Scott Spradling:

Good afternoon, everyone. And welcome to Peterborough. My name is Scott Spradling. I will be the moderator for today's afternoon, public forum on GraniteOne and Dartmouth Hitchcock health. Today's public forum is hosted and held by the New Hampshire Attorney General's office. We'll be here for approximately the next couple of hours, and I'll go through what you can expect during that time a minute. But first I would like to introduce for some welcome statements, Mr. Tom Donovan, the director of Charitable Trusts from the New Hampshire Attorney General's office. Tom.

Tom Donovan:

Thank you, Scott. Welcome everyone. As Scott mentioned, I'm the director of charitable trusts at the Attorney General's office, and we have a responsibility to review proposed healthcare transactions. And on our plate now is a proposed transaction between the GraniteOne hospitals, and Dartmouth Hitchcock health. In our review, we look at a number of factors, but they include whether the transaction is in the best interest of the hospitals, and the communities they serve. And that's where you all come in here tonight, either virtually or in this room. We want to hear from you. We want to hear your questions and comments, and I'm all ears. So now I'm going to take it back to Scott, and he'll introduce the panel.

Scott Spradling:

Thank you, Tom. I appreciate it. So for today's logistics, we will be here from four until basically six o'clock. The first hour will be a presentation by those who are deeply involved in this process, and we will actually start with Catherine London. She is the principal for health law and policy of Commonwealth medicine. At UMass Chan medical school. She will provide an overview of the transaction, some hospital profiles, some questions that she will essentially leave behind that she believes, as an expert in the industry, and asked to review this process by the Attorney General's office. She will leave behind questions she believes are the notable questions that the public should be getting answers for.

Scott Spradling:

After Catherine's presentation, we will open it up to our esteemed panel, which includes Cynthia McGuire, president and CEO of Monadnock community hospital, Joe Pepe, CEO of GraniteOne health, Joanne Conroy, president and CEO of Dartmouth Hitchcock health, Marcia Ober of the board of trustees of GraniteOne health, and Michael Shea, chairperson of the board of trustees for Monadnock community hospital. They will go for roughly 25 minutes explaining to you why the transaction is important, what it means for the public and answering some of the questions that have been raised here in this community dialogue, to this point.

Scott Spradling:

At that point, that'll take us to roughly five o'clock, where we will move to the audience Q & A. As of now, obviously, we have a number of folks and faces here in this room, but we are also using technology to provide this public forum access as a zoom conversation. So we will have, for folks that are watching from their computers, we will have an opportunity for them to be able to click on the raise your hand function. We will recognize them, unmute them. They can ask their question or make their statement of two minutes. We will then mute them and allow the panel to be able to provide answers.

Scott Spradling:

For those who don't want to either step up to their own microphone or do this here, we do have sheets where you can write down a question. It can be given to me. There will be a chat function online where you can do the same, and those questions will also be cycled to me. We will get through as many as possible. We may very well have more question and need more time than what is allotted for this, the first of three public forums. What we are urging you to do at that point is, as we wrap up, if we did not get to you, our apologies, but the Attorney General's Office really wants to hear from you. So we will give you the email link at the end of this forum so that you can send along your questions or your comments. I guarantee you the N a G T will move forward and, and look at that.

Scott Spradling:

So I will review more details of the Q & A portion of our, of our forum in just a few minutes, but first let me now formally welcome Katherine London. Again, the principal for health law and policy of Commonwealth medicine at UMass Chan medical school, who will now give her review. Catherine?

Catherine London:

Thanks Scott. Hi, I'm Catherine London, as Scott said. I'm here from UMass Chan medical school, my team, and I spent a good part of time over the last year and a half, two years, reviewing all of the documents that were submitted by these two parties about their plan for forming a new entity. And I'm going to take a little bit of time to explain the transaction to the best that we understand it, to highlight some of the potential benefits, some of the potential concerns. There's a fact sheet in the back of the room and also available on the Attorney General's website that you can and look at the same. I'm going to go over the same information that's in the fact sheet. So I'm not going to go reading every data element. You can read that yourself, but I'm going to try to explain what's in here and why we included that.

Catherine London:

So let's see, we'll jump ahead to slide four. So as you know, GraniteOne and Dartmouth Hitchcock have proposed to merge to form one large organization. GraniteOne includes Monadnock Hospital, which has already been part of GraniteOne. Monadnock, and Catholic medical center and Huggins, and some other entities, are all part of GraniteOne. They would be joining with Dartmouth Hitchcock, and there are five hospitals. So Dartmouth Hitchcock, Cheshire, and three other hospitals that are part of Dartmouth Hitchcock, plus some other entities, a bunch of clinics. So this is going to be a very large organization. This is a very complex transaction. And so, just bear with me a little bit as we go through this. And we wanted just start with a little bit on the potential benefits. So slide five. And this is largely... We're passing on what we've heard from the hospitals when they have described this transaction and what they think the benefits will be.

Catherine London:

So one of the big benefits is that people will be able to be, to access more services closer to home. That we know that lots of people travel long distance for hospital care, particularly specialty care. A lot of people go into Massachusetts because certain specialty services are not available close by in New Hampshire. So making the more of those services available in New Hampshire, at all, and then also available, to Monadnock through telehealth connection, with Dartmouth, and the other hospitals. So that's a way of bringing more services closer to home. Hopefully everyone can travel a little bit less and that's a benefit. There are a number of plans for expanding some services, containing costs, building out infrastructure, spreading best practices is for quality of care, for outcomes, and building those out in a

consistent way across all of the facilities. Having a standard electronic health record, all of these systems building over time, bringing them into one consistent system. And so there are benefits to having an integrated set of facilities that are all working according to the same protocols, and sharing information.

Catherine London:

And then another big piece of this. So Dartmouth, and we'll talk... I'm going to come back to all of these things later. Dartmouth is an academic medical center. It has a medical school, it has a number of specialty programs, but it's in a very isolated area. And so in order to support having the level of specialty care, you need to have enough patients to keep those physicians busy. Basically, if you have somebody who is the world's expert in a very unique area, there aren't going to be enough patients in the Lebanon area to keep that doctor busy, and they're going to have to spend half of their time doing kind of more routine care. And that may be less attractive and might be more difficult to attract the top level specialty physicians to Dartmouth.

Catherine London:

So part of the plan of spreading care, and making this access available to all of the member facilities is to provide enough patients to those subspecialists. So overall, that's kind of the, the picture of this provide more patients. You can have more subspecialists. People can see them, they don't have to go to Boston. They don't have to go to travel long distance.

Catherine London:

So then we go... Next slide. To what are the potential concerns. That all sounds great. Should we be worried about this at all? And there are a number of outcomes that are not so positive, that are could come out of this. I'm not saying that they will, but there are possibilities that we should be thinking about. So we've talked about investing in a number of these facilities. What is the cost for that? How is that cost going to be passed on to insurers and to patients? What's the debt that's going to be passed on to those member facilities?

Catherine London:

For people in Carroll county, the choice of hospitals that are close by will mostly all be part of this network. So you still could travel to Nashville. You can travel to Manchester, but more of the facilities that are close by are part of the same system. And that's great in some ways, because you get more coordinated care. If you had some reason that you didn't want to be getting services as part of this system, maybe you're have an insurer that doesn't cover that care, you would have to travel a much longer distance to get care. So that's something to watch out for.

Catherine London:

There is the issue about that Catholic medical center, obviously, is a Catholic facility, and is responsible for upholding the ethical and religious directives of the Catholic church, which prevents provision of certain services. Other facilities do provide those services. So there's some complexity about how to manage that, and I'll talk through that a little bit later. And there's some concern about, will Monadnock be giving up some local control? How much control will the local board have over what happens here at Monadnock?

Catherine London:

Next slide. And I should just mention, and some of you may remember, that there was a proposal for these two organizations to merge a number of years ago, and it didn't work out for a variety of reasons. The parties have taken that very much to heart and have fought long and hard about the issues that blocked the merger in that previous time.

Catherine London:

And believe that they've come up with a solution that overcomes those issues, but you can judge that for yourself. And I should say, as I'm going through this, you should be thinking about what concerns you have, as listeners, as members of the community. And if something strikes you as not quite right, or that you have a question about it, jot it down. And as Scott said, there will be a chance for people to ask questions toward the end of the second hour. I'm also going to suggest some questions at the end of my presentation.

