Your comments and feedback are a part of that. Once the definitive agreement has worked out, the two boards would vote on that in order to move forward on filing the change of control notice with the State of New Hampshire, and are anticipating that to be about mid- July. At that point, the Division of Charitable Trust will do their due diligence and will have to make any modifications that may be brought up with that due diligence. Once that is done, we're anticipating, if all goes smoothly, to become one organization by the end of this calendar year.

Mark Lavalle, Bow (Former CRVNA Trustee): I've learned a lot listening. However, I do have a specific question. What does CRVNA get out of this merger?

Beth Slepian: I think that we all are working in the changing environment and the assumption that a large organization is sustainable for the long haul would be a mistake for us. As we look towards being around for another 120 years, we feel that this coming together would support our staff, provide opportunities for growth and development for both organizations. It will fill staffing gaps. I think we all see that in the work environment that we're in, with nursing shortages and others. In the world of the COVID pandemic, which nobody asked us about, being a larger organization and having different communities served, would've actually helped support our workforce because we each have different challenges in that realm. We want to be able to support our partners as care is being delivered in the community. We really feel that by moving and being able to expand our community health programs and community benefits, we'll really be creating a positive and healthy environment for New Hampshire and for the Central and Capital Region, Lakes Region, and really fulfilling our mission and being able to continue the work that we are doing. We feel that we will be getting a lot out of it.

Corrine Smith, Wolfeboro: Without infringing on other agencies and their territories, will the merger present opportunities to expand the patient catchment areas?

Lisa Dupuis: At this point it's not a merger for growth, it's really to come together for sustainability and for increased services to the communities we currently service. At this point it's not looking to increase our catchment area.

Christopher Parkinson: I think it's an excellent opportunity, totally supported Beth's comment that it isn't for growth and it make me wonder a bit. I think if things are done right, growth should follow. As I noted, I'm totally in support of it. Make sure communication is kept up, as this is often the area that creates problems. Keep your staffs informed about what's going on.

Beth Slepian: I think we are trying to keep our scope in check and understand really what the needs are in the community. I think that growth sometime becomes a natural extension of good work but as we said, we are approaching this as better way to serve our current communities and looking toward the future and what opportunities will hold.

Jessica Barker: Will the employee benefits be merged and health insurance change? If both organizations have different health insurance providers, which provider will be chosen for the newly merged organization?

Beth Slepian: That's all work that is done as the entities come together. We will ultimately be one organization, which would lend itself to one employee benefit package and pay scale. We can't speak to where that would be, that's all the work that comes after the definitive agreement occurs and we can begin looking at integrating the organizations.

Mary DeVries (Wolfeboro Area Chamber of Commerce Executive Director): All the best to you with moving forward with this significant merger.

Mark Lavalle: As to bylaws of the new entity, will former Board members with expired term limits be able to be considered for Board positions in the future?

Lisa Dupuis: As a part of this whole process and the definitive agreement is to come up with new bylaws for the new entity. They are not final yet so I don't necessarily have that answer, it could be possible.

Margaret Franckhauser: I've heard a lot of comments to you about the importance of being community responsive. What I'd like to share is that I've had an opportunity to live outside New England for several years now. In most of this country, home care and hospice are provided by for-profit providers. They may be very good providers but their commitment at the end of the day is not to communities. This is a strengthening of the nonprofit resource in the state of New Hampshire in home care, and that is a gift of enormous proportions. A very strong nonprofit network helps to assure the community needs are the primary reason that the organization exists. I think that a merger of the two that helps to strengthen that nonprofit network is absolutely critical, and will continue to provide community responsive services that would not be provided were it not a nonprofit.

APPENDIX R
Presentation Slides: Central VNA Board of Trustee Meeting 2/20/20

The Journey to Partnership?

CENTRAL NEW HAMPSHIRE VNA & HOSPICE
(CNHVNAH)
LISA DUPUIS, CEO

CONCORD REGIONAL VNA
(CRVNA)
BETH SLEPIAN, CEO

The First Step

- Conversation began in August 2019 between the Board Chairs
  - Gina Finocchiaro, CNHVNAH
  - Lisa Dupuis, CEO CNHVNAH
  - Mel Severance, CRVNA
  - Beth Slepian, CEO CRVNA
- Both agencies agreed that there were common goals and that a Trustee workgroup from both organizations should meet to explore potential partnership

CNHVNAH

- Serving 43 towns around Lake Winnipesaukee
- Operating Budget of 8.4 million
- $981,000 in community benefit this past year
- Net assets of $13,768,251
- Home Health, Hospice and Pediatric and Maternal/child health programs
- Home Health Census ≈ 280-300; Hospice census ≈ 55
- 75-80 % of revenue is Medicare
- Approximately 100 employees
- Two offices- parent in Laconia; branch in Wolfeboro (resulting from merger of Community Health and Hospice with the VNA of Southern Carroll County and Vicinity in 2010)
- CNHVNAH owns both buildings-no debt- with the recent purchase and renovations to Wolfeboro this year

CRVNA

- Central New Hampshire, Serving 44 towns
- Operating Budget of $36 million
- Over $5.1 M in community benefit this past year. Innovative programming and investments in community Mission- e.g., $1.8M Hospice House, and Positive Aging Through Home Supports (PATHS) program collaboration with CATCH Neighborhood Housing to improve the wellness of residents.
- Net assets of $38,210,358
- Home Health, Hospice and Pediatric and maternal/child health, Private Duty and Community Health Services including flu clinics, senior health clinics. Health education programming. Palliative Care, is joint program with CH.
- Home Health Census is approximately 1100 patients, Community Hospice is approximately 120, and the Hospice House is 10 beds with a 96% occupancy
- 71 % of revenue is Medicare
- Approximately 400 employees
- CRVNA owns its Concord administrative building- no debt-and has a 20 year lease with Concord Hospital for the HH
- Member of Capital Region Health Care

SERVICE AREAS

- We have some overlapping towns served; there are more that are not overlapped. Together, we would increase our service area and number of communities served
- Overlap includes:
  - Barnstead
  - Belmont
  - Franklin
  - Gilmanton
  - Laconia
  - Northfield
  - Sanbornton
  - Tilton

November 21, 2019
facilitated by: Kevin Stone

CNHVNAH	CRVNA
• Kristen Gardiner • Gina Finocchiaro • Susan Houghton • David Huot • Lisa Dupuis • Brian Winslow	• Mel Severance • Mark Broth • Michelline Dufort • Jay Mullins • Andrea Stevenson • Jessica Pollack • Beth Slepian • Geri Holmes

Agenda

- Increase familiarity of each organization
- Key considerations of potential affiliation
- Regulatory considerations

Questions to be considered:

- What is the business case?
- How does each organization's culture appear to fit with the other?
- What do we want to achieve? Overall goals of relationship?

THE CONVERSATION

- Why Explore Affiliation? What do we want to achieve? why would we be doing it? what is driving it?
  - Articulating a compelling reason that would enhance the provision of the Mission and enhance services to the community.
- Culture of two agencies and the towns they serve
  - The "parochial" nature of New Hampshire. Will we lose "localness?" Consider from the viewpoint of key stakeholders (community, consumer and donors).
- What would we gain from a partnership?
  - Resource depth (small and fragile, better to be part of a bigger system).
  - Fill some clinical gaps or shore up services
  - Workforce retention and recruitment
  - Improve access, wait times, reduce NTUC (not taken under care)
  - Improve service cost/visit - spread fixed administrative cost over greater base
  - Expand services & access to Hospice House
  - Strengthen referral relationships
  - Sustainability
- Considerations
  - Two different EHRs
  - Shifting hospital / patient referral patterns

“SACRED COW” CONSIDERATIONS

- Wolfeboro presence
- Hospice House
- Current reserves available for the present community

December 17, 2019
Facilitated by Kevin Stone

CNHVNAH	CRVNA
• Kristen Gardiner • Robin Michaud • David Huot • Lisa Dupuis • David Emberley • Brian Winslow	• Mel Severance • Mark Broth • Jay Mullins • Mike Griffin • Beth Slepian • Geri Holmes

Agenda

- **Understanding Organization Financial Circumstance**
  - CNHVNAH
  - CRVNA
- **Organization Structure and Services**
  - Clarifying questions about background material
  - Community Education Provided (CRVNA)
- **Continuing Discussion: Affiliation Goals & Rationale**
  - Why could affiliation benefit respective communities served
  - Business case for affiliation
  - Sense of the workgroup whether to proceed

Financial Performance

- Reviewed most recent audited Financial Statements
  - CNHVNAH
    - Positive bottom line
    - Municipal support
    - Board designated funds
    - Less impact from Medicare Advantage
  - CRVNA
    - Negative bottom line due to NH State Employee benefit change and increased Medicare Advantage-Payor Mix
    - Hospice House operates at a loss and is CRVNA's commitment to the community
    - Strong investment portfolio
    - FY20 budget based on expense reduction
  - Similar approaches to budget and financial management

ORGANIZATIONAL STRUCTURE

- Provided organizational charts for both organizations
  - Will be discussed at next meeting

Continuing Discussion

- Business Case
  - Distributed & acknowledged
- Overhead reduction
- Workforce enhancement
  - Compensation – recruiting; benefits
  - Career opportunities & retention
- Decrease duplication of services
- Hospital landscape
  - Concord Hospital
  - Lakes Region General Hospital

First Process Checkpoint

- Do we continue the conversation?
  - Unanimous agreement to continue
- Next Meeting:
  - Governance
  - Leadership

February 5, 2020
facilitated by: Kevin Stone

CNHVNAH	CRVNA
• Kristen Gardiner • Gina Finocchiaro • Susan Houghton • David Huot • Lisa Dupuis	• Mel Severance • Mark Broth • Michelline Dufort • Andrea Stevenson • Beth Slepian

Agenda

- **Management Integration**
  - Leadership- CEO; COO
- **Governance Integration**
  - Establishment of Guiding Principles
- **Process Checkpoint- Letter of Intent**
  - Full Boards presentation/discussion
  - Timing
  - Process
  - Consultant need
  - Other considerations

Management Integration

- Leadership- proposed
  - CEO- Beth Slepian
  - COO- Lisa Dupuis
    - Both current leaders have strong operational skills and similar leadership values
      - The proposed positions are well-aligned with leader's strengths
    - CRVNA has been addressing the need for COO. This structure fits into organizational planning
- Executive Leadership team
  - Beth and Lisa would develop the team and structure

Governance Integration

- Guiding Principles
  - The Board composition will be intended to reflect a fair representation of the service area covered;
  - Diversity in Board member skill set will be desired;
  - Gender, ethnic, and age diversity will be sought;
  - Board members would have 3 year terms;
  - The Board should have member term limits of 3 or 4 consecutive terms;
  - The Board can/should use non-Board members to serve on select Board Committees to help ensure greater community input and support future Board member recruitment;

Guiding Principles (continued)

- There is an expectation that Board Committees are working committees that will help process issues and support the overall Board responsibility;
- The initial composition of the Board should be in proportion to the two entities;
- Supermajority voting requirements can be used for very select board decisions that would have significant consequences to the organization. The supermajority requirement would be such that a vote of at least one or more Board members from each initial entity would be required in the affirmative;
- The initial Board composition entity proportionality would be time limited and expected to sunset in the future

Second Process Checkpoint

- Go or No Go?
  - The committee unanimously agreed to proceed to full Board votes
    - Non-binding letter of intent
  - Each organization has engaged counsel
  - Timing
    - February Board Meeting discussions
    - February 21 meeting with Montagne Communications
      - Press release, internal and external communications, Q and A's
  - Consultant
    - Simione Consulting
  - Division of Charitable Trust

Time Line

- February
  - Board votes
  - Draft Letter of Intent
  - Montagne Communications
  - Preliminary Meeting with Tom Donovan, Division of Charitable Trust
- March
  - Engage Consultant
  - Finalize communication plan

Execution of Letter of Intent/Public Announcement

mid to end of March 2020

Budget

- Kevin Stone- Facilitation
- Simione Consulting
- Legal Counsel
- Montagne Communications

$150K budget to be shared by both organizations equally
There is potential grant funding being explored to offset costs

Discussion Questions?

Votes

- Enter into a Non-Binding Letter of Intent (LOI) and full exploration of affiliation.
- Authorize the Executive Committee to review the LOI and authorize CEO to enter in to agreement on behalf of the Board of Trustees.
- Approve $75K budget to explore affiliation.

APPENDIX S
Nonbinding Letter of Intent

NONBINDING LETTER OF INTENT

March 4, 2020

This letter summarizes the intention of **Central New Hampshire VNA & Hospice**, a New Hampshire voluntary corporation with a principal place of business at 780 North Main Street, Laconia, New Hampshire 03246 ("CNHVNAH") and **Concord Regional Visiting Nurse Association**, a New Hampshire voluntary corporation with a principal place of business at 30 Pillsbury Street, Concord, New Hampshire 03301 ("CRVNA") (collectively the "*Parties*") to integrate their organizations in an affiliation transaction designed to enhance the quality of, and access to, home health and hospice care in their respective service areas (the "*Proposed Affiliation*"). Representatives of the Parties have met to identify the potential benefits to each of a Proposed Affiliation, and the Parties now wish to commit to a more comprehensive evaluation process with the goal of reaching a definitive agreement on the terms of the Proposed Affiliation (the "*Definitive Agreement*").

Part One

The following paragraphs will not be binding or enforceable by the Parties unless later incorporated into the Definitive Agreement:

1. Strategic Imperatives for the Affiliation. Each of the Parties recognizes that the evolution of the healthcare landscape continues to challenge the delivery of home health and hospice services. To respond to these challenges, the Parties seek greater efficiencies in operations to maintain and increase access to quality care, enhanced strategic alignment to foster referral relationships and integration along the continuum of care, and the development and expansion of innovative models of home health and hospice care and delivery.

The Parties believe that further due diligence will demonstrate that the Proposed Affiliation will assist them in addressing these demands by decreasing collective business expenses, reducing duplicative services, identifying and distributing innovative models of care, and enhancing workforce development and recruitment.

2. Commitment to Charitable Missions. The Parties acknowledge the compatibility of their charitable missions and their commitment to addressing the health needs of the communities they serve. The Parties agree that the Proposed Affiliation must continue their charitable missions and maintain the exemption from federal and state taxes currently held by each Party.

3. Determination of Legal Structure. The Parties anticipate that the Proposed Affiliation will result in a combination of their existing organizations and operations that is sufficiently integrated to allow them to coordinate clinical care, achieve economic efficiencies and enhance the sustainability of their charitable assets and missions. With the assistance of legal counsel and other professional advisors, the Parties will evaluate various legal structures for

the Proposed Affiliation, which structures may include the formation of a new entity into which the Parties will be combined or a merger of the Parties. The mutually-agreeable legal structure, and the legal actions necessary to consummate the Proposed Affiliation, will be set forth in the Definitive Agreement.

4. Governance. The Parties anticipate that their existing boards of trustees will be combined into a single governing board under the Proposed Affiliation. In the course of negotiating the Definitive Agreement, the Parties will address governance issues including, but not limited to: board composition to reflect representation of the areas served; board size; trustee qualifications; trustee nomination and election process; transition/integration periods, if any; super-majority and/or block voting; composition of board committees; and board officer selection.

5. Operations. The Parties anticipate that the Proposed Affiliation will result in the integration and centralization of their administrative, financial and clinical functions. The Definitive Agreement will describe the nature of this integration and centralization, and will include the commitment of the Parties to continue planning for the successful integration of their operations until and after the closing of the Proposed Affiliation. In developing their integration plan, the Parties will consider their existing reimbursement arrangements, purchasing and vendor contracts, joint ventures and affiliations, and other similar matters. The Parties do not anticipate the termination of any existing necessary health services, but the nature in which such services are delivered may be modified as a result of the Proposed Affiliation. The Parties agree, however, that they will maintain their existing facilities in Concord, including the Hospice House, Laconia, and Wolfeboro following the consummation of the Proposed Affiliation for a mutually-agreeable period of time.

6. Senior Management and Staff. The Parties anticipate that the entity resulting from the Proposed Affiliation will be managed by a chief executive officer, and assisted by a chief operations officer. The Definitive Agreement will describe the responsibilities of each executive officer, and identify the individuals who will hold each office upon the consummation of the Proposed Affiliation. The Parties will evaluate post-Affiliation staffing needs, and intend to retain the existing work force and manage any consolidation of positions through natural attrition and the elimination or modification of positions following their vacancy.

7. Restricted Funds and Pre-Affiliation Reserves. Any restrictions imposed upon either Party's "endowment funds," as such term is defined by the Uniform Prudent Management of Institutional Funds Act ("UPMIFA"), New Hampshire RSA 292-B, will continue to be honored following the Proposed Affiliation. Furthermore, the Parties agree that any board or other operating reserves existing on the closing date of the Proposed Affiliation will be identified by each Party and may be used only for the communities served by the Party which accumulated such reserves before the closing.

8. Conditions. The Proposed Affiliation will be subject to the following:

(a) *Due Diligence*. The Parties will commence full due diligence on each other and their respective operations immediately following the signing of this letter of intent. The results of such due diligence must be satisfactory to the Party conducting the review in order for the Proposed Affiliation to proceed.

(b) *Regulatory Requirements*. The Parties will conduct such public hearings and file any notices required by law, and will receive all required regulatory approvals prior to completing the affiliation, including without limitation the notice and approval required under New Hampshire RSA 7:19-b, the so-called "Change in Control" law.

(c) *Definitive Agreement*. The Parties will undertake the negotiation and execution of a Definitive Agreement satisfactory to each of them, such Agreement to contain representations, warranties, covenants, conditions, indemnifications, and other terms and conditions customary for a transaction of this nature and to which the Parties mutually agree.

(d) *Board Approval*. The Definitive Agreement must be approved by the Board of Trustees of each Party after review of the due diligence results and consideration of input from the public hearing(s).

9. Affiliation Date. If all of the conditions in Section 8 above are met, the Parties will use their best efforts to consummate the Proposed Affiliation on or before December 31, 2020 or such other date to which the parties in writing mutually agree (the "Affiliation Date").

Part Two

The following paragraphs of this letter of intent are legally binding and enforceable by the parties (the "Binding Provisions"); provided, that the provisions of this Part Two (except for paragraph 4 regarding Confidentiality) will lapse if, despite their good faith efforts, the Parties have been unable to finalize the Definitive Agreement by June 15, 2020, or such other date to which the parties in writing mutually agree:

1. Access to Information for Due Diligence. Subject to the confidentiality provisions referenced below and any restrictions under applicable law, including antitrust regulations, immediately following execution of this letter of intent by both parties, each Party will provide to the other Party all information reasonably requested regarding such Party's administrative and clinical operations, assets, liabilities, tax-exemption, information technology, privacy and security procedures, litigation, and similar matters for the purpose of conducting due diligence.

2. Legal, Accounting and Other Expenses. Each Party will pay its own legal, accounting and other expenses and costs incidental to the negotiation of the Definitive Agreement and completion of the Proposed Affiliation.

3. Exclusive Dealing. The Parties mutually agree that, until either the termination of this letter of intent or the Affiliation Date and with respect to any affiliation or other arrangement

for the provision of home health and/or hospice care in any of the Parties' aggregate service area, neither of them will: (a) offer to affiliate or enter into a joint venture or similar arrangement with any other third party; or (b) enter into discussions or negotiation with any other third party during the pendency of negotiations between the Parties under this letter of intent.

4. Confidentiality; Communications and Required Disclosures. The terms of the Confidentiality Agreement executed between the Parties as of September 9, 2019 ("Confidentiality Agreement") are specifically incorporated by reference herein and made an integral part of the Binding Provisions. All terms contained in the Confidentiality Agreement will survive the termination of this letter of intent. The Parties jointly will develop and implement a communication plan and process for purposes of publicly announcing the Proposed Affiliation, communicating the Proposed Affiliation to their employees, providers and other internal constituencies, and responding to any inquiries regarding the Proposed Affiliation. Such communications regarding the Proposed Affiliation must be approved by both Parties prior to being released. If either Party determines that it is required by law to make any disclosure concerning the Proposed Affiliation, then it will notify the other Party and the Parties shall work cooperatively on the content of the proposed disclosure, the reasons that such disclosure is required by law, and the time and place that the disclosure will be made.

5. Operation in Ordinary Course of Business. Beginning on the date this letter of intent is executed, and continuing until either the date of its termination or the Affiliation Date, each Party will conduct its business and maintain its assets in a prudent manner consistent with past practice, and will use commercially reasonable efforts to preserve its existing operations, maintain the condition of its facilities, and conduct its business in compliance with all applicable obligations, laws, and regulations.

6. Entire Agreement. The Binding Provisions constitute the entire agreement between the Parties, and supersede all prior oral or written agreements, understandings, representations and warranties, and course of conduct and dealing between the Parties on the subject matter hereof (except to the extent expressly incorporated herein by reference). Except as otherwise provided in this letter of intent, the Binding Provisions may be amended or modified only by a writing executed by both of the Parties.

7. Waiver; No Assignment. A waiver of any right under this letter of intent will be effective only if it is written and signed by the waiving party, and no waiver of any right will be deemed to be a waiver of any future right under this letter of intent. The identity of the Parties is an essential element of the Proposed Affiliation, and so neither Party may assign its rights or duties under this letter of intent without the other Party's prior written consent, in its sole discretion.

8. Governing Law; Specific Enforcement. The Binding Provisions will be governed by and construed under the laws of the State of New Hampshire without regard to conflicts of laws principles. The Parties agree that a breach of the Binding Provisions cannot be remedied by monetary damages; therefore, a Party may seek specific performance if the other Party has breached, or is threatening to breach, any of the Binding Provisions.

