Response to Request No. 1

Part I

ISHC Board of Directors Meeting
September 30, 2020

INDIAN STREAM HEALTH CENTER

Board of Directors Meeting
September 30, 2020
Zoom Meeting

Attending: Gail Fisher, President; Mike Burtnick, Frank Sawicki, Suzanne Phinney, Dave Thatcher, Treasurer; Myriam Beauchesne, Amber Dodge
Staff: Greg Culley, Interim CEO
Corr: Billie Paquette

Agenda item	Action	Discussion
Call to Order	• Meeting was called to order at 5:03 pm.	None
Meeting Discussion		• This meeting was called to discuss ISHC's future. Dr. Culley spoke that he felt the Health Center was not sustainable for the long term however there was no need to hurry into joining another facility as a Rural Health Clinic (RHC) or merging with another FQHC. He reminded the Board that he had a vote of confidence from them at the August 2020 Board meeting. • Morale is picking up through-out the building. Dr. Watts is doing very well and there will be two other providers joining ISHC as locums next week; Dr. Brunelle and Elizabeth Bean, PA. Dorothy Jordan, PA will be joining ISHC on the 15th and Dr. Douglas who has 8-years' experience will be starting on the 26th. Dr. Breda will be coming on board in mid-November.

INDIAN STREAM HEALTH CENTER

Board of Directors Meeting
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		• Dr. Culley discussed that as a RHC the savings is not passed onto the patients. They can usually provide a sliding fee scale to patients but they have higher prices so costs will be higher to the patient. The Board expressed that they expect Greg to attend the meetings for the RHC. Greg has an appointment this Friday and cannot attend but has agreed to attend future meetings. Greg felt that the HIPAA issue should be resolved first and there should be either a MOU or a letter of intent. Greg has agreed to cooperate with the upcoming Meditech meeting. • Greg will be meeting on Friday with Bob McCloud from Mid-State. • ISHC is hiring a full time IT Desk Support Person who will be trained on Meditech. Discussed some of the issues with Meditech including that a hard wired system is needed and possibly get rid of Sky-Wire. Mike and Myriam will look into getting ISHC hard wired. They will need to communicate with Ron and Ozzy on this. • Billie Paquette spoke about the service and commitment to patients that ISHC employees provide including the 340B Program and how important this program is to so many people. Billie mentioned how staff has poured their heart and souls into ISHC and that they would really like the chance to see if they can get ISHC turned around and become sustainable again.

INDIAN STREAM HEALTH CENTER

Board of Directors Meeting
September 30, 2020
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Adjourn	• **Motion made by Dave to adjourn meeting at 6:00pm, Seconded by Suzanne, Motion carried.**	

Chair_____ Date____/____/____
Gail Fisher, Board President

ISHC Board of Directors Meeting
October 8, 2020

INDIAN STREAM HEALTH CENTER

Board of Directors Meeting
October 08, 2020
Zoom Meeting

Attending: Gail Fisher, President; Suzanna Phinney Vice President; Dave Thatcher, Treasurer; Mike Burtnick; Amber Dodge; Frank Sawicki
Absent: Myriam Beauchesne,
Staff: Kevin J. Kelley, President/CEO;
Guest: Attorney Jennifer Riggle
Corr: Billie Paquette

Agenda item	Action	Discussion
Call to Order	• Meeting was called to order at 5:33 pm.	None
Meeting Discussion: • HIPAA Breach		REDACTED

INDIAN STREAM HEALTH CENTER

Board of Directors Meeting
October 08, 2020
Zoom Meeting

		REDACTED
	REDACTED	
REDACTED		REDACTED
ISHC's Future Options		• It was discussed that ISHC would continue discussions with Ken Gordon and Bob McCloud regarding a MSO partnership and also discussions with UCVH for a RHC. Letters of Intent and MOU's with each facility will need to be completed and signed. These agreements will be reviewed by Attorneys.

INDIAN STREAM HEALTH CENTER

Board of Directors Meeting
October 08, 2020
Zoom Meeting

Executive Session	**Motion made by Mike to go into Executive Session at 6:38 pm, Seconded by Dave, Motion carried** **Motion made by Mike to come out of Executive Session at 6:52, Seconded by Dave, Motion carried.**	Billie was excused from the meeting at 6:38 pm
Adjourn	• **Motion made by Mike to adjourn meeting at 6:53 pm, seconded by Dave, Motion carried.**	

Chair_____ Date____/____/____
Gail Fisher, Board President

RHC Work Group
Email to 340B Subgroup
Dated December 11, 2020

Billie Paquette

From: Sergio Zullich
Sent: Thursday, July 15, 2021 3:39 PM
To: Billie Paquette
Subject: FW: 340B Subgroup Deliverables
Attachments: Draft December 9 2020-updated CKP, 12-11-20.docx

FYI...

From: Celeste Pitts <Celeste.Pitts@northcountryhealth.org>
Sent: Sunday, December 13, 2020 4:45 PM
To: Sergio Zullich <szullich@indianstream.org>
Cc: Robert Gooch <rgooch@ucvh.org>; Jonathan Pantenburg <JPantenburg@stroudwater.com>; Scott G. Colby <scolby@ucvh.org>
Subject: RE: 340B Subgroup Deliverables

Hi Sergio, sorry for the lateness. I thought I sent this Friday, but it was still sitting as a draft in my in=box. Between year-end, Meditech and price transparency (due 1/1) I don't know whether I'm coming or going!

I don't have much detail on the drug prices – will have to leave that to Rob & Jonathan for help. But I can give you the details of the UCVH charity program and what it would be on our end.

It is not a Sliding fee program – it is 100% charity care. That being said, I do like the idea of a dispensing fee. But that would be something we would need to build in.

I've added in red the comments for UCVH. Before we share with the entire group, I wanted to give you a chance to look it over and to see if my team would have anything to add. Thanks!

Celeste Pitts, CFO
Upper Connecticut Valley Hospital
Weeks Medical Center
603-788-5321
E:mail: celeste.pitts@northcountryhealth.org

Please note – new e-mail effective 6/18/20 – celeste.pitts@northcountryhealth.org.

