Scott Spradling:

Once again, good evening ladies and gentlemen. Welcome to Wolfeboro for those of you who are here at the Kingswood Arts Center and for those watching on Zoom. Again, my name is Scott Spradling. This is the beginning of the third and final public forum on the GraniteOne and Dartmouth-Hitchcock Health combination proposal. Through the course of the next couple of hours, we will hear presentations from those involved in this proposed combination as well as expert testimony on a review that was recently conducted. This hearing is being hosted by the New Hampshire attorney general's office, and it is now my pleasure to introduce Attorney Tom Donovan the director of charitable trusts at the AG's office. Tom?

Tom Donovan:

Thank you Scott and good evening. Welcome to this forum on the proposed transaction between the Dartmouth-Hitchcock entities and the GraniteOne entities. We're happy to be here in Wolfeboro this evening. Our office, the attorney general's office has the responsibility to review transactions that are proposed between healthcare organizations. And when we conduct this review, we look at a number of factors. And that includes whether the proposal is in the best interest of the hospitals and whether it's in the best interest of the communities they serve. And that's where you come in tonight whether watching remotely or here in the auditorium. We want you to ask questions, we want you to make comments because it's important to our process. I'm all ears. When we're through with this process at some point, we will issue a report that will make some conclusions. But tonight is your night, and we look forward to hearing from you. And now I'll turn it back over to Scott Spradling who will be the moderate. Scott?

Scott Spradling:

Thank you Tom. To run through the basic schedule for this evening, for the first hour of our public forum, we will take testimony and hear from the proposal starting with Katharine London who is the principal for health law and policy with Commonwealth Medicine UMass Chan Medical School. Then our folks from Wolfeboro as well from Manchester, from Dartmouth-Hitchcock and Catholic Medical Center will make a proposal laying out the reasoning behind this proposed combination. At that point then we will open up for public testimony, questions, and comments that will come in two forms. One, in room here from the microphone in the center of the room and also from on Zoom on the chat function. Those of you watching from offsite on Zoom, please submit your questions through the chat function.

Scott Spradling:

The only request and requirement that we have is please do not submit an questions anonymously. We'd like to know who you are and where you are from. Those are the questions we are using. And for those of you who will be here in the room asking a question, I will ask the panelists to actually remove their masks if they are comfortable to be able to clearly be able to present so that everybody can hear very well. But for the purposes of not having to continue cleaning the microphone for those of you here asking a question or making a comment, please just leave your mask on. Thank you very much. I'd like to now start with the presentation portion with Katharine London, principal for Health Law and Policy Commonwealth Medicine, UMass Chan Medical School who has reviewed this on behalf of the attorney general's office. Katharine?

Katharine London:

Hi, thanks Scott. So yes, so my team and I have spent a number of months much longer than we expected since this all got delayed during the pandemic. But we've been looking at this transaction for the past year and a half to share some information about it with members of the public so that you have a better sense of what's happening and then you can develop questions and an informed opinion about it. This is a very complicated transaction, and so I'm going to spend a little time going over it. In your packet, you have a fact sheet that we developed that has a lot of detail. I'm not going to read from this word from word. You can follow all the data, but I'm going to try to pull out some themes as we go through. Next slide.

Katharine London:

So I'm going to first go through some background on the transactions, some pros and cons, what's actually happening and then provide a little bit information about the hospitals and how they compare to each other in terms of cost and quality and benefits to the community. And then I'm going to stop at the end, go through a number of questions that you might consider as you're thinking about this transaction. And so as I'm going through, if you have thoughts or there's something that you're particularly concerned about, that would be a good question to write down, and you can ask it of the panel later on. So next and next.

Katharine London:

So as you know, GraniteOne and Dartmouth-Hitchcock are proposing to combine. GraniteOne is a system of three hospitals, Dartmouth-Hitchcock is a system of five hospitals, and they each have a number of clinics and other entities. And they're joining together to form one big, big organization. Next. And the reasons why they're doing this and this is from the materials provided by the hospitals, they're manyfold. One overriding issue from the point of view of Dartmouth-Hitchcock is an academic medical center. And it's basically competing with other academic medical centers that are further away and tend to be in large population centers. Dartmouth is up in Lebanon and does not have a big population center to draw on. If you're an academic medical center and a teaching hospital and a medical school to provide a full range of services, particularly specialty services, you need to have enough patients to keep the doctors busy focusing on their specialty. Because if you're a doctor who has a very narrow specialty and maybe they enough patience for you to focus on your specialty two days a week, then the other days you are just doing general doctor stuff.

Katharine London:

And that might not be so exciting for a doctor to join that kind of a institution and they might prefer to go somewhere else. So in order to attract the full range of specialists, Dartmouth needs to draw more patients to Dartmouth. So that's one piece of this. Another piece is that rural hospitals like Harvard have patients who need a wide range of services and right now have to drive a long way to get those services. So to the extent that Dartmouth and GraniteOne together can make a really broad range of services available at the local level through telehealth or through having their doctors travel to visit every now and then or making it easier for you to get to Lebanon, that makes more services available closer to home either here or in Manchester or in Lebanon.

Katharine London:

So that's the overall frame of why do this. The hospitals also have a goal of spreading infrastructure across all of the hospitals in the group, which can bring down the cost of operating. They can have some joint purchasing, which brings down the cost of buying services. They would like to spread best practices

for quality and safety, which can have an overall benefit investing in workforce development. Dartmouth has a whole workforce development institute where people can train for a wide range of health professions, and those staff could then be made available back to other hospitals in New Hampshire. And they would like to invest more in mental health and substance use services for the communities. So that's generally the reason for doing this. So next slide.

Katharine London:

So that sounds great. And what might you be worried about? So this is going to be a very big group, what does that mean for others in the state? It will be a big competitor for other healthcare facilities, it will have a big voice with insurers, with state regulators. There's a concern that the additional investments that the group wants to make in individual hospitals could result in debt that those facilities need to pay back. So there's a concern that rates could rise in order to pay for those costs. There is a concern about local control and what issues the local board will be able to control versus what will be deferred to the board, what if this large group overrides decisions of the local board? So that's a concern.

Katharine London:

And then for Catholic Medical Center that has a very strong Catholic identity, there's a concern around, and we heard from some people actually at the hearing on Thursday, there's a concern about the compliance with the ethical and religious directives of the Catholic Church and how that will be managed and how all the other facilities will be exempted from those directives and how those two will fit together. So there's some complications here. And these are not things that will happen, these are things that could happen that people have expressed concerns about.