9. Counterparts. This letter may be executed in one or more counterparts, each of which will be deemed to be an original copy of this letter and all of which, when taken together, will be deemed to constitute one and the same agreement.

[The Remainder of this Page Intentionally is Left Blank]

By executing this letter of intent, each of the Parties confirms that it agrees in principle to the contents of this letter of intent and will proceed promptly and in good faith to complete due diligence and to negotiate and finalize the Definitive Agreement as contemplated above.

CONCORD REGIONAL VISITING NURSE ASSOCIATION

By: _____
Name: Beth Slepian, MBA, PT
CEO
Duly-authorized

CENTRAL NEW HAMPSHIRE VNA & HOSPICE

By: _____
Name: Lisa Dupuis, MBA, OTRL
CEO
Duly-authorized

APPENDIX T
Due Diligence Request List Presented to Concord VNA

DUE DILIGENCE DOCUMENT REQUEST

MATERIALS TO BE PROVIDED BY CENTRAL NEW HAMPSHIRE VNA & HOSPICE AND CONCORD REGIONAL VISITING NURSE ASSOCIATION

This request list (the "Request List") has been prepared for use in the due diligence investigation to be conducted by Central New Hampshire VNA & Hospice ("CNHVNAH") and Concord Regional Visiting Nurse Association ("CRVNA," and together with CNHVNAH, the "Parties," and at times, each a "Party") in connection with a proposed affiliation transaction (the "Transaction"). To the extent available, the items specified below should be produced by each Party and copies of such items should be provided to the other Party. Legal counsel for each Party is amenable to conducting an on-site review of those documents which the other Party does not wish to post electronically due to such documents' size, confidentiality, etc. For purposes of the following requests, the term "Affiliates" for any Party will include: (i) all subsidiaries and other organizations that may be owned or controlled by such Party, in whole or in part, directly or indirectly, whether by stock ownership, membership, or otherwise; and (ii) any corporate members (i.e. "parent" companies) that may own or control any party, in whole or in part, directly or indirectly.

Each Party reserves the right to request additional information or documents prior to completing its due diligence investigation for the proposed Transaction.

The following is requested with respect to each Party:

A. CORPORATE ORGANIZATION AND GOVERNANCE

A-1. Articles and Bylaws. Current Articles of Agreement, Bylaws, and any amendments proposed or otherwise under consideration.

A-2. Organizational and Management Charts. Organizational charts showing the organizational and management structure of the Party, and the Party's relationship to any Affiliates.

A-3. Minutes and Resolutions. Minutes and resolutions of all trustee/director meetings for the past two (2) years, including meetings of Executive, Finance and Audit Committees (if any).

A-4. Officers/Members/Directors. A list of all trustees, directors, and officers, as applicable, and their respective occupations and length of term on the board.

A-5. Joint Ventures/Partnerships/Equity Interests.

(a) A list, description and copies of all joint venture, partnership, limited liability company operating, joint operating and similar agreements between the Party and any Affiliates and any non-Party entity and all organizational documentation related thereto, including, but not limited to:

(i) a list and description of all non-affiliated entities in which the Party has an equity interest; and

(ii) copies of any shared services arrangements.

(b) A description of, or copy of relevant documents regarding, any joint operating agreements between the Party and any Affiliates.

A-6. Relationships with Non-Affiliated Healthcare Entities. Description or copies of any memorandum of understanding or similar agreements between the Party, and/or its Affiliates, with any non-affiliated healthcare organizations relative to collaboration on clinical services planning, financial resources, etc. (exclusive of documents described in A-5(a) above).

A-7. Conflict of Interest Policies and Disclosures.

(a) Copies of all conflicts of interest policies adopted pursuant to applicable state or federal tax law, or otherwise.

(b) Copies of any disclosure form completed and filed annually or otherwise by trustees, directors or officers pursuant to such conflicts of interests policies.

(c) Description of the process for review of the disclosure forms and evaluation of potential conflicts of interest reported on such forms.

(d) Copies of any information or materials that may indicate a potential conflict of interest of any officer or board member of a Party (and any Affiliates) with respect to this proposed affiliation with the other Party.

A-8. Consents. A list of any parties (regulatory, contractual and otherwise) whose consent to (or notification of) the proposed transaction between the Party and the other Party will or may be required, and copies of all relevant documents evidencing the same.

B. LICENSING AND REGULATORY COMPLIANCE

B-1. Operating Permits. A list and copies of all material federal, state, local and other governmental or quasi-governmental agencies' operating permits, licenses and approvals, including, but not limited to, registered trade names, home health agency, hospice and other licenses and certificates of occupancy, including material related to any suspended or revoked governmental or quasi-governmental agency permits, licenses and approvals, as well as evidence of timely application for renewal if any permit/license has expired.

B-2. Accreditation.

(a) A copy of the most recent survey and report (including correspondence) by any accreditation organization; and

(b) copies of any deficiency reports and plans of correction received from or issued to any accreditation organization within the last three (3) years.

B-3. Regulatory Compliance. Copies of reports, notices and correspondence received from or issued by any governmental regulatory or licensing agency regarding regulatory non-compliance with any material rule, regulation or requirement (including deficiency reports and plans of correction) and any pending or ongoing investigations and/or governmental proceedings. Copies of any reports, notices and correspondence sent to any government regulatory or licensing agency regarding any self-disclosure of any potential regulatory non-compliance matter.

B-4. Corporate Compliance.

(a) Copies of the Party's Compliance Plan and any related policies and training materials.

(b) A summary of the number and type of compliance related issues arising during the past two (2) years and how the issues were handled along with any corrective action.

B-5. NH Charitable Trust Compliance/Community Benefits Plan.

(a) Copies of registration form NHCT-1.

(b) Copies of annual reports filed with NH Charitable Trusts (NHCT-2A) for the last two (2) years.

(c) Copies of all community benefits plan(s), related community needs assessments and documentation, including correspondence related thereto, filed with NH Charitable Trusts pursuant to New Hampshire RSA 7:32-e and 7:32-f

for the past two (2) years.

B-6. NH Pecuniary Benefit Transaction Filings. Copies of all annual and other disclosure forms filed with the New Hampshire Director of Charitable Trusts pursuant to New Hampshire RSA 7:19-a, the pecuniary benefit transaction statute, for the last three (3) years.

B-7. Antitrust Filings. Copies of any Hart-Scott-Rodino filings or any filings with the NH Attorney General with regard to antitrust matters within the past five (5) years.

C. TAX AND FINANCE MATTERS

C-1. IRS Determination Letters and Rulings; Tax Returns.

(a) Copies of all IRS tax-exempt determination letters.

(b) Copies of Forms 990 and/or other federal, state and local tax returns, including those pertaining to unrelated business income (i.e. IRS Form 990Ts), filed for the last three (3) fiscal years, for the Party and any Affiliates, partnerships and joint ventures. Copies of IRS ruling requests made and rulings received in last three (3) years.

C-2. Audited Annual Financial Statements. Copies of audited annual combined financial statements with associated or independent auditors' reports and management letters of recommendation, lawyers' letters, side letters from auditors and responses thereto, including discussion of disclosed and undisclosed material liabilities for the last three (3) fiscal years, together with any correspondence responsive thereto.

C-3. Interim Financial Statements. Most recent interim combined financial statements and all quarterly combined financial statements for the Party and any Affiliates for the last year, including statistical comparisons.

C-4. IRS Audits. Copies of all correspondence, findings and reports regarding any IRS audit, Attorney General audit or state revenue agency audit conducted during the last three (3) years.

C-5. Indebtedness Agreements. A list, description and copies of all documents and agreements evidencing indebtedness incurred pursuant to bond issues, commercial loans or otherwise, including, bonds, trust indentures, debentures, letters of credit, loan and credit agreements, promissory notes, and all security agreements and mortgages, and guarantees delivered in connection therewith.

C-6. Operating Budget.

(a) Operating budgets for the current fiscal year.

(b) Board presentation materials related to above.

C-7. Capital Budgets.

(a) Capital budgets for the current fiscal year.

(b) Board presentation materials related to above.

C-8. Official Statements, Etc. Copy of the most recent official statement, offering memorandum, prospectus, or similar disclosure documents utilized in connection with bond or similar debt issues, if any.

C-9. Compliance with Debt Covenants. A description of the effects of the proposed affiliation, if any, on applicable debt covenants or tests (including covenants relating to permitted reorganizations, permitted indebtedness, additional indebtedness and debt service coverage); and description of consent that may be necessary from banks, trustees, authorities, bondholders, bond insurers, liquidity facility providers or others.

C-10. Financing Plans. Plans for new short and long-term financing and refinancing of existing debt.

C-11. Investments. Copy of significant investment policies, including investment policies for board designated and pension funds. Copies of current investment allocations and statement of investments for significant investment funds, including board-designated and pension funds.

C-12. General Finance Matters. Documentation regarding the following:

(a) Access to independent auditor work-papers for most recent financial audit. Additional financial due diligence materials may be requested.

(b) Reports, studies and projections prepared by the Party's management regarding the business, financial condition or operation of the Party (and any Affiliates), including any budgets, business plans and capital spending plans.

(c) Reports and studies prepared by outside consultants on the financial condition or operations of the Party (and any Affiliates), including credit reports by banks or other services as well as copies of all ratings and related correspondence from nationally recognized rating agencies which have examined the credit of the organization.

(d) Description of restatements, asset write-downs, severance and other charges exceeding $100,000.

(e) Description of all guarantees, commitments, indemnification

agreements and other agreements to which the Party (and any Affiliate) is a party and copies of all such documents relating to such arrangements.

D. PAYOR MATTERS

D-1. Payor/Service Mix. A list of payor mix (by revenue and payor category) for the last three (3) years.

D-2. Agreements. A list, summary of the status of, and copies of all current contracts/participation agreements with Medicare, Medicaid, Blue Cross, and any other third party payor, HMO, PPO, or self-insured employer. Price or other sensitive information contained in agreements with managed care or other third party payor plans, which are subject to non-disclosure provisions, may be redacted.

D-3. Medicare Cost Reports. Medicare cost reports for the last three years.

D-4. Audit Adjustments. Copies of documentation and correspondence concerning any Medicaid and Medicare audit adjustments during the last three (3) years.

D-5. Reimbursement Appeals. Copies of documentation and correspondence concerning any pending appeals of reimbursement determinations issued during the last three (3) years including status of pending rate of reimbursement appeals and/or exception or adjustment requests and amounts in controversy.

D-6. Intermediary Exit Conference. Intermediary exit conference summaries and reports from most recent audit.

D-7. Utilization Data. Summary of utilization data over the last three (3) years, with explanations for any significant changes.

D-8. Liabilities. Analysis of third party liabilities and reserves for third party payors (including government payors) by year, and any other material threatened liability.

E. PLANNING DATA

E-1. Service Area. A description, map (or relevant documentation) of service areas.

E-2. Strategic Plans. Copies of all current strategic plans including long and short term capital expenditure objectives, service initiatives, financings, and refinancing.

F. CONTRACTS

F-1. Management/Consulting Agreements. A list, description and copies of all management, consulting or operating agreements, including without limitation contracts under which the Party or any Affiliate is managed by an outside entity, or where the organization manages another entity.

F-2. Exclusive Contracts. A list, description and copies of all exclusive contracts with physicians, suppliers, managed care plans, etc.

F-3. Significant Contracts. A list, description and copies of any contract or other arrangement imposing a significant or unusual commitment outside of the ordinary course of business.

F-4. Non-compete Agreements. Copies of secrecy, confidentiality or non-compete agreements.

F-5. Group Purchasing Agreements. Copies of significant group or joint purchasing agreements, including the basis for all discounts, and any covenants or exclusivity provisions.

G. PROVIDER AGREEMENTS

G-1. Provider Employment Agreements.

(a) A list and description of all employment agreements with licensed providers including the name of the provider, the date of the agreement, a description of the services obtained, a description of the financial obligations, a description of billing arrangements, description of the nature and amount of compensation to providers (including without limitation salary, incentive payments, all benefits, tail insurance purchase agreements, etc.) and a statement of the status of any such financial obligation.

(b) Copies of any such agreements including documentation related thereto (i.e., correspondence, letters of intent, security agreements, promissory notes, etc.).

G-2. Other Provider Agreements.

(a) Copies of all other agreements with health care providers, including, but not limited to, those for the purchase or sale of goods or services, purchase and sale agreements for stock or assets (including real estate).

(b) Copies of all other agreements with health care providers or provider-owned entities, including but not limited to professional service contracts with independent contractor providers or provider-owned entities and

leasehold arrangements.

H. INSURANCE

H-1. Policies.

(a) A list and description of all insurance policies, policy amounts and schedule of premiums including schedules showing summary of coverages, deductibles and policy limits.

(b) Copies of all policies, including certificates of insurance.

(c) Each insurance company's most recent claims report or "claims log" with loss reserves established for each claim for the past five (5) years related to professional liability, anti-trust, directors and officers, employment practices liability and federal or state billing related investigations.

(d) A list of any insurance contracts and/or policies which were canceled during the last five (5) years.

H-2. Self-Insurance. Any self-insurance documents and actuaries' reports thereon (including related financial statements).

I. PHYSICAL PLAN AND REAL ASSETS

I-1. Facilities List. List of all owned real property, identified by location and deed references or legal descriptions, and names of all mortgagees.

I-2. Property Leases. A list and copies of all real property leases and sub-leases for real property leased by the Party or any Affiliates identifying landlord (and specifically noting any landlord who is a physician or family member of a physician), location, rent (and any other amounts paid), term, renewal, extension, purchase rights, and principal use.

I-3. Capital and Equipment Leases. A list and copies of all capital leases, other major equipment leases, real estate leases, installment purchases, purchase options (as grantor or grantee), and long-term and/or material contracts of any kind.

I-4. Real Estate Tax Exemption Matters. Copies of correspondence with municipal officials regarding exemption from local real estate taxes and any other documentation related thereto, including without limitation any payments in lieu of taxes (PILOT) agreements.

I-5. Real Property Matters. Documentation regarding the following:

(a) Construction contracts for proposed or ongoing construction.

(b) List of fixed assets and equipment, including ownership status.

(c) Copy of any UCC, State and Federal Tax Lien and Bankruptcy Search completed within the last 12 months.

(d) Existing zoning opinions pertaining to any property of the Party or any Affiliates.

(e) Copies of all variances, special permits, other similar approvals and decisions.

(f) Historic district approvals or determinations, if any.

(g) Environmental permits (federal, state and local), including stormwater permits, wastewater permits, storage tank licenses/registrations, air emission approvals, registrations, and permits, nuclear regulatory commission permits, etc.

(h) Right to Know Law (Form R) and Toxic Use Reduction Act (Form S) filings.

(i) Notices of release of hazardous materials or oils, list of transformers containing PCBs and locations where asbestos insulation is present, and all PCB inspection reports and asbestos surveys.

(j) Copies of any environmental site assessments, surveys or questionnaires relating to a Party (or any Affiliates) completed internally or by third parties and including documentation and correspondence related thereto.

(k) Title matters, including source deed(s), most recent title insurance policy or title abstract with copies of all encumbrances, and most recent boundary and as-built surveys (if any).

J. PERSONNEL

J-1. Benefit Plans. Provide a description of all employee benefit plans, including both pension and welfare plans, including, but not limited to:

(a) Qualified pension plans, including defined benefit and defined contribution plans;

(b) 403(b) plans;

(c) Bonus plans;

(d) Non-qualified deferred-compensation plans;

(e) Non-qualified retirement plans; and

(f) Welfare benefit plans.

For each identified plan, please provide copies of the following: IRS favorable determination letters for all pension plans, plan documents (including summary plan descriptions) and any adoption agreements, description of method of funding, any trust documents, any group annuity contracts, summary plan descriptions, Form 5500 filings including schedules for last two (2) years.

J-2. Collective Bargaining Agreements. Copies of all collective bargaining or other labor agreements, including any side letters or written or unwritten understandings regarding the same.

J-3. Investigations and Grievances. Documentation regarding the following:

(a) Affirmative action plans, polices and investigations and complaints.

(b) Description of employee grievance procedures.

(c) Identification of all pending employee grievances and grievance procedures concluded within the last 12 months, indicating the nature of the grievance and either the status of pending grievances or the resolution of those concluded.

J-4. Employment Regulatory Issues. All correspondence with and reports to federal and state agencies and other regulatory authorities relating to any employee dispute or complaint for the last three (3) years, including but not limited to Occupational Safety and Health Administration, the New Hampshire Department of Labor, the New Hampshire Commission for Human Rights, and the Equal Employment Opportunity Commission.

J-5. Key Executive Employment Contracts.

(a) Copies of any agreements, including unwritten commitments or understandings or transactions not otherwise applicable to employees, with officers, trustees, directors or senior personnel relating to their employment or services including perquisites, compensation, insurance, incentives, indemnification, loans or guarantees, severance (including those triggered by a change of control or other affiliation), or other special or targeted benefits.

(b) A description of the Compensation Committee or other established

methodology, if any, for determining level of executive compensation and a copy of any policy regarding executive compensation.

J-6. Handbooks. Copies of all employee handbooks and/or other written policies/policy statements, regarding the rights, privileges and obligations of employees.

J-7. Personnel Contracts and Other Arrangements. Copies of the following information:

(a) a summary of any recent disputes with employees;

(b) severance agreements in excess of $100,000; and

(c) loans and guaranties to or from trustees, directors, officers or employees or any related party.

J-8. Incentive Programs. List of incentive programs and pay-out criteria (including service awards).

K. MATERIAL LITIGATION

K-1. Audit Responses. Copies of audit letter responses from law firms for the last three years.

K-2. Threatened or Pending Litigation and Administrative Proceedings. A list and description of litigation, arbitration, administrative proceedings or governmental investigations, claims or inquiries, pending or threatened, including but not limited to, the Internal Revenue Service, the U.S. Department of Health and Human Services Office of the Inspector General, Medicaid Fraud Control Unit, the Environmental Protection Agency, the Equal Employment Opportunity Commission, the Occupational Safety and Health Administration, state agencies with similar jurisdiction to each of the foregoing, insurance carriers (reports regarding pending litigation and incident reports) and private parties. For each such claim provide the name of the claimant, the nature of the claim, the status of the proceedings, copies of all pleadings, files, opinions of counsel, correspondence and analysis of material litigation status, consent decrees, injunctions and other documents relating to any pending litigation and a description of insurance coverage or reserves set aside for each such action and an estimate of potential exposure.

K-3. Settlements or Judgments. A list and description of judgments against, or settlements or releases entered into, by the Party or any Affiliate during the last three (3) years including copies of all settlement documents entered into during the last three (3) years or which are currently in effect as well as copies of any decrees,

orders or judgments of courts or governmental agencies issued during the last three (3) years involving the Party and/or any Affiliate.

K-4. Contested Contracts. A listing of contested contracts exceeding $10,000.

L. DATA PRIVACY AND SECURITY

L-1. Privacy Policies. Copies of all privacy policies with respect to data held by a Party and any Affiliate, including without limitation those required under HIPAA and HITECH.

L-2. Security Policies. Copies of all security policies for each entity, including without limitation the Security policies required under HIPAA and HITECH.

L-3. Risk Assessments. Copy of the latest security risk assessment/analysis in compliance with HIPAA and HITECH Security requirements and a description of any steps taken or planned to address any identified risks.

L-4. Privacy/Data Breaches. Summary of all privacy, information security or data breaches for the last three (3) years, including what actions were taken (including reporting) as a result of those breaches.

L-5. Business Continuity Plans. Description of the entity's business continuity plan, including a description of any testing in connection therewith.

L-6. Physical Security Guidelines. Copies of documented physical security guidelines to ensure security of any buildings, data centers, computer rooms, critical computer infrastructure, etc.

L-7. Known Events. Descriptions of all known event(s) which could give rise to a claim as a result of a privacy or information security incident or data breach.

L-8. Data Governance Policies. Copies of all data/information governance policies/guidelines and standards, including information governance categories, retention and destruction policies for each category.

L-9. Data Risk Assessments. Summaries of other data risk assessment and risk management programs, including copies of any reports issued in connection with such programs for the last two (2) years.

M. INTELLECTUAL PROPERTY

M-1. Trademarks and Service Marks. Schedule of all trademarks and service marks (registered and unregistered), trade names, domain names, copyrights and patents that relate to all products, websites, services, operations and names of the Party or any Affiliates.

M-2. Dates of First Use. Date of first use of each unregistered or unapplied-for trademark.

M-3. Registration Documents. All documents concerning registration of trademarks and service marks, including registration certificates, applications, correspondence and searches, and the results of any trademark or service mark searches conducted by the Party or any Affiliates.

M-4. Domain Names. List or registrars for all domain names and dates of expiry for current registration of each domain name.

M-5. Assignment, Purchase, Licensing Documents. All agreements and documents concerning assignment, purchase, sale or license (in or out) of proprietary rights, royalties or maintenance, including patents, copyrights, trade secrets, trade dress or trademarks.

M-6. Claims and Disputes. Documents relating to claims or disputes concerning any products, services, or intellectual property including any agreements regarding intellectual property rights owned or used by the Party or any Affiliates.

M-7. Third Party Agreements. Copies of all agreements with third parties relating to the development of the Party's (or any Affiliate's) product/service/site, including by way of example and not limitation, licenses (all software, data, technology etc.), listserv agreements, data sharing agreements, subscription agreements etc.

N. OTHER DOCUMENTS OR INFORMATION

N-1. Government Contracts and Subcontracts. All agreements and correspondence related to contracts and/or subcontracts with federal or state governmental entities.

