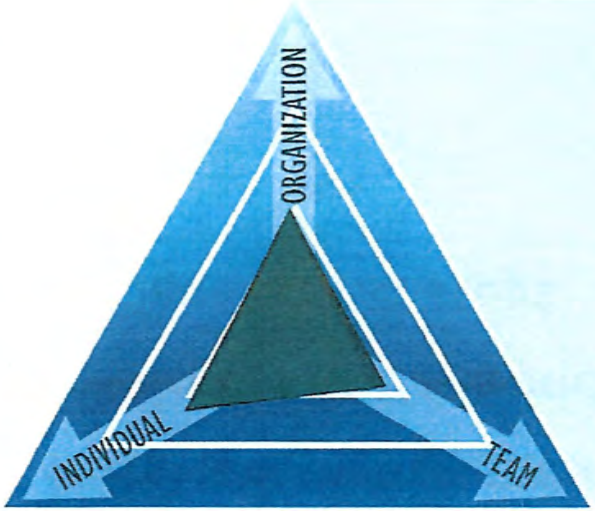
RESPONSE TO #7

WELLESLEY PARTNERS



Performance Catalysts

Valley Regional Healthcare Strategic Planning

Subcommittee of Board
February 25, 2019

Purpose and Agenda

- Agenda
  - Review themes of Strategic Planning intake
  - Review management response
  - Discuss options and/or modifications
  - Decide next steps

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Interview Themes

The Good News

- The hospital is surviving, growing, improving
- Leadership has given the organization an opportunity to continue to prosper
- The opportunity to continue to improve "post-Peter" is clear

Theme: The Local Gem

Summary:

- This hospital shares the attributes of a local institution and all of its best qualities and charm

Specifics:

- Institution that the community wants to support
- We know our patients, we value our patients
- Participation in community events
- Largest local employer – critical to the community

Local Needs Assessments (see handout)

- Primary Care
- Mental Health Care (drugs, alcohol, tobacco)
- Specialty Health Care
- Cancer
- Mothers and babies
- Heart disease and stroke
- Obesity/Diabetes

Theme: Physicians

Summary:

- We need more employed MDs and more specialties

Specifics:

- There is a strong need for additional access to specialty care, orthopedics being a prime example
- We have lost some connection to providers. NOT to provide care, but to represent the hospital in the community, to live nearby and "show up"
- We have too few employed physicians on the Medical Staff to cover all of the responsibilities in a reasonable way

Theme: Brand

Summary:

- VRH's brand needs to expand to the region vs. the town of Claremont while retaining the close connection to the community

Specifics:

- How to become the go to place for a larger geographic area, through reputation and brand awareness
  - Urgent Care in Charlestown, Newport key foundation
  - Stop dating – build reputation
  - Overcome brand of Claremont vs. the region
- Increase hours for certain common needs when commuters are here, e.g. Mammograms, dermatology, Pediatrics, etc.
- Continue positive focus on ED (getting better)

Theme: Space

Summary:

- How space is configured/utilized sends a very strong message to staff at all levels

Specifics:

- 3rd floor: very strong feelings about substance abuse and psych
  - How to support community without perpetuating a stereotype
- Medical Office space is a morale-killer and inefficient from a staffing perspective
  - "How can they be opening Urgent Care Centers when they can't fix what we have?"

Theme: Management

Summary: Lack of basic management competencies

Specifics:

- Good that we promote from within, but then we need formal training for the promoted
- Recruiting and retention directly tied to lack of 1st line management skills
  - Becomes perceived as "abuse" – heard that word a lot
- Thirst for education and training, including about our own capabilities
- Organization needs a break
  - ➢ Growth, energy, creativity are all good
  - ➢ However, it isn't uncommon for an organization to need to "consolidate" its wins before continuing to move on

Theme: Dartmouth Hitchcock

Summary:

- This relationship needs to be improved: either stronger ties or stronger contracts, but not staying where it is today

Specifics:

- Is DH supportive or our biggest barrier to success and competitor?
  - DH grabs MDs if they need them – not contractually committed nor vested in our success
  - DH grabs pts. but is overbooked and no parking: how do we set expectation of getting our patients "back"
- Pure logistics:
  - Communication with DH impossible: e.g. medical record
  - DH EMR: we cannot communicate with it

Theme: "Post Peter"

Summary:

- This process needs to proceed and quickly

Specifics:

- Staff know something is going on with Mt. Ascutney
- Community is confused: "Too bad VRH is closing"
- Recruiting/Retention will be even more difficult
- Opportunity to reevaluate the CEO contract with DH

Management:
Local Strategy Thoughts

Strategy

Mission/Vision: Quality Care with a Hometown Touch

Market/Product

- Develop clinical strategy and hire more MDs
- Share locally where necessary
- Continue Urgent Care strategy
- Settle 3rd floor

Quality

- Fix morale
- Quality is about consistency:
  - Fix clinics
  - Measure
  - ID where staff questions quality

People

- Increase our management competencies at all levels of the organization in order to better support our front-line staff.
- Better manage space "PR"

Financial health

- Focus on leakage occurring to DH
- Support HR initiatives focused on continuing to reduce turnover
- Continue to reduce travelers

"Strategic" Tactics

Mission/Vision: Quality Care with a Hometown Touch

Market/Product	Quality	People	Financial health
• Develop clinical strategy and hire more MDs • Share locally if necessary • Continue Urgent Care strategy • Settle 3rd floor	• Fix morale • Fix clinics • Measure • ID issues (where staff question)	• Increase our management competencies at all levels of the organization in order to better support our front-line staff. • Better manage space "PR"	• Focus on leakage to DH • Support HR initiatives focused on continuing to reduce turnover • Continue to reduce travelers
• Continue to grow Urgent Care • Prioritize money-making community needs of hospitalists, orthopedic surgery, general surgery, oncology and HIRE • 3rd Floor: CHOOSE	• Continue improvements in ED (Front Door) • Focus on hospitalist competency required • Fix clinics (management)	• Pause, organize, operate • Management fundamentals training • Redefine management structures • Prioritize and align, use project charters • Create messages and reinforce	• Identify DH leakage & manage • Initiate a Task Force to improve pure operating functions with DH • Initiate discussion w other systems • Budget for HR initiatives such as 1st line management training

WP: Big Picture Strategy Thoughts

Draft Goals

- Urgent care in 3 places
- Create a plan for MOB, including assessment of benefits as well as cost
- Improve patient flow with DH
- Bring clarity to long term relationship with DH and long term system strategy
- Focus on communication and training

Affiliate with Dartmouth

- None of these issues go away
  - Still need more local, employed docs
  - Still need to rationalize how patients transition back and for the from one place to the other
  - Still need a local brand (regional)
  - Still need to provide 1st line management training
  - Still need to recruit and retain staff
- Need clarity around what the affiliation would bring?
  - Brand?
  - Capital?
  - Management?
  - EMR?

Define objectives for affiliation

- Model for success is Southcoast Health System: creating more critical mass regionally by merging programs that don't require AMC-level care
- Brand is "Care at Home"
- Or affiliate with another large hospital such as Concord

Curriculum for Management Training

- Role and accountability of a manager
- Performance management principles and practices
- Interpersonal skills to facilitate being a manager
- Relationship of manager to HR in staff management
- Delegation
- Coaching individuals on the team
- Understanding one's temperament and how to manage one's "flat side"
- How to create high performing teams

Rural Health Challenges and the MAHHC Journey

Valley Regional Healthcare

Board of Trustees

April 24, 2019

Mt. Ascutney Hospital
and Health Center
Dartmouth-Hitchcock

Our Journey

- Mission and Vision
- Affiliation and Leadership Transitions
- Culture Change
- Making the sausage

Mt. Ascutney Hospital
and Health Center
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MISSION

To improve the lives of those we serve.

VISION

Mt. Ascutney Hospital and Health Center will provide the highest quality care, patient satisfaction, and value through:

Development of programs based on community need and sustainability
Multi-disciplinary and regional cooperation
Involvement of patients in their own care decisions
Empowerment of and respect for our staff
Fiscal responsibility

Our success will be measured by the improvement of the health, wellness, and comfort of those we serve.

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Affiliation with Dartmouth-Hitchcock Health

- After 12 months of due diligence, contracts signed to enter D-HH in July, 2014
- Now what…?
- Early losses, later victories

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Leadership Role

- Alleviate the fears of losing autonomy and sense of place with affiliation into a larger health system
- Imperative to "stay on message"
- Manage the bumps/bruises
  - Loss of service lines
  - Search for and elevate local talent into management positions, whether at MAHHC or DHMC

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Leadership Transitions

- 2010- 27yr. CEO Richard Slusky retires
- Kevin Donovan- CEO 9/10-6/16
- Gay Landstrom – Interim CEO 6/16-12/16
- Joe Perras – Inpatient Services Director 2013, CMO 2014, CEO 1/17
- New COO- 2012 (P. Calandrella)
- New CFO – 2012 (David Sanville)
- New CNO – 2016-2019 (Deanna Orfanidis)

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Early Work

- Number one priority in 2017 was to ensure a stable leadership transition
- Looking for small early victories
- Intense focus on employee wellness
- Institutional commitment to Quality and Patient Safety

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Lets hire!