Katharine London:

I should mention also, next slide, there was a previous proposal. So Catholic Medical Center and Dartmouth-Hitchcock had proposed to merge a number of years ago, and that transaction did not go through for a number of reasons. The parties of this transaction are a little bit different because it's the two groups and not just those two hospitals. But they feel that they have taken those issues very much to heart and addressed them and that this proposal is substantially different and so we shouldn't expect that it's going to go the same way. Next.

Katharine London:

So this is the complicated governance part of this. So the overall organization is going to change its name to Dartmouth-Hitchcock Health GraniteOne. There is a plan for one board that's going to oversee all of these entities, eight hospitals, clinics, CNAs, everything. I'll go to the board issues in a minute. Actually, you know what, go ahead to the next slide. I'm going to just show the picture because it's a little bit easier. I'll keep talking. So the plan is that the Dartmouth-Hitchcock hospitals that are the green hospitals on the slide will continue to be a group and will constitute region one and will report up to a region one president who to start with will be Dr. Conroy who's currently the president of Dartmouth-Hitchcock. And then region two is the Granite hospitals and clinics will report up through Dr. Pepe who is currently the president of GraniteOne.

Katharine London:

So those structures will continue. Catholic Medical Center will also report up through the bishop of Manchester for the purpose of these ethical and religious directives of the Catholic Church. So that sort

of dual reporting structure continues. If you go to the next one. This is a chart that actually comes from the hospitals' documents. So this is the plan for the seats on the board of this overall, the board that's going to oversee all of these different entities. And there are a number of seats set aside for Dartmouth-Hitchcock board members are green and then GraniteOne members are blue. And then there's people who serve based on their positions in the hospitals in the next official capacity.

Katharine London:

What's unusual here, so each of these terms, they're either one, two or three-year terms. But what's unusual is that they automatically renew for another three years. So the plan is to have no change in the board makeup for four years, which I guess is probably to maintain stability of vision, but it's very unusual. And I have to just say, I keep saying that at each hearing, I have never seen a transaction that had this structure before. That usually the boards are supposed to turn over members and they have term limits so that you have new people coming in who have a fresh view, fresh ideas, test the going ideas of what's happening. And that's not going to happen here, there's just going to be the same people for four years, no possibility for change unless somebody chooses to leave. And then they can continue for up to nine years, so that's a very long time for a board. Next, and actually go ahead to the next one. Look at the picture here.

Katharine London:

So this is again about the ethical and religious directors of the Catholic Church. This is a complicated plan, but the idea is that services that comply with the ethical and religious directives will report up through the region two president. These are the GraniteOne hospital services that comply will report up through the region two president. But to the extent that hospitals like Huggins provide services that don't comply with those religious directive, they will report up through the region one president. So it provides some flexibility here at Huggins. Let's see, let's go ahead. And the next one.

Katharine London:

So this is just some basic information about the hospitals. This chart only shows the four community access hospitals, so Huggins and Monadnock are currently part of GraniteOne and Alice Peck Day and New London are part of Dartmouth-Hitchcock. And I thought it would be helpful just to show them all together because they're hospitals that are similar to each other and will likely fare similarly under this new plan. So there's some statistics in the fact sheet that show you that they are sort of similar. Next. So this is a map to show what the transactions are going to look like. So the dark green are the five Dartmouth-Hitchcock hospitals, and the GraniteOnes are in a purple-ish color. You can see Huggins up in the middle here. On the east side, you know where you are.

Katharine London:

It's still a ways to Lebanon and a ways to Manchester. But as you know, from having been part of the GraniteOne these last years it does provide some support to the local hospital. And this transaction is aiming to provide a little bit more support to the local hospital. Next slide. And this is to just emphasize this issue about academic medical centers. So you can see Dartmouth way up there in Lebanon. And we know that folks in Southeastern New Hampshire tend to go South if they need specialty healthcare. They leave the state, they go to Boston or they go to UMass. And a lot of people don't stay in New Hampshire. So part of the goal of this transaction is to provide more specialty services closer to home. People don't have to drive as far, there are more services provided in New Hampshire and less out of state. Let's see, next.

Katharine London:

And this one is just to emphasize, this is a very, very large group. So Dartmouth-Hitchcock by itself was a huge part of healthcare in New Hampshire, adding GraniteOne makes it even larger. So this new group is going to represent somewhere a third or depending on how you count up to 40% or so of the hospital care provided in New Hampshire. And this is just hospital services, it doesn't even include the clinics and so on. But this is a big deal. Next. So one of the concerns that people had is around what the cost of services might be under this new group. And this again is looking specifically, Huggins is the third column here and comparing Huggins to these other hospital.

Katharine London:

So what we did with this analysis is we looked at the set of services that each hospital provides and we compared it to what the hospital receives in terms of payments for its services and what payment it would receive at the average price for the state. And it's a little bit all over the place, but in general Huggins has lower prices for office visits, outpatient services, a little bit more higher for radiology services, but it's sort of in the middle. The other community critical access hospitals are pretty much similar, there's just not a big difference here. And so when you join this big group, we're not expecting that the prices will be particularly different at Huggins. And I don't have these slides here. But in Manchester at Catholic Medical Center, there is a goal to invest in more specialized services than are provided right now at Catholic Medical Center.

Katharine London:

The cost of those services will be higher than the average of what Catholic Medical Center provides now. They're more expensive, more intensive services. But probably the cost of providing those services in Manchester will be less than the cost of providing them in Boston because of the higher cost of salaries and real estate in Boston. So there is some savings there and also the savings in terms of not having to travel as far. The next slide is about out-of-pocket costs from uninsured people. Huggins cost uninsured people are quite low but very similar to New London. And again, we're not expecting to see any change there. Next, let's see.

Katharine London:

And we looked a little bit at the financial health of the hospitals. For many of these transactions that we review for the attorney general's office, the hospitals are coming together because one of them, one or more of them are in really deep financial trouble. And if we don't go forward, there's not going to be a hospital. That is not the case here. These hospitals are in decent shape. Whether they stay separate or join together, we're not concerned that any of these hospitals are about to go out of business. So this is looking at operating margins for the four community hospitals, for, I'm sorry, critical access hospitals. The top dark line is the average operating margin for New Hampshire hospitals. Critical access hospitals by and large have lower operating margins than the average.

Katharine London:

So this is basically the income earned on patient services based on the payments received for those patient services. Critical access hospitals have really hard time keeping up just based on their payment rates. Huggins is the sort of diamond shape line that runs through here and is not too dissimilar from the other hospitals. But when you look at the next slide is total margins, so that brings in other sources of revenue, supports from the state, from philanthropy, other kinds of revenue. It comes up, again, not as

high as the average for all hospitals, but above zero and at a point where we're pretty confident that the hospital can keep doing what it's doing. So not a concern there.