N-2. Other Agreements/Information. Any other documents or information significant to the business or condition, financial or otherwise, of the Party or any Affiliate and not otherwise requested in this Request List, including, but not limited to:

(a) Exclusive contracts with professional suppliers, managed care plans, etc.

(b) Agreements with hospitals and other providers and/or networks of

providers.

(c) Any agreement that includes a covenant by any person restricting the business activities of that person.

APPENDIX U
Presentation Slides: Central VNA Board of Trustee Meeting 4/22/20

CENTRAL NEW HAMPSHIRE VNA & HOSPICE

Affiliation Structures

PRESENTING TO

Board of Trustees

DATE

April 22, 2020

PREPARED BY

Mark S. McCue, Esq.
Partner, Health Practice Group Chair

HINCKLEY ALLEN

Presentation Goals

- Review of Affiliation Goals
- Assessment Considerations
  - Affiliation Partner Attributes
  - Need for Integration
- Assessment of Potential Affiliation Structures in Relation to Goals
- Begin Consideration of Elements of Consolidation, if Chosen Structure

Fiduciary Reminder

- Fiduciary Roles
  - **Obedience to the Mission** (organize and operate to further charitable purpose)
  - **Stewardship of Charitable Assets** (prudent investment and use of funds to further purpose)
- Fiduciary Duties
  - **Duty of Care** *(act in good faith with the care a person of ordinary prudence would use in like circumstances and in a manner reasonably believed to be in the best interest of the institution and the communities it serves)*
  - **Duty of Loyalty** (obligation to put the interests of the organization above others)

Fiduciary Metaphor

- The Nonprofit Board ensures that the ship is aimed at the right destination and has the capacity to make the voyage

- Management charts the course (without straying from the destination chosen by the Board) and staffs and supplies the ship during its voyage

- What kind of seas must be navigated by the health care organization today (and tomorrow)?

Structuring the Affiliation

- Although there are basic models, every affiliation is UNIQUE
- The appropriate model depends upon the goals and resources of the parties, their circumstances, and their agreement regarding the management of inherent risks
- ***Form follows substance…..***

Affiliation Goals

- **Create Economies Of Scale/Reduce Costs**: Reduce the direct cost of service production and associated administrative structure
- **Financial Strength:** Improve bottom line for stability and sustainability; potentially enhance access to capital to support infrastructure and growth opportunities
- **Clinical Integration and Enhancement**: Improve access to, and efficiency and quality of, clinical care – enhance community education and specialty care, sharing of best practices

Affiliation Goals, cont'd.

- **Reimbursement Positioning:** Prepare for global payment or other types of population-based reimbursement, and/or enhance ability to participate in ACOs or other delivery networks and alliances
- **Staffing Retention and Recruitment:** Stabilize workforce and ideally enhance recruitment
- **Adjust to Changes in Hospital Industry:** Effect of Lakes Region Healthcare struggles on patient migration
- **Other?**

Affiliation Partner Attributes

- **Similarity of Charitable Missions**
- **Congruent Organizational Structures (Nonprofit VNA) and Service Lines**
- **Adjoining Service Areas**
- **History of Collaboration Between the Organizations**
- **Beneficial Financial Strength and Experience**
- **Strong Management and Administrative Operations**
- **Cultural Fit** (Patient centric, fiscally prudent, respectful, committed staff, similar priorities, etc.)

The Importance of Integration

- **What is Integration?**
  - ***Clinical*: The ability to establish and manage care protocols and standards, exchange patient data, direct/re-direct services, measure outcomes, align incentives among providers and patients across the continuum of care**
  - ***Financial*: The ability to consolidate financials, leverage borrowing capacity, and re-direct resources (including capital investments and shared savings) throughout the affiliation**
  - ***Operational*: The ability to reduce administrative infrastructure and costs**
  - ***Strategic:* The ability to establish and implement unified strategic plans**

The Importance of Integration, cont'd.

- **Why is Integration Helpful?**
  - ***Legal***:
    - Antitrust laws prohibit competitors from colluding, and Stark and Anti-Kickback prohibit payments to induce patient referrals
    - If clinically and financially integrated, parties considered to be a single actor and thus cannot collude or induce referrals – any such actions are ancillary to the integrated purposes of the parties
    - Therefore, parties can share resources, make referrals and make and receive capital investments

The Importance of Integration, cont'd.

- **Why is Integration Helpful, cont'd?**
  - ***Clinical***:
    - Clinical integration fosters the Triple Aim (better care, less cost, improved population health)
    - Permits participation in shared savings under risk-based contracts
    - Facilitates provision of specialty care and provider recruitment
  - ***Financial/Operational***:
    - Consolidated financials leverage borrowing capacity
    - Facilitates capital investments
    - Economies of scale and centralized administration allow for efficiencies

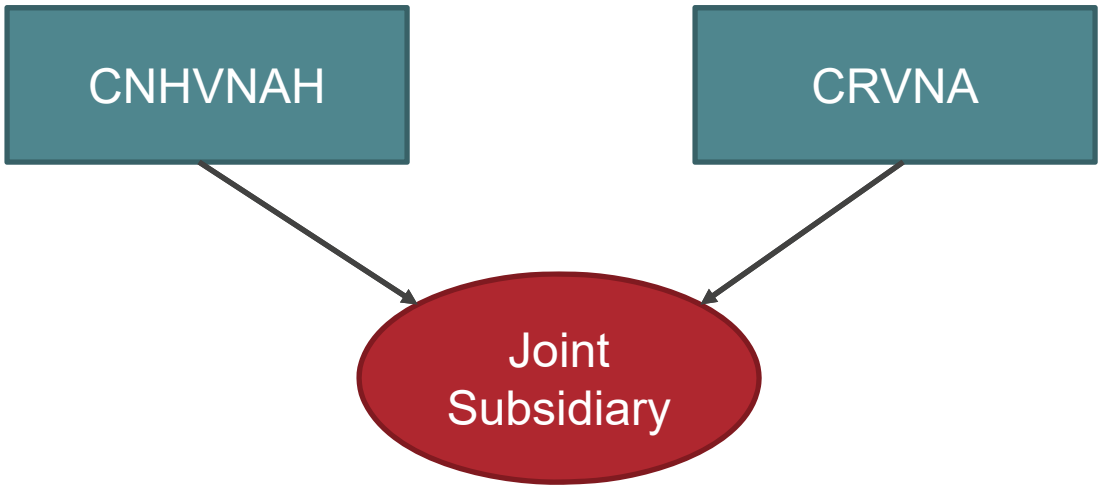
The Importance of Integration, cont'd.

- **Why is Integration Helpful, cont'd?**
  - ***Strategic***:
    - Clinical integration and greater number of covered lives position provider organizations for new reimbursement paradigm focused on outcomes and not volume of services
    - If affiliation partners have compatible cultures and values and aligned goals, they can become better positioned if industry consolidation continues

Affiliation Models to Consider

- Although there are many variations of Affiliations, three structures accomplish at least some of the Goals:
  - **Joint Subsidiary Model**
  - **Common Parent Model**
  - **Combined Entity (Merger/Sale) Model**

Joint Subsidiary Model



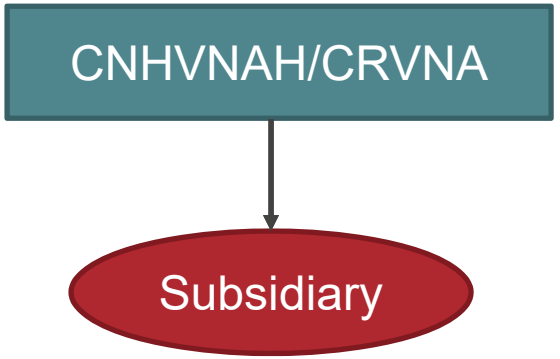
- Entities retain separate legal existence, create commonly-owned separate entity to consolidate integrated functions

Joint Subsidiary Model, cont'd.

Advantages	Disadvantages
Each organization retains separate legal existence and board (if desired)	Need to create and maintain additional legal organization
Does not trigger "Change of Control" and limited antitrust concerns	No clinical, financial or strategic integration
Achieves administrative efficiencies	Does not achieve other goals (clinical integration, financial strength, reimbursement positioning, recruitment/retention

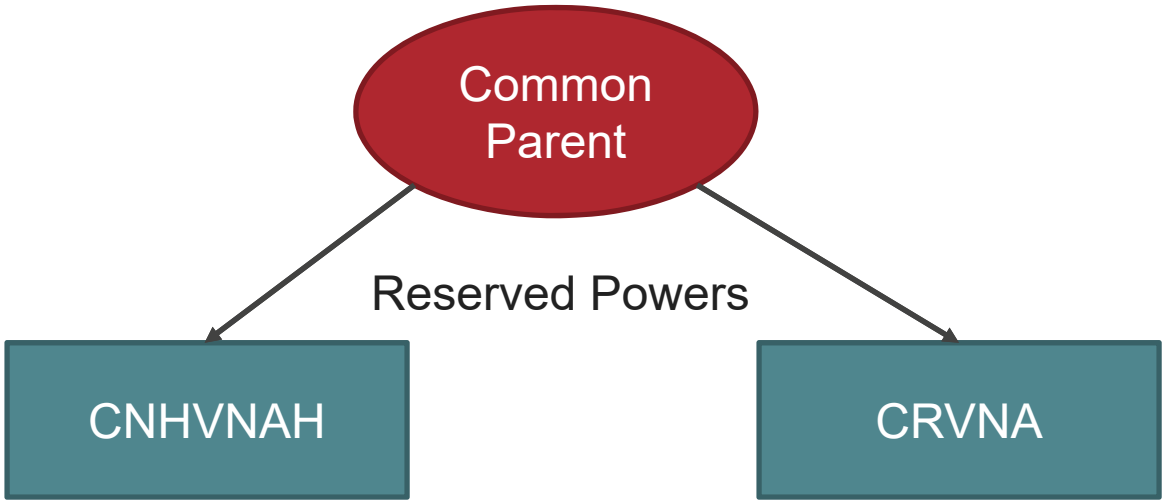
Joint Subsidiary Model, cont'd.

- Commonly used to share "back-office" functions
- Sometimes used as singly-owned subsidiary in connection with a consolidation by merger or sale



  - Allows for separate line of business to be continued post-affiliation
  - Establishes foundation or similar supportive purpose to allow continued role of trustees who will not serve on combined board

Common Parent Model



- Parties retain separate legal existence, create common parent and cede/reserve certain powers to it

Common Parent Model, cont'd.

Advantages	Disadvantages
Allows parties to retain separate legal existence and some local control (if desired)	Requires creation and maintenance of separate legal entity
Allows for measured integration of organizations with different lines of business or in different geographic locations	Unnecessarily complex structure if not seeking to add other entities to affiliation
Likely sufficient integration to achieve some financial integration	Insufficient integration to achieve all affiliation goals (e.g. streamlined management and administration, cost reduction)

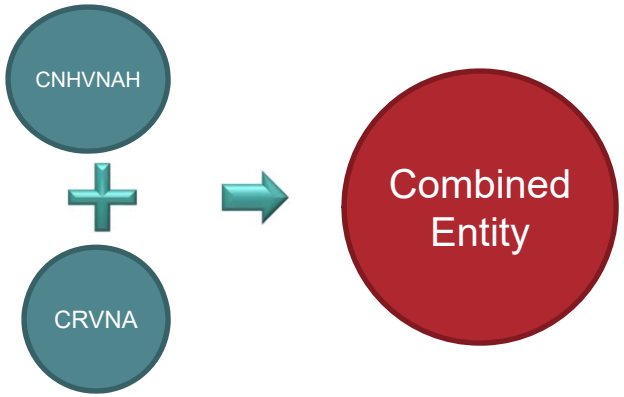
Common Parent Model, cont'd.

Advantages	Disadvantages
	Triggers Change of Control Review by Charitable Trusts Bureau
	8-12+ Months delay while await determination of 501(c)(3) status from IRS

Consolidation Model

- Legal model:

- Functional Model:



- Existing entities merge, with one being the legal survivor, but the governing documents of the surviving entity can be amended to create a “new”, consolidated entity

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Consolidated Model, cont'd.

Advantages	Disadvantages
Achieves full integration and supports all Affiliation goals	Combination requires elimination of existing independent features (board, management); possible staff reductions?
Utilizes existing exempt status, Medicare/Medicaid provider ID, and health care licensing of surviving entity – no need to create new one and incur delay and additional regulatory review	Will require amendment of health care licensing to reflect consolidated assets, liabilities, operation and governance
Structure fosters sense of unification and singularity of purpose	Requires existing commitment to unification
Most efficient structure in terms of legal costs and time to complete	Requires antitrust analysis and approval

Summary of Affiliation Models

Goal	Joint Subsidiary	Parent	Combined Merger
Economies of Scale/Reduced Costs	Some	Some	Yes
Financial Strength	No	Some	Yes
Clinical Integration	No	No	Yes
Positioning for Changes in Reimbursement	No	Some	Yes
Provider Recruitment and Retention	No	Some	Yes
Cost Efficient and Timely to Implement	Yes	No	Some

Merger Model Elements

- LEGAL STEPS
  - Conduct Due Diligence to Review Assets and Liabilities to be Combined and Evaluate Partner Choice
    - Includes evaluation of clinical and financial synergies/savings (Simeon)
  - Negotiate and Finalize Merger Agreement and Plan of Merger
  - Seek and Obtain Regulatory Approvals
    - Director of Charitable Trusts
    - NH Attorney General re Antitrust
  - File Certificate of Merger with NH Secretary of State
  - File Amended Articles of Agreement with NH Secretary of State and adopt Amended Bylaws for Surviving Entity
  - File License, Medicare/Medicaid CoP Amendments/Updates

Combination Model Elements, cont'd.

- SELECTION OF SURVIVING ENTITY
  - Financial and/or Clinical Advantages
  - Indebtedness and other Contractual Commitments
  - Management Strength
  - Hospital and other Provider Relationships
  - Gift Restrictions/Donor Considerations
- COMBINED MISSION STATEMENT
  - Guide Star for Combined Entity
- NAME OF "NEW" ORGANIZATION
  - Consider Reserving Existing Names as Trade Names

Combination Model Elements, cont'd.

- GOVERNANCE
  - Board Size
  - Proportion of Representation from each of CNHVNAH and CRVNA
  - Process for Future Trustee Elections
  - Actions Requiring Super-Majority Votes (if any)
  - Board Officers
- MANAGEMENT
  - Consolidated management most efficient
  - Determine level of staffing for each location reporting to single CEO

Combination Model Elements, cont'd.

- OPERATIONS
  - Maintenance of two/three facilities/location
  - Re-Hiring of Staff by Surviving Entity
  - Consolidation of Employee Benefit Plans
    - Process and Filings
    - Amendments (e.g. prior service credit)
  - Alignment of Clinical Practices
  - Consolidation of Financials and Finance Policies
  - Assign, Amend or Terminate Material Contracts
  - Other?

Questions and Discussion

- Thank you for your time and questions
- Next Steps and Schedule
  - Due Diligence Performed and Results Reported to Board
  - Merger Agreement Drafted and Negotiated
    - Identify process (e.g. by CEOs/Lawyers, or with Board/committee involvement)
  - Communities Informed and Feedback Solicited and Considered
  - Board Review and Approval of Merger Agreement

APPENDIX V

Board Materials for July 1, 2020 Central VNA Board of Trustees Meeting

Certain Information Contained in This Appendix is Confidential, and Excluded from Public Disclosure Under NH RSA 91-A:5(IV)

Mission Statement

"Promoting dignity, independence and well-being through the delivery of quality home health, hospice and community-based care services."

Agenda
Board of Trustees' Meeting
Date: July 1, 2020
5:30 P.M.
Virtual meeting via Zoom

I.	Call to Order	Kristen Gardiner
II.	Approval of Minutes*	Kristen Gardiner
III.	Approval of Board Designated Funds for Merger*	Lisa Dupuis
IV.	Presentation of the Legal Due Diligence	Mark McCue
V.	**Committee/Task Force Reports:**	
	A. Project Committee	Kristen Gardiner
VI.	Approval of the Definitive Agreement for Merger *	
VII.	**New Business**	
	A. Next Meeting Location: Virtual	
	B. Next meeting date: July 22, 2020	

*Requires a Vote

NOTE: Finance Committee meeting prior to the board meeting at 4:45pm by Zoom.

Concord Regional VNA, Inc and Central NH VNA & Hospice
Merger Documents

Merger Agreement: This document has been reviewed and agreed upon by both organizations Trustee Work group. It describes the transaction, Board of Trustee Composition and size, and the composition of the Executive Committee. This document is filed with the Charitable Trust Unit and shows our commitment to the Merger transaction. This document outlines the further work that needs to occur before the close of the transaction such as: Mission, By-Laws, Board of Trustees, and Name of the Combined Entity. Exhibit B and C are drafts of future documents that must be filed with the Charitable Trust Unit.

Helms and Company Community Impact Assessment: Kevin Stone, Senior Consultant. The Community Impact Assessment is a critical document to outline how this transaction will benefit all communities to be served by the Combined Entity. It brings together information received from the **public listening session** and the **Proforma** to evaluate the potential impact of the merger on the communities. Kevin did an excellent job creating an understanding of the community's needs, and the strength and resources the organizations will bring together to better increase access and focus on quality.

Simione Healthcare Consultants Proforma: Marian Entin , Principal and Ron Barrera, Managing Director. The proforma creates a consolidated financial plan based on current assumptions. In year two- it is expected that the combined entity will convert to a single electronic health record. The capital expense associated with this conversion is $1.5M in year two.

Virtual Public Listening Session Transcription: On June 3, 2020, a virtual listening session was help to provide the opportunity for the community to ask questions related to the proposed merger. The entire session can be viewed at www.vnaforthefuturenh.com . The transcription of the questions and answers are attached. This is an important document to review prior to voting to insure we have considered the community's input.

Legal Diligence: Mark McCue, Esq. The legal due diligence report will be a slide presentation during the Board meeting.

RSA 7:19-b (II) Standard Certification: This is the document that all of the Board of Trustees need to sign after the vote is completed and it is voted to proceed with the Merger.

Resolution: This document is the Board vote to approve the Merger Agreement and begin the regulatory filings. There are five votes included in the resolution. ***Please familiarize yourself with this document prior to our vote.***

Please do not hesitate to contact me with any questions you may have prior to our meeting.

MERGER AGREEMENT

This MERGER AGREEMENT (the "Agreement") is made as of this __ day of _____, 2020 ("Effective Date") by and between **Concord Regional Visiting Nurse Association, Inc.,** a New Hampshire non-profit corporation with a place of business at 30 Pillsbury Street, Concord, New Hampshire 03301 ("CRVNA") and **Central New Hampshire VNA & Hospice,** a New Hampshire non-profit corporation with a principal place of business at 780 N. Main Street, Laconia, New Hampshire 03246 ("CNHVNAH") (each of CRVNA and CNHVNAH is referred to as a "Party" and collectively they are referred to as the "Parties").

Preamble:

This Agreement is based on the following circumstances and mutual understandings of the Parties:

A. CRVNA is a licensed Medicare and Medicaid certified home health and hospice agency serving 44 municipalities in the Capital Region of New Hampshire. Formally established in 1899, CRVNA provides a range of personalized services and programs including home care, hospice, palliative care, personal home services, pediatric and maternal child health services, and wellness programming.

B. CNHVNAH is a licensed Medicare and Medicaid certified home health and hospice agency serving 45 municipalities in the Lakes Region of New Hampshire. Established through a 2010 merger of Visiting Nurse Association – Hospice of Southern Carroll County and Vicinity, Inc., founded in 1918, and Community Health & Hospice of Laconia, founded in 1975, CNHVNAH provides home health, hospice, rehabilitation, pediatric and maternal child health services, and educational programs.

C. CRVNA and CNHVNAH operate in separate but adjoining service areas in New Hampshire with some overlap, and have worked collaboratively in the provision of some health and hospice services in the Capital and Lakes Regions.

D. Given the compatibility of their missions, the adjacency of their service areas, their collective health services as described in Paragraphs A and B herein (the "Healthcare Services"), and their shared charitable missions of providing Healthcare Services to individuals living within the Capital and Lakes Regions, CRVNA and CNHVNAH have engaged in an exploration of a collaborative venture through which they can address current economic,

regulatory, and legislative challenges, maintain and potentially increase their ability to meet the community needs of their respective service areas, and enhance the quality and sustainability of their charitable services. As a result of this process, the Parties have concluded that the legal and operational integration of their respective organizations ("the Merger") into one legal entity will result in a more effective means of providing Healthcare Services in their combined service areas.

E. Representatives of the boards of trustees of CRVNA and CNHVNAH and of the senior management teams of both entities (collectively the "Trustee Workgroup") worked together over several months, with the advice of healthcare consultants and legal counsel, to analyze and negotiate the myriad issues involved in creating an integrated home health care and hospice organization which could further their mutual interests and respective missions, while addressing the health care needs of their communities.

F. Based on such analysis and negotiations CRVNA and CNHVNAH desire to merge their organizations into a single entity (referred to hereinafter as the "Combined Entity").

G. CRVNA and CNHVNAH wish to describe the composition of the Combined Entity, and the various steps which need to be taken to facilitate the Merger and fully integrate the Parties. The Parties desire and intend to consummate this Agreement subject to: (i) further due diligence; (ii) review by appropriate regulatory bodies and the public pursuant to New Hampshire RSA 7:19-b; and (iii) any mutually acceptable modifications resulting from such due diligence and review.

Elements of Merger:

IN CONSIDERATION of the mutual promises described below, and for other valuable consideration received, the Parties agree as follows:

1. STATEMENT OF PURPOSE AND MUTUAL VISION

The Parties declare the following purposes for the Merger and the shared vision of its results.