Catherine London:

Let's see, can we jump ahead to slide nine? So this is what the merged entity is going to look like. There are this whole set of hospitals that will all be part of one big organization. Hospitals, clinics, other organizations, Mary Hitchcock, Memorial hospital, four other dart, Dartmouth hospitals, a number of clinics, VNA, Monadnock, Huggins, Catholic medical center. So this is a big, big organization. The plan is to maintain two separate regions that the GraniteOne facilities will be called region two. The Dartmouth Hitchcock facilities will be called region one. They will each have a leader.

Catherine London:

Catholic medical center will continue to also report up through the Bishop of Manchester for purposes of these services that comply with the ethical and religious directives of the Catholic church. So they will on be ongoing. There will be some kind of joint oversight where each of the hospitals will continue to have their own board that makes decisions for local issues. But all of those local boards will be overseen by the system board. And they will be... The system board will have the ability to override decisions that an individual facility might make, and might make decisions that affect the entire organization around moving to a common system of... Whatever, lots of different things. So that's, that's generally the structure.

Catherine London:

I did want to highlight one issue about the board. So the way this is structured is that there are a number of board seats for this larger system board, the Dartmouth Hitchcock GraniteOne system board, and the merger plan lays out a certain number of seats that have been designated as previous GraniteOne seats, and previous Dartmouth Hitchcock seats, and they will continue.

Catherine London:

We can go to the next slide. And this is actually a chart that came from the hospitals, from the transaction documents. The plan is for the people who sit in these seats to stay in those seats for quite a number of years. And I would guess that the plan for that is to provide stability. I will point out that, to me, this is highly unusual. I have never seen a plan where there was a plan for each seat to auto renew. So every person starts at the new board with a term of one, two or three years, but then that term automatically renews for another three years. So the plan is for there to be no turnover in the board for those first four years. So no new blood, no changes. Everybody is on board with the plan as it is, and no changes going forward. So keep that in mind, as you're thinking about how this might play out.

Catherine London:

Let's see. Can we jump ahead to slide 12? So back to this idea about the two systems are going to continue in this regional structure that we've talked about. So the GraniteOne facilities will continue to report up. There are, and two president who to begin with will be Dr. Pepe, and the region one facilities will continue to report up to a region one president, who will be Dr. Conway. At least start with, those positions presumably could change at some point. They're not going to stay forever, but for a long time, we hope. There's a very complic to plan for managing the services that do not comply with the ethical and religious directives of the Catholic church. And that plan is that the compliant services report up through the region, two president. Any services that do not comply, oversight for those services will report over to the region one president. So that is how those two sets of services will be held separate.

Catherine London:

Let's see, I'm going to jump... We put a fair amount of data in the fact, and I'm just going to talk through it really quickly, because you can read it, but we'll just jump ahead a little bit. On slide 14 there's... So this is a comparison of Monadnock to some of the other critical access hospitals that are also part of this transaction. So Monadnock and Huggins are part of GraniteOne. Now new London and Alice Peck Day are part of Dartmouth Hitchcock. And we just thought that a reasonable comparison for each other, because they're similar size, have similar challenges. So you can look at some of that data, and we'll come back to that in a minute. The next slide shows a little bit of the geography. This is the issue that I was talking about, where people might need to travel to get to a facility that's not part of the system.

Catherine London:

So on this map, Monadnock, where the little blue dot at the bottom in the center. The one a little bit to the west is Cheshire, that's green. So Cheshire, and the other green dots, are Dartmouth Hitchcock, and the other Dartmouth hospitals. And you can see the other blue to the east is Catholic. That's a pretty wide area in that bottom left triangle, and you all know that because... It'll be a distance. So that's just visually a caution. But the reason for doing this is the next slide, I wanted to... So, this issue about how to get to an academic medical center, which is a lot further away. And right now, many people in Southern New Hampshire travel south to go to either one of the Boston hospitals, or to UMAS Memorial, and don't travel up to Dartmouth. And so the idea is that if these hospitals that are on the Monadnock and Catholic, are closely linked with Dartmouth Hitchcock, when you get a referral as a patient, if you get a referral to a specialist, that specialist is likely going to be at Dartmouth.

Catherine London:

And so you're going to have more of a tendency to try to, if you need to have that specialty care, to go north rather than south, and to keep that care in the state. So that's just a visual of that. Next slide. One other concern that people have raised is just that this organization is going to be very, very large. Dartmouth already represents a big share of hospital care in New Hampshire. And then With Granite together, they will represent something a little bit more than a third of the hospital care in New Hampshire.

Catherine London:

And that can have an effect. So if you think about, as hospitals are negotiating with insurers, or with municipalities, or whatever else they need to do, it's a very large organization that will have of a loud voice in any kind of discussion. So keep that in mind, as we're balancing all the benefits of bringing them together.

Catherine London:

I'll jump a little bit to slide 19. So this is people had expressed concerns about cost and what the cost of service is would be. And this, again, we're comparing the critical access hospitals. Catholic will be a little bit of a different story, but what we wanted to do here with this analysis is we looked at each hospital and the services that it provides and the level of payment that it receives for those services. And we compared that to the average price for that same set of services.

Catherine London:

So, for each of these hospitals, the set of services that they provide, what is the average price for those services across the state? How does that compare to that hospital? And in general, actually, Monadnock's payment levels are a little bit higher than these comparison critical access hospitals. So it is possible. I don't know for sure, but it is possible that when Monadnock joins this larger system, and has the same base services that it can rely on, it is possible that cost could actually become relatively more affordable than they are now, if it becomes more like these other hospitals.

Catherine London:

And then the next slide, this was specifically looking at the cost faced uninsured people, so people who pay out of pocket for their care. And again, Monadnock is slightly higher than Huggins and new London, more similar to Alice Peck Day. There's... This payment level data does not suggest that becoming more like these other hospitals will result in higher rates, but we do have this question still about if there's a big investment in infrastructure that cost could potentially be passed on.

Catherine London:

Let's see. Oh, and then we looked just at... The next slide. Financial stability is always a big question, and I'm sorry, this is a very busy graph. In general this is looking at operating margins for the state of New Hampshire, average, as a whole. That's that dark blue line at the top, and the four hospitals that I've been talking about are the lines below it. Monadnock is the light blue with the circles. In general, critical access hospitals are not as profitable as other hospitals. It's just one of those things. They're small, they rely a lot on public payers, and generally they're not profitable just based on the services that they provide and the payments they get for those services. The critical access hospitals, as a group, require additional protections, require additional financing, and we get that from various sources. So that's why you see that the lines for all of these hospitals are lower than the average.

Catherine London:

So operating margin is just payment for the cost of operating and the payment for operating. So specifically around patient revenues, generally, sometime a little bit of other things, but mostly about patient revenues. When you go to the next slide, it is total margin. So that's bringing in all costs, all revenues, all sources of revenue, and when you do that... I mean, again, the critical access hospitals are all below that average state line, but they look a lot more profitable, and in general, we're not worried about the financial health of any of these hospitals. They're all about where they need to be to continue doing what they're doing. And I don't see anything in this transaction that would risk the financial health of any of these facilities.

Catherine London:

When we look at quality of... Next slide, please. So this is just a very simple rendition. We looked at a lot of different quality measures, but overall, Monadnock has good quality of care. All four of these hospitals have good quality of care. Patients are comfortable. There's very strong showing for, would you recommend this hospital to your family and friends? You know, there's other kind of measures of patient satisfaction. Very, very good scores.

Catherine London:

But it is also the case that all of these hospitals have very good scores. So there's some room for improvement, maybe with the bringing in some of these standard best practices, there's some room for improving what Monadnock is doing now. And as we move into the future, and everything becomes more highly technical, this is a way for a Monadnock to keep up and maintain those high quality scores.

Catherine London:

I'm just going to fly through these next ones really quick. If you jump to 25, it's just a, a picture of the communities that Monadnock serves, based on what the hospital says that they serve for their community benefits that they provide.

Catherine London:

In general, this area is pretty healthy. We looked at a whole lot of different community health measures and only came up with a few that were really higher risk than other areas, but in general... And actually you can go to the next slide. The one that stands out is a little bit higher level of drug related deaths per a hundred thousand. So there's an ongoing concern about the increase in substance use disorder all over, and here is a little bit worse than other places. But this is a national issue, and a couple other things... But generally healthy community. The hospital provides good benefits to the community. We don't have concerns there.

Catherine London:

So I'm going to just jump ahead to questions. So we spent some time really thinking about what is it that as consumers in this community, what are the questions that I would have? That I would want to ask my hospital? So we've laid out some questions and I'm sure the panel will answer some of these. If are the major concern for you, you can write these down, use them to seed your own questions that you might want to send to Scott. So, overall...