Katharine London:

The next one, so this is just looking at some really basic quality measures, and Huggins is the third column. Huggins scores very, very well in quality measures that by far the highest of all the hospitals we've looked at. Perhaps the other hospitals in the group will be coming to learn from Huggins, and patients rate it very highly. You all love your hospital. And that's not likely to change. This investment having access to more services through the telehealth is not going to bring down that level of quality. Next slide. So this is the set of communities that the hospital primarily serves. This is based on its own map of the benefits that it provides to its community, this isn't based on any kind of competitive thing, but these are the communities.

Katharine London:

And the hospital has a plan that it files every year with the attorney general's office that talks about the benefits that it provides to its community overall. Next slide. Carroll County is a pretty healthy place to live as you wall know. There are some challenges, but by and large, it looks better than most communities. The challenges that did stand out are higher rates of asthma and hospitalization due to asthma and then also a lack of mental health providers so that people struggle to make those appointments. So those are some things to consider as you're thinking about these things. See if we can jump to ... So this is, as I promised, we had put together a set of questions to consider. And I'm going to talk through these, and you can can think about whether these are questions you would want to ask.

Katharine London:

So overall as Tom Donovan said, we're looking at is this proposed transaction in the best interest of the community? And there are a lot of different ways to think about that question. So will the transaction provide financial stability for the Dartmouth-Hitchcock hospitals and clinics, for the GraniteOne hospitals and clinics and for competitor hospital and clinics are there concerns there? Will the transaction result in higher in state costs for care or lower costs or contain costs? Will the transaction bring new revenues into the state? Will the transaction improve access to care or create access issues? And particularly, you can think about access to different services, primary care, maternity care, mental health, and substance use services, general hospital services, specialty hospital services. Will the transaction maintain access to services for uninsured individuals, for people who rely on Medicaid or Medicare, what will the effect be on local employment? Next.

Katharine London:

What will the effect be on quality and safety of care? Will the needs of the local community be taken into account? When this large group sets its priorities? How much local control will the board maintain? Will a patient being treated at Catholic Medical Center, a facility that's covered by the ethical and religious directives for healthcare services, will a patient who is there be informed that services that are not allowed under these directives are available at the member hospitals? And how will patients be aware of what those directives are and how they apply? And then specifically for Dartmouth, how will this affect Dartmouth's ability to attract specialty physicians and bring research funding into the state? So a lot of big questions, I'm going to hand it back to Scott.

Scott Spradling:

Thank you Katharine very much, appreciate that. One quick adjustment for the panel and for the rest of the hall, our hosts respectfully ask that I keep my mask on and the panelists do the same for their presentation out of an abundance of caution. So we will do the best we can to maintain clarity while keeping our masks on for the remainder of the evening. I'd now like to hand things over to the panel. Our introductions for tonight, Jeremy Roberge who is the president and CEO of Huggins Hospital, Dr. Joseph Pepe, who is the CEO of GraniteOne Health, Dr. Joanne Conroy, the president and CEO of Dartmouth-Hitchcock Health, and Howie Knight, chairperson of the board of trustees for Huggins Hospital. Jeremy, the floor is yours.

Jeremy Roberge:

Thank you Scott. Hopefully everyone can hear me okay. Welcome and thank you all for joining us this evening to hear about our proposed combination with Dartmouth-Hitchcock Health. I want to start off by thanking Katharine for setting the stage for us with an excellent presentation. And thank you also for emphasizing our high equality scores, I really appreciate that. I'd also like to thank those of you that joined us tonight via Zoom. We do have a very short presentation to go through tonight that'll just cover some of the highlights or the benefits we can expect for our community and for Huggins Hospital. But most of all, tonight's to hear from all of you. So there'll be plenty of time at the end for you to ask questions and for us to answer your questions. I want to start off first by talking a little bit about what's happened in the healthcare landscape over the last few years.

Jeremy Roberge:

When I first started at Huggins in 2012, just before that, the state of New Hampshire was essentially all independent hospitals with the exception of HCA. Now, today, almost every hospital in New Hampshire is part of a larger system. And when you look at the hospitals around Huggins Hospital in particular, people in our service area do have a choice. And within a half hour drive to an hour drive, depending on where you are in our service area, there's several other hospitals you could go to. All of those hospitals are in a larger system. Memorial Hospital in Conway is now part of Maine Health, Frisbie Hospital who struggled financially for a couple of years and urgently needed to find a partner is now part of HCA, which is one of the largest systems in our nation. Wentworth-Douglass is now part of Mass General. And Lakes Region who also struggled financial and filed for bankruptcy is now part of Concord Hospital's new system.

Jeremy Roberge:

I'm very pleased and proud to say that Huggins is not in those difficult situations right now. We're actually very strong, and we've remained strong for a number of years both clinically and financially. And over the past few years, we've actually seen quite a bit growth by investing and expanding our primary care services and our surgical services along with strengthening our emergency department. We've been able to do all of this even through a pandemic largely due to our incredible and dedicated workforce. We have some of the best employees, and I really can't say enough about what they've done for us and for this community especially over the past year and a half. Our goal in joining this system is to continue this growth and continue the strength that we've seen at Huggins Hospital over the last few years and look for opportunities to add new services. By expanding services in Wolfeboro and our surrounding areas along within Manchester, we hope to keep our community closer to home when they need healthcare services. Next, slide, please.

Jeremy Roberge:

It's hard to believe we started on this journey almost three years ago. And when we started on this journey, we knew that we were dealing with an aging population in need of more services. We've seen times where patients needed to be transferred to another hospital. And due to a lack of beds in New Hampshire, that was very difficult for us to do. We've also seen the negative impact on behavioral health patients not getting the services they need in a timely manner. And as I've already mentioned, we've seen significant change in the competitive landscape in healthcare. All of these changes exist today and were only intensified by the pandemic.

Jeremy Roberge:

Combining with Dartmouth creates a New Hampshire based solution that will help us meet the growing needs of our community. It's always been important to Huggins, our leadership, and our board to be a part of a New Hampshire system, especially a New Hampshire system that's proven that they understand and support the unique challenges of rural healthcare. And we look forward to having that all accomplished as part of this new system as we join the Dartmouth system. Next slide, please. I'm now going to turn the presentation over to the Huggins Hospital board chair Howie Knight to say a few words on behalf of our board of trustees.