1.1 Furtherance of Compatible Missions. Each of CRVNA and CNHVNAH seeks to further its charitable mission of providing Healthcare Services that are accessible to all members of the communities they serve and designed to achieve the best possible outcomes. Particularly given the economic and regulatory burdens in providing such services, the Parties believe that their respective missions will be achieved best by creating a single, integrated home health and hospice agency.

1.2 Integration of Operations: Expansion of Beneficial Services and Sustainability. The Parties will consolidate their administration and operations in the Combined Entity in order to expand beneficial Healthcare Services within the communities they serve. By streamlining their infrastructure into a single combined entity, the Parties expect to achieve cost savings that will make the pursuit of their mission more viable and sustainable. If successful, the Merger will result in a stronger and more efficient organization, better positioned to maintain local control over the delivery of Healthcare Services within the communities they serve and withstand economic uncertainties.

1.3 Continuation of Services in the Affected Communities. The Combined Entity will continue the current Healthcare Services and programs of both Parties following the Merger. While the Combined Entity Board of Trustees subsequently may modify its services and programs based on community needs and available resources, the Parties envision that by creating a combined organization that can utilize resources and deliver services more effectively and efficiently, the Combined Entity will be able to improve the quality of such services and potentially expand them in the future.

1.4 Respect for Parties; Heritage: Integration into a Combined Entity. Although for legal reasons CNHVNAH is merging into CRVNA in accordance with the requirements of New Hampshire law, the Parties envision that the surviving corporation will operate as an integrated entity that will be respectful of the identity and heritage of each of the Parties. The Parties expect that, after the Integration Period described below, the Combined Entity will have evolved into a unified entity pursuing its charitable mission without the need to maintain separate powers or protections for its founders. Operationally, this will not be a merger by which one organization subsumes and extinguishes another, but instead will be the integration of two home health and hospice licensed agencies with comparable missions to create one strong and vibrant home health and hospice agency, while preserving their respective charitable pursuits.

2. GUIDING PRINCIPLES

2.1 Commitment to Health Care Needs of the Community. The healthcare needs of the communities served by the Parties are paramount, and the Combined Entity will be designed and operated to best address the needs of the residents of the communities being served. Healthcare Services and programs will continue to be provided in a manner consistent with the combined charitable mission of the Parties as set forth in the Articles of Agreement of the Combined Entity.

2.2 Commitment to Quality, Effective, and Efficient Services through Integration. Through this Merger, the Parties seek to provide the highest achievable quality and most

effective Healthcare Services in an efficient manner by integrating the services provided by, and the governance, administration and operations of, the Parties. Future programmatic and service delivery decisions will be consistent with this goal, subject to limitations imposed by economic conditions, resources, funding and applicable laws and regulations.

2.3 Furtherance of the Parties' Charitable Missions. The Parties have acknowledged the compatibility of their missions and the furtherance of those missions by the Combined Entity.

2.4 Compliance with Applicable Charitable and Tax-Exempt Requirements. The Combined Entity at all times will be operated in a matter consistent with the combined charitable missions of the Parties as stated in the Combined Entity's amended Articles of Agreement, and it will not be required to take any action pursuant to this Agreement which may impair or jeopardize its tax-exempt or public charity status under federal income tax law, or its charitable status under state law.

2.5 Commitment to Unified Entity and Fiduciary Duties. While remaining respectful of the identity and heritage of each organization, the Parties are committed to creating a unified entity as described in Section 1.4 above. Particularly during the Integration Period described below, the trustees of the Combined Entity are encouraged to share their perspectives and histories for the enrichment of discussion at Board of Trustees meetings. In furtherance of their fiduciary duties of loyalty and due care, however, the trustees of the Combined Entity ultimately will make informed decisions which, in their collective judgment, are in the best interests of the Combined Entity and its mission.

3. DESCRIPTION OF MERGER

The Parties agree to take, or cause to be taken, the following actions to create the Combined Entity:

3.1 Legal Merger. As of the Merger Date (as defined in Section 3.1.7 below), CRVNA and CNHVNAH will be merged and CRVNA will be the legal surviving corporation under New Hampshire RSA 292:4. Simultaneously with the Merger on the Merger Date, however, the CRVNA Articles of Agreement and Bylaws will be amended to reflect the revised, combined governance and management structure described below, and the merged entity will be re-named as mutually agreed by the Parties before the Merger Date. The integrated entity which is the surviving corporation under the Merger is referred to in this Agreement as the "Combined Entity".

3.1.1 *Continued Existence and Effect.* Except as specifically provided in this Agreement the corporate existence of the Combined Entity, with all its powers and rights, will continue unaffected and unimpaired by the Merger.

3.1.2 *Assets of CRVNA and CNHVNAH.* As of the Merger Date and without any further action or conveyance, the Combined Entity will succeed to all rights and interests, and will become the holder or record title to all of the property (real, personal, and mixed), of the Parties and CNHVNAH will not retain any rights or reversionary interests regarding such assets. Pursuant to the Merger, the Combined Entity will honor, assume responsibility for, and continue the maintenance, support, preservation and management of any assets of the Parties that are donor-restricted. The Parties also agree that any board restricted or other operating reserves existing on the Merger Date will be identified by each Party in a schedule to be delivered at closing (the "Pre-Merger Operating Reserves"), and the Combined Entity will use the Pre-Merger Operating Reserves only for the communities served by the Party which accumulated such Pre-Merger Operating Reserves before the Merger Date. Neither Party will permit its Board of Trustees to impose any designations or restrictions upon its unrestricted assets prior to the Merger Date. Pursuant to its Articles of Agreement and applicable law and subject to the foregoing restriction on Pre-Merger Operating Reserves, the Combined Entity will utilize its combined assets and resources in furtherance of the combined mission of the Parties.

3.1.3 *Debts and Claims of CRVNA and CNHVNAH.* All debts, obligations and liabilities of the Parties, in addition to all rights, privileges, powers and defenses of the Parties, automatically will vest in the Combined Entity of the Merger Date.

3.1.4 *Accounting Treatment.* The assets, liabilities and surplus of the Parties will be reflected on the books of the Combined Entity in accordance with generally accepted accounting principles. Nothing in this Agreement will prevent the Board of Trustees of the Combined Entity from making any future changes in its accounts to the extent required by applicable law or to conform to sound financial practices.

3.1.5 *Principal Place of Business of Surviving Corporation; Commitment to Three Principal Offices.* As of the Merger Date, the legal address of the Combined Entity will be 30 Pillsbury Street, Concord, New Hampshire 03301. The Combined Entity Board will endeavor to maintain at least three principal places of business, one in the Capital Region area and the other two in the Lakes Region area, so that the communities in the Parties' existing service areas will continue to be served by the Combined Entity.

3.1.6 *Trade Names*. From and after the Merger Date, the Combined Entity may register and conduct business under the names of either or both Parties as trade names if a new name is chosen for the Combined Entity by the Trustee Workgroup.

3.1.7 *Merger Date*. The Merger will become effective upon the filing of a Certificate of Merger with the New Hampshire Secretary of State as described in Section 4.1 below, which filing will occur within thirty (30) days of the date on which all of the conditions precedent to the Merger under this Agreement have been satisfied, or such other date as may be agreed upon the Parties (the "Merger Date"). The Parties' goal is to complete the Merger by December 31, 2020.

3.2. Mission Statement. Prior to the Merger Date, the Trustee Workgroup will prepare a unified statement of the corporate purposes and mission statement of the Combined Entity, which combines the existing mission statement of each Party for submission to each Party's board of trustees for approval prior to the Merger Date. Upon approval by both Parties, the unified mission statement will be attached as Exhibit A by an amendment to this Agreement and set forth in the amended Articles of Agreement of the Combined Entity to guide its activities and the decisions of its Board of Trustees.

3.3. Endowment and Investment Policies. As of the Merger Date, the Combined Entity will adopt, in its discretion, any necessary or desirable provisions of the endowment spending policy and investment policy of CNHVNAH as an addition to CRVNA's endowment spending policy and investment policy (the "Combined Endowment and Investment Policies").

3.4 Combined Entity Board of Trustees. The Parties will work collaboratively through the Trustee Workgroup to establish an initial board of trustees of the Combined Entity (the "Combined Entity Board"). To ensure that the Combined Entity Board adequately reflects the Parties' intent to form an integrated organization which respects each Party's heritage and identity, and to provide each Party with meaningful representation, the Combined Entity Board initially will be comprised of twenty-one (21) voting trustees, fourteen (14) of whom will be nominated by CRVNA (the "CRVNA Nominees") and seven (7) of whom will be nominated by CNHVNAH (the "CNHVNAH Nominees"). Each Party will review its current trustees to determine their current terms and expertise and will identify a list of nominees for election to the Combined Entity Board in accordance with Section 3.6 below. The Combined Entity Chief Executive Officer will serve on the Combined Entity Board *ex officio*, without voting rights.

3.5 Board Composition. The Parties desire that the Combined Entity Board will reflect, over time, the diversity of the communities served and be composed of members diverse in age, ethnicity, gender, experience and skills. After the nomination of the initial board of trustees of the Combined Entity, which will be attached as Exhibit B by an amendment to this Agreement, subsequent trustees will be nominated by a nominating committee formed under the Combined Entity Bylaws (as described below) and elected by the Combined Entity Board. If,

during the Integration Period defined in Section 3.7 below, any CRVNA or CNHVNAH Nominee serving on the Combined Entity Board resigns, is removed or otherwise is unable to complete his or her term, then the remaining Nominees of the organization with which the Nominee is associated will nominate a successor, and the Combined Entity Board shall vote to approve such nomination or re-elect (as the case may be) his or her successor.

3.6. Election Process; Officers of the Combined Entity.

3.6.1. *Initial Board.* Prior to the Merger Date, the Trustee Workgroup will serve as an *ad hoc* nominating committee for purposes of nominating the slate of directors for the initial Combined Entity Board to be approved by the existing board of trustees of each of CRVNA and CNHVNAH. The Trustee Workgroup also will stagger the terms of the initial Combined Entity Board so that roughly 1/3 of the Board is subject to re-election or replacement each year beginning on the expiration of the Integration Period, as shown on Exhibit B. After the Merger, the Combined Entity Bylaws will require the establishment of a nominating committee which initially, and throughout the Integration Period, will be comprised of a representative number of CRVNA Trustees and CNHVNAH Trustees, respectively.

3.6.2. *Initial Officers.* The Trustee Workgroup will nominate from among the CRVNA Nominees and CNHVNAH Nominees a slate of Board officers to be elected by the Combined Board as soon as possible after the Closing. The initial officers of the Combined Entity will serve for a term of two (2) years, and at least one officer will be a CNHVNAH Nominee. The Chairs of CRVNA and CNHVNAH as of the Effective Date shall serve as *ex-officio* voting members of the Combined Entity Board's Executive Committee during the Integration Period.

3.7 Integration Period. The Parties envision that over a period of twenty four (24) months following the Merger Date (the "Integration Period"), their respective missions, resources, leadership, clinical practices, administrative policies, and staff will become fully-integrated in the Combined Entity.

3.8 Governance Decisions Requiring Supermajority Approval by the Board. To help further the vision described in Section 1 above, the following decisions of the Combined Entity Board will require an affirmative vote of three-fourths (3/4) of the members of the Combined Entity Board entitled to vote (and not simply three-fourths of the trustees participating in a meeting at which a quorum is present) ("by supermajority vote"):

3.8.1. *Capital Expenditures; Debt.* Any unbudgeted capital expenditure or incurrence of debt, either in a singular instance or in a series of related transactions, in excess of $100,000;

3.8.2. *Material Change in Clinical Services/Programs.* Except for actions necessitated by regulatory requirements, the material expansion or contraction of any clinical services or programs of the Combined Entity;

3.8.3. *Principal Office and Location or Closure, Geographic Change in Service Area.* The relocation or closure of any principal office or any existing principal clinical facility of either Party, or the expansion or contraction of the current service areas of CRVNA and CNHVNAH, respectively;

3.8.4 *Corporate Reorganization.* The merger or reorganization of the Combined Entity with another organization, or the substitution or elimination of the existing sole corporate member of the Combined Entity;

3.8.5 *Dissolution.* The dissolution or other cessation of operations of the Combined Entity; and

3.8.6 *Amendment to Governing Documents.* Any amendment to the Articles of Agreement or Bylaws of the Combined Entity which modifies or removes these supermajority voting provisions.

3.9 Decisions Requiring a Supermajority Vote of the Combined Entity Board Only During Integration Period. To ensure that the Parties honor their commitment to respect each other's identity and heritage, the following actions of the Combined Entity Board will require a supermajority vote of its trustees for approval but only during the Integration Period;

3.9.1. *Hiring and Termination of Chief Executive Officer.* The hiring, evaluation, compensation and/or termination of the Combined Entity's Chief Executive Officer;

3.9.2 *Budgets.* The approval of operating and capital budget for the Combined Entity and its related operations and any proposed deviations in excess of $100,000 from such budgets; and

3.9.3 *Endowment and Investment Policies.* A material change in the Combined Endowment and Investment Policies.

3.10 Combined Entity Articles of Agreement and Bylaws. After the Effective Date and before the Merger Date, the Trustee Workgroup will review the governance documents of each Party and will propose amendments to the Articles of Agreement and Bylaws of CRVNA which (a) incorporate the governance and related provisions of this Agreement, or (b) facilitate the integration of the governance of the Combined Entity. The proposed amendments to the CRVNA Articles of Agreement (the "Combined Entity Articles") and to the CRVNA Bylaws (the "Combined Entity Bylaws") will be approved by the board of trustees of each Party and appended to this Agreement as Exhibit E and Exhibit F, respectively.

3.11 Senior Management. The Combined Entity will utilize a single Chief Executive Officer in recognition that the Parties will have combined their operations and to experience the efficiencies of such combination. Beth Slepian will serve as the initial Chief Executive Officer of the Combined Entity and Lisa Dupuis will serve as the initial Chief Operating Officer of the Combined Entity. The Parties also agree that Ms. Slepian and Ms. Dupuis will develop an integration plan for the senior leadership of the Combined Entity (the "Senior Leadership Plan"). The Senior Leadership Plan will consider the experience and skills of the existing senior management of each of CRVNA and CNHVNAH, and will be presented to the Trustee Workgroup before the Merger Date for input.

4. IMPLEMENTATION OF MERGER.

4.1 Plan and Certificate of Merger. Following the satisfaction of the conditions described in Section 4.3 below and on or prior to the Merger Date, and in conjunction with its final approval of the Merger Agreement, the board of trustees of CNHVNAH and the board of trustees of CRVNA will approve the Plan of Merger substantially in the form attached as Exhibit C. On the Merger Date, CRVNA will file a Certificate of Merger with the New Hampshire Secretary of State substantially in the form attached as Exhibit D.

4.2 Amendments to CRVNA Organizational Documents. Following the satisfaction of the conditions described in Section 4.3 below and on or prior to the Merger Date, CRVNA will file with the New Hampshire Secretary of State, the Clerk of the City of Concord, New Hampshire, and the Clerk of the City of Laconia, New Hampshire, the amended and restated Articles of Agreement and Bylaws of CRVNA in the form of the Combined Entity Articles and Combined Entity Bylaws attached Exhibit E and Exhibit F, respectively.

4.3 Conditions to Closing. The obligation of the Parties to effect the Merger as described above is conditioned expressly upon the satisfaction of the following conditions:

4.3.1 *Receipt of Regulatory Approvals.* The receipt of all applicable regulatory approvals, including but not limited to the approval of the New Hampshire Director of Charitable Trusts under the so-called "Change of Control" provisions of RSA 7:19-b, and review by the New Hampshire Attorney General, Consumer Protection and Antitrust Review.

4.3.2 *Remaining Due Diligence Matters.* The completion by each Party, and receipt of satisfactory results, of due diligence into various operational, legal, financial, tax, administrative, political and other issues and matters which may impact the successful consummation of the Merger. The Parties agree to conduct such diligence as promptly as possible, and in any event prior to the Merger Date.

4.3.3 *Additional Board Votes.* To the extent that any material modifications are required to this Agreement or any of the documents attached as exhibits as a result of the

regulatory review and/or public hearings under RSA 7:19-b, then such modifications must be approved and this Agreement ratified by the respective boards of CNHVNAH and CRVNA.

4.3.4 *Capital Region Health Care Corporation Approval.* The receipt of the approval of Capital Region Health Care Corporation, the sole corporate member of CRVNA.

4.3.5 *Third Party Consents.* The receipt of any required third-party consent under any material agreement or commitment, including but not limited to financing arrangements.

5. MANAGING THE PARTIES' RELATIONSHIP

5.1 Representations and Warranties. Each Party represents to the other, which representations will be deemed re-affirmed as of the Merger Date, as follows:

5.1.1 *Organization and Standing.* The Party has been duly organized under the laws of the State of New Hampshire as a nonprofit corporation and is in good standing under those laws.

5.1.2 *Corporate Action.* The Party has taken all necessary corporate action and has obtained, or by the Merger Date will have obtained, all necessary licenses, permits and approvals in order to execute this Agreement and perform or satisfy any undertaking herein contained.

5.1.3 *Authorization.* The Party has full and complete right, power and authority to execute this Agreement and to carry out the Merger subject to the conditions stated herein. This Agreement constitutes a legal, valid and binding obligation, of the Party in accordance with its terms.

5.1.4 *Restrictions. Consent of Third Parties.* Subject to the procurement of any necessary third party consents, the execution by the Party of this Agreement and the performance or satisfaction of any undertaking will not violate any provision of the Party's organizational documents, any contract, agreement or regulatory ruling or condition by which the Party is obligated or any provisions of applicable law. Attached as Schedule 5.1.4 is a list of any third party consents which must be obtained before Closing.

5.1.5 *Home Health, Home Care, and Home Hospice Care Provider Status.* The Party is licensed under the New Hampshire Administrative Rules as a home health and hospice agency under PART He-P 809, with respect to CRVNA only a home care service provider under PART He-P 822, and a home hospice care provider under PART He-P

823, and is organized and operated in such a manner as to meet all applicable statutory and regulatory requirements imposed on such licensees.

5.1.6 *Tax Status*. The Party is qualified as a tax-exempt 501(c)(3) corporation and a 509(a) public charity pursuant to the Internal Revenue Code of 1986, as amended.

5.1.7 *Financial Statements and Condition*. The Party has furnished its most recent audited financial statements together with the report of its independent accountants pertaining to said financial statements. Such financial statements present fairly the financial condition and the results of the operations of the Party at the dates thereof, using generally accepted-accounting principles consistently applied. Since the above date, there has been (i) no material adverse change in the financial condition or business of the Party; (ii) no material loss, destruction or damage to the properties of the Party; and (iii) no agreement, contract or commitment has been entered into or agreed to be entered into except for those in the ordinary course of business or as has been otherwise disclosed to the other Party in writing.

5.1.8 *Taxes*. The Party has filed all tax returns it is required by the United States Government and by the State of New Hampshire to file, and all taxes, assessments and other governmental charges due from the Party have been duly paid, other than taxes or charges which are not yet due and have been properly accrued on the books.

5.1.9 *Legal Proceedings*. [Except as disclosed on the attached Schedule 5.1.9,]There are no suits, actions, claims, proceedings (including, without limitation arhitration or administrative proceedings) or investigations pending against the Party or the properties, assets, or business thereof, or against any of its officers, trustees, employees, agents or consultants in connection with the business of the Party, and to their knowledge, there are no threatened suits, actions, claims, proceedings (including, without limitation arbitration or administrative proceedings) or investigations against the Party or its properties, assets or business.

5.1.10 *Contracts and Commitment, etc.* The Party has disclosed, or during the due diligence period will disclose, all material contracts to which it is a party. The Party has performed all obligations required to be performed by it to date and is not in default under and no event has occurred which, with the lapse of time or notice by a third party, or both, could result in a default by such Party under any outstanding mortgage, contract, lease or other agreement to which the Party is a party or by which the Party is bound.

5.1.11 *Insurance*. The Party has maintained and will continue to maintain until the Merger Date its usual and customary property, casualty, liability, extended coverage, and other insurance, including without limitation, insurance on the Party's tangible personal property and realty, whether owned or leased, against loss or damage by fire or other casualty, in amount equal to or in excess of one hundred percent (100%) of the

replacement value thereof, subject to current deductibles; all such insurance is in full force and effect on the Effective Date of this Agreement, is carried in reputable companies authorized to do business in New Hampshire, and is in amounts and with coverages normally and customarily carried by similar businesses in New Hampshire.

5.1.12 *Opportunity for Due Diligence.* The Party has had full opportunity to conduct due diligence regarding legal, financial, operational, regulatory, clinical and other matters pertaining to the other Party specifically, and the Merger generally, and the completion by the Party of the actions described in Section 4 above will be conclusive evidence that the results of such diligence are satisfactory to the Party.

5.2 *Trustee Workgroup.* The Trustee Workgroup will continue in existence after the execution of this Agreement until the Merger Date and will assist the Parties as reasonably necessary to complete the actions needed to consummate the Merger, as contemplated under Sections 3.2 through 3.6 above. The Trustee Workgroup also will oversee in an advisory capacity senior management's preparation and planning for the integration activities outlined in Section 3.7 above. The Trustee Workgroup will ensure that such management activities include planning for the integration of: the clinical and administrative practices and policies; patient records of the Parties; the clinical and administrative staff; and operational practices and policies of the Parties.