From: Sergio Zullich <szullich@indianstream.org>
Sent: Friday, December 11, 2020 8:32 AM
To: Scott G. Colby <scolby@ucvh.org>; Jonathan Pantenburg <JPantenburg@stroudwater.com>; Celeste Pitts <Celeste.Pitts@northcountryhealth.org>; Robert Gooch <rgooch@ucvh.org>; Greg Culley <gculley@indianstream.org>
Cc: Paula J. Ehly <pehly@ucvh.org>
Subject: RE: 340B Subgroup Deliverables

Good Morning to All,

If anyone would like to send me the information I can add it to the draft for Monday.

Thanks,

Sergio

From: Scott G. Colby [mailto:scolby@ucvh.org]
Sent: Friday, December 11, 2020 8:26 AM
To: Sergio Zullich; Jonathan Pantenburg; Celeste Pitts; Robert Gooch; Greg Culley
Cc: Paula J. Ehly
Subject: RE: 340B Subgroup Deliverables

Excellent Sergio!

UCVH team:

Who will be providing the side-by-side comparison including our requirements around charity care, our self-pay discount and our pricing program for 340B?

Thanks.

SCOTT G. COLBY
President & CEO

NCH Upper Connecticut Valley Hospital | Modern Healthcare Best Places to Work 2020

181 Corliss Lane
Colebrook, NH 03576
P 603.388.4110 | **C** 603.331.1689 | **F** 603.237.4452
E scolby@ucvh.org | ucvh.org

From: Sergio Zullich [mailto:szullich@indianstream.org]
Sent: Friday, December 11, 2020 8:15 AM
To: Jonathan Pantenburg <JPantenburg@stroudwater.com>; Celeste Pitts <Celeste.Pitts@northcountryhealth.org>; Robert Gooch <rgooch@ucvh.org>; Scott G. Colby <scolby@ucvh.org>; Greg Culley <gculley@indianstream.org>
Cc: Paula J. Ehly <pehly@ucvh.org>; Sergio Zullich <szullich@indianstream.org>
Subject: 340B Subgroup Deliverables

Good Morning to All,

Please find attached the latest draft for the presentation. I have added a few more lines under the introduction and added more medications on the comparison list. Please review and we'll discuss revisions and finalize our presentation on Monday at 9am.

I appreciate everyone's input...

Thanks,

Sergio

ISHC/UCVH RHC Workgroup
340B Subgroup
DRAFT

Introduction

- 340B Drug Program is a federal program that requires pharmaceutical manufacturers to sell medication to eligible providers at a discount
    - Purpose of program is to stretch scarce federal resources
    - Revenue generated by program used to expand and enhance healthcare services
    - FQHCs required to provide medication at an affordable cost
- Health Resources and Services Administration (HRSA) has oversight of program
    - Not federally funded – manufacturers subsidize medication cost
    - Not all medication falls under 340B Drug Program
        - Drug list updated quarterly
- Covered entities may use contract pharmacies to obtain revenue
- 340B Drug Program expanded with Affordable Care Act
- FQHCs under Section 330 are obligated to provide a sliding scale fee for patients for medical care
    - Medication are provided at affordable prices via sliding scale fee

UCVH Charity Program
Eligibility – would follow the same guidelines as ISHC for patient eligibility per 340B guidelines

Sliding Fee Scale – UCVH currently offers 100% coverage up to 300% of the Federal Poverty Guidelines for all current services. There is currently no patient liability. May want to consider following an ISHC Dispensing fee formula or possibly a minimal co-pay, based on cost of drug.

ISHC Sliding Fee Program

Eligibility

- Based on the following requirements:
    - Must be an active patient of ISHC (visit within past 18 months)
    - Prescription must be from ISHC provider
        - Prescription from other provider may be eligible if referred by ISHC provider

Sliding Fee Scale

S100A

- Dispensing fee of $4 and ISHC covers up to $50 cost of medication
    - Patient responsible for cost above $50
- Minimum charge $4.00

S075B

- Dispensing fee of $4 plus 25% of drug cost.
    - Patient responsible for cost above $100 plus 25%
- Minimum charge $5.25

S050C

- Dispensing fee of $6 plus 50% of drug cost.
    - Patient responsible for cost above $100 plus 50%
- Minimum charge $8.50

S025D

- Dispensing fee of $6 plus 75% of drug cost.

- Patient responsible for cost above $100 plus 75%
- Minimum charge $9.75

C100X

- Cash patient will pay 100% of drug cost plus dispensing fee of $8.
- Minimum charge $13.00

Income

- Household assessment is required to determine eligibility
- Sliding fee scale based on federal poverty guidelines

Poverty Level	Income Range (based on family size)	Sliding Fee Scale
0 to 100%	0 to 44,120.00	S100A
101 to 180%	12,760.01 to 79,416.00	S075B
181 to 190%	22,968.01 to 83,828.00	S050C
191 to 200%	24,244.01 to 88,240.00	S025D
UCVH Guidelines		
0 to 300%	0 to 132,360.00	100% coverage

- Medicare Part D patients have the option to use cash price once they are in the "donut hole"
  - Limited to 2 prescriptions per month
- May qualify for sliding fee scale discount if household assessment has been completed

Cost Comparison

- Frequently used medication with sliding fee cost compared to Good Rx price quote (Walgreens)