Howie Knight:

Thank you Jeremy. On behalf of the board of trustees of Huggins Hospital, I want to welcome you all here tonight. My job along with all the board members has been to make sure we do a fiduciary responsibility to protect the hospital and promote our mission. We are a small critical access hospital. Therefore, we cannot meet all of our clinical needs on our own, we need to partner with a larger hospital. A good example is our longstanding partnership with Catholic Medical for heart and vascular services. As part of our financial responsibilities, we have examined the financial health of Dartmouth-Hitchcock Health and negotiated alongside them during this whole three-year process. We feel Dartmouth is a natural partner for us and our GraniteOne hospitals. And you'll hear more about that through this brief presentation.

Howie Knight:

One focus I want to point out is the support for rural healthcare, we are a rural hospital. Throughout this process, it's been clear that we all, meaning all, I mean, everybody that's been negotiating has a current understanding of what it means to serve the rural community. And we are committed to keeping that rural health and rural hospital strong. I look forward to hearing what questions you may have. Thank you for being here. Jeremy, back to you.

Jeremy Roberge:

Thank you Howie. Next slide, please. So this slide focuses on some of our priorities and what we intend to do to strengthen rural healthcare. I want to start off by mentioning what we already do partner with Dartmouth on, some fairly new contracts that we have with them to provide radiology services or physician services for our radiology department, which have been a huge improvement in the level of service and the quality of care that we've seen over the last year or so since joining Dartmouth on that. We also partner with Dartmouth for telepharmacy. So they provide coverage for us when we don't have a pharmacist on site, which again has also been a great improvement for us. And of course, we're looking forward to the benefits of even more partnerships as we join this system and have a tighter alignment with Dartmouth. As Huggins has grown as I've mentioned previously, what I did not mention is we're starting to feel the pressure of limited resources to continue that growth.

Jeremy Roberge:

A lot of these limited resources come naturally from us being in a rural setting, and it also comes from the strains of the pandemic over the past year and a half. Again, just to give an example before the pandemic we've seen probably close to a 15% increase in our volumes over the first couple of years before the pandemic, then through the pandemic. And today we've seen another 25% increase in our patient volumes. And we have not seen the same kind of increases in our FTEs. Again, some of that due to the strain from the pandemic and some of it due from the issues of living in a rural setting. We're looking forward to joining a system that will help us by offering more services in the form of telehealth.

Jeremy Roberge:

As I mentioned, we already do telepharmacy and some teleradiology. But we're looking for increased service support with our inpatient services and our emergency department. We're also looking forward to building more capacity in Southern New Hampshire. As I mentioned earlier, we've had times where it was very difficult to transfer patients out of our hospital, and we hope that this will make it much easier on us and get patients to the higher level of care that they need without having to look to out-of-state options or without delaying the care that they need.

Jeremy Roberge:

Eventually we'll move to a more integrated information system. So we're excited to be a part of that and have that benefit to our patients. Dartmouth has a much more capable, more elaborate system that again will be integrated across the entire system. And what that means for our patients is that when they have their primary care services or emergency department services at Huggins and need to be transferred to Catholic Medical Center or to Dartmouth or if they go there for additional services when they arrive at those facilities, the providers there will have a complete and direct access to all their medical record information further improving the coordination of care between our facilities. And again, as we've mentioned, the main goal of this system is to expand services locally and support the needs of each hospital in our system. Next slide, please.

Jeremy Roberge:

One of the biggest priorities of this new system will be to strengthen behavioral health across the state for those who need mental health and substance use disorder treatment. As individual organizations, we've done our best to care for those who need support. But oftentimes too often, we've seen patients staying in our emergency departments and our inpatient units for extended amounts of time waiting for the appropriate service to become available. Our new service will create a strong statewide network of support with investments of over 20 million toward behavioral health services. At Huggins today, we do provide some services which include MAT or Medication Assisted Treatment. We provide those services in our emergency department in our primary care offices.

Jeremy Roberge:

We also provide counseling services through our licensed social worker who quite honestly has a schedule that is always full and we're never able to get people in quick enough to see her. And we've also partnered with local organizations to provide peer recovery coaches and mental health evaluations in our emergency department. With the added support of our new system, we're looking to expand our services to include even more mental health and substance use treatments, including clinical support for psychiatric care. Next slide, please.

Jeremy Roberge:

Another important service that actually right now is not currently offered at Huggins Hospital is cancer care. Many people in our community currently travel close to an hour several times a week to receive cancer treatment. Cancer is the leading cause of death in New Hampshire. And in our last needs assessment that we did, Carroll County was shown to have a higher rate of death from cancer than the rest of the state. As a rural hospital, we know this is an issue, but it's very difficult without being part of a larger system. It's almost impossible at times to hire a part-time oncologist to run an oncology program, which is why we don't have one today. By combining with Dartmouth, we'll finally be able to add cancer treatment of Huggins and support early intervention needed in our community. This obviously means a lot to us and our patients, especially to those patients who require daily infusions of chemotherapy. Next slide, please.

Jeremy Roberge:

We already have a great long-term relationship with CMC to provide health and cardiovascular services. And with this combination, we could see the addition of other specialty services, which would include spine care and obesity management. Our community will also have access to clinical trials and research through our connection with an academic medical center. Next slide, please. I'll now turn the presentation over to Dr. Conroy to cover the next three slides.

Joanne Conroy:

Thanks Jeremy. We are the most rural academic medical center in the country, so we acutely understand the challenges for both providers and patients who often have to travel hours to receive care. There are some advantages to having us all work together, the least of which is access to the Norris Cotton Cancer Center, which is one of the 51 cancer centers across the country that are designated by the National Cancer Institute. We are very fortunate in that we have access to close to 600 clinical trials currently, and 170 of those are in oncology. Research in oncology actually saves lives, it proves care. We did much of the groundbreaking research in this state on remdesivir for the coronavirus. We were working on the convalescent plasma studies, and that is research that translates directly to patient care.

Joanne Conroy:

Because we're an educational institution, we've invested heavily in our educational programs for all staff. Our Workforce Readiness Institute has been incredibly successful in retraining New Hampshire citizens for jobs in healthcare and actually affording them a career ladder in a whole range of specialties from medical assistants and pharmacy techs, which are in high demand across the state to surgical techs as well as certified nursing assistants and just an expanding array of career opportunities that we hope to expand across our entire new combined system. We also are fortunate to have an incredible data analytics institute where data helps us make better decisions for patients. And when you can actually marry data with clinicians and present patients with their options, it just benefits care for everybody. Next slide.

Joanne Conroy:

Our focus has been delivering care closer to home. Let me talk a little bit about the out migration of patients. Now, out migration of patients aren't patients that just live on the New Hampshire, Massachusetts border and actually closer to hospital. We're talking about 10,000 patients that actually drive by other hospitals in New Hampshire to receive care in Massachusetts or New York. We know what issues these patients travel for, and 80% of them could be served at state. They're low acuity

patients, we have both the expertise and the services to care for them here. Well, why is that important for the citizens of New Hampshire? The cost is significantly higher both in commercial and Medicare for those patients that receive care in Massachusetts. And then not only does that cost the entire healthcare system more, but we also have a number of patients that high deductible plans in the state. And so it hits their pocketbook.