5.3 Confidentiality; Public Communications

5.3.1. *Confidentiality.* Except as and to the extent required by law, the Parties will not disclose or use, and will direct their representatives not to disclose or use to the detriment of the disclosing Party, any Confidential Information (as defined herein) with respect to the disclosing Party furnished by it or its representatives to the receiving Party or its representatives at any time or in any manner other than in connection with the transactions contemplated by this Agreement. For purposes of this paragraph, "Confidential Information" means any information stamped "confidential" or identified in writing as such by the disclosing Party to the receiving Party promptly following its disclosure, unless (a) such information is already known to the receiving Party or its representatives, (b) the use of such information is necessary or appropriate in making any filing or obtaining any consent or approval required for the consummation of the transaction, or (c) the furnishing or use of such information is required by or necessary or appropriate in connection with legal proceedings. Upon the written request of the disclosing Party, the receiving Party will promptly return any Confidential Information furnished to it or its representatives, and will not retain any copies, reproductions or extracts thereof and will certify in writing to the disclosing that it has done so.

5.3.2. *Public Relations.* Notwithstanding the above, the Parties may disclose the terms of the Merger to any regulatory authority but only as necessary to obtain requisite

approvals, and only upon prior consultation with each other regarding the content and timing of such disclosure. Any press release or other communication to the public will be agreed upon in advance by the Parties.

5.4. Concerns: Conflict Resolution.

5.4.1. *Prior to Merger Date.* Prior to the Merger Date, each Party agrees to inform the other promptly of any concerns or of any circumstances which may impair the Party's performance of its obligations under this Agreement. The Parties agree to refer any such matters to the Trustee Workgroup to discuss and seek to resolve any such concerns promptly and in good faith.

5.4.2. *Following Merger Date and During Integration Period.* After the Merger Date and during the Integration Period, the Combined Entity Board will use its best efforts to operate the Combined Entity in accordance with the applicable organizational documents and in furtherance of the vision and purpose described in Section 1 above. Any concerns or disagreements among the members of the Combined Entity Board will be addressed promptly in good faith and through the application of the guiding principles described in Section 2 above.

5.5. Duration of Merger.

5.5.1. *Perpetual Existence of the Combined Entity.* CNHVNAH and CRVNA have expended considerable resources to effect this Merger and, therefore, the Parties expect that their combination as embodied in the Combined Entity will continue in perpetuity.

5.5.2. *Reorganization or Dissolution During Integration Period (Un-Winding).* Notwithstanding the foregoing, if either of the following events occurs during the Integration Period, then the Combined Entity Board will dissolve or reorganize the Combined Entity and seek to un-wind the Merger as described below: (a) a subsequent and material change in applicable laws or regulations which prohibit or substantially impair the ability of the Combined Entity to effect the mutual vision and purpose of the Merger contemplated under Section 1 above; or (b) the determination by the Combined Board by a supermajority vote (as described in Section 3.8 above) that such mutual vision and purpose is unlikely to be furthered or achieved by the Combined Entity.

5.5.2.1. *Returning the Parties to the Status Quo Ante.* The Combined Board will devise a plan of reorganization for Combined Entity that seeks to re-establish the separate and independent corporate identities of the Parties. In allocating assets and liabilities to the re-constituted Parties under the plan of reorganization, the Combined Entity Board will consider the respective assets and liabilities of the Parties as of the Merger Date; and any subsequent actions taken jointly in furtherance

of this Agreement, including, but not limited to, the acquisition of property, the incurrence of debt and the entry into contracts with third parties, and will endeavor as nearly as practicable under the circumstances present at the time of the termination event to restore the Parties to their respective rights, titles and interests and financial condition which they each enjoyed immediately prior to the Merger Date. To the extent one Party has agreed to pay expenses of the other Party with respect to the Merger itself, such expenses will be part of the financial reconciliation. All expenses incurred by the Parties on or after the Merger Date will be shared equally by the Parties.

5.5.2.2. *Cooperation; Non-Solicitation/Interference; Non-Disparagement.* The members of the Combined Entity Board agree promptly and in good faith to extend such cooperation with each other, execute such instruments and generally take such action as may be needed to formulate and implement the plan of reorganization of the Combined Entity and the resulting unwinding of the Merger. Following the reorganization, each Party agrees that it will not (a) interfere with the relationships between the other Party and any of its trustees, officers, managers, employees or agents, and third-party vendors; (b) disparage the other Party; or (c) use or disclose any Confidential Information of the Other Party.

5.6 No Assignment. The identity of the Parties is an essential element of their relationship, and so neither Party may assign its rights or duties under this Agreement without the other Party's prior written consent.

5.7 Application of Legal Principles. The following legal principles will apply to the interpretation of this Agreement and the Parties' actions under it.

5.7.1. *Choice of Law and Jurisdiction.* This Agreement and the obligations of the Parties under it will be governed by and interpreted under New Hampshire law. Any legal action will be brought and conducted in a New Hampshire court with appropriate jurisdiction over the dispute, and any choice of law provisions to the contrary will not apply.

5.7.2 *Waiver.* A waiver of any right under this Agreement will be effective only if it is written and signed by the waiving Party, and no waiver of any right will be deemed to be a waiver of any future right under this Agreement.

5.7.3 *Integration.* This Agreement including all exhibits, which are incorporated herein by reference, represents the entire understanding and agreement between the parties and supersedes all prior negotiations, representations and agreements, both written and oral, made by and between them. This Agreement may be amended or modified only by a written document signed by the Parties.

5.7.4 *No Third-Party Beneficiaries*. No person, organization or other party not a signatory to this Agreement will be regarded as a beneficiary of its terms or will have the standing or right to enforce any of the provisions of this Agreement.

5.7.5. *Severability*. If any particular provision of this Agreement is determined to be invalid or illegal, it will not affect the other provisions of this Agreement; instead, the Agreement will be construed as if the invalid or unenforceable provisions were limited to the fullest extent permitted by law and consistent with the spirit and intention of this Agreement.

5.7.6 *Availability of Rights and Remedies*. Nothing in this Agreement is intended to limit the nature or extent of legal or equitable rights and remedies available to the Parties under New Hampshire law. The Parties agree that non-performance of this Agreement cannot be remedied by monetary damages, and that the equitable remedy of specific performance should be available to them as an appropriate remedy.

5.7.7. *Headings*. The headings used in this Agreement will not in any way be construed to limit or alter the meaning of any provision.

5.7.8. *Counterparts*. This Agreement may be executed in any number of counterparts, and each counterpart will be deemed to be an original instrument, but all such counterparts together will constitute one Agreement.

5.8. Provisions Surviving Effective Date. The Parties intend that this Agreement will guide their future actions regarding the Merger until the expiration of the Integration Period, and thus its provisions will survive for a period of twenty-four (24) months following the Merger Date. If and to the extent there is an inconsistency or conflict in the terms or operation of this Agreement with the terms or operation of Articles of Agreement and Bylaws of the Combined Entity, then the terms or operation of this Agreement will govern.

[The Remainder of this Page Intentionally is Left Blank]

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their duly authorized officers.

CONCORD REGIONAL VISITING NURSE ASSOCIATION, INC.

_____
Witness

By: _____
Name:
Title: Board Chair

CONCORD REGIONAL VISITING NURSE ASSOCIATION, INC.

_____
Witness

By: _____
Name:
Title: President/CEO

CENTRAL NEW HAMPSHIRE VNA & HOSPICE

_____
Witness

By: _____
Name:
Title: Board Chair

CENTRAL NEW HAMPSHIRE VNA & HOSPICE

_____
Witness

By: _____
Name:
Title: Chief Executive Officer

STATE OF NEW HAMPSHIRE
COUNTY OF _____

The foregoing instrument was acknowledged before me this ____ day of _____, 2020 by _____ duly authorized Board Chair of Concord Regional Visiting Nurse Association, Inc., a New Hampshire non-profit corporation, on behalf of the corporation.

_____
Notary Public
My Commission Expires:

STATE OF NEW HAMPSHIRE
COUNTY OF _____

The foregoing instrument was acknowledged before me this ____ day of _____, 2020 by _____ duly authorized President/CEO of Central New Hampshire Visiting Nurse Association, Inc., a New Hampshire non-profit corporation, on behalf of the corporation.

_____
Notary Public
My Commission Expires:

STATE OF NEW HAMPSHIRE
COUNTY OF _____

The foregoing instrument was acknowledged before me this ____ day of _____, 2020 by _____ duly authorized Board Chair of Central New Hampshire VNA & Hospice, a New Hampshire non-profit corporation, on behalf of the corporation.

_____
Notary Public
My Commission Expires:

STATE OF NEW HAMPSHIRE
COUNTY OF _____

The foregoing instrument was acknowledged before me this ____ day of _____, 2020 by _____ duly authorized Chief Executive Officer of Central New Hampshire VNA & Hospice, a New Hampshire non-profit corporation, on behalf of the corporation.

_____
Notary Public
My Commission Expires:

EXHIBIT A

Combined Mission Statement

[To Be Completed and Attached Before Merger Date]

EXHIBIT B

Initial Combined Entity Board of Trustees

[To Be Completed and Attached Before Merger Date]

EXHIBIT C

PLAN OF MERGER

This PLAN OF MERGER (the "Plan of Merger") is made by and between **Central New Hampshire VNA & Hospice**, a New Hampshire non-profit, voluntary corporation with a principal place of business at 780 N. Main Street, Laconia, New Hampshire 03246 ("CNHVNAH") and **Concord Regional Visiting Nurse Association, Inc.**, a New Hampshire non-profit, voluntary corporation with a principal place of business at 30 Pillsbury Street, Concord, New Hampshire 03301 ("CRVNA") (each of CNHVNAH and CRVNA is referred to as a "Party" and collectively they are referred to as the "Parties").

WHEREAS, the respective Boards of Trustees of CNHVNAH and CRVNA have determined that it would be in their respective interests to merge their organizations into a single combined entity, with CRVNA being the surviving entity under the new name of [_____] (the "Surviving Corporation"); and

WHEREAS, the terms of such merger are set forth in a certain Merger Agreement between the parties dated as of [_____] [___], 2020 (the "Merger Agreement"), and the Parties wish to set forth the plan for effecting the merger in accordance with the Merger Agreement;

NOW, THEREFORE, in consideration of the undertakings contained in this Plan of Merger and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

1. MERGER. The Parties will be merged pursuant to New Hampshire RSA 292:7 (the "Merger"). The Surviving Corporation will survive the Merger and will continue to be a non-profit, voluntary corporation governed by the laws of the State of New Hampshire.

2. EFFECTIVE DATE AND TIME. The Merger will become effective for tax and other purposes at 12:01 a.m. on [_____] [___], 2020 (the "Effective Date"), even if, for any reason, the requisite public filings with respect to the Merger should occur on some other date. The Parties will make the filing required by RSA 292:7 with the New Hampshire Secretary of State and any other required filings, which filings may be made prior to the Effective Date.

3. SUCCESSION. On the Effective Date, the Surviving Corporation will succeed to all of the rights, privileges, debts, liabilities, powers and property of CNHVNAH. Without limiting the foregoing, on the Effective Date, all real property, personal property, rights (including without limitation beneficial rights under testamentary or other gifts -- or other conditional rights -- which have not yet vested), privileges, franchises, patents, trademarks, licenses, registrations, and other assets of every kind and description of CNHVNAH will be transferred to and vested in the Surviving Corporation without further act, instrument or deed. CNHVNAH will not retain any rights or reversionary interests regarding such assets. The Surviving Corporation will adhere to, assume responsibility for, and continue the maintenance, support, preservation and management of, any board restricted or other operating reserves of CNHVNAH or the Surviving Corporation. Specifically, any board restricted or other operating reserves of CNHVNAH existing as of the Effective Date will continue to be used after the Effective Date for programming and related uses in CNHVNAH's historic service area. All rights of the creditors of CNHVNAH and all liens upon any property of CNHVNAH will be preserved unimpaired, and all debts,

liabilities and duties of CNHVNAH will attach to the Surviving Corporation and may be enforced against it to the same extent as if said debts, liabilities and duties had been incurred or contracted by it.

4. FURTHER ASSURANCES. From time to time, as and when required by the Surviving Corporation or by its successors and assigns, there will be executed and delivered on behalf of the Parties such deeds and other instruments, and there will be taken or caused to be taken on behalf of each of them such further and other action, as will be appropriate or necessary in order to vest or perfect in or to confirm of record or otherwise in the Surviving Corporation the title to and possession of all the property, interests, assets, rights, privileges, immunities, powers, franchises and authority of the Parties, and otherwise to carry out the purposes of this Plan of Merger, and the officers and trustees of tbe Parties are fully authorized in tbe name and on behalf of the Parties or otherwise to take any and all such action and to execute and deliver any and all sucb deeds and other instruments.

5. AMENDMENT AND TERMINATION. This Plan of Merger may be amended or terminated by mutual written agreement of the Parties at any time prior to the Effective Date.

6. COUNTERPARTS. This Plan of Merger may be executed in any number of counterparts, each of which will be deemed to be an original and together will constitute a single instrument.

IN WITNESS WHEREOF, each of the Parties has caused this Plan of Merger to be executed and attested on its behalf by its duly-authorized officers.

CENTRAL NEW HAMPSHIRE VNA & HOSPICE

_____ By: _____

Witness Name: _____

Title: _____, duly authorized.

CONCORD REGIONAL VISITING NURSE ASSOCIATION, INC.

_____ By: _____

Witness Name: _____

Title: _____, duly authorized.

STATE OF NEW HAMPSHIRE

_____, SS.

The foregoing instrument was acknowledged before me this ____ day of _____, 2020 by _____, duly authorized _____ of **Central New Hampshire VNA & Hospice**, a New Hampshire voluntary corporation, on behalf of the corporation.

_____
Notary Public
My Commission Expires:

STATE OF NEW HAMPSHIRE

_____, SS.

The foregoing instrument was acknowledged before me this ____ day of _____, 2020 by _____, duly authorized _____ of **Concord Regional Visiting Nurse Association, Inc.**, a New Hampshire voluntary corporation, on behalf of the corporation.

_____
Notary Public
My Commission Expires:

EXHIBIT D

STATE OF NEW HAMPSHIRE

Recording fee: $25.00 RSA 292:7

CERTIFICATE OF MERGER OF DOMESTIC VOLUNTARY CORPORATIONS

CENTRAL NEW HAMPSHIRE VNA & HOSPICE
(Merged Corporation)

INTO

CONCORD REGIONAL VISITING NURSE ASSOCIATION, INC.
(Surviving Corporation)

PURSUANT TO THE PROVISIONS OF NEW HAMPSHIRE RSA 292:7, THE UNDERSIGNED CORPORATIONS CERTIFY THAT THE FOLLOWING RESOLUTIONS WERE ADOPTED FOR THE PURPOSE OF MERGING THE MERGED CORPORATION INTO THE SURVIVING CORPORATION, EFFECTIVE [_____] [__], 2020 at 12:01 AM:

1. The following resolution was adopted by the Board of Trustees of Central New Hampshire VNA & Hospice on [_____] [__], 2020 in [_____], New Hampshire in the manner prescribed by New Hampshire law and the corporation's bylaws:

RESOLVED: That Central New Hampshire VNA & Hospice (the "Corporation") approves the Plan of Merger regarding the merger of the Corporation with and into Concord Regional Visiting Nurse Association, Inc., in the form presented to the Board of Trustees, which Plan of Merger is in the best interests of the Corporation.

2. The following resolution was adopted by the Board of Directors of Concord Regional Visiting Nurse Association, Inc. on [_____] [__], 2020 in [_____], New Hampshire in the manner prescribed by New Hampshire law and the corporation's bylaws:

RESOLVED: That Concord Regional Visiting Nurse Association, Inc. (the "Corporation") approves the Plan of Merger regarding the merger of Central New Hampshire VNA & Hospice, with and into the Corporation, in the form presented to the Board, which Plan of Merger is in the best interests of the Corporation.

3. Attached is the Plan of Merger adopted by the Boards of Trustees of each of the corporations.

We, the undersigned, being the chief executive officer and president, respectively, of each of the above-named New Hampshire nonprofit corporations, do hereby certify that the foregoing resolutions approving the merger of the corporations, and the attached Plan of Merger, were duly and lawfully adopted and remain in full force and effect.

CENTRAL NEW HAMPSHIRE VNA & HOSPICE

DATE: [_____] [__], 2020

_____
By: Lisa Dupuis
Its Chief Executive Officer, duly authorized

CONCORD REGIONAL VISITING NURSE ASSOCIATION, INC.

DATE: [_____] [__], 2020

_____
By: Beth J. Slepian
Its President/CEO, duly-authorized

EXHIBIT E

Amended Articles of Agreement of CRVNA (Combined Entity)

[To Be Completed and Attached Before Merger Date]

EXHIBIT F

Amended and Restated Bylaws of CRVNA (Combined Entity)

[To Be Completed and Attached Before Merger Date]

CRVNA & CNHVNA AFFILIATION
COMMUNITY IMPACT ASSESSMEMT

June 23, 2020

Overview: Concord Regional VNA (CRVNA) has served the greater Capitol Region for over 120 years providing needed home-based care to patients and residents. Central NH VNA & Hospice (CNHVNA) has provided services to southern Carroll County for over 100 years and to the greater Laconia Region for over 45 years. These organizations have been vital components of the fabric of their communities supporting individual care in the home setting. These organizations have proposed a merger to consolidate the resources and services into one home health and hospice organization.

Simione Healthcare Consultants and Helms & Company, Inc. each were engaged to evaluate the potential impact of the proposed merger from both a financial perspective and a community benefit perspective – with focus on access to quality services to meet physical and mental health needs. The Consultants were provided historic information on both organizations and conducted leadership interviews. Drawing on overall industry knowledge, the Consultants provide this assessment of the potential community benefit of the proposed combination.

Covid-19 Impact: The healthcare shut down resulting from the Covid-19 pandemic clearly impacted patient volume, demand, and financial performance of both organizations. While some areas of health care delivery may see permanent change as our country adjusts to the impact of the Covid virus, the home health industry likely will see a return to "pre-Covid" volumes and demand. If anything, the lasting impact of the pandemic may be to increase public interest and acceptance for care delivery in the home setting. Already as NH begins slow re-opening, the two agencies already have returned to patient service demand levels close to those seen before the shutdown. This analysis assumes that the post-Covid home care environment will mirror the "pre-Covid" environment and the merger benefits anticipated before the pandemic will remain valid into the future. Given the recent rise in home health demand we believe this is the appropriate assumption upon which to base our evaluation

EXECUTIVE SUMMARY: The Concord Regional VNA and Central NH VNA propose merging to improve their overall clinical and financial stability at a time of great uncertainty in the health care industry. A critical consideration in the proposed merger is the ongoing melding of the Lakes Region market with the Concord market. Over the past few years more Lakes Region residents have sought care from providers in the Capitol Region Health Care system- in which CRVNA is an integrated member. CNHVNA has seen a significant market share loss to CRVNA. It is more cost-effective for CRVNA to merge with an existing agency- that has similar culture and approach to service delivery- to meet referral demands than to build new capacity. Under current laws, CRVNA cannot share referrals with CNHVNA without organizational integration.

The proposed merger should have many benefits to the patients and providers currently served by CNHVNA. The combined entity will bring greater clinical specialty resources and depth, enhance community education programs, increase community health and wellness program offerings, and reduce clinician travel time through better overall staff deployment to a larger population. CRVNA has many years of experience supporting a health care system with ACO involvement and Total Cost of Care contract performance. These skills can enhance post-acute care services to Lakes Region and southern Carroll County providers as they become involved in Accountable Care relationships.

The Community should benefit by the combined organization having improved opportunity for workforce acquisition and retention. Labor is a huge percentage of overall cost and together the organization should be able to offer enhanced work opportunities, reduce turnover and position vacancies, and provide for greater ongoing education and training. All of this should enhance the overall timeliness of care requested for patients.

Both organizations have been involved with their respective Integrated Delivery Networks which will continue post-merger. Together, they should be better positioned to develop new programs identified to support IDN mission and needs of federal payment reform. They will expand the delivery of the OASIS assessment to include all patients not just those with Medicare coverage. This may help identify behavioral health needs. An immediate benefit will be the support that CRVNA can offer to the CNHVNA nascent Palliative Care Program.

While the goal of the proposed merger is enhanced stability and not cost reduction per se, the combined entity should realize reduce administrative cost that can lower/hold down its overall average cost per visit or cost per episode. Since most home health and hospice reimbursement is on a fixed basis, being able to lower administrative cost per service is critical in maintaining operating funds to invest in needed community services. To achieve this administrative cost improvement, the parties are committed to identifying and implementing a common Electronic Health Record. This will be a cornerstone of the ability to eliminate unnecessary or duplicative administrative costs.

Nationally, there has been ongoing evolution in the home health and hospice industry toward more For-Profit enterprises providing care. While these organizations can offer high quality services they are ultimately driven by financial goals and not by community goals. Creating a combined organization will strengthen and help preserve a critical non-profit resource governed by community members ensuring that meeting community needs are always the primary consideration.

Current Industry Environment: The healthcare environment has become increasingly challenging for smaller non-profit service organizations. Each agency receives over 75% of its revenue from Federal programs (primarily Medicare) and major federal payment reform was instituted at the start of 2020. This has increased the financial uncertainty of both organizations. The New Hampshire market has seen an aging nurse workforce – a critical component of home-based services. Recruitment and retention of quality staff has become a greater challenge for VNAs. The non-profit home care industry has also seen increased competition from For-Profit organizations that enjoy greater access to capital. This environment has created a need for non-profit consolidation to achieve greater economies of scale and resource depth to compete with the burgeoning of profit entities.