Drug	S100A	S075B	S050C	S025D	C100X	Good Rx
Advair 250/50 Diskus – 1 unit	4.00	5.25	8.50	9.75	13.00	135.39
Amlodipine 5mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	15.00
Breo Ellipta 100/25 – 1 unit	4.00	5.25	8.50	9.75	13.00	367.96
Atorvastatin 40mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	49.40
Atorvastatin 80mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	48.21
Breo Ellipta 200/25 – 1 unit	4.00	5.25	8.50	9.75	13.00	367.96
Chantix Monthly Start Box	4.00	5.25	8.50	9.75	13.00	467.19
Clopidogrel 75mg – 30 tablets	4.00	5.25	8.50	9.75	13.00	60.29
Dulera 200/5 – 1 unit	4.00	5.25	8.50	9.75	13.00	331.18
Duloxetine DR 60mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	59.28
Eliquis 5mg. – 60 tablets	4.00	5.25	8.50	9.75	13.00	496.71
Escitalopram 10mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	43.00
Flovent 220mg – 1 inhaler	4.00	5.25	8.50	9.75	13.00	391.89
Gabapentin 300mg – 90 capsules	4.00	5.25	8.50	9.75	13.00	30.76
Humalog 100units/mL Pens – 1 box	4.00	5.25	8.50	9.75	13.00	126.45
Humira 40mg/0.8mL – 2 pens	4.00	5.25	8.50	9.75	13.00	5,776.13
Invokana 300mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	546.24
Janumet 50/1000 – 60 tablets	4.00	5.25	8.50	9.75	13.00	499.39
Januvia 50mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	499.39
Januvia 100mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	499.39

Lantus Insulin Pens – 1 box	4.00	5.25	8.50	9.75	13.00	357.01
Jardiance 10mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	504.33
Jardiance 25mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	504.33
Levemir 100units/mL Pens – 1 box	4.00	5.25	8.50	9.75	13.00	487.77
Levothyroxine 50mcg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	9.96
Levothyroxine 75mcg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	10.10

Drug	S100A	S075B	S050C	S025D	C100X	Good Rx
Lisinopril 5mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	10.63
Lisinopril 10mg – 30 tablets	4.00	5.25	8.50	9.75	13.00	13.11
Lisinopril 20mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	14.98
Lisinopril 40mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	18.91
Losartan 50mg – 30 tablets	4.00	5.25	8.50	9.75	13.00	26.00
Losartan 100mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	30.84
Metformin 500mg. – 60 tablets	4.00	5.25	8.50	9.75	13.00	13.72
Metformin 1000mg. – 60 tablets	4.00	5.25	8.50	9.75	13.00	21.14
Metformin 500mg. ER – 90 tablets	4.00	5.25	8.50	9.75	13.00	26.22
Metoprolol Succinate ER 50mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	15.61
Metoprolol Succinate ER 100mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	22.43
Metoprolol Tartrate 25mg. – 60 tablets	4.00	5.25	8.50	9.75	13.00	10.11
Montelukast 10mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	49.39
Novolog 100units/mL Pens – 1 box	4.00	5.25	8.50	9.75	13.00	132.91
Omeprazole 20mg. – 30 capsules	4.00	5.25	8.50	9.75	13.00	31.39
Omeprazole 40mg. – 30 capsules	4.00	5.25	8.50	9.75	13.00	61.42
Pantoprazole 20mg – 30 tablets	4.00	5.25	8.50	9.75	13.00	42.85
Pantoprazole 40mg – 30 tablets	4.00	5.25	8.50	9.75	13.00	50.00
Potassium Chloride 20mEq – 60 tablets	4.00	5.25	8.50	9.75	13.00	21.26
Proair HFA 90 mcg. – 1 inhaler	4.00	5.25	8.50	9.75	13.00	25.03
Rosuvastatin 10mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	85.78
Sertraline 100mg – 30 tablets	4.00	5.25	8.50	9.75	13.00	29.60
Simvastatin 20mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	31.10
Spiriva Handihaler – 1 unit	4.00	5.25	8.50	9.75	13.00	480.54
Spiriva Respimat – 1 unit	4.00	5.25	8.50	9.75	13.00	439.73
Stiolto Respimat – 1 unit	4.00	5.25	8.50	9.75	13.00	407.30
Tamsulosin 0.4mg – 30 capsules	4.00	5.25	8.50	9.75	13.00	35.13
Tradjenta 5mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	400.32
Ventolin HFA 90mcg. – 1 inhaler	4.00	5.25	8.50	9.75	13.00	29.63
Victoza 18mg/2ml Pen 1 box	4.00	5.25	8.50	9.75	13.00	1012.64
Vitamin D2 1.25mg – 4 capsules	4.00	5.25	8.50	9.75	13.00	9.27
Symbicort 160/4.5 – 1 inhaler	4.00	5.25	8.50	9.75	13.00	258.98
Xarelto 20mg. – 30 tablets	4.00	5.25	8.50	9.75	13.00	495.80

RHC Work Group
340B Subgroup
DRAFT – December 14, 2020

ISHC/UCVH RHC Workgroup
340B Subgroup
DRAFT – December 14, 2020

Introduction

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    - Not federally funded – manufacturers subsidize medication cost
    - Not all medication falls under 340B Drug Program
        - Drug list updated quarterly
- Covered entities may use contract pharmacies to obtain revenue
- 340B Drug Program expanded with Affordable Care Act
- FQHCs under Section 330 are obligated to provide a sliding scale fee for patients for medical care
    - Medication are provided at affordable prices via sliding scale fee

UCVH Charity Program
Eligibility – would follow the same guidelines as ISHC for patient eligibility per 340B guidelines
Uninsured patients have a self-pay discount of 40.5% for a provider visit whether they qualify for free care or not. If the bill is paid within 30 days there is 10% prompt pay discount for any self pay balance.

Sliding Fee Scale – UCVH currently offers 100% coverage up to 300% of the Federal Poverty Guidelines for all current services. There is currently no patient liability. May want to consider following the ISHC Dispensing fee formula or possibly a minimal co-pay, based on cost of drug.