PART 1 OF 4 ENDS [00:27:04]

Catherine London:

Thank you, Scott. So overall, as Tom said at the beginning, the question here is, is this transaction in the best interest of the community? And there are a lot of different ways to think about what the best interest of the community means. It means different things in different ways. So will this transaction provide financial stability for all of the Dartmouth-Hitchcock hospitals and clinics, for the Granite One hospital and clinics, for competitor hospitals and clinics? Will the transaction result in higher costs? Will it bring new revenue into the state? Now it's going out of state. Will it bring new revenue into the state? Will it improve access or will it create access issues? And specifically, what is the future of primary care, mental health and substance use disorder, general hospital services, specialty hospital services? Is there a trade-off in investing in one of these over another? Maternity care is always an issue.

Catherine London:

What about access for people who don't have health insurance, who're paying out of pocket for their care, for people who are covered by Medicaid or covered by Medicare? What's the effect on local and employment? Will the same set of people who are working at the hospital now keep their jobs? Will there be an expansion in the workforce? Will there be a reduction in the workforce because some services are centralized? Do we go on? Next slide, have more even. Will this transaction maintain the quality of care and the quality and safety of care that's provided in the hospital?

Catherine London:

Will there be any challenges that we need to worry about? What will be the role of the local hospital board and what kinds of decisions can that local hospital board make? And what will happen if the system board overrides those decisions, will the needs of the community be met? And then there's this question around the ethical and religious directives of the Catholic church, how will patients be informed that the facility that they are... Where they're seeking care does or does not follow those ethical and religious directives? How will they be informed that they can get services at a different facility that does or doesn't, depending on the patient preference, follow directives?

Catherine London:

How will the system ensure that all of the facilities are following those rules, about that balance between meeting the directives or not? And then back to the medical school, will this... This is a big change, this transaction is going to cause a lot of changes for a lot of people, at the end of the day how do we know it's going to result in the medical school being able to attract more physicians to Dartmouth and their ability to bring in research dollars and other good things for that facility? So that's a lot of questions and I think we're going to have a very robust discussion. Thank you.

Scott Spradling:

Katherine, thank you very much. Before we move over to the hospital's presentation, a quick reminder, once we start with the Q and A in the room here, for those of you who came in and checked in at the front desk, hopefully you signed up, that sign up sheet is actually what will be brought up to me so that I can go call folks up. I know that there's a couple of chairs that are up here, so what I will do is, I'll call people up two at a time here in the room for efficiency and flow purposes. But before we do that, let's now move to the presentation from the hospitals and let me turn it now over to Cindy.

Cindy:

Great, thank you very much, Scott. And thank you all for joining us both virtually and live this afternoon. Katherine, thank you for the overview and the context for us to talk to our community today. We're here today to talk about the proposed combination of our system, Granite health and Dartmouth-Hitchcock health. Our shared goals are improved access to high quality care, adding more value to our patients by providing care to our patients when and where they need it. Today, we will talk a little bit about our structure, our governance structure, and about the benefits we can expect here in our community. Most importantly, we do want to hear from all of you and be able to answer your questions. The healthcare landscape is ever changing even more so over the last 18 to 20 months as we've navigated through the COVID 19 pandemic. Today nearly every acute care hospital in New Hampshire is part of a combined entity or a health system.

Cindy:

As a rural hospital, we struggle, we have remained strong financially at MCH yet often we don't have the bandwidth to do what we need each and every day, to stay ahead of increasing regulatory requirements, technological advancements, and dealing with the workforce challenges. Our board of trustees has taken its role very seriously as it considered our strategic direction. And at this time I'm going to ask two of our board members, Marcia Ober, past chair of the Monadnock Community Hospital board of trustees and member of the Granite One health board, and Mike Shea current chair of our board of trustees, to talk to you a bit about our work over the last several years, leading us to where we are today.

Marcia Ober:

Thanks Cindy. I'd like to start by telling you that in 2016, Monadnock Community Hospital made the decision to become part of a new health system. We'd worked with a national consultant who provided us with a comprehensive analysis of the current healthcare environment, the future as it would be impacted by reforms and the effect on MCH over the next five years. I can still see the two terrifying graph that showed progressive yearly losses of 2-3-5-6 million dollars by 2019. If we continued to go at it alone. Our board at that point filled it imperative to move forward at a time when MCH was in a position of financial strength. So we sought a partnership that would be innovative, responsive to industry reform and a system that could adapt successfully.

Marcia Ober:

Ultimately the MCH board chose to join Catholic Medical Center as part of a newly formed New Hampshire based health system called Granite One Health. Then in late 2018 MCH began discussions as part of Granite One Health with Dartmouth-Hitchcock Health about the creation of a new combined system. Our MCH board was confident in such a system because of our history of collaborative relationships with both Dartmouth-Hitchcock and CMC. Importantly to us, they were the only systems that had a strong record of supporting rural hospitals throughout the state. And our board agreed that being part of a system with a nationally recognized academic medical center would enhanced the care we currently provide to our community. So in September 2018, we voted to move forward in support of the combined health system, Dartmouth-Hitchcock Health Granite One.

Mike Shea:

Thank you, Marcia.

Marcia Ober:

You're welcome.

Mike Shea:

As we first came together with CMC and Huggins to form Granite One, we realized it was just the beginning and that one day we would have the opportunity to become part of an even more beneficial system. That opportunity is before us now and we are very excited about what it means for us and the communities we serve. The goals and purpose of the proposed Dartmouth-Hitchcock Health Granite One system are increased to services, broader high quality care, and greater value for our patients. These are completely aligned with our unwavering mission and vision at MCH, as we are committed to improving the health and wellbeing of our community. Of critical importance in the system's commitment to rural health, both Granite One Health and Dartmouth-Hitchcock Health have longstanding records of providing support for rural hospitals. By way of example, here at MCH, we've

been receiving cardiology services and in-patient hospitalist services from CMC, along with other supporting services since our affiliation in 2016.

Mike Shea:

We have also worked for many years with Dartmouth for our cancer center and for our GI digestive health services. While the new system will have an integrated governance structure, it is important to note that MCH will also maintain a local board of trustees who will continue to be the primary governing body for MCH, with the responsibility of assuring our mission of care for our community. Monadnock Hospital will maintain its name, local fundraising will be under the purview of MCH trustees, and the trustees will have oversight of our MCHS assets, including donor restricted and endowment funds. This combination will allow our patients to have improved access to specialty care, high quality care closer to home, and will assure long term financial stability through increased access to capital at lower cost. We believe it is important for MCH the community we serve in New Hampshire and we are looking forward to the bright future ahead. Thank you.

Cindy:

Thank you so much, Mike, can we have the next slide please? And the next slide, please. I want to spend the next few minutes talking about the commitments from the health system and support of strengthening rural healthcare and what this means for our community. Our vision at MCH is to provide 75% of healthcare to our community. Our focus continues to be on stability and on growth. In the last three to five years, we have lost a significant number of physicians, both primary care and specialty care. It is very difficult to recruit, it's difficult nationally and it's even more difficult in a rural community. Part of the challenge is that we don't have enough volume of patients to support full-time specialists in our rural area. For example, here at MCH, we have enough general surgery for about one and a half general surgeons and the same for orthopedics, but we need hire at least three general surgeons to cover our service 24/7, 365 days per year.

Cindy:

And to provide support to our ER, we can expect to receive additional support for these service lines, strengthening our existing programs and providing coverage for our emergency room for orthopedics in general surgery. Another innovative approach is the use of telemedicine to enhance access to specialists while allowing our patients to stay close to home. We have an aging demographic and sometimes the distance to travel can be very difficult. Currently we use telemedicine to provide stroke care, night pharmacy coverage, and psychiatry. We have invested significantly in the last couple of years in telemedicine as a way to support our community. We've invested in people and technology. These investments require a strain of our resources, multiple contracts, different software vendors, many different technological platforms, and a use of a lot of our IT resources. The combined systems will commit to centralizing these resources and build upon the services already being offered, creating both access and efficiency.

Cindy:

Other specialty services are being developed and enhanced for Southern New Hampshire, including pediatric inpatient care, additional birthing services, bariatrics, orthopedic care, spine and pain management care, and oncology and cancer care. MCH has a wonderful cancer center, it's new within the last several years. However, in the last three years, three oncologists have retired in our community, making it very difficult for our patients. Right now, our patients are going in two different directions for

care for cancer. The new health system plans a more robust Norris Cotton Cancer center at CMC with increased access to surgical treatments for cancer and increased access to advanced clinical trials for cancer care.