- Addition of new member to the senior leadership team
- Created position: Director of Quality, Patient Safety and Compliance
- Empowered to build team
- FTE growth from 1.5 FTE to 5 FTE

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- Mock surveys for every department and care location over 12 months with corrective action plans developed based on results.

- Development of an extensive quality dashboard to provide real time reporting on D-HH system metrics, ACO measures, Blueprint/PCMH requirements, Patient Satisfaction, and internal QI projects.

- Investment in compliance software to improve surveillance and reporting.

- **Ready for the next patient, not the next survey.**

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Second Task

- CEO-led development of a comprehensive annual implementation plan centered on critical issues and goals
- Greater focus on system integration
- Roadmap for clinical and operational success
- **Leadership evaluations** based on meeting metrics and outcomes of the AIP
- Frequent/required reports on progress

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Institutional Wellness

- Employee health and fitness
- Social determinants of health AND workplace dysfunction
  - Expanded EAP
  - Working Bridges adoption
- Provider Burnout workgroup formed
- Leadership Development Curriculum
- System wide succession planning completed

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What can we offer the System

1) Rehabilitation Center of Excellence

- 1 of 2 Acute Rehabilitation centers in Vermont and closest in NH is Concord.
- Full suite of inpatient and outpatient rehab services, including a therapeutic pool.

2) BEDS/Hospital Medicine Expertise

- Significant inpatient capacity of CAH and Acute Rehab Unit in 2010-13

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Goals

- Attain accreditation by Commission on Accreditation of Rehabilitation Facilities (CARF).
- Multiyear process, but signals to payers and patients our commitment to quality and patient safety with the highest possible outcomes.
- We are the only CARF- accredited facility in VT and closest in NH are in Manchester and Salem.
- Renovation of Nursing home into state-of-the-art Acute Rehabilitation Center.

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"Just Fill It"

- CAH average daily census (ADC) in 2013 was 15
- Acute Rehab ADC in 2013 was 7

- We have beds, D-H needs post acute beds
  - Hire hospitalists, 24/7 coverage
  - Simplify referral process, allow weekend and evening swing admissions
  - Take MDs out of the admissions workflow
  - Conversion to ALL private rooms to enhance capacity

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Since 2014

- 450+ post acute and acute rehab admissions yearly, most from DHMC.
- ADC increased to 20+ in CAH and 8.8 on Acute Rehab.
- Focused efforts on more complex swing and acute rehab patients.
- Significant growth of ancillary services (and revenue) to support the influx of patients.

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System Integration: Overview

D-HH is expanding integration efforts and expediting certain initiatives to ensure that members are better connected with each other and with system-level management.

Key Integration Areas

- Analytics Institute
- Bed Utilization
- Clinical Engineering
- Compliance & Audit
- Corporate Finance
- ED/Hospital Medicine
- Facilities
- Financial Planning
- Health Information Systems
- Human Resources
- Information Systems
- Legal Services
- Medical Staff Office
- Pharmacy
- Revenue Management
- Service Lines
- Supply Chain

Capacity Planning: Overview

D-HH has plans to ensure patients get the proper care in the right setting, use resources efficiently, and anticipate future capacity needs.

Capacity Goals

- Develop a new inpatient tower at DHMC to expand bed capacity
- Develop system-wide capacity planning infrastructure
- Coordinate surgical services across the system
- Coordinate system and regional patient management (e.g., care management, inpatient capacity & transportation)
- Explore capacity expansion at member facilities
- Strengthen our post-acute and home-care networks
- Proceed with other ongoing capacity initiatives (e.g., telehealth, system bed utilization, etc.)

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Making the Sausage

- Significant financial risk in filling the hospital with post-acute patients
  - CFO/finance team meets weekly with Care Management to discuss individual cases and payer issues.
  - CMO review of all extended stays, readmissions.