A major consideration in home health affiliations is the ongoing provider consolidation that is occurring in health care – especially among hospital providers. Federal payment policy is pushing for total cost of care (TCOC) accountability and Accountable Care Organization (ACO) development. This has pushed hospitals to create both vertical and horizontal integration arrangements to broaden patient population and better manage the entire continuum of care. In the Capitol region, Concord Hospital (CH) is part of NH Cares ACO that includes CRVNA. Commercial insurance products also have introduced elements of total cost of care responsibility and Concord Hospital is one of a few hospital owners in the Tufts Freedom Health Plan. Such arrangements incent hospitals to seek post-acute care relationships that can cover both the full clinical spectrum of post-acute care patients and a bigger geography typically covered under TCOC arrangements. This creates issues for smaller more locally focused home health agencies to remain viable partners for the expanding health care systems.

Merger Rationale: The respective Boards of Trustees have stated the main goal for the proposed merger is the preservation of valued non-profit community resources to continue supporting community and home-based care delivery. An expected outcome of the merger is greater organization stability – both financial and clinical – to meet the shifting needs of referral sources and the communities served. Both organizations currently provide high quality services as evidenced by quality metrics tracked by Medicare Star Ratings, Home Health Compare, and Strategic Health Programs (SHP). By combining, the enhanced stability created should enable the organizations to continue offering good access to their quality services and maintain their high quality outcomes. The organizations should be better positioned together to meet future needs and weather health care changes like Medicare payment reform.

Changing Local Hospital Landscape: A major factor in the decision to seek this affiliation is the change that has been occurring in the Lakes Region. Lakes Region General Healthcare (LRGH) has been undergoing significant financial problems for the past few years. Despite efforts to identify a financial/clinical partner, no organization has emerged. The hospital closed its maternity service and many patients now go to CH for their deliveries. Because of the ongoing financial uncertainty, other elective services have been migrating from the Lakes Region to CH. The Belknap County home health and hospice out migration to the Concord area is shown in ***Table 1***. Over the five-year period from 2013 through 2018, CNHVNA has lost 19% share in home care and 24% share in hospice. Most of this share reduction has gone to CRVNA due to the ongoing exodus of Lakes Region patients to the Concord health care delivery system.

Table 1- Belknap County Market Share Change

Service	Home Health Organization	2013 Share	2018 Share	Share Change
HOME CARE				
	CNHVNA	59%	40%	-19%
	CRVNA	4%	15%	11%
	Franklin VNA	8%	11%	3%
	Lakes Region VNA	13%	17%	4%
	Newfound (Nana)	2%	2%	0%
	All Other	17%	15%	-2%
HOSPICE				
	CNHVNA	67%	43%	-24%
	CRVNA	<5%	17%	>=12%
	Franklin VNA	<5%	7%	>=2%
	Lakes Region VNA	<5%	5%	>=1%
	Compassus	<5%	5%	>=1%
	All Other	<27%	23%	N/A

Source: Home Care Market Atlas

Concord Hospital is highly integrated with its Medical Staff. The CRVNA is a member of Capital Region Health Care and has several programs that are integrated with CH service lines. These include:

- Joint Replacement "Pre-hab" Program;
- Palliative Care Services;
- Baby's First Homecoming;

- NH Cares ACO;
- COPD Collaborative;
- Transitional Care Nursing;
- IDN-2 Capital Region Healthcare.

The migration of patients from Lakes Region to Concord creates issues for both agencies. For CNHVNA, the loss of volume threatens its ability to continue to offer a full array of services cost effectively since the fixed cost administration is spread over a smaller volume thereby raising the average cost of services that are rendered. This reduces the overall resources that CNHVNA can make available to support services that do not cover their cost. Over time as this trend continues, CNHVNA would be forced to reduce or eliminate certain services.

The CH health care system looks to its integrated home care partner – CRVNA – to deliver needed post-acute care to all patients including those coming from the Lakes Region. Current Federal regulations prohibit CRVNA from 'sharing' referrals with CNHVNA. Thus, CRVNA would need to extend its services and hire more staff to cover a greater geography to meet the ongoing referral needs of the CH Medical Staff. This would be much less efficient than bringing the CNHVNA resources under the same organization so that these resources can be legally shared to maximize the effectiveness of providing post-acute care to patients receiving clinical care from Concord Hospital & Concord Medical Staff regardless of their residence. On average, the total cost to recruit, hire, on-board, and provide supplemental training to one new employee is $4,000-$5,000. It also takes an average of 40-60 days from time of position identification to fill the needed position ready to render patient service. Once hired, it takes an average of 3 months for the new hire to attain full productivity because of ramp up learning curve. This is a cost equivalent of nearly $15,000 per position.

Over time, CRVNA might need to hire an additional 5-10 FTEs to meet a continuing demand increase to serve Lakes Region patients seeking clinical care from the Concord Hospital healthcare system. The cost and time delay of building additional capacity can be avoided by combining with an organization already established to provide most of the needed services. But, an integrated organizational relationship – like the proposed merger – is required to legally allow for this coordinated work. Without the proposed merger, it would be difficult for either organization to most cost effectively meet the referral needs of the Concord Hospital Medical Group as more Lakes area patients seek services in Concord.

Both respective Boards of Trustees have considered other affiliation options over the past few years. However, given the ongoing blending of the Lakes Region market with the Concord market, both Boards independently concluded that a merger of these two organizations has greatest potential for overall community benefit. No other affiliation affords the same opportunity to plan for the most effective delivery of home-based services to patients receiving elements of health care from both the CH and LRGH delivery systems. Through numerous discussions, the Boards determined that the organizations have comparable cultures and the proximity of the respective service areas and the comparable approaches to care delivery should allow the organizations to readily integrate without significant disruption.

Clinical Service Stability and Improvement

Specialty Clinical Services Provision: The demands on the home care industry for increasingly complex care delivery has stressed staffing for specialty clinical services such as wound care, home infusion care, special pediatric care, etc. Currently CRVNA has greater resource depth in these specialty areas than CNHVNA. Often CNHVNA has only one clinical specialist available and if that person is away on vacation, out sick, or engaged in a lengthy case, CNHVNA is unable to provide timely care to a referral needing specialty services. By combining with CRVNA, greater clinical specialty resource depth can be shared and deployed to maximize ability to meet patient need. The overall timeliness of care should be enhanced which is highly valued by referring providers.

Table 2 contains a comparison of the Clinical Specialist FTEs for each organization. This shows that together a greater complement of specialty services can be more broadly available. In some cases, CRVNA has certain clinical specialists that CNHVNA lacks. By combining, these specialty services could now be made available to CNHVNA patients, thereby improving overall access to services- especially for patients in the Lakes Region.

Table 2- VNA Clinical Specialty Resources Summary

As of June 2020

Clinical Specialty	CRVNA FTEs	CNHVNA FTEs	Combined FTEs
Wound Care Certified RN	3.00	1.00	4.00
IV Certified RN	2.00	0.00	2.00
Lymphedema – PT	2.00	1.50	3.50

Lymphedema – OT	1.00	2.00	3.00
Vestibular PT	1.00	0.00	1.00
Behavioral Health Coordinators	1.00	0.00	1.00
Community Health Educators	2.00	0.00	2.00
Advanced Illness Management Nurse	1.00	0.00	1.00
Transitional Care Nurse Coordinator	0.25	0.00	0.25
Total Specialty Services	13.25	4.50	17.75
Source: Home Care Market Atlas			

Palliative Care Development: CRVNA has a robust Palliative Care service in collaboration with CH that complements its home hospice and hospice house services as well as its home care services. CNHVNA has recently launched a Palliative Care service to support Belknap and Carroll County patients as part of end of life care continuum. The proposed merger would support this new initiative – currently in its infancy – and CNHVNA can draw on the experience and expertise of CRVNA in developing comparable Palliative Care services. Because many patients receive care from both the Lakes Region and Concord medical communities, having a consistent Palliative Care service across both communities should benefit providers, patients, and families.

Behavioral Health Care Delivery: CRVNA has behavioral health resources that CNHVNA currently lacks. With the support of a Community Services grant, CRVNA was able to expand its behavioral health service to two individuals (1 FTE) who have served a census of 80 clients. These resources helped identify over 240 patients with behavioral health needs leading to 144 referrals to social work services. By combining, the agencies should be better able to continue funding these services that do not always cover their full cost. Additionally, a larger organization should be more attractive to granting agencies looking to provide funds where a larger impact can be made. The organizations have stated their intent to extend behavioral health support services to the Lakes Region after affiliation.

Both organizations have supported the statewide Clear Path initiative launched by the NH Home Care Alliance to provide training on behavioral health for home based services. Both organizations have had staff trained to support behavioral health needs identification in patients. Currently CRVNA conducts an OASIS assessment on all home care patients encountered (not just Medicare). Post-affiliation, the combined organization will conduct this assessment on all patients

including those historically served by CNHVNA. The OASIS assessment can help identify behavioral health issues that may have been missed by hospital health care providers. The merger should strengthen the resources of the combined organization allowing for more ongoing community support of mental health needs detection and social services referrals.

Staff Turnover: An element that impacts both cost of care and access to care is staff turnover. Pre-Covid, both organizations – and the home care industry overall – were facing increased staff turnover and vacancies. Greater turnover increases cost as organizations must recruit, train, and on-board new employees and endure a ramp up period before the new employee can achieve the same productivity as an outgoing employee. In 2019, CRVNA had a turnover rate of 16.5% and CNHVNA had a rate of 10%. Having unfilled positions can reduce patient access as agencies must restrict the number of patients taken under care to ensure that existing staff can provide needed services. Pre-Covid CRVNA had eight unfilled positions while CNHVNA had two. A combined entity is expected to see reductions in both turnover and vacancies.

While staff can leave for a variety of reasons, some can involve a relocation within the state or can result from an employee seeking more overall responsibility where no opportunity exists within the agency. A combined entity should be more flexible to potentially provide ongoing employment after a relocation. More importantly, the larger combined organization could provide more career advancement opportunities because of greater organization scale and breadth. This may help retain some employees seeking more responsibility. Over time, a larger organization may be able to provide more creative options for flexible employment, benefit provision, and continuing education – all of which can positively impact staff acquisition and retention.

Community Education: CRVNA has a robust community education program with commitment of two full time Community Health Educators. These individuals conduct home visits to support education goals as well as supporting wellness and a speakers bureau that has reached over 500 participants. With the merger, the community education program will be expanded to augment the current work of CNHVNA. This will enhance community benefit by sharing and expanding these resources. By combining, the joint financial strength should allow the combined organization to invest in more community education services. The organizations intend to bring the full panoply of community education services to the Lakes Region and southern Carroll County. Education programs anticipated to be extended to more of Belknap and southern Carroll County include:

- "A Matter of Balance"
- "Better Choices, Better Health"
- Powerful Tools for Caregivers
- Aging Mastery Program
- Aging Mastery Program for Caregivers@

Community Program Expansion: CRVNA currently offers many programs that support community health. Post-merger these can be expanded to the Lakes Region and southern Carroll County broadening the array available. Programs targeted for this expansion include:

- -Flu Clinics – both public and private locations;
- -Health Clinics – Foot clinics and Blood Pressure Management clinics;
- -Memory Café;
- -Caregiver Café;
- -Walk-in-Wednesday;
- -Dying to Talk;
- -Community Health Educator – Home Visits;
- -PATHS (Positive Aging Through Home Supports).

New Program Development: Combining the resources of the two organizations could support future new community-based program creation congruent with overall healthcare reform. Already both organizations are part of their respective Integrated Delivery Networks (CRVNA in IDN2 and CNHVNA in IDN5) with representatives serving on the Governance level. If/when the Lakes Region becomes part of an Accountable Care Organization initiative, the experience of CRVNA would be immediately made available to support development efforts and share lessons learned. This should be beneficial since organizations participating in ACOs have found that there is a learning curve to evolve to meet ACO needs. Since many of the new payment and delivery models contain elements of shared economic risk, a larger organization will be better positioned to spread risk over a greater patient base. It should have more patients with common clinical needs to lower the risk associated with new care approaches and programs designed to improve outcomes and reduce hospitalizations.

Financial Stability and Cost Structure Improvement

The proposed merger should enhance the financial strength of the combined organization allowing it to better withstand future reimbursement cuts by federally funded programs and more cost effectively deploy staff in the face of labor shortages and rising employee costs. Labor expense represents 75%-80% of VNA operating revenue. A larger organization can create efficiencies to offset the escalating cost per FTE. Much of the payment for VNA services is fixed – either per visit or per episode of care. Thus, finding ways to manage cost structure – particularly administrative overhead costs – is critical to ongoing viability. Because of current and anticipated future clinical service demand, the purpose of the proposed merger is NOT to reduce clinical FTEs. However, management leadership is confident the merger will allow for reduction of administrative overhead that can be spread over a greater patient base. This is reflected in Years 2 & 3 of the financial pro forma prepared by Simione. Administrative Expense represents 30%-35% of total expenses and a 5% improvement would represent more than a 1% enhancement of overall operating performance.

Integrated Electronic Medical Record (EMR): A cornerstone of the ability to reduce the average cost per visit resulting from the proposed merger is to establish a single common information technology platform for all. Immediately after merger approval, the organization will embark on a comprehensive needs analysis and a thoughtful process for EMR technology evaluation. This will result in identifying the best EMR system to support workflow efficiencies and overall organization needs. As demonstrated in the three-year pro forma financial statements, the parties anticipate creating common policies and procedures in Year 1 while going through the EMR evaluation. An EMR system will be selected and implemented throughout the organization in Year 2. A degradation in financial performance is anticipated in this year while the organization incurs one-time expense and loss of productivity to train users and install the system. However, this will set the stage for realization of improved efficiencies and cost savings that will reduce the overall average cost. This improvement is reflected in Year 3 of the pro forma. This is an ideal time to select a new EMR because Medicare instituted a new prospective payment system – the Patient Driven Groupings Model (PDGM) in January. As the needs for success under this new payment system – which impacts over 70% of the combined revenue – an appropriate EMR can be selected.

Anticipated Administrative Cost Efficiencies: Because so much of the home health and hospice revenue is derived from Federal programs, there is significant administrative burden placed on these agencies. This has made it increasingly difficult for small agencies to survive because the high administrative cost burden cannot be recovered under the fixed payment contracts that exist. Combining these two organizations under one license and Medicare provider number will allow for some administrative economies of scale. This should occur in areas such as;

- Medicare survey readiness;
- Medicare cost reporting;
- Development and maintenance of policy and procedure manuals;
- Preparation and delivery of statistical reporting;
- Participation in Professional Advisory Committees;
- After hours call coverage;
- Accreditation fees;
- Professional and Trade Organization Membership fees;
- Computer Hardware and Software Licensure fees.

There also should be savings from coordination of office space utilization and associated utility costs; office equipment costs; and supply inventory management. CRVNA long term planning has identified the need for more space to support planned program growth and anticipates it will grow beyond its current facility capacity. CNHVNA currently has a surplus of space and by combining the aggregate facility use can be optimized allowing CRVNA to delay, or avoid altogether, the expense of acquiring more facility capacity.

Both CRVNA and CNHVNA have participated in performance benchmarking through the VNA Health System of Northern New England. One measure calculated is average cost per visit associated with overhead as opposed to direct clinical service related costs. For the past few years, CRVNA and CNHVNA have had similar direct costs per visit for both skilled nursing and physical therapy services (the two highest volume services in home care). However, CRVNA has an average overhead cost per visit that is less than half the amount of CNHVNA. This shows the impact that greater scale can have on overall cost per visit. The merger should allow the overhead cost per visit associated with CNHVNA historic volumes to reduce closer to the CRVNA level.

Staff Deployment: Creating a larger combined organization with a common EMR supporting a common service area should support enhanced geographic assignment of clinical resources. This can reduce the travel time between patients which

reduces mileage costs and the down time of a clinician engaged in non-patient care activity. Currently the travel time component of a home care visit represents 17%-24% of total visit time. Historically CNHVNA has had greater travel time than has CRVNA in part because of fewer patients and less resource depth. The goal post-merger would be to bring the CNHVNA portion of visit time associated with travel closer to the CRVNA level. More efficient scheduling of staff to cover a larger patient base within the geographic coverage area can reduce this cost and enhance the number of patients per day that can be served.

In aggregate, these various cost improvements should result in a lower overall average cost per visit or cost per episode and improved net margins. This will lead to an increase in the number of patients the combined organization can serve resulting in better patient access and outcomes.

Preservation of Non-Profit Mission Driven Community Organization

The proposed merger is important to ensuring a vibrant non-profit home health service can continue to serve the community. Nationally, for-profit organizations have increased their presence as health care delivery shifts to more of a home and community-based focus. NH has seen growth of organizations such as Compassus, Interim, Bayada, LHC Group, Amedisys, etc. While these organizations can offer quality services, they are driven by the profit motive and not by community service. They do not feature community voices in their governance structure. The VNAs have a long history of providing valuable services driven by community needs – some of which may conflict with maximization of profit. It is critical to preserve and strengthen the non-profit voice during this period of health care stress and consolidation. This merger will ensure ongoing governance input from Merrimack, Belknap, and Carroll County members in guiding the home care and hospice delivery to the communities served.

Respectfully Submitted,

Kevin C. Stone
Senior Consultant

MONTAGNE
COMMUNICATIONS

Concord Regional VNA / Central New Hampshire VNA & Hospice
Proposed Merger Virtual Public Listening Session – June 3, 2020
Question, Answer & Comment Transcript

Following is a transcript of the question, answer and comment portion of the virtual public listening session. The session was moderated by Martha Tecca, who managed the incoming questions and comments from attendees. This transcript does not include the introductions and presentation portions of the program, or the closing remarks. The full video recording of this session can be viewed at www.vnaforthefuturenh.com.

Michelline Dufort, Concord: We look forward to hearing from community members on this.

B.J. Entwisle, Canterbury (Capital Region Health Care Board): You talked about the two leaders figuring out the executive teams, leadership teams. What would the process be for figuring out the two executive teams and would there be full retention of jobs in both organizations?

Beth Slepian (CEO and President, Concord Regional VNA): We are committed to our workforce and we do not have plans to reduce our workforce. We both feel that we have very talented leadership and management teams and we are committed to making sure that the talent is utilized and retained to the best manner. I think that everybody will be pleased and relieved when they see the structure and the organization roll out.

Lee White: What do you both, as leaders, see as the cultures of your organizations? I think that is critical to the future of any merger.

Lisa Dupuis (President, Central NH VNA & Hospice): Looking at the culture of our two organizations, we feel that there are a lot of similarities in the cultures. Concord and Central have worked together over the years and are members of an organization where we come together and we do a lot of processes together, quality, IT, and work groups. We collaborate on a lot of levels already, our cultures are already well aligned for this type of arrangement.

Beth Slepian: I would also add that we are both very mission-driven, committed to the communities, and want to see both organizations come together so that we are sustainable and will continue to be able to serve the communities. We are aligned in how we deliver care in many respects, and our staff have worked together in the past. We feel through the board discussions and the board groups that a lot of the synergies have been identified already. We feel as though we can work on that and continue that.

Margaret Franckhauser, New Hampton (Former director of Central VNA): I fully understand the reason for a merger. I think this is a very challenging business in the world of health care and I think these are two wonderful organizations that have been working very closely together for a number of years, so I'm very much in support of the merger. How would a merger possibly benefit people in the community?

Lisa Dupuis: We really feel that as one organization, and being sustainable for the future coming together, that we have a lot to continue to offer the community. It would be sustainability as well as services. There are some differences in our services, and by coming together we would meld those services and they would be available to all of the communities that we both service, as one entity.

Beth Slepian: We are looking forward to bringing our community benefit programs for the community up into the lake's region. I think that is an asset that we bring, and we also do have some specialized clinical programs that the lakes region would also benefit from as we come together.

Donna Davey, Concord: I'd be concerned that opening up the Hospice House to the central area would mean that there will not be enough room to accommodate the Concord regional area, which keeps it at 96% capacity now.

Beth Slepian: I want to clarify the Hospice House and eligibility. Currently, we do have patients come from a large service area and are able to accept patients from central New Hampshire if they chose to come to the Hospice House for their care. So, we are not concerned about access. That is certainly something that we will continue to look at but our patients do come from outside our initial region as well. There are only two hospice houses in the state and so it is a benefit, really, to everybody. We will continue to look at and monitor access and ensure people can benefit from those services.

Rosemary Heard (President/CEO of Catch Housing): On the outset I would like to commend both organizations for pursuing a merger here. We are much stronger together and obviously see footprints of services greatly enhanced by this. We happen to have an incredible partnership with Concord Regional VNA on a program called PATHS, which is "Positive Aging through Home Supports." This is a pilot program that we have at our only age-restricted property. The impact of this has been incredible for our residents. I hope to see other programs like this throughout the new footprints together. It is something that is so valuable and can replicated in other places. I think that with a stronger new entity, perhaps that would be possible. How will this new entity be identified? Will lakes region still have its own name, or will there be a new entity for this going forward? Thank you all for the

work, I know that this is an enormous undertaking to get to where you are today, so thank you.

Beth Slepian: The name remains to be determined. We are extremely sensitive to the heritage and the history of both organizations. As we move forward over the next few months, we will understand greater how we can best represent the new entity both in name and how we create a brand in the new area.

Lisa Dupuis: We do not want to jump to a name, we want to really work on it together as the two entities come together and make it meaningful – both organizations have set that in our first step in moving together.

Lisa Gloddy, Franklin (Dartmouth-Hitchcock Concord Surgical Specialties Manager): How will the leveraging of resources help us with coverage for patients with post-operative care? As well as the ability for expansion for community-based clinics?