Cindy:

And lastly, we look forward to an integrated IT system and a shared electronic patient record. At MCH we have two different records right now, one for our outpatient system and one for our inpatient system, though they are interoperable on a small scale, they do not fully relate to each other. It creates great inefficiency for our providers and our clinicians, and it's difficult for our patients to have a seamless experience of care. And when our patients go to other hospitals right now, the records don't necessarily translate across the systems. An integrated IT system will go a long way to provide a coordinated approach and a seamless level of care for our patients and will also help reduce some duplication. Next slide, please. We've lost our slides there. We have significant commitments and in the combined system to enhance resources for behavioral health and this is of course a major area of concern throughout our state.

Cindy:

All hospitals are struggling to provide behavioral health services because there is a major lack of resources on many levels. MCH is fortunate to have an outpatient behavioral health practice, but like in other specialties, we have seen a decline in the level of providers and clinicians to help us in that department. And we're challenged constantly with keeping our positions filled in behavioral health, this lack of services on the outpatient side and the preventive care approach leads to a situation where patients are often visiting our ER and may require inpatient admission and they end up waiting, waiting for access to inpatient care. The system is committing support, significant support for the continuum of care for behavioral health, outpatient psychiatry services and primary care support are things that we can provide in our communities. And we should provide this preventive approach, it's the right care for our patients and it will reduce the burden on the inpatient side. And next slides, please, I'd like to turn the present over to Dr. Conroy to talk about some system perspectives.

Dr. Joanne Conroy:

We'll take the next slide please. Thank you. Thank you, Cindy. The cost of care is top of mind for patients, for communities, and people ask appropriate questions about how will this decrease the total cost of care. First thing I'd like to talk about is out migration, which means patients that actually leave the state for care. And we're not including in this number patients who may be closer to a hospital in Massachusetts, meaning they live very us to the border, but those patients that actually drive past other hospitals for care in Massachusetts or in New York, we know when they receive their care out of state, the costs are far higher than they are at either Dartmouth-Hitchcock Medical Center in Lebanon or at CMC. So this is one aspect of lowering costs that's immediately apparent, but there are many other costs that are not as visible, when we mean delivering care close to home, we are enabling families to care for their loved ones when they're in facilities, to visit them, to make sure that they get the right outpatient care in an integrated fragmented system that's easier to navigate.

Dr. Joanne Conroy:

When we talk about lowering costs, we're talking about working together as a system to eliminate services or tests that don't deliver any value to patients. And that's something that we can do together. Look at our history, we are highly recognized for actually eliminating unnecessary care and that's

something that we would plan on working together with our members at Monadnock to identify care that's very appropriate to be given both within the community as well as throughout the system. Could I have the next slide please?

Dr. Joanne Conroy:

We are New Hampshire's only academic medical center and it does benefit patients and staff across the state. We have state of the art science that actually translates to delivering care. The research we do improves the care we deliver every single day. And we would hope to extend that opportunity to deliver... To receive cutting edge care, wherever patients access our system, be it at Monadnock in Lebanon or anywhere across our health system. We're very fortunate to have the Norris Cotton Cancer Center, which is an NCI designated cancer center, one of a very small number across the country, which offers close to 600 clinical trials, almost 170 of them are in cancer or oncology alone. And we would hope that patients will be able to access this level of care again, wherever they touch the system. We do have infrastructure and metrics that help guide us in terms of delivering high value, high quality and lower cost care across the health system.

Dr. Joanne Conroy:

We are very fortunate because we're an educational institution that we educate physicians, nurses, pharmacy techs, people that actually may be less visible to you, but are critically important to delivering the care you deserve in your communities. We have a robust workforce development Institute and graduate hundreds of people every single year that continue to live and work in New Hampshire. And of course the opportunity to work together allows us to create career ladders across the health system where individuals don't have to leave the system in order to pursue a career in academic medicine, they can start at any one of our locations and have a whole range of opportunities for career progression. If they're a nurse, if they're a pharmacy tech, if they're administrator and sometimes even as they start as a transporter within our health system, when you look at the origins of any CEOs across the country, many of them started in clinical roles in institutions like Monadnock and like Dartmouth-Hitchcock, and just found their way to leadership within their organizations. Could I have the next slide?

Dr. Joanne Conroy:

So this is the value slide, what are the benefits to the community? How do we deliver a greater degree of convenience, that means keeping care close to home, and how do we work together to decrease the cost? That is the definition of value, value is in the eye of the beholder, but most patients would agree that these are the things that drive their decisions about where they want to receive care. Our mantra is great care, more affordable, close to home, greater access to the resources within an academic health system, and let's be honest, we're facing a staffing crisis across the country. So we need to invest in training nurses, physicians, allied health providers across our system that will stay and work in New Hampshire.

Dr. Joanne Conroy:

Financial stability for the hospitals within the system, we lock arms and we sit together on our own bottom line, identifying when it's important to invest in infrastructure capital programs at any of our facilities. We do maintain separate payer negotiations so that is... Look at our history that's what we've done across our health system to a date and we would continue that. I would say it creates a little bit of opportunity and maybe some confusion for patients who may look at a hip replacement at any one of our organizations and find that the prices are a little bit different, but that's a beauty of separate payer

negotiations and we offer people choices across our health system. Next slide. And I'll turn it over to Cindy.

Cindy:

Thank you, Joanne. And in conclusion, then our board has strategically considered the future and has been proactive in positioning MCH for long term sustainability and success. Our hospital and our board of trustees, as you've heard, will maintain a local level of control with oversight of our assets, fundraising, donor restricted funds and endowment funds. We will remain strong for the future by being part of a uniquely New Hampshire system for healthcare, with demonstrated commitment to rural health and together we will continue our nearly 100 year charitable mission of improving the health and wellbeing of our community, providing our patients access to care when and where they need it. And I thank you all for your time this afternoon, and we look forward to answering your questions.

Scott Spradling:

Cindy, thank you very much, Joanne, thank you. I appreciate it from the members of the board. Quick apology that I know for those of you who are watching from computers offsite, we did have a temporary glitch. Please know that we are recording this session and we will post a link to it in the very near future so that you can cover what might have been missed for a couple of minutes of downtime but welcome back it's nice to have all of you here and we'd like to now move to the Q and A portion of this public forum. A couple of quick ground rules, please remember that we are going to accept questions via the chat function online, as well as through essentially the zoom function for those who are watching from your computers offsite. If you have a question and you would like to ask that question yourself, please raise your hand.

Scott Spradling:

Do the chat function, a click on the raise hand function, we will notice that when I'm doing it, because these are anonymous folks who have signed up to be able to do this, I don't know who you are. So when we are calling on someone online, to be able to ask a question, we will be able to unmute you. So please watch your screen, if you have been unmuted, please start talking and ask your question. We will find our rhythm for this because I will combine that with the texted in chat questions, through the website and through the zoom function as well as in the room. So while we get ready here, I'll read the ground rules and I would like Dewitt Clark and David Irwin to please come up to the front, Dewitt you can go first and David, there's a seat right close by. Here are the basic ground rules.

Scott Spradling:

If I can just go through them real quickly, Dewitt, before you ask your question. So questions are coming in from a number of places. Each speaker has two minutes to ask your question or make your statement or combine the two. If you can do it more rapidly, fantastic, if not, that's fine you have two minutes. You will see behind me, very handsome gentleman named Griffin [Khamon 00:53:06]. He is holding a series of cards, one is yellow and one is red. When you see yellow, you have 30 seconds. Once you see the red, please wrap up and make your final thought, please finish your sentence. What I would ask is to please observe that, see it out the corner of your eye, I will give you a little bit of leeway, but because we have a lot of interest in a number of people asking question, I'm going to try to stay pretty disciplined with this, for both the questions and the answer so that we can cover some ground, there's a lot to talk about.

Scott Spradling:

Again, for those online, I will ask you once we've unmuted, please identify yourself and where you live, so that we have some context. Then you can ask your question and again, two minutes, hopefully you can see it. I apologize if for any reason you're online and you're going long, I will most likely just ask you to be muted and cut you off, assuming you simply cannot see Griffin or the red sign, the cutoff sign. So I apologize if that seems somewhat abrupt or rude, but that's all in the name of trying to keep things moving.

PART 2 OF 4 ENDS [00:54:04]

Scott Spradling:

Somewhat abrupt or rude, but that's all in the name of just trying to keep things moving. And one final reminder, we are the town meeting state here in New Hampshire. We're good at this.

Scott Spradling:

This can sometimes be an emotionally charged conversation, but we can be civil and get our point across at the same time. So I impress upon you to use your better angels of expression and stay as positive as possible and we'll get through all of this together.