- Would not be possible without institutional commitment to expense management and growth of non-operating revenue

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Non-Op/Other Revenue

- 340B
  - Retail optimization- $750K to bottom line
    - Outreach to local pharmacies and regional offices for pharmacy chains
    - Analysis of provider practices, determine value
    - Set up data feeds, leverage EMR and reporting

- Grants - $1 million+ yearly in grant funding for community health efforts

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Expense/Cost reduction

- 340B (again)
  - Mail order pharmacy benefits, offset expense- $100K
  - Inpatient/Swing, expense reduction- $75K
- Cost report post-mortems
  - Yearly review with BNN
    - What's changed, where is opportunity
    - $50-$100K pick-up yearly
- GPO pricing for major equipment
  - $100K savings in last 12 months by leveraging capital purchasing power with D-HH
  - NEAH pharmacy/materials management

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- Refinancing debt with fixed rate
  - Unwound SWAP on variable debt $120k/yr.
  - $30k/yr. on fixed rate

- Locums & Travelers Strategy
  - Employee and institutional wellness focus has improved recruitment and retention, cutting traveler dependence

- Limited Consulting – important matters/opportunities, and only if we had the will and bandwidth to make the changes

Harder Calls

- Closing nursing home (2012-2013)
  - Improved bottom line $1.4m
  - Shooting selves in feet
- Repurposing NH for private IP Rehab rooms
  - Increased ADC 1.5
  - Added 30+ Admissions; $1.5m revenue
- Closing practices- plastic surgery and a podiatry location
- FTE reductions, getting lean
  - 6 FTE reduction in Finance alone
    - Leveraged technology and efficiencies
  - 2012 = 356; 2018 = 326
  - Position Control – Every FTE and job replacement reviewed by senior leadership team weekly

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There but for the grace of God…

- What keeps me up? (everything)
  - ACO, downside risk
  - Workforce shortages and traveler costs
  - All hot hands eventually cool off, ours have
  - Continued DISH cuts in VT (40% cut over last 24months)
  - State and federal uncertainty
  - Further senior leadership attrition

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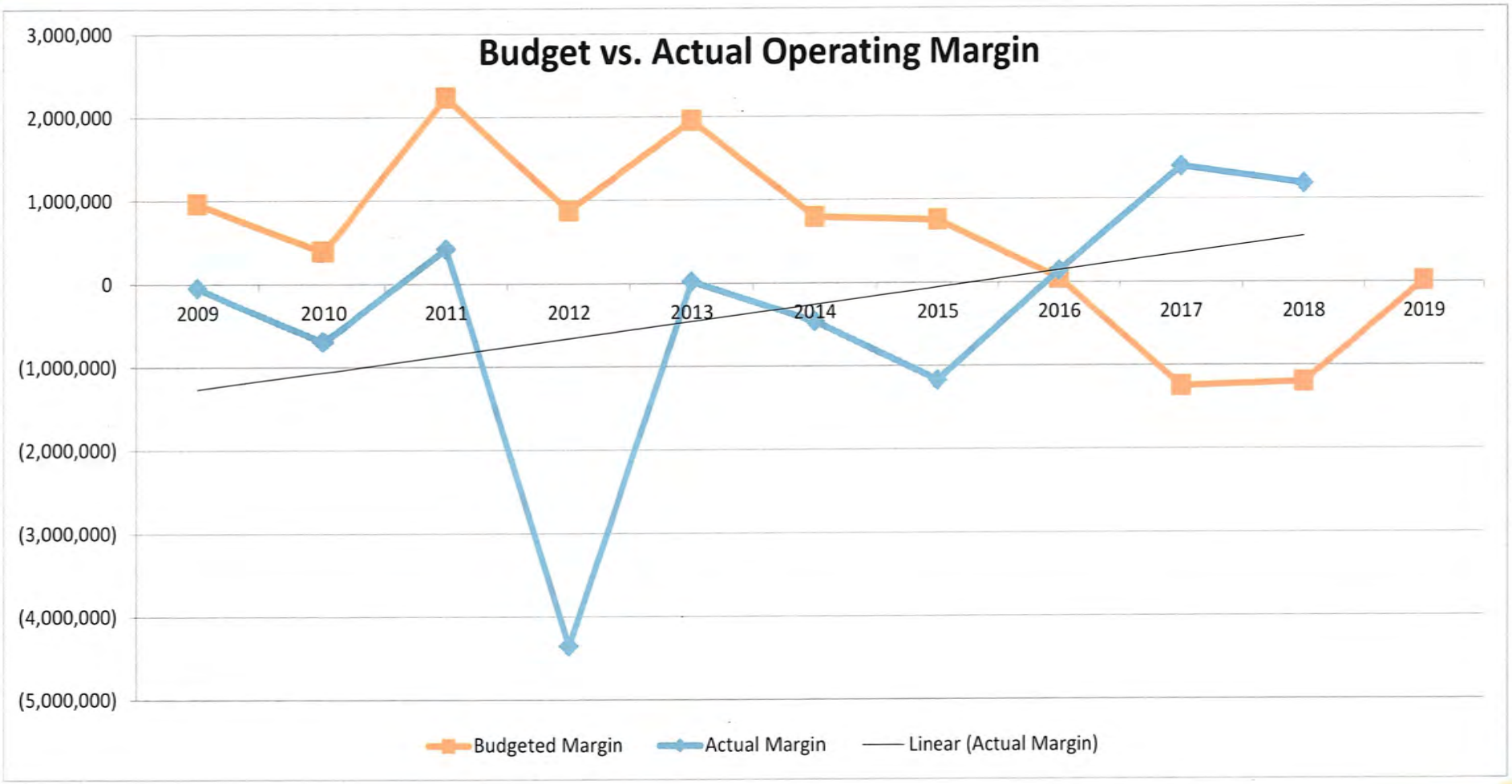