Beth Slepian: We feel that coming together will really allow us to better support the communities. What we are seeing in Concord is that many patients are coming to Concord Hospital for their care and we are receiving referrals to service an expanded area. We are challenged as everybody else is with the workforce, and by coming together we can really leverage our workforce and be efficient in making sure all of the programs can be brought into the surrounding area. We're eager to be partners, we're looking forward to that, but we do think that with the scale that the organization will create, that we will be able to better serve specialty clinics, the surgical needs, and can move forward with innovative programs.

Betsy Rinehart, Hopkinton (Concord Hospital): Thank you for the helpful overview. How will the community and New Hampshire as a whole benefit from the merger?

Beth Slepian: I think we are all well aware of the aging population in New Hampshire and we are dealing with a future that will require significant investments into population health and the infrastructure that will allow us to deliver care to people in their homes. It is not just the care though. It is the wellness programs and the community health education, and it is also the programming that we can put in place together to make sure that we can meet those needs. I think we could also be a model for New Hampshire as a whole in health care, where home health care and hospice can look towards the future in a positive way of coming together and being sustainable so that organizations can continue to provide the necessary care for the community. We know it's cost effective, we know people want to be at home, we hope that this sets an example for care across the state.

Lisa Dupuis: As a larger organization, we'll be able to better service the community and the rapid changing of the industry. There is a lot of other changes within the healthcare industry, there's regulatory changes, payment changes. As a stronger organization with more support and resources, we'll be able to make those changes to then be able to continue to be around long into the future.

Kevin Donovan (President/CEO of LRGHealthcare): Central VNA is an important partner to LRGH and to the entire lakes region. Expand upon how Central VNA and the joint communities will benefit from the transaction?

Lisa Dupuis: Together as one organization with a broader depth we'd be able to... People from the Lakes Region are leaving to go to get health care other places and we want to be here in the community for when they come back to their home and be able to get that care. And I think that this type of partnership will allow that.

Jessica Barker, North Sandwich: I'm moving to Laconia in June. What is the new name and what contact number should be used?

Lisa Dupuis: First, as we go through his process someone can always visit the website we are giving, www.VNAforthefuturenh.com. As we go through this process, updates, questions, answers, and comments, everything will be posted there so everyone has one place to go so they can see where we are in the process. At this point we are still two entities so if you need to reach out to one of us you can find us on the web, you can reach out to either one of us if you need services or if you have any questions, you can call either Central's main number or Concord's. To stay educated on where we are in the process the best thing to do is go to the website.

Jay Mullins, Hopkinton (CRVNA Board of Trustees): I believe this merger has a strong business rationale. As the delivery of care becomes more complex with ever-increasing technology and regulatory demand, this combined organization will be in a better position to meet these demands.

Margaret Pritchard (CEO of Lakes Region Mental Health Center): Could we or should we expect some of the programing with partners in the lakes region to expand? I think both organizations have worked hard to collaborate and integrate services. Can we expect more of the same with the new entity?

Beth Slepian: We are approaching this partnership as coming together for sustainability, we are not coming together as a growth opportunity. If that is the question, should we expect more expansion? That is not in our plan. Certainly not at the moment. We are committed,

both Lisa and I, to creating relationships both new and making sure the old relationships that both organizations have are well cared for and to understand what the opportunities are, and again move forward in how we deliver care. We know how we deliver care today is very different from how delivered care in February of this year, which we all can appreciate. So I think our first step is really to understand what the ongoing needs are and how can we best meet them while creating new opportunities.

Lee White: I am generally a very positive person, are there any disadvantages to this merger?

Lisa Dupuis: I have not come across any yet, to be honest. I am not saying there isn't something that exists. We have not come across that, but everyone we have talked to about it has been very positive, has said positive things – haven't come across anything negative at this point. We continue to remain in all three offices and we'll be continuing to serve all of the communities we service just in a stronger way. So I'm not sure I found any negative in that yet.

Beth Slepian: We don't think it's going to be easy. We know there will be challenges. We have found this to be a very positive experience between both boards, between both organizations and also the community support we have seen. I think our negative is *not* doing something and really taking the future and doing this in positions of strength not in a position that we need to. I think there are absolutely more positives, although, like I've said, we don't expect it to be easy.

Rosemary Heard: Going back to one of Lee's earlier comments about culture and corporate culture as it relates to a merger. Having been through three mergers in the private sector and one merge function in the nonprofit sector, one of the things that we found incredibly valuable, albeit that we thought we had two cultures that would naturally come together when we really got down to brass tacks we found that that was not necessarily the case, and so we brought in a corporate phycologist to work with the two groups. We found that it was incredibly valuable, money really well spent, and I think that's the one area in which mergers do fail and are challenged going forward, because one group or another changes them some way. So, if there is money in your budget to consider doing that, I would highly recommend that moving forward. I think it's a great way to give everyone a voice at the table and dispel any myths and get everybody rowing in the same direction.

Brian Winslow (Central VNA): I want to comment on Lee White's question about disadvantages. In all my discussions with supporters and community members, there hasn't been really anyone talking about the disadvantages, except for the disadvantages if this doesn't happen. I wanted to point out that out, that there are certainly disadvantages if this

doesn't happen for both agencies, and even if we start and can't finish there are disadvantages. When it comes to actually accomplishing this there are no real disadvantages that I've identified.

Melissa Reep (CRVNA): How will this change my day-to-day work life? I have a hard time imagining how this will affect me.

Beth Slepian: I think you will continue to deliver care in the manner in which you always have. I would not expect that your day-to-day life will be changed. Certainly, there will be opportunities in this, we would like to bring our certified services into the central New Hampshire and catchment area, and I think it will create opportunities for our employees and Central NH's employees for growth and development. But in day-to-day work life, you're caring for the community and we would not expect that to change.

B.J. Entwisle: I was part of an organization once where the boards couldn't get along. It was a big merger and so it's a similar question about the two boards of the organization. It's easy to think the two parts of New Hampshire are very different, but probably are not as different as we think, and I loved Rosemary's comment about get some help if you need it because it helps to keep talking and take advantage of what sounds like a terrific opportunity. My questions is about the two boards, as opposed to the institution themselves.

Melvin Severance (Chair, CRVNA Board of Trustees): The boards have worked together now for several months in terms of discussion about what will be the normal operational elements, technology. We've spent a great deal of time together talking about the people in the community and the people in the organizations. One of our main concerns, originally, was that we wanted to do this with doing no harm to anybody or any program, and we spent a great deal of time at the board level making sure of that. We have been unbelievably lucky to have Beth, Lisa, and a great board from Central to work with and have a discussion, although we could probably use all the psychological help on the planet. But part of that, if we get that opportunity it would probably be great, but at this point, we've been comfortable working with each other and we're coming down to working on branding, and we'll see how that goes but everybody has really seen value in this process.

Kristen Gardiner (President, Central NH VNA & Hospice Board of Trustees): I think the boards do have very similar missions and both boards are very committed to this project. We have anticipated and talked about some issues and we've done a great job at giving each board their say and their ability to provide input. We're not being swallowed up, Central is not going to be swallowed up by Concord. I feel that they've been really receptive to us and I think we've worked really well together.

Christopher Parkinson (Former CRVNA Trustee): Could you address competitive aspects of Lakes Region Visiting Nurse Association? My understanding is that the Lakes Region Visiting Nurse Association has grown quite a bit in the last couple of years. Will they be a threat to us in the lakes region? How will we compete against them? What differentiates us versus them?

Beth Slepian: Both of our organizations have really focused on the strength of what we bring. Our strength and ability to be successful in the region is to bring high quality care and programing to the lakes region. Through our partnerships with referral sources and talented staff, I think we will be able to do that. One thing that does differentiate Concord at the moment, and hopefully together, are the community benefits that we bring to the regions we serve. I think that really does differentiate us from many of our colleagues and competitors and we will continue to be committed to that. Certainly, we deal with competitors all the time, both in the for-profit and nonprofit world. We have to deliver the best care and understand our communities. I think our commitment will lead us forward. This is about being stronger together from positions of strength, not a growth transaction. As we move forward and create those relationships, I think we will be identified as the leader of care in the community.

Lisa Dupuis: Competition is good. It's not a bad thing to have competition. It keeps you on your toes and there's a lot of positive things to having competition.

Susan Houghton, Alton Bay (Central VNA): Many of the towns on both sides of the lake are rural and/or summer resort communities, how will this area be incorporated into a new, larger "big city" VNA?

Beth Slepian: Our service area includes very rural areas both in Washington and Hillsboro, so although we do service Concord, we do consider ourselves as serving the rural community. These are things that we need to work together to understand our community, but it is important that our care will remain local. We have the same staff that are living in the communities we're serving, so the care will still be delivered. We hope as we come together, and develop our culture together, that we learn to appreciate the differences and address those in our programing. So it's an opportunity for us to be able to come together in that manner, but I would say that our staff at Concord, who were in Washington today, would not feel that they are working in the city, but that they are treating rural New Hampshire. Just to give you also an understanding, our staff last year traveled 1.5 million miles to care for our community. So if we were caring in a city environment, I would not expect us to cover that much ground.

Lisa Dupuis: Our staff are remaining and will continue to be in those communities. It's not that Concord staff is going to come up and work in Wolfeboro or Ossipee - the workers that are living in those areas are going to continue to service those patients and the cultures of those communities will remain.

Rosemary Heard: I live down the street from Jessica Barker in Sandwich, New Hampshire, be it that I run an organization in Concord, so I'm very familiar with the lakes region and the challenges up here. We are seasonal communities and residence have been slow. So, I wonder if it's appropriate to say that this merger will also help with some of that ebb and flow we see from summer to winter. We're a very aging community up here so I would think that this would also bring some stability to the lakes region because of that. Working together may really help in that instance as well.

Beth Slepian: We too have gaps in our staffing and we see the advantages of not overlapping but sharing those staff to serve the community.

Jessica Barker: Who proposed this merger, did Concord Regional VNA approach Central or vice versa?

Lisa **Dupuis:** Beth and I are colleagues, we sit together on a lot of different organizations and the Alliance, and earlier we had mentioned that we do things together. We started having a conversation, what if? It was a mutual discussion, as challenges are happening and as we had a major change in the way we're reimbursed in January of 2020. We talked about if we were to become one organization, what would that look like and how would that work? So, it was a mutual coming together.

Norma and Ron Daviault, Allenstown: What effects would it have on coverage?

(Asked via moderator, already covered)

Susan Houghton: The Central New Hampshire VNA currently has a community presence in Laconia and in Wolfeboro and addresses the specific needs and reflects the cultures of those two very different communities. How will this be affected by a merger with a much larger VNA that is focused on the capital region? Will the merger bring a culture shift? Will the service stay the same or improve, in what ways can we expect?

(Asked via moderator, already covered)

Kristen Hayes, Concord: Will there be any changes in employee positions?

(Asked via moderator, already covered)

Rosemary Heard: Timing moving forward, where do you see the next steps and the timing of a formal kind of operating merger going forward?

Lisa Dupuis: We're right now working on the definitive agreement. Your comments and feedback are a part of that. Once the definitive agreement has worked out, the two boards would vote on that in order to move forward on filing the change of control notice with the State of New Hampshire, and are anticipating that to be about mid- July. At that point, the Division of Charitable Trust will do their due diligence and will have to make any modifications that may be brought up with that due diligence. Once that is done, we're anticipating, if all goes smoothly, to become one organization by the end of this calendar year.

Mark Lavalle, Bow (Former CRVNA Trustee): I've learned a lot listening. However, I do have a specific question. What does CRVNA get out of this merger?

Beth Slepian: I think that we all are working in the changing environment and the assumption that a large organization is sustainable for the long haul would be a mistake for us. As we look towards being around for another 120 years, we feel that this coming together would support our staff, provide opportunities for growth and development for both organizations. It will fill staffing gaps. I think we all see that in the work environment that we're in, with nursing shortages and others. In the world of the COVID pandemic, which nobody asked us about, being a larger organization and having different communities served, would've actually helped support our workforce because we each have different challenges in that realm. We want to be able to support our partners as care is being delivered in the community. We really feel that by moving and being able to expand our community health programs and community benefits, we'll really be creating a positive and healthy environment for New Hampshire and for the central and capital region, lakes region, and really fulfilling our mission and being able to continue the work that we are doing. We feel that we will be getting a lot out of it.

Corrine Smith, Wolfeboro: Without infringing on other agencies and their territories, will the merger present opportunities to expand the patient catchment areas?

Lisa Dupuis: At this point it's not a merger for growth, it's really to come together for sustainability and for increased services to the communities we currently service. At this point it's not looked to increase our catchment area.

Christopher Parkinson: I think it's an excellent opportunity, totally supported Beth's comment that it isn't for growth and it make me wonder a bit. I think if things are done right, growth should follow. As I noted, I'm totally in support of it. Make sure communication is kept up, as this is often the area that creates problems. Keep your staffs informed about what's going on.

Beth Slepian: I think we are trying to keep our scope in check and understand really what the needs are in the community. I think that growth sometime becomes a natural extension of good work but as we said, we are approaching this as better way to serve our current communities and looking toward the future and what opportunities will hold.

Jessica Barker: Will the employee benefits be merged and health insurance change? If both organizations have different health insurance providers, which provider will be chosen for the newly merged organization?

Beth Slepian: That's all work that is done as the entities come together. We will ultimately be one organization, which would lend itself to one employee benefit package and pay scale. We can't speak to where that would be, that's all the work that comes after the definitive agreement occurs and we can begin looking at integrating the organizations.

Mary DeVries (Wolfeboro Area Chamber of Commerce Executive Director): All the best to you with moving forward with this significant merger.

Mark Lavalle: As to bylaws of the new entity, will former board members with expired term limits be able to be considered for board positions in the future?

Lisa Dupuis: As a part of this whole process and the definitive agreement is to come up with new bylaws for the new entity. They are not final yet so I don't necessarily have that answer, it could be possible.

Margaret Franckhauser: I've heard a lot of comments to you about the importance of being community responsive. What I'd like to share is that I've had an opportunity to live outside New England for several years now. In most of this country, home care and hospice are provided by for-profit providers. They may be very good providers but their commitment at the end of the day is not to communities. This is a strengthening of the nonprofit resource in the state of New Hampshire in home care, and that is a gift of enormous proportions. A very strong nonprofit network helps to assure the community needs are the primary reason that the organization exists. I think that a merger of the two that helps to strengthen that nonprofit network is absolutely critical, and will continue to provide community responsive services that would not be provided were it not a nonprofit.

The following is provided for informational purposes only. This certification must be signed and filed with the Change of Control Notice only if, and after, the Board approves the Merger Agreement. Each of the numbered paragraphs paraphrase the statutory requirements of RSA 7:19-b (the Change of Control law). It is intended to guide your evaluation of the proposed Merger Agreement. An execution version will be circulated after the Board meeting if the Board approves the merger.

CENTRAL NEW HAMPSHIRE VNA & HOSPICE
BOARD OF TRUSTEES

RSA 7:19-b (II) Standards Certification

We, the members of the Board of Trustees of **Central New Hampshire VNA & Hospice** ("**CNHVNAH**"), certify to the New Hampshire Director of Charitable Trusts that in approving the terms of the Merger Agreement (the "**Transaction**") between **CNHVNAH** and **Concord Regional Visiting Nurse Association, Inc.**, we have considered in good faith and complied with all of the requirements of New Hampshire RSA 7:19-b (II), which statutory requirements are itemized as follows:

1. We have determined, upon advice of our legal counsel, that the proposed Transaction is permitted by applicable law, including, but not limited to, RSA 7:19-32, RSA 292, and other applicable statutes and common law.

2. Due diligence has been exercised in structuring the Transaction, in engaging and considering the advice of expert assistance, in negotiating the terms and conditions of the proposed Transaction, and in determining that the Transaction is in the best interest of CNHVNAH and the communities which it serves, including the communities' need for access to quality and affordable physical and mental health care services.

3. Any conflict of interest has been disclosed and has not affected the decision to enter into the Transaction, and the Transaction does not constitute or establish any pecuniary benefit transaction as defined in RSA Chapter 7.

4. No proceeds or other consideration will be paid or received in connection with the Transaction.

5. The assets of CNHVNAH will continue to be devoted to charitable purposes consistent with the charitable objects and mission of CNHVNAH and the needs of the communities which it serves, including the communities' need for access to quality and affordable physical and mental health care services.

6. Each of the parties to the Transaction is a New Hampshire health care charitable trust.

7. Reasonable notice of the proposed Transaction and its terms has been provided to the communities served by CNHVNAH, including but not limited to transaction documents and an analysis of how the Transaction will meet the communities' need for access to quality and affordable physical and mental health care services, along with reasonable and timely opportunity for such communities to inform our deliberations regarding the proposed Transaction through well-noticed public meetings and other similar methods, and we have considered carefully all public testimony and input during our deliberations to approve the Merger Agreement.

The following are all of the currently qualified and elected Trustees of Central New Hampshire VNA & Hospice and have signed this Certification effective as of _____ __, 2020. This Certification may be signed in counterparts. ***[separate signature pages will be sent so it can be signed in counterparts]***

TRUSTEE NAME: SIGNATURE:

_____ _____

CENTRAL NEW HAMPSHIRE VNA & HOSPICE
BOARD OF TRUSTEES

PROPOSED RESOLUTIONS

July 1, 2020

WHEREAS, in recognition of the regulatory and economic pressures on the delivery of home health, hospice and community-based care services, the ongoing reforms in health care reimbursement and the renewed emphasis on population health, the challenges of recruiting and retaining qualified health care providers in rural areas, and the increasing need of the aging population in its service area for access to quality home health, hospice and community-based care services, the Board of Trustees of Central New Hampshire VNA & Hospice (the "Corporation") determined that a long-term affiliation providing clinical integration, economies of scale and enhanced access to quality care for its patients would be in the best interest of the Corporation and in furtherance its charitable mission; and

WHEREAS, the Corporation identified Concord Regional VNA ("CRVNA"), a New Hampshire health care charitable trust, as the most suitable institution with which the Corporation could affiliate given the history of successful collaboration between the Corporation and CRVNA, the compatibility of their charitable missions, the contiguity of their service areas, and their shared vision of an integrated and strong regional health provider committed to meeting the home health, hospice and community-based care needs of local communities through quality, value-based care; and

WHEREAS, the chief executive officers, Board chairs and Trustee representatives of each of the Corporation and CRVNA formed a joint Trustee Workgroup facilitated by a health care consultant to evaluate the nature and potential advantages and disadvantages of an affiliation between the two organizations; and

WHEREAS, as a result of the diligence and recommendations of the joint Trustee Workgroup and with the assistance of legal counsel, the Corporation has negotiated the terms

and conditions of a merger agreement with CRVNA (the "Merger Agreement") under which the Corporation will be merged into CRVNA to form a single, consolidated entity; and

WHEREAS, with the assistance of legal counsel and health industry and financial advisors, the Corporation has conducted preliminary due diligence of CRVNA, the results of which have been presented and are satisfactory to the Board of Trustees; and

WHEREAS, the Corporation and CRVNA established a joint web site dedicated to informing the public about the nature of the proposed transaction and the manner in which it will promote access to quality home health, hospice and community-based care, and conducted a noticed public informational session to receive public input, all of which has informed the Board of Trustees' deliberations; and

WHEREAS, the Corporation's Board of Trustees desires to approve the Merger Agreement and commence the necessary regulatory filings;

THEREFORE, the Board of Trustees of the Corporation adopts the following resolutions:

VOTED: That a merger with CRVNA in accordance with the terms of the Merger Agreement is in the best interest of the Corporation and in furtherance of its charitable mission, including without limitation the promotion of access to quality physical and mental home health, hospice and community-based care services; and

FURTHER VOTED: That the Merger Agreement in the form presented to the Board of Trustees is approved and accepted; and

FURTHER VOTED: That the Corporation promptly commence the preparation and filing of all regulatory notices and applications required by law, and the fulfillment of any condition to the Merger Agreement within the Corporation's control; and

FURTHER VOTED: That the Corporation's Trustees serving on the joint Trustee Workgroup and the Corporation's CEO, in collaboration with the CRVNA representatives on the joint Trustee Workgroup, (i) develop, evaluate and propose revisions to the CRVNA articles of agreement and bylaws to become effective when the merger

is consummated (the "Governance Revisions"), (ii) nominate individuals to serve as representatives of the Corporation on the board of trustees of the combined entity following the merger (the "Board Nominees"), and (iii) propose a slate of individuals to serve as officers of the combined entity board following the merger (the "Officer Nominees"), which Governance Revisions, Board Nominees and Officer Nominees will be submitted to the Corporation's Board for approval prior to the consummation of the merger; and

FURTHER VOTED: That each of the Chair of the Board of Trustees and the President and CEO of the Corporation, acting individually on behalf of the Corporation, is authorized to execute and deliver the Merger Agreement, regulatory filings, and such other documentation, and take such actions, as are necessary or desirable, in her sole discretion, to effect the foregoing resolutions.

APPENDIX W
Minutes of July 1, 2020 Central VNA Board of Trustees
Meeting (approving Merger Agreement)

Minutes
Board of Trustees
July 1, 2020 5:30 pm

Location: ZOOM Meeting

Present:

Lisa Dupuis, Kristen Gardiner, Brian Winslow, David Huot, Susan Houghton, Mark Edelstein, Andrew Livernois, Joel Arsenault, Corrine Smith, Kristin Snow.

By Phone: Robin Michaud

Excused: David Emberley, Connie Turner, Cecile Chase

Guest: Mark McCue

The meeting was called to order by Kristen Gardiner

Approval of Minutes

Kristen Gardiner opened the meeting with a request to approve the meeting minutes.