Scott Spradling:

And again, for those that we don't get to today, if that is an issue, please remember you can reach out to the Attorney General's office directly and to Tom Donovan. And I'll give you that information at the end. Dewitt, the floor is yours, sir.

Dewitt:

I'm a transplant and I am a patient up at Lebanon. We made that decision very specifically. Loved the integrated healthcare record system, very great. I want to talk about the limitations on Monadnock as a community access hospital.

Dewitt:

A couple months ago, I had a friend up here and he started bleeding internally and he was shocky. I'm a whooper, I know what shock looks like. So we got him over to, I live five minutes from the hospital, got him over there.

Dewitt:

It was in the evening. Took seven hours to get him a bed up at Dartmouth. Could not be admitted because you didn't have the specialist on-call and then it took another four or five hours to get his blood type for the match for the type of transfusion he needed, all right?

Dewitt:

All of this could have cost him much more than the discomfort. So it's more than convenience. It is critical care. So my questions are, and I know something about medical schools. I used to work in them.

Dewitt:

What is the plan for clinical education at Monadnock? Will residents be placed there? For example, that would help with the staffing. Got it. And what is the plan of change to upgrade Monadnock's status as a community access hospital? Thank you.

Scott Spradling:

Thank you Dewitt. Cindy?

Cindy:

Thank you very much. I thank you for teeing that up. It's exactly the point I was making in many respects, I think with our difficulties. I would just preface by saying that certainly we are all challenged right now since the pandemic with bed access, which is really driven predominantly by staffing.

Cindy:

We've had significant loss of staff over the last 18 months, and these are exactly the kinds of services that we need to have strengthened in our community hospitals for sure.

Cindy:

We are a critical access hospital, but our ER is very often busy with these kinds of patients. And we frequently transfer patients to Dartmouth and to CMC. Even prior to the COVID-19 pandemic, we have had a limited access to beds.

Cindy:

And part of our plan is to build some additional capacity for the system of the future. And I'll turn over to Joanne to talk about residents and training effects.

Dr. Joanne Conroy:

Thanks, Cindy. We are actually expanding our bed capacity up in Lebanon. We'll hopefully have 64 additional beds in 2023. But your question about medical education is a little bit more complicated.

Dr. Joanne Conroy:

Our role is to actually assess what care the patient needs and decide whether or not it can be safely delivered at that facility. If it can, there are so many things that we can do to assist the facility in delivering care.

Dr. Joanne Conroy:

Telehealth consult, we have a tele-ICU, we have a tele-ED. We can walk people through the initial evaluation and treatment of many, many diseases. However, there is a point that we do the best for a patient by transporting them to a higher level of care, be it at CMC or at Dartmouth Hitchcock.

Dr. Joanne Conroy:

And transporting patients is one of our top priorities. How do we actually build a transport system that's both responsive not only to our needs, but the needs of the broader community? We aspire to be an academic health system.

Dr. Joanne Conroy:

That means education should be a priority everywhere. Dean Compton who's the Dean of Geisel School of Medicine is always looking for opportunities for medical students to have experiences, especially in rural settings.

Dr. Joanne Conroy:

And if a medical student has a great experience, they often come back as a resident or come back as a licensed practitioner in order to deliver the care in that community. So there are any number of opportunities to do that.

Scott Spradling:

Thank you very much. Dewitt, thank you for the question. And he totally did exactly something that I wanted to reinforce. So thank you for being the first questioner. For those that are stepping up to the mic, if you wouldn't mind please leaving your mask on.

Scott Spradling:

These folks are in place and they can do the mask down and up to answer questions, but because this is a community microphone, if you keep the mask on, we don't have to stop and clean it every time. So, way to go Dewitt. Thank you for doing that. And let's get David Irwin up, David.

David Irwin:

My name is David Irwin. I live here in Peterborough and I would urge your office, Mr. Donovan, to deny this application. I'm a little embarrassed to admit that I was part of the health planning process a long time ago when I was a member of the CON board, which I believe is now defunct.

David Irwin:

I was appointed by Judd Gregg when he was governor, so that must've been late 80s or early 90s. And in that capacity, we spent a lot of time listening to hospitals make these same arguments, that if you allow us to get a little bigger, if you allow us to provide this service or that service, if you allow us to do this or that, then we'll be able to save money and be able to enhance the access to healthcare.

David Irwin:

It just plain didn't work. And I could give you a lot of examples of how the bigger and better approach didn't work, but I don't think I can do it within the two minutes here. For that reason, I would urge you to deny the application.

David Irwin:

And I'm not sure what the solution is nor am I sure what the alternative is. It may just be what former president Trump mentioned that healthcare is complicated.

David Irwin:

But I don't have any reason to believe that the bigger is better approach will work this time any more than it has in the past. Thank you.

Scott Spradling:

Thank you, sir. Cindy, would you like to say anything in a comment?

Cindy:

Well, I think that I'm not sure what time period David was in that role, but certainly I know he had spoken with one of us earlier about some prior decisions that related to cost and dollars.

Cindy:

And I can't really speak to those because I wasn't here. But I don't know, Laura or Rich I'll call on you if you have any perspective from the past of what we were seeking.

Cindy:

I don't believe it was anything similar to this transaction at this point in time. Anything Laura you want to add or you're good?

Laura:

I don't think there's anything going that's pertinent to this-

Scott Spradling:

Nothing pertinent.

Laura:

[inaudible 01:02:00]

Scott Spradling:

Okay.

Dr. Joanne Conroy:

Our past performance probably is the best indicator of what we would do. When we added Cheshire Medical Center to our health system, there were a number of things we did to actually improve the cost structure of that organization, which allowed them to deliver better value to their patients.

Dr. Joanne Conroy:

There are things when you become an integrated system that just make sense to do centrally and things that really need to remain at the local site. But we identified a number of ways that they could actually decrease their total costs.

Dr. Joanne Conroy:

And they went from a negative margin to run a positive margins. We were also able to expand the census at the facility. We almost doubled it and that allowed them to use their resources more effectively to deliver care to the community and actually achieve the financial stability that they aspired to.

Dr. Joanne Conroy:

I appreciate that there are many national articles that talk about this, but there are bright lights where organizations actually can deliver care at a lower cost. And that's something that we are committed to.

Scott Spradling:

Thank you very much. Let me go to a chat question that was just handed to me. The larger the medical provider group, the more the covered lives and more clout that a system has with insurers to raise the cost of their services for more reimbursement. In this plan, what assurances are provided to prevent costs from rising?

Cindy:

I'll let Joanne take that one.

Dr. Joanne Conroy:

So our past performance is that all of our entities actually negotiate separately. That's why if you're looking for a hip replacement, you're going to find different prices everywhere on our public websites.

Dr. Joanne Conroy:

And we have felt that that's the way that we can actually be very responsive to the communities. And we're committed to doing that. So we've historically done that, we have no intention of changing.

Scott Spradling:

Thank you. Cindy-

Cindy:

I could just add that being able to purchase at lower costs because we have a group purchasing arrangement helps keep our costs under control and keep our costs lower.

Cindy:

And those costs are passed on because we're a cost-based reimbursement type system. So I think that is a huge impact for a small hospital to be able to be part of an organization that can have those kinds of savings.

Scott Spradling:

Thank you. Tom Bates, please feel free to come up to the microphone, sir.

Tom Bates:

Tom Bates from Westmoreland, New Hampshire. It's about 10 miles west of Keene. And I want to thank the entire panel up front for your presentation. I appreciate that. Your presentation really talked about the advantages and disadvantages of a combination.

Tom Bates:

I suggest when you move forward, you look at this angle. What are the disadvantages of not combining? We know that the future does not hold good things for small critical access hospitals as they're closing

as we see them. Monadnock Community Hospital is not here seeking this combination because the future is bright, because their financial future is secure.

Tom Bates:

As a matter of fact, the demographics of this community are going to change such that the financial future of this organization will change dramatically.

Tom Bates:

I take a little exception to Catherine London's comments that you are not worried about financial health of the hospitals. I think what you have to do is look forward. Your graph about operating margins and historical information is okay for the olden days.

Tom Bates:

You've got to look to the future. What's your patient base going to look like? What's your employment base going to look like? What's the cost of future services going to look like?

Tom Bates:

You have to look to the future as to what would happen to an organization this small. I neglected to tell you my relationship or my position. I'm a trustee of the hospital. Thank you.

Scott Spradling:

Thank you, Tom. Cindy, any comment or anything?