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Questions?

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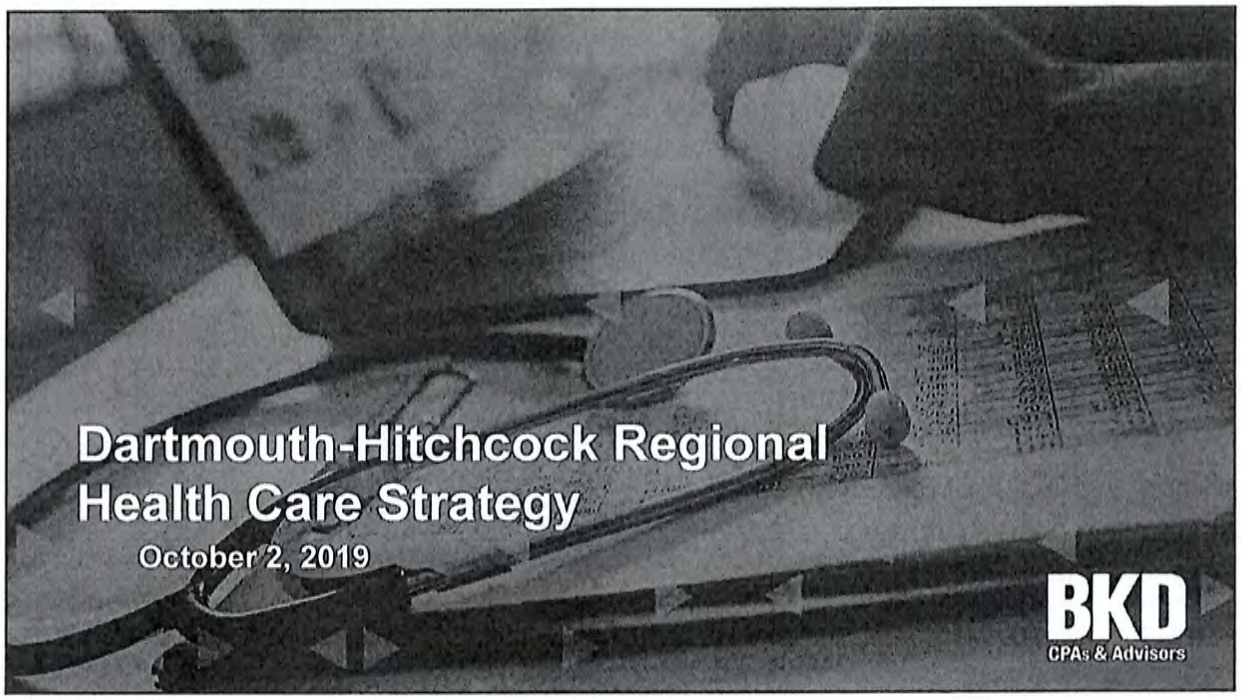


TODAY'S AGENDA

1. Observations and Regional Structures for Critical Access Hospitals (CAH)
2. Three CAH model
3. Two CAH and Micro-CAH model
4. Two CAH and Provider Based Departments
5. Next Steps

Key Observations

- **Critical Access Hospital Key Financial Concepts:**
  - By nature designed for small hospitals to pay cost reimbursement for core/basic hospital services
  - Typically rural hospitals that have very high Medicare volumes
  - Key to success is to limit non-core hospital services to only high margin producing services