ISHC Sliding Fee Program

Eligibility

- Based on the following requirements:
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- Dispensing fee of $6 plus 75% of drug cost.
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C100X

- Cash patient will pay 100% of drug cost plus dispensing fee of $8.
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- Household assessment is required to determine eligibility
- Sliding fee scale based on federal poverty guidelines

ISHC Guidelines for Rx

Poverty Level	Income Range (based on family size)	Sliding Fee Scale
0 to 100%	0 to 44,120.00	S100A
101 to 180%	12,760.01 to 79,416.00	S075B
181 to 190%	22,968.01 to 83,828.00	S050C
191 to 200%	24,244.01 to 88,240.00	S025D

- Medicare Part D patients have the option to use cash price once they are in the "donut hole"
    - Limited to 2 prescriptions per month
- May qualify for sliding fee scale discount if household assessment has been completed

UCVH Guidelines

Poverty Level	Income Range (based on family size)	Sliding Fee Scale
0 to 300%	0 to 132,360.00	100% coverage

Cost Comparison

- Frequently used medication with sliding fee cost compared to Good Rx price quote (Walgreens)
- 340B Cost is similar for all entities since it is a national program

Drug	340B Cost	S100A	S075B	S050C	S025D	C100X	Good Rx
Advair 250/50 Diskus – 1 unit	0.13	4.00	5.25	8.50	9.75	13.00	135.39
Amlodipine 5mg. – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	15.00
Atorvastatin 40mg. – 30 tablets	0.81	4.00	5.25	8.50	9.75	13.00	49.40
Atorvastatin 80mg. – 30 tablets	1.01	4.00	5.25	8.50	9.75	13.00	48.21
Breo Ellipta 100/25 – 1 unit	54.42	8.42	33.42	60.42	62.42	62.42	367.96
Breo Ellipta 200/25 – 1 unit	79.79	33.79	58.79	85.79	87.79	87.79	367.96
Chantix Monthly Start Box	0.50	4.00	5.25	8.50	9.75	13.00	467.19
Clopidogrel 75mg – 30 tablets	0.95	4.00	5.25	8.50	9.75	13.00	60.29
Dulera 200/5 – 1 unit	0.11	4.00	5.25	8.50	9.75	13.00	331.18
Duloxetine DR 60mg. – 30 tablets	1.10	4.00	5.25	8.50	9.75	13.00	59.28
Eliquis 5mg. – 60 tablets	39.21	4.00	13.80	25.61	35.41	47.21	496.71
Escitalopram 10mg. – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	43.00
Flovent 220mg – 1 inhaler	0.11	4.00	5.25	8.50	9.75	13.00	391.89
Gabapentin 300mg – 90 capsules	0.64	4.00	5.25	8.50	9.75	13.00	30.76
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Humira 40mg/0.8mL – 2 pens	0.02	4.00	5.25	8.50	9.75	13.00	5,776.13
Invokana 300mg. – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	546.24
Janumet 50/1000 – 60 tablets	0.57	4.00	5.25	8.50	9.75	13.00	499.39

Drug	340B Cost	S100A	S075B	S050C	S025D	C100X	Good Rx
Januvia 50mg. – 30 tablets	0.28	4.00	5.25	8.50	9.75	13.00	499.39
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Lantus Insulin Pens – 1 box	0.14	4.00	5.25	8.50	9.75	13.00	357.01
Jardiance 10mg. – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	504.33
Jardiance 25mg. – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	504.33
Levemir 100units/mL Pens – 1 box	0.14	4.00	5.25	8.50	9.75	13.00	487.77
Levothyroxine 50mcg. – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	9.96
Levothyroxine 75mcg. – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	10.10
Lisinopril 5mg. – 30 tablets	0.28	4.00	5.25	8.50	9.75	13.00	10.63
Lisinopril 10mg – 30 tablets	0.28	4.00	5.25	8.50	9.75	13.00	13.11
Lisinopril 20mg. – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	14.98
Lisinopril 40mg. – 30 tablets	0.88	4.00	5.25	8.50	9.75	13.00	18.91
Losartan 50mg – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	26.00
Losartan 100mg. – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	30.84
Metformin 500mg. – 60 tablets	0.57	4.00	5.25	8.50	9.75	13.00	13.72
Metformin 1000mg. – 60 tablets	0.57	4.00	5.25	8.50	9.75	13.00	21.14
Metformin 500mg. ER – 90 tablets	1.49	4.00	5.25	8.50	9.75	13.00	26.22
Metoprolol Succinate ER 50mg. – 30 tablets	0.37	4.00	5.25	8.50	9.75	13.00	15.61
Metoprolol Succinate ER 100mg. – 30 tablets	0.37	4.00	5.25	8.50	9.75	13.00	22.43
Metoprolol Tartrate 25mg. – 60 tablets	0.37	4.00	5.25	8.50	9.75	13.00	10.11
Montelukast 10mg. – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	49.39
Novolog 100units/mL Pens – 1 box	0.14	4.00	5.25	8.50	9.75	13.00	132.91
Omeprazole 20mg. – 30 capsules	0.29	4.00	5.25	8.50	9.75	13.00	31.39
Omeprazole 40mg. – 30 capsules	0.42	4.00	5.25	8.50	9.75	13.00	61.42
Pantoprazole 20mg – 30 tablets	0.37	4.00	5.25	8.50	9.75	13.00	42.85
Pantoprazole 40mg – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	50.00
Potassium Chloride 20mEq – 60 tablets	6.20	4.00	5.69	9.39	11.08	14.77	21.26
Proair HFA 90 mcg. – 1 inhaler	0.09	4.00	5.25	8.50	9.75	13.00	25.03
Rosuvastatin 10mg. – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	85.78
Sertraline 100mg – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	29.60
Simvastatin 20mg. – 30 tablets	0.30	4.00	5.25	8.50	9.75	13.00	31.10
Spiriva Handihaler – 1 unit	0.29	4.00	5.25	8.50	9.75	13.00	480.54
Spiriva Respimat – 1 unit	49.09	4.00	16.27	30.55	42.82	57.09	439.73
Stiolto Respimat – 1 unit	47.39	4.00	15.85	29.70	41.54	55.39	407.30
Tamsulosin 0.4mg – 30 capsules	0.29	4.00	5.25	8.50	9.75	13.00	35.13
Tradjenta 5mg. – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	400.32
Ventolin HFA 90mcg. – 1 inhaler	0.09	4.00	5.25	8.50	9.75	13.00	29.63
Victoza 18mg/2ml Pen 1 box	0.06	4.00	5.25	8.50	9.75	13.00	1012.64
Vitamin D2 1.25mg – 4 capsules	0.24	4.00	5.25	8.50	9.75	13.00	9.27
Symbicort 160/4.5 – 1 inhaler	0.10	4.00	5.25	8.50	9.75	13.00	258.98
Xarelto 20mg. – 30 tablets	0.29	4.00	5.25	8.50	9.75	13.00	495.80
Totals	295.53	270.21	391.46	630.71	705.96	891.21	17,038.48