Joanne Conroy:

And that's something that we need to make sure that patients have alternatives to receive lower cost care closer to home in the state. Next slide. So when we go through the checklist of how we're delivering value on this combination, we focus on great care, more affordable, and closer to home. We focus on improving access to academic medicine and all its glory, its research, its education, and creating an academic health system where everybody advances their career if they're a frontline staff or a clinical researcher at any of our facilities. We need to educate and generate the next group of leaders for this state. That means nurses and physicians and the whole range of allied health professionals.

Joanne Conroy:

By coming together, we will also create a level of financial stability for the hospitals in the system. We're going to hold hands and sit on the same bottom line together and make decisions about where we need to invest capital so our organizations can each grow and meet the needs of their community. And we pledge that each hospital will maintain their payer negotiations. So when people do say, well, why does it cost different for me to have my hip replacement at hospital A versus hospital B in our system, it's because each individual hospital will already maintain their payer negotiation separately. And all of that is already at a lower cost than in Massachusetts. So let me turn it back over to Jeremy.

Jeremy Roberge:

Thank you, Dr. Conroy. Next slide please. So this is our last slide in the presentation. And what I want to point out here is that our mission to empower the fulfillment of life through better health and our vision that we will be the community's home for health and wellbeing, both of those remain intact and supported by this combination. One of the main reasons Huggins is so strong today is because of our commitment organization-wide to this vision and mission as well as our support for our employees through our strong family-like culture that we have. We'll keep this culture and we'll remain focused on our strengths well into the future as part of our new system. Being part of a system with Dartmouth-Hitchcock Health is just another example of us being proactive and taking advantage of an opportunity to continue our success. That concludes our presentation for tonight, and we will open it up for questions and answers. Thank you all very much.

Scott Spradling:

Jeremy, thank you very much. Again, we are receiving questions from both here in the room but also from those on Zoom who are watching us offsite. Please use your chat function to type in a question, that'll actually be jotted down and given to me here in real time as best we can. We'd like to get to the questions. Some quick ground rules. For those who are speaking, please keep your comments or questions to two minutes and then we will give the panel a chance to be able to answer. For those who have signed up. I'll just call you up right there to the microphone in the middle of the room one at a time. Please keep your mask on when speaking, the microphone will certainly be able to amplify your voice.

Scott Spradling:

When asking a question, please state your name. When the panelists are done with their question, the next person can step forward and I will call them. I will intersperse the in-person sign-ups with what we have gotten on Zoom and some questions that we have also received online in advance. So with that, I would like to start by calling up the first person Ken Norton.

Kenneth Norton:

Good evening. My name is Kenneth Norton, and I have family members with mental illness as well as substance use disorders. I offer my comments on behalf of NAMI, New Hampshire, the National Alliance on Mental Illness where I currently serve as executive director. Dartmouth-Hitchcock is a leader in our state in the area of mental health. Time prevents me from providing more detail about this, but I will do so in my written testimony. Today's focus is whether this proposed merger meets the needs of communities involved, communities who have rated mental health and substance abuse treatment as among their top areas of need.

Kenneth Norton:

For over a decade, New Hampshire has been in the midst of what Governor Sununu has repeatedly called the mental health crisis. Two of the most visible facts of this are high rates of suicide and the inhumane practice of people in a mental health crisis being boarded in emergency departments for days and weeks waiting for an inpatient bed. Yesterday, there were 18 adults and 25 children waiting. In 2016 in the midst of this crisis, Dartmouth chose to close the voluntary inpatient unit at Cheshire Hospital. It's remained closed since then then removing an important community resource and compounding the daily emergency department boarding crisis in our state.

Kenneth Norton:

Dartmouth operates the only children's hospital in the state and has expertise in child psychiatry. It offers no inpatient psychiatric beds for children, demand for which has more than tripled since the start of the pandemic. Despite the statewide need for inpatient psychiatric beds, Dartmouth and CMC are constructing new inpatient capacity, which to the best of our knowledge does not include any additional inpatient psychiatric beds. Dartmouth stated focus on outpatient mental health care is the philosophical and business decision that's inconsistent with their mission statement and does not meet the current mental health needs of our community. Please excuse my social work math if I miscalculated, but Dartmouth's proposal to invest 20 million in behavioral health during the next five years represents less than 1% of the overall budget of the combined systems involved. Despite the innovations and excellence, the institutions in this proposed merger have Dartmouth Health and all of the other systems, this investment in mental health and substance use disorders is wholly inadequate and does not reflect the community needs in the areas served by these many hospitals and systems.

Kenneth Norton:

My questions are will Dartmouth commit to increasing psychiatric inpatient capacity by reopening the Cheshire inpatient unit, adding children's inpatient psychiatric beds, and consider adding other regional mental health inpatient beds? Does Dartmouth currently have the capacity to meet outpatient demand across the system, and will the combined entities be able to do so in the future with reports that the pandemic has resulted in increased stress, anxiety, and depression across all age groups? And will Dartmouth commit to investing in mental health services on par with other disease conditions and at a

level which meet current and future needs of the communities this proposed merger will serve? Thank you.

Scott Spradling:

Thank you very much. Jeremy, I'll start with you.

Jeremy Roberge:

Since most of that seems like it was directed at Dartmouth, I will actually turn it over to Dr. Conroy. I don't know if you want to answer it or have our front row expert talk about it.

Joanne Conroy:

I'm happy to answer it. So thank you for your comments. And mental health is one of our biggest priorities in this state. We have been following actually the 10-year mental health plan, which as yet has not necessarily been fully activated. But all of our recommendations and all of our commitments align up to support that. But what I'd like to do, I've got an expert here in the audience, Dr. Will Torrey who has been very involved in designing how we should actually meet the growing demand in the state and can address many of your specific questions. But thank you for your comments. Will?

Will Torrey:

Thanks very much. Ken and I have worked for many years to increase access to mental health care in this state, so I really appreciate your advocacy and your comments and wisdom that you've brought to our state over many years. These are extremely common difficulties. Part of the challenge here is that about half of Americans, half of us will have a mental health or addictive difficulty at some time in our lives. This is really a huge number of people. And the illnesses are painful and difficult, they actually account for 25% of illness of health-related disability, which is higher than for cancer or diabetes or heart disease. So it's a huge problem nationwide, and it's clearly a big issue here in New Hampshire. Nationwide only about 40% of people with a psychiatric illness get any care at all and about half of that care is from a mental health specialist. So there's a huge gap between what's currently available and the need.