Cindy:

Thank you, Tom. Your perspective is always appreciated. And Tom is also the chair of our finance committee and treasurer of our board.

Scott Spradling:

Thank you, Cindy. Catherine.

Catherine London:

So I did want to comment that Monadnock is not an independent hospital now and the choice, I didn't see that as being a choice that it staying with Granite Health as a separate organization or Granite Health and Dartmouth joining. So either way it would be part of a larger organization.

Scott Spradling:

Thank you. If anyone else in the room would like to ask a question, please feel free to raise your hand, in just a moment I'll call on you. And for those who are watching online offsite, a quick reminder, please raise your hand as part of the chat function.

Scott Spradling:

At the moment, we don't have any live questions coming from Zoom online. Just some texted questions that have been written down and sent to me. So let me ask that next question.

Scott Spradling:

Global budgeting, a proposal by progressive national health legislation would provide reimbursement based on preceding years care necessities for rural hospitals rather than what specialty services are most profitable.

Scott Spradling:

How does Monadnock board or similar rural hospitals view these reform proposals for global budgeting?

Cindy:

I guess I'll ask Joanne to help us with that.

Scott Spradling:

Sure, thank you.

Cindy:

We have looked at this a little bit and done some analysis but I'll call on Joanne.

Scott Spradling:

Thank you. Joanne.

Dr. Joanne Conroy:

So I have to disclose that I'm the chairman of the primary care task force on capitation for the American Hospital Association of which I'm a board member. And we have been looking at this over the last year.

Dr. Joanne Conroy:

There are several things that make this very difficult for rural hospitals. The first is that they have such a small service area. Often working within a globally capitated system is actually quite difficult with small populations.

Dr. Joanne Conroy:

In and of itself, unless they're part of a larger system, they often have to send people outside of their service area for complex care. Again, outside of their system and something that they lose control of their ability to really control costs.

Dr. Joanne Conroy:

And I would say finally, the staffing crisis that affects all hospitals across the country is particularly acute for rural small hospitals, especially in the recruitment of primary care providers to their networks.

Dr. Joanne Conroy:

And most of these capitated systems are really aligned and associated with a primary care network. It doesn't mean that at a national level we're not considering it, but it is incredibly complicated.

Dr. Joanne Conroy:

I think Vermont has tried to pick through this for the last three years and has had some really mixed results with the hospitals that have participated in their statewide ACO.

Scott Spradling:

Thank you very much.

Cindy:

Thank you Joanne.

Scott Spradling:

If nothing more, we do have someone who is online with their hand raised. So Jake Berry, I'm going to ask Jessica to unmute you. We're unmuting you now. Jake, hopefully you can hear us and we can hear you.

Scott Spradling:

You're our first test case on this thing. So please ask your question. We can see you. We can't hear you yet. Let's try it again. Anything yet? Jake, I'm going to move to another question while we're working on that.

Scott Spradling:

I'm going to try you again. If we need to, I'll put you on the chat function to be able to type in your question, but don't go away. I have a different one here. How will this merger address the staffing shortage going on at individual facilities? Maybe Cindy you'd like to start?

Cindy:

I think that all of us are having a staffing shortages of a major proportion right now. And at Monadnock Community Hospital, we have about 92 open positions as of this morning.

Cindy:

And I know that Dartmouth has 1000 plus open positions. Dartmouth has a workforce readiness training program. They have relationships with Colby Sawyer for training. CMC has relationships with St. Anselm and the community college and training support staff.

Cindy:

We are too small really to have that kind of a training program. So being part of the system will give us access to individuals and training support.

Cindy:

We plan to offer career ladders as Dr. Conroy mentioned earlier, and that gives a reason for our staff to stay within the system and have opportunities to grow in their position.

Scott Spradling:

Joanne, anything you'd like to add? And Joe, maybe you'd like to add on this too.

Joseph Pepe:

I would just say that bringing academic medicine and training to Southern New Hampshire will not only improve care, but it will allow us to recruit and retain top talent, which will be very good for the citizens of New Hampshire.

Scott Spradling:

Joanne, anything more? He took care of it. Jake, we're going to try this again. I'm going to try unmuting you. Can we hear you now?

Speaker 1:

No.

Scott Spradling:

No, okay. So Jake, I'm going to ask if you're willing to, to please type your question in on chat because we've got fast fingered folks over here standing by to write your question down and get it to me.

Scott Spradling:

So we can do that and hear it is. Okay, at least here... Different question? Okay. The relative cost of urgent care is less one, handled in urgent care centers like ConvenientMD.

Scott Spradling:

It is also widely reported that customer service is better in these facilities. Certainly not in an emergency room. How will this, they use the term merger, expand opportunities for urgent care and reduce emergency room visits and waits?

Dr. Joanne Conroy:

Urgent care facilities really serve a very important niche in the community. I'm sure any of you with high school children that require a sports physical and you find out the day before they're supposed to start training with their team, have actually taken advantage of an urgent care facility.

Dr. Joanne Conroy:

And we agree that patients that need care that is actually not emergent should be seen in a different environment. However, we are just embarking on a broad telehealth program that actually offers many of the urgent care services to people without leaving their homes or without leaving their place of work.

Dr. Joanne Conroy:

And that's part of the evolution of urgent care. My expectation is we would continue to work with all of our members to figure out if a telehealth solution is right for their community.

Dr. Joanne Conroy:

It's not right for every patient, or if it a collaboration with urgent care centers is the way that we get people to use centers like this for low acuity issues that are not emergent. That will decompress our emergency rooms and help us with many of our staffing issues.

Scott Spradling:

Anything that you want to add Cindy or Joe?

Cindy:

No, I think that's great Joanne. And I think we struggle even in our primary care offices to offer urgent care slots. We're doing more of that these days, I think with the COVID-19 crisis.

Cindy:

But certainly urgent care has a role in what we do and we don't have urgent care centers in our local community. So I think a telehealth approach would be superb.

Joseph Pepe:

At CMC, we have collaborated with urgent care group and it works quite well for what it's supposed to work for. And that is eight to eight when someone needs care and they can't get into their primary care physician.

Joseph Pepe:

But as you may know, your child gets an earache, not usually eight to eight. And so that's where telehealth can come in and can provide an extended care as we pull our resources.

Scott Spradling:

Thank you very much. I did get Jake's question, so I'll ask it in just a second. I have one just before it from online chat. Since substance abuse issues are a bit higher in the MCH region, what are the plans for enhancing SUD services?

Cindy:

And I would just want to add that thank you for that question. I think Hillsborough county is a very large county, so it's not necessarily just the Monadnock region, but we certainly are faced with those challenges and we recognize the need for support services.

Cindy:

I think medication assisted treatment opportunities would be great from the system perspective. And I know those are planned. Also I think access to telehealth for support for medication assisted treatment would be a very welcome.

Cindy:

We attempted this on our own in our practices and had grant support to build that here, but we've been unable to successfully achieve that due to loss of providers and lack of access.

Dr. Joanne Conroy:

We are committing tens of millions of dollars to support expanded behavioral health. But I have an expert in the audience, Dr. Will Torrey who, Will, if you could stand up and maybe face the camera.

Scott Spradling:

You should go to the microphone so people who are not in the room can hear you.

Dr. Joanne Conroy:

All right, thank you. And talk about what we have planned for substance abuse expansion, program expansion.

Dr. Will Torrey:

So there's really no health without mental health and that includes substance use challenges. And mental health and addiction are common, painful, disabling, and sometimes deadly as we all know and the main challenge... And they're also very treatable.

Dr. Will Torrey:

People do better when they have access to science supportive care in a timely manner. But the main challenge across the nation and locally is getting that access.

Dr. Will Torrey:

So I think that this combination agreement provides, and I've been working to enhance and grow care for more than 30 years in New Hampshire, and so this combination agreement provides a really wonderful opportunity to expand access to care.

Dr. Will Torrey:

It not only will expand access directly to care using models that we've had the chance to try out in putting substance use care and mental health right into primary care, including opioid use disorder MAT care as well as alcohol use disorder care, which is incredibly a common difficulty.

Dr. Will Torrey:

And the other thing is that we have been training psychiatrists, psychologists, licensed social workers, psychiatric nurse practitioners. And this combination agreement allows for a broader training across the entire system.

Dr. Will Torrey:

And people who train locally tend to stay there. So I think that it would enhance our capacity to meet the state's needs not only in the next few years, but over the next decades through training more people.

Dr. Will Torrey:

So I guess in summary, there really is no health without mental health and increasing access to a substance use care as well as mental health care will relieve suffering, improve function and make lives of those individuals and their families just go much better.