Email Communication to ISCH Board of Directors Dated January 5, 2021

Billie Paquette

From: Sergio Zullich
Sent: Thursday, July 15, 2021 3:41 PM
To: Billie Paquette
Subject: FW: Questions for both RHC & FQHC Workgroups

-----Original Message-----
From: Scott G. Colby <scolby@ucvh.org>
Sent: Tuesday, January 05, 2021 9:32 AM
To: Gail Fisher <snomtn@together.net>; Greg Culley <gculley@indianstream.org>
Cc: Suzanne Phinney <suzannekphinney@gmail.com>; Dave Thatcher <Dave.Thatcher@deluxe.com>; David Thatcher <Dthatcher@nebs.com>; Mike Burtnick <mburtnick@icloud.com>; Lori Morann <lmorann@indianstream.org>; Billie Paquette <bpaquette@indianstream.org>; Sergio Zullich <szullich@indianstream.org>; celeste.pitts@northcountryhealth.org; Monique A. Hand <mhand@ucvh.org>; Robert Gooch <rgooch@ucvh.org>; Rona Glines <Rona.Glines@northcountryhealth.org>; Jonathan Pantenburg <JPantenburg@stroudwater.com>; pehly@ucvh.org
Subject: RE: Questions for both RHC & FQHC Workgroups

Gail:

Thanks for the email below...and I've pulled in the UCVH/WMC team as well.

Here are the responses - Rona and Jonathan - Please feel free to weigh in:

1. UCVH has already begun recruiting physicians and allied health providers and envisions at least 4.5 FTE providers in Colebrook - Physicians non-physicians. We have posted for both and currently employ 1.8 FTE physicians for Colebrook/N. Stratford and 1 FTE PA for Colebrook/N.
Stratford.

2. Overall staff will follow existing NCH models locally (in Colebrook) with clinical support for each provider, case mgt/outreach, registration staff, behavioral health staff, as well as on-site/local management. We will need facilities/maintenance, IT support and of course retail pharmacy locally. Other support areas will be handled by NCH - these may or may not be in Colebrook and include: Finance, billing, coding, additional care management/outreach support, quality, provider recruitment, marketing, purchasing, HR, etc.

3. This is being pulled together by UCVH counsel. NH's Attorney General will have to be involved in any transaction since both UCVH and ISHC are healthcare charitable trusts. This is the part that I suspect will take the longest to get through as there are all ready pre-defined processes in place under NH law. We are vetting that process now and will report out to the group.

4. We are hopeful to have this available by January 20th - We should be able to answer whether we can offer the same level of 340B savings to patients under an RHC as under the current FQHC. This last piece will be driven by the financial information we receive on how the performance of the retail pharmacy subsidizes the overall practice.

Please let me/us know if you have any additional questions.

Thanks.

SCOTT G. COLBY
President & CEO

181 Corliss Lane
Colebrook, NH 03576
P 603.388.4110 | C 603.331.1689 | F 603.237.4452 E scolby@ucvh.org | ucvh.org

-----Original Message-----
From: Gail Fisher <snomtn@together.net>
Sent: Saturday, January 2, 2021 8:51 AM
To: ISHC Greg Culley Work <gculley@indianstream.org>; Scott Colby <scolby@ucvh.org>
Cc: ISHC BOD Suzanne Phinney <suzannekphinney@gmail.com>; Dave Thatcher <Dave.Thatcher@deluxe.com>; ISHC BOD Dave Thatcher <Dthatcher@nebs.com>; ISHC BOD Mike Burtnick <mburtnick@icloud.com>; ISHC Lori Morann <lmorann@indianstream.org>; ISHC - Billie Paquette <billie.j.paquette@indianstream.org>; ISHC Sergio <szullich@indianstream.org>
Subject: Questions for both RHC & FQHC Workgroups

Greg and Scott,

Members of the ISHC Board have expressed (in different ways) the common sentiment - there is a definite need to do a major overhaul of ISHC.

The opinion is that the following information needs to be answered by both those advocating the FQHC model and those advocating the RHC model.

1. Plans for recruiting permanent, full-time providers (especially physicians).

2. Plans for right-sizing the overall staff, with attention to an appropriate/efficient and cost-effective ratio of provider: support staff

3. An in writing timeline for implementation of each proposal (RHC v FQHC) along with an explanation of the regulatory, legal and cost implications for the transition.

4. Specifically from Scott, a concrete (not just verbal agreement) plan for a 340B program near comparable to the current ISHC program as well as the RHC proposal for care management, Outreach and Behavioral Health.

The answers to the above needs to begin with the next meeting of each workgroup.

Please contact me with any question.

Thanks
Gail

Email to FQHC Work Group dated January 7, 2021

Billie Paquette

From: Robert MacLeod <rmacleod@midstatehealth.org>
Sent: Thursday, January 7, 2021 8:46 AM
To: Greg Culley; Ken Gordon; Sergio Zullich; Lori Morann; Billie Paquette
Cc: Adam Crawford
Subject: RE: My "Final" comments at the Presentation
Attachments: Health care partnerships.docx

Hi all:

Attached is my brief paragraph of partnerships/associations. Not pride in authorship—revise as necessary.