Will Torrey:

And any one of us who's tried to help ourselves or a loved one get care understands that access to timely science-supported mental health or addiction care is extremely difficult. This combination agreement creates a wonderful opportunity to expand access to care. We've been meeting for three years to think about where can we put resources that would have the greatest impact on the population health? We've been moving ... And a lot of the thinking is that increasing access to care where people go, primary care, emergency rooms, and inpatient hospitalizations for non psychiatric illness. Making screening in science-supported care right there will stave off more serious difficulty and help people get care at the point where they go for help anyway. In addition, the addition at Hitchcock does increase our inpatient beds sum, and we have committed to five designated receiving facility beds, which is new for us and we're in the process of sorting out how to do that architectural at Hitchcock.

Will Torrey:

The other topic that's related to this is having, an academic health system being engaged across the state will allow us to expand our training of social workers, psychologists, psych nurse practitioners,

psychiatrists and specialists psychiatrists. And people do tend to stay where they train. So in brief, I think that this is an opportunity to expand care across the system. We can use many of the models and spread them elsewhere, and we believe it will have a major impact. Thank you.

Scott Spradling:

Thank you Will. Is there anything more to add on that question? Okay, seeing none, I'll move to the next question that we got online. And thank you for that Will. This comes from Holly. Will you agree to transparent reporting on your consolidations outcomes over the next five years to assure the AG's office and the communities that the promises made during all three public hearings have been kept? Would you be open to some sort of a community oversight board for the first five years post combination that would hold GO and DHH accountable to the communities they serve?

Jeremy Roberge:

Go ahead.

Joanne Conroy:

Go ahead [inaudible 00:54:24].

Jeremy Roberge:

All right. I'll start and then you can take it from there. I'll just start by mentioning that it's my understanding that there's some expectation that we will be reporting to the state on many of these. We've set these out as standards and expectations that the state will be monitoring. So we will do that. I also just want to mention just in general these organizations tend to be very open, honest, transparent organizations, and we'll do everything we can to report out information as it becomes available. And we'll probably report it out because I think we'll have a lot of quality outcomes that will be good news for people to hear. So I'll just mention that and then I'll turn it over to Dr. Conroy.

Joanne Conroy:

I have nothing to add, that was perfect. Thank you.

Scott Spradling:

Thank you. Anything more? Okay, seeing nothing. From Andrew, out migration of patients is not unique to New Hampshire, UMass Memorial Health faces the same issues with its Boston counterparts. How can this merger change that when a large system like UMass Health is also challenged by this issue?

Joanne Conroy:

So I'll take that one Jeremy. People make choices about where they receive their care for many different reasons. It can be convalescent time and being close to family. It can be more commonly sometimes that their friend had a good experience somewhere and they want to repeat that experience at that institution. However, an increasing number of patients sometimes leave the state because they do not realize both the quality and the scope of the expertise that actually rests within the state. The most successful systems actually work very hard to make sure that patients appreciate the value, which is both cost and quality ad they appreciate the importance of actually receiving care close to home where their families and friends can help support them. This is not something that you can legislate or you can

mandate, but we are committed to earning the trust and respect from patients that may be looking South to instead look North for their care.

Scott Spradling:

This question comes from I believe a patient Jim from the local area. As Jeremy said, this is the fifth consolidation to affect the health system that serves Carroll County residents. As noted, systems are now controlled by the boards far from here. I have to say that for one I can't see that much improvement in access to cost of care, and some things have definitely not improved. Costs are up, and in many cases, access is reduced. How is this consolidation going to contain cost and improve access?

Jeremy Roberge:

Thanks. So as I mentioned throughout the presentation, the goal of this system is to increase access, increase services at Huggins Hospital and the surrounding hospitals in our system to make it easier for patients to get care at Huggins or when they can't get care at Huggins to have more options in the Manchester area, which is about an hour away from us. So really that's our focus. I think when you talk about the cost side of things, for me the focus is more on the volume and having more services offered to patients. That actually helps us keep our costs down, it spreads the cost across more people. So for me, it's more of a focus of maintaining the service we have, growing the services we have, which will also in turn help us keep our costs down by spreading it across more patients.

Scott Spradling:

Another question from Andrew. Michael Porter and Elizabeth Teisberg would suggest that the value equation is different than the one presented by Dr. Conroy. The value equation is outcome divided by cost. Would this merger increase quality outcomes or would it lower costs? Without either of these attributes changing, why do this?

Joanne Conroy:

So I read that book as well in 2006. And it was actually the reason I went to Washington to be part of changing how we deliver care in the United States. So there are a couple of ways in which we are going to focus on actually improving quality and decreasing cost. We know that when rural hospitals actually join larger health systems that their quality improves, although Jeremy it's going to be hard to improve your quality because it's already pretty high. But we know that comes from really sharing best practices and working together to learn from each other and improve the quality across the health system.

Joanne Conroy:

In terms of reducing costs, we are fortunate in that Dartmouth-Hitchcock is one of the highest performers, probably in the top 10% in the country in terms of eliminating low value care. That's not care that doesn't deliver any value, but it's lower value care. And that's really the first step in eliminating waste in healthcare is just asking, does this test, does this intervention, does this procedure actually deliver value to a patient? And I would say finally the increasing focus on price transparency, in all of our organizations, you can see how much everything costs according to your own insurance on our websites, actually helps patients make that value decision. Understanding the outcomes and understanding the costs, they can make a decision about where they're going to receive their care.

Scott Spradling:

Thank you. Next question. Will this transaction result in increased or decreased local employment? And what does the healthcare job market look like through the lens of this transaction?

Jeremy Roberge:

Again, as I spoke about during the presentation, our goal of this system is to increase services here at Huggins Hospital or at least if nothing else stabilize the services we have. But again, the bigger focus is on growing services and adding options for our patients. So with that in mind, I would see more likely a situation where we would increase our FTEs if they're available. The second part of that question was about the workforce, and that's one of the struggles we all have right now is currently at Huggins Hospital I think we have close to 80 open positions. And I don't see that changing anytime soon. So one of our biggest struggles is how are we going to continue to grow with the workforce shortage that we're all dealing with right now.? And we're all going to have to get pretty creative to make that work and make sure we keep our employees motivated, keep the morale up, and keep offering the quality service that we've been offering.

Scott Spradling:

Joe.

Joe Pepe:

And I would just say that bringing academic medicine and training to member hospitals really will improve care and it will help us recruit and retain top talent. And that will be great for patients of New Hampshire.