Dr. Joanne Conroy:

I neglected to introduce Will who's chairman of our department of psychiatry at Dartmouth Hitchcock. Thank you Will.

Scott Spradling:

Thank you Will. This is related and in some cases may be covering some of the same ground, but out of respect to Jake Berry from New Futures who was trying to connect with us. He has a behavioral health question that is as follows.

Scott Spradling:

Thank you for your commitment to behavioral health. As you know, this is a primary concern across the state. It seems like your plans differ or I'm sorry, call for much more significant investment in inpatient and specialty care and mental health.

Scott Spradling:

Can you touch on why this is and how you plan to support integrated behavioral health in the communities that you serve? And do you plan to report on future investment decisions and outcomes to the public?

Dr. Joanne Conroy:

That's you again Will.

Scott Spradling:

You're back up.

Dr. Will Torrey:

So that's a great question. So our sense is that there's never going to be enough psychiatrists to care for all the psychiatric illnesses that happen in New Hampshire or anywhere.

Dr. Will Torrey:

And so we've really worked for many years on how to leverage the specialty knowledge to touch more lives. And one of the key ways to do that is to build it in systematically into primary care so that you have screening and then decision support and resources that help the primary care doctors to be more effective.

Dr. Will Torrey:

Primary care doctors can do an awful lot of mental health care but they can do a lot more when someone has their back, when someone's there if there's a challenge and if they have some support from a licensed social worker in the practice itself.

Dr. Will Torrey:

And so we've been working out how to do that. So we believe that integrating the care right into primary care, putting psychologists in specialty care, putting really good mental health care for people that are inpatients, because a lot of inpatients have co-occurring substance use disorders or psychiatric illness.

Dr. Will Torrey:

And if you're going to address both at the same time, their outcomes are much better. And so we think that a real place to put the energy is actually in outpatient, it's in emergency rooms. It's in hospital care in combining it with general medical care for more effective whole...

PART 3 OF 4 ENDS [01:21:04]

Dr. Will Torrey:

Combining it with general medical care for more effective whole healthcare.

Scott Spradling:

We'll stay there for just a second. Jake has a follow-up but I think it's more of the numbers and accounting and less about policy. His follow-up is, this merger could have broad impacts on healthcare access and costs across the state for years. Will you commit to publicly reporting on consolidation outcomes over the next five years?

Dr. Joanne Conroy:

I think I need a little bit more definition in terms of consolidation outcomes, meaning our outcomes in behavioral health. So we are already tracking how many people have access to MAT or medically assisted treatment, that actually come through our facilities and our goal is to have a very high percentage of people that are, have risk factors, actually be evaluated and be offered MAT if they do need it. We are talking about expanding access across the Southern part of the state. That runs the gamut between both expanded inpatient beds as well as outpatient services. Will, do you want to add anything else?

Scott Spradling:

Anything more?

Dr. Will Torrey:

And then for substance use in particular we also are really interested in expanding our training capacity so that psychiatrists get more addiction training but people that are general medical physicians also have access to more specialized addiction training because that just creates more opportunity to meet people when they have that need. I guess I would also want to say, up at the Academic Health Center, we have a lot of experts in addiction. We have tremendous expertise in how to use tele or how to use digital technology to help people have substance use disorders and how to build that in. There's a National Institute of Drug Abuse Center at Dartmouth that our department's deeply involved with them. And so we do research studies on addiction in emergency rooms, in primary care settings and having a bigger system allows for more knowledge to be built and those research projects bring resources to system to increase care as well. And also you get to have cutting edge care. So I think that that academic angle is really helpful and the combination agreement enhances that opportunity.

Scott Spradling:

Thank you Will.

Dr. Joanne Conroy:

Thank you.

Scott Spradling:

See nothing further. I'll go to the next question. Peter Leishman is here in the audience and I would like to call him up.

Peter Leishman:

Thank you, Scott. Good to see you.

Scott Spradling:

Good to see you too, Sir.

Peter Leishman:

I do have some written testimony but I won't read it. I'll just provide some pieces of it but I like to give it to the Attorney General's office. I certainly appreciate you all here with your presentation. I'm sure I speak for everybody behind me but I'd like to read one particular thing in the sentence paragraph. The proposed agreement between Dartmouth GraniteOne hopes to quote realize system wide operational efficiencies over time. As we all know, Cheshire Medical Center is nearby. And a business model might suggest that consolidation of some services would make good business sense. What assurances are you giving the residents of this area that we won't see a loss of services because as we all know, a commute to Keene or Nashua for a life threatening emergency could be life ending.

Peter Leishman:

For those of you that aren't familiar with our area, we live in a valley and then during the winter it becomes inaccessible at times. I live off 101, near pets, not pets, near Temple Mountain and oftentimes the road is closed during the winter. Often the folks around town call it Scary Mountain. And to the East to [inaudible 01:25:12] we also have hills and mountains, as the locals say Scary Lake, to get around. So I'm very concerned about this merger and the impact and certainly would echo some of the comments that Mr. Irwin made earlier. Thank you.

Scott Spradling:

Thank you, Peter. Cindy.

Cindy:

Thank you. Thank you, Peter, for joining us tonight. And I just want to say that our board of trustees very meticulously asked the same questions to make sure that the combined system recognized the importance of our local community hospital. The system is about stability and growth. You heard us talk previously already about lack of beds and lack of access. The proposed system needs our beds and they are committed to maintaining our local community care. It is important to our board of trustees and I feel the agreement that we have, the combination agreement, supports that principle. Anything Joanne or Dr. Pepe want to add?

Dr. Joanne Conroy:

Sure. Yeah, I would say that again, the best evidence of our future conduct is our past performance. If you look at our critical access hospitals that are in our system, we have only expanded services there and we have no plans to decrease any services at Monadnock. And in fact, our first conversations will be, how can we provide services there that allow people to actually remain in the community?

Scott Spradling:

Another text question for the board. What are the entities specific plans for the future given the impact of COVID-19? Cindy, you referred to this actually in the conversation in your presentation before but this question asks about whether the controlling organization will be transparent in decision making and responsive to local communities and decisions and did this add urgency to this proposed combination, given the circumstances that we've all faced the last 18 months to two years?

Cindy:

Certainly it has added urgency, I think. During our pandemic we have lost even more clinicians, some planned and some unplanned. We are continuing to lose staff. Very difficult to compete in that environment. It's a national problem. The combination is here to shore up and strengthen what we do together. I will tell you that during the COVID-19 pandemic, our hospitals, and we were part of a regional call and we are still part of a regional call, every single day about beds. What beds are available, the kind of beds that are available and where can we best place our patients? Dartmouth and CMC are both higher level of care organizations. We have local beds. Sometimes the larger facilities beds are full and we can assist those organizations by taking patients in our community to free up the higher level beds at Dartmouth. So that's an example of how we can come together and the things that we can do for our communities.

Scott Spradling:

Anything more? Okay, thank you. Another question from the chat. I'm going to actually combine two because it's essentially around the idea of transparency of reporting, around the finances. So one of the questions leads off with the sense that parents and businesses have lost some faith in healthcare delivery. They don't necessarily trust and many can't afford it. You're combining to become the largest system in New Hampshire, controlling nearly half of healthcare patient revenue. So the question on this sheet is, how can you be accountable? And on this one, as it talks about costs through this collective effort being lowered, how do we see that as a community? How are you expected to show it and be transparent in that arena? So very similar questions.

Dr. Joanne Conroy:

So let me answer it in pieces. Each organization that's in both Dartmouth-Hitchcock Health and GraniteOne actually has transparent access to information about the cost of care on our websites. We even have people that will actually help our patients and families actually navigate. What does that mean? That is the cost of the episode of care within the facility and sometimes includes some of our outpatient care but for people to really understand the total cost of care, we have a number of financial counselors that will meet with them, to make what arguably sometimes is a difficult field to navigate, a little bit easier for patients and their families.

Dr. Joanne Conroy:

Our financial performance, large across the health system is publicly available in all the radiant agencies, publish all of it and it's available to anyone that actually wants to look at our individual financial performance. We are actually very focused on transparency and for any of you that want to access either our website or any of the government websites, it's very easy to look at our morbidity or mortality. That means patients that have complicated courses or patients who don't survive their illnesses at all of our facilities. And we're compared to hospitals across the country.

Scott Spradling:

Thank you. As a follow-up question, Mark Fournier, who is a Benefits Plan Administrator wants to ask basically about that. The difference on why institutions are continuing to negotiate individually. The difference between the dynamic with published rates and then insurer negotiated discounts. It does not appear to change the current negotiation and landscape. So why is it that this methodology might continue in the future?