Regards,
Bob

Robert MacLeod, DHA
Chief Executive Officer
101 Boulder Point Drive
Plymouth, NH 03264
Direct Line: 603.238.3525
Main: 603.536.4000
Fax: 603.536.4001
rmacleod@midstatehealth.org

From: Greg Culley [mailto:gculley@indianstream.org]
Sent: Thursday, January 7, 2021 8:42 AM
To: Ken Gordon <kgordon@ccfhs.org>; Robert MacLeod <rmacleod@midstatehealth.org>; Sergio Zullich <szullich@indianstream.org>; Lori Morann <lmorann@indianstream.org>; Billie Paquette <bpaquette@indianstream.org>
Cc: Adam Crawford <acrawford@indianstream.org>
Subject: My "Final" comments at the Presentation

Group,
As I said on the earlier email, I will make these comments at the end of the slide on "Implementation."
When I've finished, I'll ask Adam to put up the Balloon slide and turn it over to Bob.
Greg

Gregory A Culley, MD
Interim CEO
603-573-0235
603-388-2473
Indian Stream Health Center
141 Corliss Lane
Colebrook NH 03576

Health care partnerships are a collaborative relationship between two or more parties based on trust, equality and mutual understanding for the achievement of a specified goal or goals. A partnership may offer many benefits for health care organizations including bridging the gap in expertise and knowledge, better cash flow, cost savings, service line opportunities, better work/life balance, collegial/peer support, and new perspectives and ideas for the good of the organizations. The presentation today will provide examples of what can be accomplished through a partnership.

Minutes of ISCH Board of Directors Meeting
January 7, 2021

MINUTES OF THE FQHC WORK GROUP PRESENTATION

January 7, 2021 via zoom

Attendees: Dr. Culley Culley, Interim CEO Indian Stream; Gail Fisher, ISHC Board Chair; Dave Thatcher, Treasurer ISHC Board; Suzanne Phinney, Mike Burtnik, Maggie Fitzgerald, Frank Sawicki; ISHC Board, Sergio Zullich, Pharmacy Director ISHC, Billie Paquette, HR Director and Board Liason, ISHC, Lori Morann, Practice Manager ISHC, Adam Crawford, IT, ISHC; Bob McLeod, CEO Mid State, Bill Sweeney, CFO MidSate, Ken Gordon, CEO Coos Family Health Center, Phil Kneer, CFO Coos Family Health Center, Guy Stever, CCFHS Board President.

Report of the FQHC partnership Group

Dr. Culley prefaced the meeting by stating that he will be presenting the FQHC Partnership proposal via powerpoint presentation, and asked that questions be held until the completion of the presentation. Information was sent to ISHC board members in advance of the meeting. He noted that Bob and Ken would be able to expand on their parts with regard to the partnership.

Goal of the group was to sustain the viability of the FQHCs Process started in August when ISHC approached Coos Family Community Health Center to see if they were interested in a merger or acquiring us; and at the time their board declined; but stated that they were interested in forming a strategic alliance. Gail, Ken and Dr. Culley subsequently met with attorney Jackie Leifer, who shared the range of what other FQHC's had done with strategic partnerships. The goals being shared services to reduce overhead, enhance revenue and improve the quality of care. Jackie prepared a MOU for ISHC and within a month Bob McLeod of Mid State joined into the discussions.

Dr. Culley detailed the process to date: Starting in November there were a number of meetings of this large group, and many with a smaller administrative group which focused on which services to be shared, and opportunities for expense reduction. In addition, Bob, Ken and Dr. Culley met to fill in the gaps exploring new programs, and exploring improvements to existing programs.

Expense reductions could come from combining billing and finance, credentialing, and employee health insurance plans. These reductions were detailed in the slide presentation. IT was not included as the expenses would be a wash. It was noted that Mid State would provide the billing services at a 5% level. Credentialing could be done at Coos Family. Dr. Culley detailed the Health Insurance Association pooled risk proposition. Details of the savings were noted in the slide presentation with total expense reduction estimated at $524,341.

Revenue enhancement opportunities included Medicare chronic care management, Medicare annual wellness visits, pharmacy professional consultation, and possible new patient revenues. A report from consultant Susan Whittaker detailing chronic care management services was shared with the board prior to the meeting. The new patient revenue that could come from the transfer of patients from a local practice where the principal provider will be retiring was detailed. Total revenue gains are estimated at $1,215,600 (low end) (this figure includes the additional $110,000 from taking over the Nursing home oversight.)

A comparison chart of the RHC and FQHC models was shown. Dr. Culley reminded the board of the larger benefit to the patient given by the FQHC model, and noted that the sliding scale is much different

than the charity care model of the RHC; with the added consideration of the benefits of the 340B program.

The implementation comparison showed that the FQHC model would give an immediate start to the financial relief with a completion in 3 to 6 months; management change would require HRSA approval which would take approximately 6 months. The RHC model would involve a waiting time of between 6 months to a year for the NH Attorney General's approval, plus six months for HRSA approval prior to any cost reductions or revenue enhancements.

Dr. Culley posed that this decision would determine how this center would provide quality, affordable primary care, and stressed that the only consideration for this decision should be patient care. He implored that "the decision should be based on verifiable fact and data, not emotions or fear of competition." He also asked for the board to consider the time from when the decision is made to the time of implementation, stressing that a long transition period holding together the operations would be difficult to maintain; as the staff and providers would be difficult to retain as there a many other options for providers. Dr. Culley stated his personal commitment and efforts to continue operating ISHC as an FQHC.

Bob McLeod began his presentation expressing his concern for the well-being of the ISHC population, and a nod to a prospective working relationship with Ken Gordon of CCFH. He discussed the possible transfer of patients from North Country Medical and Wellness, and discussed the possibility of Mid-State being in the upper Coos area. Bob also spoke regarding his discussion Bi-State and noted their support of a continued FQHC presence in upper Coos, and then confirmed the commitment of Mid-State to maintain an FQHC in the area. He asked to be allowed to do due diligence for this shared management structure. He felt it was an un-wasted use of energy, as things put together moving forward would be maintained. He stressed that this action is not competitive, nor predatory; but a maintenance of an FQHC presence. Bob noted that should the board go in another route that he would continue to work with Nick Valais to transition that practice. Bob noted that this was a two-step approach: first ISHC board approval to move forward and second HRSA approval whose primary concern is to have an FQHC in the area. Dr. Culley asked Bob to clarify, and he did confirm that the intent was that ISHC would become a satellite of Mid-State.