Scott Spradling:

Next question. It's basically about the affordability of the enhancements, some of the infrastructure, spending, and expansions that are going to be proposed here. From Lisa, if your hospitals combined you'll control over three billion in healthcare spending and have a monopoly on services in many regions in the state. We can't afford any more healthcare expenditures, yet many of the plans include large investments in higher end, high cost specialty care. How do you plan to lower costs when making these kinds of investments?

Joanne Conroy:

That's a great observation. I would bring to your attention however that we are in a state where the average age of the population is growing. New Hampshire, Vermont, and Maine have the oldest populations in the country. We're also not growing in terms of our state populations as quickly as the rest of the country. So we have an older population that has increasing needs for healthcare services with the same infrastructure we had 20 years ago, and maybe even a less robust infrastructure if you look at hospital closures. So right now we are in a position where we have to expand our physical plant to take care of patients that are being transferred from outside facilities that need the care at our tertiary and quaternary care facilities. I would say that we deny transfers from other hospitals. It used to be about 300 a month, and it's close to 500 a month now. CMC is often in a similar position where they have to deny a transfer, and that's simply because of lack of beds. And that's the first thing we need to do is actually address the care needs of the aging population.

Scott Spradling:

Joe?

Joe Pepe:

Yeah. And also we won't be joint contracting, which means we will not be using the size or the number of hospitals to negotiate prices. And that's very different from some of the other out of state behemoths that many more billions have and are doing at this time. So I really do think it comes down to what we said before, we'd be expanding the physical and specialty access. And when we do so, we can bring volume locally. And some of that high acuity volume, the sicker patients can go to CMC where their care can be done for a much lower cost than what you'd see at academic institutions, especially academic institutions in Boston.

Scott Spradling:

As a somewhat similar question, what kinds of innovations do you think can be achieved through this transaction?

Joanne Conroy:

I think telehealth is one of our major innovations. And we have invested for the last, I think it's five to eight years in a center called Connected Care where is provider to provider telehealth. That means that we work with hospitals to support their physicians in their ICU or in their EDs. And eventually primary care providers that need a specialty consult to actually keep the patient at that facility and allow them to deliver the care with support from us in our Connected Care center. And we have found that providers at rural hospitals actually do a wonderful job diagnosing, treating, and then eventually discharging from their facility to their home as long as they have that extended community through a telehealth network.

Scott Spradling:

Jeremy, a question that's basically for Huggins. Huggins is a community hospital, DH is not. Will the combination result in the loss of Huggins' identity as a community hospital?

Jeremy Roberge:

That's a great question. And I'm happy to say that no, it will not result in a loss of our identity as a community hospital. And I can speak to what Dharma has done with their other critical access hospitals in the system currently, and none of them have lost their identity. As I spoke about in my presentation, our identity is very important to us, our culture is very important to us. I credit both of those things and our employees largely for the success we've had. And I know that Dartmouth will continue to support that.

Scott Spradling:

A question from herb. Have you had discussions with the payers to determine if you are actually able to maintain current negotiated reimbursement levels? Payer contracts often include caveats which dictate what will happen with levels of reimbursement when systems merge in situations like this.

Joanne Conroy:

We have not had broad system-based conversations with payers, I think that's not necessarily legal, nor would it be in the spirit of the things we've done previously. Historically, we haven't done joint

negotiations with payers, every single facility has done their separate negotiation. And that would be how we expect to maintain those relationships in the future.

Scott Spradling:

Turning again to Huggins and local investment, Jeremy, the Huggins service area has a huge income and health disparity. The legacy donors to Huggins want their funds to be used locally. How will the local community have control over the use of those funds? Will the new system invest additional funding in improving health not just growing a bigger system?

Jeremy Roberge:

Another great question that I forgot to address that actually during the presentation. But all funds that are raised in the local community for Huggins Hospital will continue to support Huggins Hospital. So there really shouldn't be any concerns for our current donors or future donors about how those dollars would be spent, they would always be targeted towards Huggins Hospital.

Scott Spradling:

How will this transaction affect the medical school and its ability to bring in grants and be an economic engine for the community? Is DHH, GO willing to produce and release a report to the community regarding the increase in grants?

Joanne Conroy:

We already publish our grants from Dartmouth-Hitchcock Health and from the Geisel School of Medicine, we're separate organizational structures. But our activities around research and education are inextricably intertwined. Annually, we have actually increased research funding. In fact, last week we received an award at $33 million from Corrie, which is a patient centered outcomes research institute to actually study two ways of testing for colon cancer. And it's going to dramatically change how we diagnose and stratify the risks that people have in the community. Speaking to the previous question about keeping our community healthy. The best way to decrease the cost of care is actually identify issues early on and treat them appropriately. Cancer is far less expensive if you catch it early through screening and detection. And this is the purpose of this Corrie grant.

Scott Spradling:

In the work and the run-up to this proposed combination, has there been any estimation on what administrative savings this might see?

Jeremy Roberge:

Of course, we've been working on this for quite a long time as we've mentioned. And we've done some analysis on where we think there could be savings. I don't recall specifically off the top of my head. But again, the focus is more on growing services in the local community and less on cutting administrative expenses. It's more on being efficient on the administrative side and trying to align our administrative services across the system to gain efficiencies where we can. Again, I don't know if Joanne or Joe want to add anything to that.

Joanne Conroy:

I would just say that our past history probably demonstrates what will happen in the future. When we bring some of our rural hospitals on, what we find is that we can actually augment their bench. So that means sometimes the benches slim, there may be one or two people that do certain tasks at the institution. But when we're all working together, they have access to our entire finance team, our entire development team to actually help them do their job. So that's the real benefit, it's how we're stronger together rather than just looking at the specific cost savings.

Scott Spradling:

Are there plans for specialists to travel to rural hospitals in this transaction for at least some in-person visits where the patient doesn't necessarily have to travel to Hanover?

Jeremy Roberge:

Pretty question. And again, as we've spoken about quite a bit tonight, that's one of the major objectives of this system is to have more outreach in the rural areas so people do not have to travel for all of their care. Of course, there will be times that people will need to travel to CMC or to Dartmouth for services, but the idea would be whatever they can have for services here at Huggins Hospital, we can have the specialists come see them here and have many of their visits here locally.

Scott Spradling:

The two health systems currently have different electronic health records, which means obviously yet another transition and transaction and potential disruption. How do you intend to minimize the cost and eliminate any real technical challenges with information flow?

Joanne Conroy:

Our information systems are separate between CMC and Dartmouth-Hitchcock right now. And frankly, we've left it up to the IT teams to actually debate the strengths and weaknesses of the two systems and they've made recommendations to us. I would say to transition systems, it's less about the technical savings but often the disruption for our providers or physicians and our nurses that have to learn a new system. The real cost is not in the cost of the system but it's the human costs and actually deploying it throughout the health system. This would be something that would be done over a period of years in a way that allows the organizations to adapt to the significant change when you move from one electronic health record to another.