M/ Andrew Livernois S/ Mark Edelstein

Approval of Board Designated Funds for Merger

{REDACTED}

Presentation of the Legal Due Diligence by Mark McCue

- Mark McCue presented the Legal Due Diligence. Mark reminded the board of their roles and duties
    - Fiduciary Roles
        - Obedience to the Mission
        - Stewardship OF Charitable Assets
    - Fiduciary Duties
        - Duty of Care
        - Duty of Loyalty
    - Mark McCue noted that the Board has been successful in fulfilling their roles and duties.
    - Mark McCue notes that there are no areas of concern to move forward with the merger.

Q/A

Q. Kristen Gardiner asked when we should approach Capital Region Health.

A. Mark McCue's recommendation is that when both boards have voted on the merger agreement, and have signed, then get approval from Capital Region Health.

Q. Mark Edelstein asked how many years back were reviewed in regards to the financial condition of CRVNA?

A. Mark McCue noted that they reviewed 3 years of financials.

Q. Andrew Livernois asked how does CRNVA's financial health compares to Central's?

A. Lisa Dupuis noted we were a break even last year and this year was a profit. CRVNA has revised their budget to be a break even. Lisa noted the loss CRVNA exhibited last year was due to a change to the State's Retirement Plan to a MyNexxus Payor who has proven to provide denials and low reimbursement.

Q. Kristen Gardiner asked if the future Anthem Managed Care anticipated cuts were included in the budget projections.

A. Lisa Dupuis noted yes.

Q. Corrine Smith asked how we planned to handle two EMR's

A. Lisa Dupuis stated we will go onto one eventually but will close first and will chose an EMR within the first 24 months.

- Kristen Gardiner noted that Kevin Stone did a great job at outlining the benefits for both agencies to join.

- **Lisa reviewed the Proforma (beginning page 47 of board packet):**

Q. Did anyone from our organizations review these numbers?

A. Lisa Dupuis noted that Gerry from CRVNA was on the calls, did the final review, and will continue to review these numbers. Mel, their board chair, had also reviewed. His concerns was that the EMR numbers were low. HCHB confirmed that a move to HCHB would be about 2million. He was also concerned about salaries and Concord's board would like to do more review around salaries to ensure they are competitive.

Q. Question regarding David Emberley's status with the merged organization.

A. Lisa Dupuis noted that David would remain in his position while under two EMRs in the first two years. Once the conversion happens, it is proposed we would go to one CFO.

Q. Andrew Livernois expressed concerns that we are a profitable agency running in the black and are joining with an agency that has shown a loss with a hospice house that is

also a loss entity. Andrew would like reassurance that we are not subsidizing CRVNA, understanding that we will gain the volume and the market share.

A. Lisa Dupuis notes that we have been losing money in HH and making it up in Hospice. Our volume is going down in regards to referrals to Concord. We are flat currently for growth. Managed Care has also taken a percentage of our Medicare market share and that pattern continues to grow.

Brian Winslow noted that Concord is addressing their loss and planning a break-even budget. If we do not merge, there will be a 2 – 3 year shrinkage in our numbers. The results of the Performa are the EMR costs and productivity loss.

Mark McCue notes in their diligence packet, there were strategic items in Concord's plan, which included growth in our service area. The benefit to Concord is a make or buy decision; merge with an established compatible partner or compete with us. If we did not go through with this, we would be faced with significant competition from an agency significantly larger than us, with the resources to move forward.

Kristen G noted that Central has struggled with retention and we are not able to simply increase revenue per visit/period, yet have to be competitive with benefits to keep staff from leaving. With the merger, we gain economies of scale and a better package for our existing employees (salaries, benefits, training etc.).

- **Lisa presented the Merger Agreement (pages 80 of the board packet)**

  Kristen did overview as a member of the joint trustee committee and a seat holder on the committee for the prospective merger agreement.

  - Concord is a well-run organization
  - We are a well-run organization with respect to the payment structure
  - Overriding sense is we both have a compatible mission and wish to continue services in our effected communities.
  - There is respect for each heritage and background, making sure we had a place on the board and for the executive officers.
  - Integration of Operations to represent cost savings in the future and expand service.
  - Guiding principle, commitment to community with quality, effect and efficient services.
  - A two year process of integration and eventually we will be one entity and our fiduciary duties will be to the one entity.
  - The trustee work group will work on the name, mission bylaws, and articles of agreement.
  - We are aiming for a closing by December 31, 2020.

- Combined board will be a 21-member board (7 Central and 14 Concord). CEO will be a member of the board non-voting. Kristen and Mel will serve as ex-officio in addition to the 21 and will have voting rights for the first two-year period.
- Supermajority (3/4 of members must agree)
    - Capital expense over 100,000
    - Material changes to programs
    - Office locations
    - Corporate reorganization
    - Dissolution
    - Amendment to governing documents
  - Supermajority during integration period
    - Hiring and termination of CEO
    - Budgets
    - Endowment and investment policies
  - Funds raised by that community will be used in those communities.

Andrew L Livernois noted it was a terrific agreement and thought it was well done.

Kristin Snow noted that the 21 members seems to be a large number for a board. Kristen G noted that there are plans to put together a range for a member number in the bylaws. Opportunity to slim the Board exists as Concord currently has committee members as board members that may be modified in the future.

Approval of the Definitive Agreement for Merger

Note: not voting on certification to charitable trust; but on the Proposed Resolutions, Dated July 1 2020 which is a 3 page document beginning with "Whereas, in recognition…"

- Adopting the following resolution that the merger is in the best interest of agency
- Merger agreement in our packet is approved and accepted
- Agency is directed to file the necessary regulatory filings
- Joint trustee workgroups are authorized to develop bylaws, nominate officers for the board of trustees, and authorize CEO and president to execute all necessary paperwork to commensurate the merger.

M/ David Huot S/ Andrew Livernois

Further discussion: Robin Michaud joined by phone – notes she is in full agreement.

Kristen Gardiner noted we have nine of the eleven Board members (excused are Connie and Cecile).

Roll call Vote:

David Huot- Yes

Susan Houghton- Yes

Mark Edelstein- Yes

Andrew Livernois- Yes

Joel Arsenault- Yes

Corrine Smith- Yes

Kristin Snow- Yes

Robin Michaud- Yes

Kristen Gardner- Yes

Mark McCue notes next steps are preparing the regulatory filing. However, one of the orders for COVID 19 is to suspend regulatory changes while the State of Emergency order is in effect. The state of emergency order will not be lifted thru the fall. Tom Donavan plans to talk to the Governor requesting to resume public hearings in a modified version. Once we file they have 180 days and will not start until the Governor changes the order.

New Business:

A. Next meeting Location: Virtual
B. Next Meeting Date: July 22, 2020 at 5PM

Committee/ Task Force Reports

A. Property Committee

- In the Laconia office, the smoke detectors have been installed; bollards are in, and electricians are currently working on doors and lighting. We only have windows left to address.

Motion to Adjourn

M/ David Huot S/ Corrine Smith

Submitted by: Lori Nash

CENTRAL NEW HAMPSHIRE VNA & HOSPICE
BOARD OF TRUSTEES

PROPOSED RESOLUTIONS

July 1, 2020

WHEREAS, in recognition of the regulatory and economic pressures on the delivery of home health, hospice and community-based care services, the ongoing reforms in health care reimbursement and the renewed emphasis on population health, the challenges of recruiting and retaining qualified health care providers in rural areas, and the increasing need of the aging population in its service area for access to quality home health, hospice and community-based care services, the Board of Trustees of Central New Hampshire VNA & Hospice (the "Corporation") determined that a long-term affiliation providing clinical integration, economies of scale and enhanced access to quality care for its patients would be in the best interest of the Corporation and in furtherance its charitable mission; and

WHEREAS, the Corporation identified Concord Regional VNA ("CRVNA"), a New Hampshire health care charitable trust, as the most suitable institution with which the Corporation could affiliate given the history of successful collaboration between the Corporation and CRVNA, the compatibility of their charitable missions, the contiguity of their service areas, and their shared vision of an integrated and strong regional health provider committed to meeting the home health, hospice and community-based care needs of local communities through quality, value-based care; and

WHEREAS, the chief executive officers, Board chairs and Trustee representatives of each of the Corporation and CRVNA formed a joint Trustee Workgroup facilitated by a health care consultant to evaluate the nature and potential advantages and disadvantages of an affiliation between the two organizations; and

WHEREAS, as a result of the diligence and recommendations of the joint Trustee Workgroup and with the assistance of legal counsel, the Corporation has negotiated the terms

and conditions of a merger agreement with CRVNA (the "Merger Agreement") under which the Corporation will be merged into CRVNA to form a single, consolidated entity; and

WHEREAS, with the assistance of legal counsel and health industry and financial advisors, the Corporation has conducted preliminary due diligence of CRVNA, the results of which have been presented and are satisfactory to the Board of Trustees; and

WHEREAS, the Corporation and CRVNA established a joint web site dedicated to informing the public about the nature of the proposed transaction and the manner in which it will promote access to quality home health, hospice and community-based care, and conducted a noticed public informational session to receive public input, all of which has informed the Board of Trustees' deliberations; and

WHEREAS, the Corporation's Board of Trustees desires to approve the Merger Agreement and commence the necessary regulatory filings;

THEREFORE, the Board of Trustees of the Corporation adopts the following resolutions:

VOTED: That a merger with CRVNA in accordance with the terms of the Merger Agreement is in the best interest of the Corporation and in furtherance of its charitable mission, including without limitation the promotion of access to quality physical and mental home health, hospice and community-based care services; and

FURTHER VOTED: That the Merger Agreement in the form presented to the Board of Trustees is approved and accepted; and

FURTHER VOTED: That the Corporation promptly commence the preparation and filing of all regulatory notices and applications required by law, and the fulfillment of any condition to the Merger Agreement within the Corporation's control; and

FURTHER VOTED: That the Corporation's Trustees serving on the joint Trustee Workgroup and the Corporation's CEO, in collaboration with the CRVNA representatives on the joint Trustee Workgroup, (i) develop, evaluate and propose revisions to the CRVNA articles of agreement and bylaws to become effective when the merger

is consummated (the "Governance Revisions"), (ii) nominate individuals to serve as representatives of the Corporation on the board of trustees of the combined entity following the merger (the "Board Nominees"), and (iii) propose a slate of individuals to serve as officers of the combined entity board following the merger (the "Officer Nominees"), which Governance Revisions, Board Nominees and Officer Nominees will be submitted to the Corporation's Board for approval prior to the consummation of the merger; and

FURTHER VOTED: That each of the Chair of the Board of Trustees and the President and CEO of the Corporation, acting individually on behalf of the Corporation, is authorized to execute and deliver the Merger Agreement, regulatory filings, and such other documentation, and take such actions, as are necessary or desirable, in her sole discretion, to effect the foregoing resolutions.

APPENDIX X
Certification of Central VNA Trustees Regarding RSA 7:19-b(II) Standards

CENTRAL NEW HAMPSHIRE VNA & HOSPICE
BOARD OF TRUSTEES

RSA 7:19-b (II) Standards Certification

We, the members of the Board of Trustees of **Central New Hampshire VNA & Hospice** ("**CNHVNAH**"), certify to the New Hampshire Director of Charitable Trusts that in approving the terms of the Merger Agreement (the "**Transaction**") between **CNHVNAH** and **Concord Regional Visiting Nurse Association, Inc.** ("**CRVNA**"), we have considered in good faith and complied with all of the requirements of New Hampshire RSA 7:19-b (II), which statutory requirements are itemized as follows:

1. We have determined, upon advice of our legal counsel, that the proposed Transaction is permitted by applicable law, including, but not limited to, RSA 7:19-32, RSA 292, and other applicable statutes and common law.

2. Due diligence has been exercised in selecting CRVNA as the other party to the Transaction, structuring the Transaction, in engaging and considering the advice of expert assistance, in negotiating the terms and conditions of the proposed Transaction, and in determining that the Transaction is in the best interest of CNHVNAH and the communities which it serves, including the communities' need for access to quality and affordable physical and mental health care services.

3. Any conflict of interest has been disclosed and has not affected the decision to enter into the Transaction, and the Transaction does not constitute or establish any pecuniary benefit transaction as defined in RSA Chapter 7.

4. No proceeds or other consideration will be paid or received in connection with the Transaction.

5. The assets of CNHVNAH will continue to be devoted to charitable purposes consistent with the charitable objects and mission of CNHVNAH and the needs of the communities which it serves, including the communities' need for access to quality and affordable physical and mental health care services.

6. Each of the parties to the Transaction is a New Hampshire health care charitable trust.

7. Reasonable notice of the proposed Transaction and its terms has been provided to the communities served by CNHVNAH, including but not limited to transaction documents and an analysis of how the Transaction will meet the communities' need for access to quality and affordable physical and mental health care services, along with reasonable and timely opportunity for such communities to inform our deliberations regarding the proposed Transaction through well-noticed public meetings and other similar methods, and we have considered carefully all public testimony and input during our deliberations to approve the Merger Agreement.

[Signature Page to Follow]

The following are the qualified and elected Trustees of Central New Hampshire VNA & Hospice who approved the Transaction, and have signed this Certification effective as of July 15, 2020. This Certification may be signed in counterparts.

Signed: _____

[Please print name]: Joel Arsenault

CENTRAL NEW HAMPSHIRE VNA & HOSPICE
BOARD OF TRUSTEES

RSA 7:19-b (II) Standards Certification

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1. We have determined, upon advice of our legal counsel, that the proposed Transaction is permitted by applicable law, including, but not limited to, RSA 7:19-32, RSA 292, and other applicable statutes and common law.

2. Due diligence has been exercised in selecting CRVNA as the other party to the Transaction, structuring the Transaction, in engaging and considering the advice of expert assistance, in negotiating the terms and conditions of the proposed Transaction, and in determining that the Transaction is in the best interest of CNHVNAH and the communities which it serves, including the communities' need for access to quality and affordable physical and mental health care services.

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[Signature Page to Follow]

The following are the qualified and elected Trustees of Central New Hampshire VNA & Hospice who approved the Transaction, and have signed this Certification effective as of July 15, 2020. This Certification may be signed in counterparts.

Signed: _____

[Please print name]: _____Susan F. Houghton_____

CENTRAL NEW HAMPSHIRE VNA & HOSPICE
BOARD OF TRUSTEES

RSA 7:19-b (II) Standards Certification

We, the members of the Board of Trustees of **Central New Hampshire VNA & Hospice** ("**CNHVNAH**"), certify to the New Hampshire Director of Charitable Trusts that in approving the terms of the Merger Agreement (the "**Transaction**") between **CNHVNAH** and **Concord Regional Visiting Nurse Association, Inc. ("CRVNA")**, we have considered in good faith and complied with all of the requirements of New Hampshire RSA 7:19-b (II), which statutory requirements are itemized as follows:

1. We have determined, upon advice of our legal counsel, that the proposed Transaction is permitted by applicable law, including, but not limited to, RSA 7:19-32, RSA 292, and other applicable statutes and common law.

2. Due diligence has been exercised in selecting CRVNA as the other party to the Transaction, structuring the Transaction, in engaging and considering the advice of expert assistance, in negotiating the terms and conditions of the proposed Transaction, and in determining that the Transaction is in the best interest of CNHVNAH and the communities which it serves, including the communities' need for access to quality and affordable physical and mental health care services.

3. Any conflict of interest has been disclosed and has not affected the decision to enter into the Transaction, and the Transaction does not constitute or establish any pecuniary benefit transaction as defined in RSA Chapter 7.

4. No proceeds or other consideration will be paid or received in connection with the Transaction.

5. The assets of CNHVNAH will continue to be devoted to charitable purposes consistent with the charitable objects and mission of CNHVNAH and the needs of the communities which it serves, including the communities' need for access to quality and affordable physical and mental health care services.

6. Each of the parties to the Transaction is a New Hampshire health care charitable trust.

7. Reasonable notice of the proposed Transaction and its terms has been provided to the communities served by CNHVNAH, including but not limited to transaction documents and an analysis of how the Transaction will meet the communities' need for access to quality and affordable physical and mental health care services, along with reasonable and timely opportunity for such communities to inform our deliberations regarding the proposed Transaction through well-noticed public meetings and other similar methods, and we have considered carefully all public testimony and input during our deliberations to approve the Merger Agreement.

[Signature Page to Follow]

The following are the qualified and elected Trustees of Central New Hampshire VNA & Hospice who approved the Transaction, and have signed this Certification effective as of July 15, 2020. This Certification may be signed in counterparts.

Signed: 

[Please print name]: Andrew B. Livernois

CENTRAL NEW HAMPSHIRE VNA & HOSPICE
BOARD OF TRUSTEES

RSA 7:19-b (II) Standards Certification

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[Signature Page to Follow]

The following are the qualified and elected Trustees of Central New Hampshire VNA & Hospice who approved the Transaction, and have signed this Certification effective as of July 15, 2020. This Certification may be signed in counterparts.

Robin C. Michaud

Signed:

_____

[Please print name]: Robin C. Michaud

CENTRAL NEW HAMPSHIRE VNA & HOSPICE
BOARD OF TRUSTEES

RSA 7:19-b (II) Standards Certification

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The following are the qualified and elected Trustees of Central New Hampshire VNA & Hospice who approved the Transaction, and have signed this Certification effective as of July 15, 2020. This Certification may be signed in counterparts.

Signed: _____

[Please print name]: J. Kristen Gardiner

The following are the qualified and elected Trustees of Central New Hampshire VNA & Hospice who approved the Transaction, and have signed this Certification effective as of July 15, 2020. This Certification may be signed in counterparts.

Signed: Mark G Edelstein

[Please print name]: Mark G. Edelstein

CENTRAL NEW HAMPSHIRE VNA & HOSPICE
BOARD OF TRUSTEES

RSA 7:19-b (II) Standards Certification

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[Signature Page to Follow]

The following are the qualified and elected Trustees of Central New Hampshire VNA & Hospice who approved the Transaction, and have signed this Certification effective as of July 15, 2020. This Certification may be signed in counterparts.

Signed: Kristin K. Snow

[Please print name]: KRISTIN K. SNOW

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CENTRAL NEW HAMPSHIRE VNA & HOSPICE
BOARD OF TRUSTEES

RSA 7:19-b (II) Standards Certification

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[Signature Page to Follow]

The following are the qualified and elected Trustees of Central New Hampshire VNA & Hospice who approved the Transaction, and have signed this Certification effective as of July 15, 2020. This Certification may be signed in counterparts.

Signed: _____ 7/20/21

[Please print name]: David G. Huot

1" = "1" "59906684 v4" "" 59906684 v4

The following are the qualified and elected Trustees of Central New Hampshire VNA & Hospice who approved the Transaction, and have signed this Certification effective as of July 15, 2020. This Certification may be signed in counterparts.

Signed: Corrine Smith

[Please print name]: Corrine Smith

APPENDIX Y
Statement of Concord VNA Regarding Furtherance Of Central VNA Mission Post-Merger

RSA 7:19-b (III) STATEMENT OF CONTINUATION OF CHARITABLE PURPOSE
Concord Regional Visiting Nurse Association, Inc.

Concord Regional Visiting Nurse Association, Inc. ("CRVNA"), a New Hampshire voluntary corporation and party to the Merger Agreement dated July 1, 2020 (the "Merger Agreement") with Central New Hampshire VNA & Hospice ("CNHVNAH"), affirms to the CNHVNAH Board of Trustees and to the New Hampshire Director of Charitable Trusts in conjunction with the Change of Control Notice (the "Notice") being filed by CNHVNAH pursuant to New Hampshire RSA 7:19-b, as follows:

1. Sections 2.1 and 2.3 of the Merger Agreement expressly state that the Merger of CRVNA and CNHVNAH is intended to be in furtherance of the charitable missions of both parties, and CRVNA affirms its commitment to honor these contractual obligations in the exercise of its powers and other rights and responsibilities under the Merger Agreement. CRVNA further acknowledges the compatibility of the charitable missions of CRVNA and CNHVNAH, and notes that the Combined Entity will be guided by a combined mission statement established by the parties under Section 3.2 of the Merger Agreement.

2. Subsection 3.1.2 of the Merger Agreement expressly delineates that pursuant to the Merger, the Combined Entity will honor and continue the maintenance, support, preservation, and management of any assets of CNHVNAH that are donor-restricted, and that pursuant to the Articles of Agreement of the Combined Entity and restrictions on Pre-Merger Operating Reserves, the Combined Entity will utilize its combined assets and resources in furtherance of the combined charitable mission of the Parties and ensure that any CNHVNAH Pre-Merger Operating Reserves will be used only within the communities comprising the current CNHVNAH service area.

3. Section 3.1.5 of the Merger Agreement obligates the parties to endeavor to maintain at least three principal places of business, with one each in Concord, Laconia, and Wolfeboro, which will allow the communities in CNHVNAH's original service area to continue to be served by the Combined Entity.

4. During the two-year Integration Period, Section 3.9 of the Merger Agreement requires a supermajority vote of the Combined Entity's Board of Trustees prior to action on the Chief Executive Officer's hiring or termination, approval of a budget, or material change to the Combined Entity's endowment and investment policies. From the Merger Date forward, at all times a supermajority vote of three-fourths (3/4) of the members of the Combined Entity entitled to vote shall be required to affect any material change in clinical programs and services or relocation or closure of any principal office. These contractual safeguards are designed to insure

that the assets of CNHVNAH continue to be used for its charitable purposes and to address the needs of the communities in its service area.

(Signature page follows)

Executed by a duly authorized officer of Concord Regional Visiting Nurse Association, Inc.

CONCORD REGIONAL VISITNG NURSE ASSOCATION, INC.

DATE: August 4, 2020

By: _____

Name: Beth J. Slepian

Title: President/CEO