Dr. Culley opened the floor to questions.

Maggie posed the question of shared management in the clinical area. Dr. Culley answered that there could be a pool of providers, avoiding the expense of locums. He felt that a shared service contract could bring savings by combining services as stand alone organizations have difficulty with recruitment and retention. She also asked if ISHC was a satellite ofMid-State, how would the partnership with Coos be included. Economies of scale will bring savings, and including Coos Family as a partner would increase these savings. He noted that right away ISHC should be part of a captive self-insured program for immediate financial relief. Dr. Culley noted that as soon as the board would approve, we could immediately initiate savings. This would be prior to the proposed satellite structure. This immediate partnership would not require HRSA approval.

Dave posed the question of HRSA grants; Dr. Culley and Bob stated that should ISHC become a satellite organization the HRSA grants would then fall under Mid-State. Additional clarification added that these grants are based on the number of unique patients. Dr. Culley reminded the group that the RHC structure would not be able to retain nor obtain HRSA grant monies. Dr. Culley also expressed concern that HRSA and/or the Charitable Trusts Unit may not look favorable on the transfer of hard assets to an RHC. Dave also asked about the timeline for FQHC acquisition with regard to an interim CEO; Dr. Culley noted that there would be a need for an interim CEO during the transition; but that the partnership savings would be immediate. Dave questioned the need for additional staffing for the Medicare Chronic Care program; Dr. Culley felt that there would need to be two additional staff members. Bob noted that purchased software could eliminate the need for additional staff.

Suzanne expressed concern about picking up North Country Medical Wellness patients and asked how we would "weed out" those on opiates. Dr. Culley stated our need to care for these patients and discussed our strict current controlled substances policy and asked Sergio to elaborate. Suzanne expressed concern for the staff safety. Dr. Culley detailed how we took control of this issue in 2017 beginning with law enforcement presence, and then over the last three years bringing things under control with new policies and procedures. We have identified patients at risk from high use; initiated urine drug screening, documentation of care, patient agreed upon care management (contractual) and the beginning of an appropriate weaning process.

Maggie asked about the other FQHC's substance use programs, and whether there would be a consistent approach. Mid- State was said to have amore comprehensive program (MAT), and this issue would continue to be discussed. Bob noted that every practice is struggling with the substance abuse problem. Mid-State uses a combinations of behavioral health, and pain management; noting that excessive and long term use has been found to cause additional problems, beyond a patient's pain. Bob urged a thoughtful approach to transferring the care of North Country Medical Wellness patients, including asking where the patient wants to seek care and determining compatibility of a patients care with the proposed (conservative) model of care. Bob stressed the physician's ultimate call on how to manage a patient. It was noted that in certain cases, if patients don't abide by the procedures, patients may be discharged from the practice.

Gail posed what the likelihood that these patients being discussed were sliding scale patients – Bob noted that these patients are likely Medicaid patients. Of the current patient population, 10% of ISHC clinical patients are Medicaid; and 20% are Medicaid for the pharmacy. Gail also discussed her concern that the number of patients that may be made available by transfer of the North Country Medical and Wellness practice may not all be local, but coming in from outside areas. Bob stressed due diligence moving forward and continuing with the two step approach. Starting with the management agreement would give time for this diligence, and an alternative approach could be chosen moving forward.

Gail also requested an organization chart of the proposed satellite organization. Bob clarified that this would be for the second step; ISHC becoming the satellite organization. She expressed that her concern was that ISHC problems were not all financial. Recruitment and management were mentioned as being concerns within the organization; that it is "not all about the money." She felt that they couldn't "buy" the proposal as a two-step process. Mike Burtnik added detailed questions regarding the satellite concept - whether it was a complete acquisition or piecemeal. Bob noted that because Indian Stream is geographically distant, he envisions a management team that runs the day to day; and the CEO at Mid-

State would ultimately be responsible for compliance. Structurally, based on the day's presentation, you would have to have a management structure to keep ISHC operational. He will work with Dr. Culley and Ken to create a visionary structural chart. He reminded everyone that both boards would need to be in agreement with step 2, however he felt that the impact on individuals at Indian Stream would be far less under the satellite model than any other alternatives currently presented.

Dr. Culley added that a number of local individuals would be needed for governance; Bob confirmed the requirement for local representation on Mid-State's board for satellite centers.

Gail reminded the group to keep Vermont in mind, and that the board members are patient's first. She questioned whether our patients would stay with Indian Stream if it was a satellite of Mid-State. Gail was also interested in possible job loss with the second step.

Bob noted that every patient will choose the best possible care that they can get, so he felt that it is extremely important to have qualified clinicians. He also stated that he felt patients don't care who the CEO is, but are concerned that they getting the care they need. Bob continued that secondary is the thought that one doesn't want to cut jobs just for the sake of pinching every penny possible. Other relationships that the patient has with staff are just as important.

Frank expressed his concern for behavioral health care moving forward, particularly in Canaan. Dr. Culley detailed his commitment to this, but shared the current challenges. Bob spoke of the robust behavioral health program at Mid-State and the importance of telehealth in seeing BH clients.

Dr. Culley noted Bob's state award winning programming integrating food insecurity and primary care. Mid-state also has a child learning center – and feels it is important to reach all aspects of a family. He says that nothing improves overnight, but asked if an organization is trending the right way. He reiterated that he felt the partnership would

To close, Dr. Culley will send a copy of the power point presentation. The next steps will be review of the proposed organization chart; an additional meeting on the week of January 18th, Bob will reach out to Nick Valais to confirm the patient profile at North Country Medical Wellness.