Scott Spradling:

Thank you. If your hospitals combine the resulting system will be the only primary care and other specialty services in many regions in New Hampshire, how does this enhance patient choice? How will you be responsive to communities who expect value?

Joanne Conroy:

Well, I'd say with telehealth now you can get virtual urgent care, you can get virtual primary care. And those physicians don't have to live in your neighborhood currently. So with the breakthroughs in telehealth and virtual care, I would say that people have incredible choice now. However, I think we should think about the national shortage of primary care providers. All of our hospitals are looking for additional primary care providers because people still want to receive care in a physician's office or NP's office in-person often in their care. And I would say that's our biggest crisis that we really need to focus

on is training, attracting, recruiting, retaining, outstanding primary care providers so people have many choices within their community.

Scott Spradling:

A question from Lucy, what are Dartmouth-Hitchcock's plans to support the continued availability of labor and delivery services in New Hampshire's North country and keep labor and delivery in [Berlin 01:14:22] and Littleton?

Joanne Conroy:

So maternity services have been a focus area for us. With the closure of some obstetric services for any number of reasons, it actually makes mothers who are delivering drive significant distances in order to live with their babies. We do know that that results in more preterm deliveries and certainly the anxiety of driving quickly in the middle of the night with a laboring spouse is tremendously stressful. We need to however work across the state to actually figure out where our maternity deserts are and how we can support care in an integrated way across the state of New Hampshire. No one organization is resourced or organized enough to really solve it yourself. This is something that we just have to commit to working on it together.

Scott Spradling:

I'd like to Tom Raffio to the microphone.

Tom Raffio:

Thanks Scott. I've really enjoyed the questions from the chat room and the answers. I'm Tom Raffio, I'm CEO of Northeast Delta Dental. I'm speaking tonight as an observer of New Hampshire since 1995. In the spirit of transparency, I'm also a Dartmouth-Hitchcock trustee. And both CMC and Dartmouth-Hitchcock are group dental clients of Northeast Delta Dental. I think Katharine said it best actually first off when she said all of these hospitals are in financial strength situations, so now is the time for this combination because nobody's back is against the wall. They can do it logically, methodically and with all of the outcomes that have been described. Jeremy, I love your community. I was here for a road race, your trail system, I go to the Wright Museum. I get it. And I also in the spirit of transparency, I know the leadership of Dartmouth-Hitchcock, Dr Conroy, CMC, Dr. Pepe, and Alex Walker.

Tom Raffio:

These people will do the governance correctly, it's going to come down to that. And I really think that since all of these hospitals already have these longstanding clinical relationships, we're really just codifying and systematizing and making a good thing even better. We have some time to do this, but we have to act on it. As Katharine said, no one's back is against the wall, but. But in the long run, this is going to have to happen for the New Hampshire hospital systems to be successful. And let me comment a little bit on that. Speaking from personal experience, things change when an entity from outside New Hampshire takes over. So Wentworth-Douglass, we talk about population health, we talked about the health of the employees, there's a workforce shortage. So when they came under Mass General sometimes called partners, everything changed a lot from my perspective in the community, their community outreach.

Tom Raffio:

But if you just look at their employees they had Delta Dental coverage, we have a system where some of you may not know it, but some of you need three or four cleanings a year not two. We had a program that easily tells the dentist when that's necessary. Well, half of the Wentworth-Douglass employees needed those third or fourth cleanings. As soon as they went under Mass General slash partners, that extra benefit went away when they went to the other dental plan. And you could tell the same story when it comes to Frisbie when they went on to HSA, there were 6 or 700 employees many of whom and their families were using the extra dental benefits, that all went away.

Tom Raffio:

So here we have this wonderful, elegant, New Hampshire solution with each of the hospitals maintaining their own identity, yet the common thread so we can succeed as a group of New Hampshire citizens making this really successful. I'm really confident in the leadership of the organizations that they can make this happen. Just by speaking from personal experience, you can have the ... I know there were some questions on are we going to lose our identity? You won't. You may not know this, but Northeast Delta Dental, the company that I'm CEO of is actually several different companies, Delta Dental Plan of Vermont, Dental Dental Plan of New Hampshire, Delta Dental Plan of Maine.

Tom Raffio:

Each of those dentists in those three states think it's their company, yet it's the common thread of Northeast Delta Dental that makes it successful. We could never operate only as Delta Dental Plan of New Hampshire or Delta Dental Plan of Maine or Delta Dental Plan of Vermont. We knew that many years ago, which is why we developed the dental equivalent of what we're talking about here. So I think the time is right, no one's backs against the wall, and it's going to work. And all of the different things that Jeremy and others have said, I'm really confident that that will happen for the betterment of population health in New Hampshire for all of our communities, and just as importantly, for the employees of all the hospitals involved, Dartmouth-Hitchcock, CMC, Huggins, and the others. Thank you Scott.

Scott Spradling:

Thank you Tom.

Joe Pepe:

I would just like to-

Scott Spradling:

Joe.

Joe Pepe:

So I agree with you, no one has their back against the wall and certainly not doing this solely for financial reasons because no one has their back against the wall. We're doing relatively well with stable, as Jeremy said, and he's doing well. But also it's relative. In the hospital sector industry, a 2% margin is considered doing very, very well. If you look at other companies, they wouldn't sleep at night. So what we are doing is we are decreasing our financial vulnerability in mitigating the risks as we transform medicine.

Scott Spradling:

Thank you Joe. Will you be increasing primary care residency slots in New Hampshire?

Joanne Conroy:

Yes.

Joe Pepe:

We want to.

Scott Spradling:

Very succinct, and a sort of an appropriate way to wrap up. That is the list of those who wanted to speak here in-person and the questions that came on Zoom. So I want to thank Jeremy Roberge, Joe Pepe, Joanne Conroy, and Howie Knight for their presentation and their input. And I'd like to call Tom Donovan up for a few final words. Thank you.

Tom Donovan:

Thank you Scott. This has been a very good conversation tonight. I want to applaud the people both here in the auditorium and the people watching us remotely. There were some very interesting comments and questions, and for me very helpful. But we're not done. If you'd like to send in a comment or question, you can see on the screen right now, you can email us at charitabletrust2, that's the number 2, @doj.nh.gov. Or you can write to us at the Department of Justice, 33 Capitol Street, Concord O3301. So get your cards and comments into us, and that's it for this evening. This is our third and final forum with respect to this transaction. Thank you for your civility and your interest. Good night.