Dr. Joanne Conroy:

So currently on our website you actually can see the negotiated rate by insurer and it's completely transparent. That's an expectation now for every single hospital in the country. And again, it is difficult for patients to navigate that and we do rely and hope that we have continued positive interactions with insurers because the ownership of the cost of delivering care just doesn't sit with a provider or the insurer or the patient. It's shared by all of us. This may be a whole new era of working together to make it both transparent. Making sure that people actually make decisions based on what is valuable to them.

Scott Spradling:

Thank you. Next chat question, will this transaction increase or decrease local employment?

Cindy:

I hope it increases local employment. As I mentioned earlier, we have a lot of vacancies right now and all of us across the state too. There are certainly no plans to contract our employee base. We're looking to expand our services and grow the care that we provide in our community. And so we envision that we would be able to have more employees at MCH.

Scott Spradling:

Anything more? Okay. How do you envision the landscape of providers to look like if the transaction is a success and on the flip side, what happens if this is not approved?

Dr. Joanne Conroy:

We are focusing on making the appropriate steps and arguments in order to have the combination improve because deep in our hearts, we believe it. We'll improve the care for citizens in every single one of these communities as well as improve the care for citizens across the state. We are forging ahead with that single minded goal.

Scott Spradling:

Anything else?

Cindy:

In the meantime, we continue to struggle as we are right now with recruitment and finding physicians and finding support staff for all of our clinicians, on a daily basis.

Scott Spradling:

Thank you. The next text question that came in is, how much local control will member hospitals and entities retain following this process?

Cindy:

How to answer that?

Marcia Ober:

Well, we'll retain a board, the Monadnock Hospital board. We will retrain restricted gifts of money that are given as donations to our hospital, will remain with our hospital. What else am I not thinking of? I think we'll continue to... My feeling is we'll continue to operate as Monadnock Community Hospital, as an entity that just will have more chances, more help, a wider view of the healthcare world than we have now.

Cindy:

We'll continue to do much of the same things that we do right now. The difference is that we do have a system board and remember we have a system board now with GraniteOne Health and we work very collaboratively together. There's a little bit tighter control in this system but we see that as a positive from the standpoint that we are gaining significant access to support, in so many ways for our community and our healthcare services.

Joseph Pepe:

I would just say that just like with GraniteOneHealth, all the hospitals will continue their name, their charitable mission. They will have local management, a local board and nothing will change in that regard. There will be system situations in which it makes sense but day to day operations will be local.

Scott Spradling:

The next text question, where's the commitment to value-based care to real investment in population health? This person writes that behavioral health is dwindling. ACOs have fallen apart. The IDNs are no longer active. Will Dartmouth really commit to funding integrated behavioral health in primary care practices, as they've promised in the combination agreement and how will they assure there's accountability?

Dr. Joanne Conroy:

So currently we have integrated behavioral health into many of our primary care practices. That is our current operating model throughout much of our system. That's a much broader question in terms of how do you actually move to value based care? And I... It's something that we struggle with at a industry level and they actually struggle with it at a federal level as well. We participate in many demonstration projects to try to increase our muscle, meaning our ability to operate within a different payment system and it's not something that happens overnight. Much of our business is still within a fee for service or you pay for units of service but we have increasing amounts of the care we deliver that's actually in a value based model, where we are not only rewarded for eliminating any unnecessary procedures or tests but we're also held accountable for quality metrics and outcomes. And in those we're actually quite transparent with both the insurers and the public.

Scott Spradling:

Nothing more to add?

Cindy:

I would just add to that, that we have some experience with ACOs, where we have demonstrated success with improving quality and in cost savings and the New Hampshire Value Care model through GraniteOne Health recently gave us our reports and we have some very good results. So we have seen some success.

Scott Spradling:

I regret, I don't know where this person is from because they refer to our community for context but the question is, there will be very few physicians left in our community who are not DH clinic physicians. What does that mean for patient choice?

Dr. Joanne Conroy:

So I'm going to pivot to Telehealth and COVID actually showed us that we could actually deliver care in a virtual setting that had great outcomes and was high quality. In fact, Will's behavioral health program, 80% of the care is still delivered virtually and it's made us rethink how we can deliver care. We are not the only people in the Telehealth market, across the country appreciating how powerful Telehealth is. I think we have removed the question of not having access to people that aren't employed within our system. If you have a computer, you have access now.

Scott Spradling:

Thank you. Anything more to add?

Cindy:

That's great. Thank you, Joanne.

Scott Spradling:

This question that came in from Lynn, what steps have been taken to overcome the roadblocks that prevented your previous proposal? And I'm assuming this is the previous offering between CMC and DH. Do you believe joining will allow for better negotiation of costs that can be passed onto patients?

Joseph Pepe:

I'll take the last question first. Without a doubt as we combine our collective technological and human resources, we can provide more specialty and subspecialty care, more locally. And as we've been saying, that's at a lower cost. So people won't have to travel some 65 miles to Boston and inconvenience patients and their families that have to travel all the way to Boston, if you can get care locally. As far as what happened last time, that was, I would think that they were referring to 2009, some 12 years ago. Things are much different now. I would say that we, at GraniteOne Health, have compatible cultures. They may not be the same but they're compatible. And how do we know this? We've been working with them for over 20 years. Also, back then it was two hospitals combining. Now we have two systems combining and they've been very successful with those systems.

Joseph Pepe:

Also, there's much more autonomy here. You just heard recently that the day to day operations will be local and that autonomy will extend on where hospitals will keep their name, their identity, their local management, their trustees and their charitable mission. And I also, I would say that even the GraniteOne Health, excuse me, Dartmouth-Hitchcock Health GraniteOne board of trustees, GraniteOne

Health has five trustees that they will elect out of the 12 non ex-officio members that didn't happen in 2009. I think a big reason also is the environment is very different. It's different in two respects. One, back then most of the hospitals were single hospitals. They weren't associated with any other larger organizations. Now, most hospitals in New Hampshire are with a larger system and the other way the environment is different, is that it's much, much more competitive now. You have Mass General Brigham and Women's coming up 95, acquiring Wentworth-Douglass.

Joseph Pepe:

They have a lot of work they do at Exeter Hospital. They are now coming down 93 at Salem, New Hampshire and they have doctors at the other Manchester Hospital and HCA, one of the largest healthcare organizations in the country owns three hospitals in New Hampshire. They're from Tennessee. St. Joe's Parent Hospital is from Tewksbury. This here, that what we doing now is a New Hampshire solution. And I would think we'd want to build our healthcare in New Hampshire and not export it to other states. And lastly, and most importantly, the structure is very different. Back then in 2009, the corporate arm of the Bishop CMC health system was under the parent system. Here it's not under the parent. It's separate and distinct. And that's why we say the Bishops reserve powers. Separate, distinct and undiluted. And if there's ever a question on the ERDs, the ethical and religious directors for Catholic healthcare services, the Bishop has final say.

Joseph Pepe:

Also, last time we didn't have people from a Catholic point of view. They got involved late. Here the Bishop and a conservative organization called the NCBC, the National Catholic Bioethics Center, has been there from the very beginning, guiding us through. And the Bishop, unlike last time, has been there from the very beginning, guiding us through and he even issued his nihil obstat or no objection. And he even went on to say that this is a unique opportunity for Catholic healthcare in New Hampshire.

Scott Spradling:

Thank you, Joe. Anything more to be added?

Dr. Joanne Conroy:

No, thank you. That's great.

Scott Spradling:

Okay. Thank you. That actually concludes the questions that we've received online, here in person or through the Zoom chat function. So I'd like to thank all of you for your active participation, your civility. We really appreciate it. And I'd like to turn it now over to Tom Donovan for a few closing remarks.

Tom Donovan:

Thank you, Scott. Thank you, panelists and most important thank you, members of the public, both here and remotely. This was a very civil, informative discussion we had tonight. It's the sort of discussion we need to have more of in New Hampshire but we're not done. So you can still ask questions or reach out to us, and on your screen you'll see how you can reach us at the Charitable Trust Unit at the Attorney General's office. You can either send us a letter or email us at charitabletrust2@doj.nh.gov. Thank you for coming out this evening. Goodnight.

Speaker 2:
Thank you guys.

Speaker 3:
That was the shortest hearing we've ever had.

Speaker 4:
Yeah. Thank you.

Speaker 3:
[inaudible 01:45:04] have time for five words here. [crosstalk 01:45:19]

PART 4 OF 4 ENDS [01:46:27]