ISHC – UCVH Workgroup Meeting Minutes
January 20, 2021

NCH | Upper Connecticut Valley Hospital

INDIAN STREAM HEALTH CENTER & UCVH

RHC WORK GROUP MEETING

MINUTES

Date: January 20, 2021

Time: 12:30 PM to 2:00 PM

Location: Zoom

Members Present:

Indian Stream Health Center ["ISHC"]: Gail Fisher, Suzanne Phinney, Greg Culley, MD, Sergio Zullich, Lori Morann, Billie Paquette

Upper Connecticut Valley Hospital ["UCVH"]: Scott Colby, Celeste Pitts, Monique Hand, Rona Glines (Weeks Medical Center), Jonathan Pantenburg (Stroudwater)

Guests:
Members Excused: Dave Thatcher (ISHC Board), Mike Burtnick (ISHC Board), Rob Gooch (UCVH)

1. Welcome Approval of the January 13, 2021 Minutes:

The group was asked if there were any questions or proposed changes to the January 13th, minutes.

There were none and the minutes were accepted without vote.

2. Financial Analysis Update:

Jonathan Pantenburg of Stroudwater provided an update of the Financial Analysis he completed for the Board Executive Committee Presentation.

The Financial Analysis included:

- Current state of ISHC (based on 2019 due to dramatic drop in volumes in 2020 caused by the pandemic)
- Source data was the audited financials for 2019, interim 2020 financials through November, UDS and cost reports
- 2019 saw 3,600 patients served amounting to 14,000 visits
- Assets were based on November 2020 balance sheet and showed a positive cash balance – driven by CARES Act funding ($1.3M)
- HRSA Grants amount to $2.0 M annually for ISHC
- Debt is low – at approximately $150K for non-UCVH debt
- 2019 ISHC Loss: -$30 K with UCVH's grant, -$330K without UCVH's grant
    - Medical Practice: -$505K
    - Behavioral Health: -$136K
    - Pharmacy: +$610 K without overhead, +$90 K with overhead & misc. pharmacy expenses – on cost report.
- Productivity:
    - 2019 Staff suggests providers should have seen 19,000 patients (actually saw 14,000)
    - ISHC does not have productivity or quality incentives in their provider contracts – straight salary
    - UCVH employment contracts will contain industry-standard productivity and quality incentives
    - ISHC had 4.6 FTE medical providers in 2019, by April 2021, ISHC will have 3.9 FTE medical providers
- Cost/Visit:
    - ISHC:
        - 2019: $381/vst
        - 2018: $215/vst
    - UCVH:
        - <$180/vst

- Volumes:
  - ISHC:
    - Down 40% in 2020 due to pandemic – nationally most FQHCs are experiencing this reduction
  - WMC RHCs:
    - Down < 5% but bottomed-out significantly last spring
    - Almost normal now

ISHC Vs. UCVH Proposed RHC:

- FTEs*:

	ISHC	UCVH.NCH RHC
Providers (Med & BH)	6.76	5.0
Support (includes Pharmacy)	43.04	15.0
Total:	49.80	20.0

* NOTE: NCH administrative and managerial support will handle "back-office functions" with on-site care management, B.H., pharmacy and site management. Staffing includes on site care management and clinical support. RHC model includes comparable support staff for providers and front desk at current WMC RHC levels for comparable practices.

- Cost/Vst:

ISHC	UCVH.NCH RHC
$381	<$180

- Medicare All-Inclusive Rate:

ISHC	UCVH.NCH RHC
$174	$175 to $180

340B Savings Level under the RHC:

- UCVH pro forma almost complete
- UCVH should be able to preserve significant savings for patients; however, some of the savings will be needed to subsidize losses
- UCVH's Goal: It is not financial, it is first to preserve access to quality, affordable primary care

Discussion also included:

Outreach:

- Suzanne explained the current assistance in enrollment, financial assistance, etc.
- Rona explained that a lot of this (patient financial counseling, prior auth, insurance/ACA enrollment, etc.) would be handled centrally by NCH; however, we envision 2.0 FTE care managers on-site in Colebrook

Canaan Site:

- Lori asked if the UCVH proposed model include Canaan
- The model did not consider Canaan; however, the costs associated with Canaan are embedded in the 2019 ISHC data
- UCVH will consider that; however, RHC rules do not allow a satellite RHC unless the clinic as literally mobile and on wheels and cross border operations may not be allowed
- Discussion occurred about the possibility of a NH satellite in Stewartstown/Clarksville
- UCVH would like a Canaan site, Pittsburg site and Errol Site and recognizes that these satellites may need to be structured as a traditional private practice

ACTION STEPS:

- Billie will email Jose and Jonathan requesting the 2019 financial data including volumes, payor mix, staffing, etc. for the Canaan site
- Jonathan will attempt to break-out Canaan as another business unit (like Medical, Behavioral Health and Pharmacy) and model reimbursement and cost at a non-RHC rate to determine the impact on the overall performance. Rona and Celeste will be involved in this discussion
- Gail will mention a requirement of a satellite as a condition of this transaction when she and Scott meet with the NH Attorney General on January 26th

3. Executive Committee Presentation:

- Updated version attached to these minutes

- Jonathan had worked from the revised PowerPoint referring to the Financial Analysis section
- Minor changes to the MAT/BH section and Rx assistance sections were added
- The presentation will once again be shared with the entire Work Group
- Scott asked the Work Group members if there were any concerns, objections or proposed changes to the presentation since the group has had access to all but the Financial Analysis section since last week
- No objections were raised

ACTION STEPS:

- The presentation is ready for the ISHC Board on January 27th – there may be some minor changes due to the Canaan discussion.
- UCVH/NCH/Stroudwater staff to be invited for a 30-minute presentation and 30-minute Q&A

4. Priorities and Subgroup Formation:

The four subgroups reported out as follows:

Sliding Scale/Charity Care: COMPLETE

Scott had distributed the revised sliding scale Excel file last week and no questions were raised by the group.

Care Coordination & Outreach: COMPLETE

There were no additional updates.

Behavioral Health: COMPLETE

There were no additional updates.

340B Retail Pharmacy: COMPLETE

There were no additional updates.

The meeting concluded at approximately 1:45 PM

Respectfully submitted, Scott G. Colby, President & CEO, UCVH