Key Observations

- **Critical Access Hospital Key Financial Concepts:**
  - Springfield Hospital has experienced significant losses due to providing services beyond the core/basic CAH hospital services thus incurring significant physician costs and programs that pulled overhead costs away from high Medicare hospital services

Key Observations

Illustration of This:

	Total Acute Days	Medicare Acute Days	%	Total Acute Discharges	Medicare Discharges	%	Total Hospital Outpatient charges	Medicare Outpatient Charges	%	Swing-bed days
Springfield Hospital	5,488	3,399	62%	1,579	931	59%	81,300,000	14,400,000	18%	102
Valley Regional Hospital	1,622	1,064	66%	523	338	65%	52,670,000	18,600,000	35%	1,781
Mt. Ascutney Hospital and Health Center	1,410	1,074	76%	415	285	69%	54,700,000	25,100,000	46%	5,730

Key Observations

Comparison of Non-core Hospital Services Costs to Operating

		Total costs for non-core hospital services *	Operating Margin
Springfield Hospital		$ 8,920,000.00	$ (6,996,000.00)
Valley Regional Hospital		$ 1,180,000.00	$ (1,440,087.00)
Mt. Ascutney Hospital and Health Center		$ 4,325,000.00	$ 1,008,000.00

Health Care Regional Approach

- **Structures:**
  - Seven variations of structures were considered
    - Four eliminated due to not having an emergency department
      - CAH – CAH - FQHC
      - CAH – CAH – RHC
      - CAH – CAH – Urgent Care
      - CAH – CAH – Free standing ED
  - Free-standing emergency department – There is no provision in the Vermont state law and therefore the likelihood of this being a viable option is slim
  - Each structure is dependent upon physician support and referrals

Three CAH Model

Three CAH Model

- Progress Update
  - Evaluation of:
    - Overhead and full time equivalents (FTEs)
    - Match FTE's to organizational charts
- Next steps – Overhead Expenses
  - Hospital working committee review
  - Identification of overhead to remove from each CAH's cost report
  - Identification of shared overhead to allocate to three CAH's
  - Rerun each facilities cost reports to calculate impact
  - Determine combined results

Three CAH Model

- Next steps – Operational Changes
  - Identification of operational changes related to services and volumes
  - Revenues and expense modifications
  - Adjust each hospitals cost report for changes to three CAH's
  - Rerun each CAH's cost report to calculate impact
  - Determine combined results
  - Recast in combined proforma financial model

Two CAH & Micro-CAH Model

Two CAHs – Micro-CAH Model

Advantages

- Maintain CAH license for Springfield Hospital
- Maintain a "hospital" in Springfield, VT
- Maintain cost reimbursement for Medicare services
- Maintain 24hour Emergency department access
- Maintain basic ancillary services, lab, radiology, and therapy services

Disadvantages

- Minimum inpatient services
- Discontinue non-essential ancillary services
- Discontinue inpatient psych
- Discontinue services that are not cost reimbursed

Two CAH & Micro CAH Model

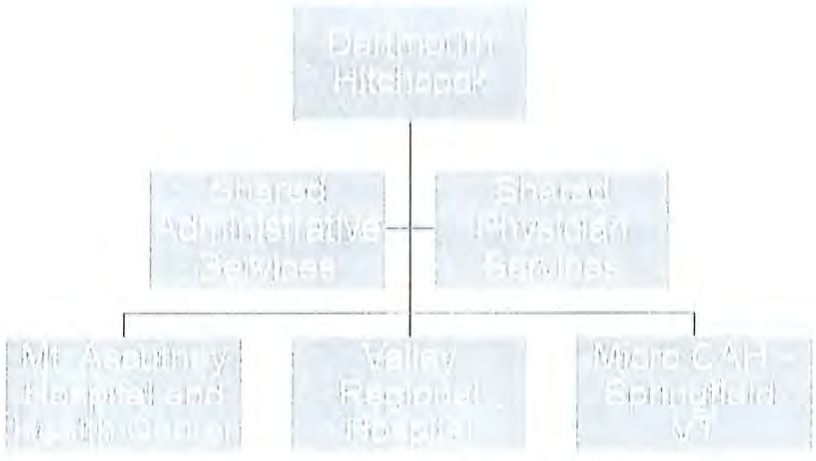
- Next steps
  - Operational review to get to micro hospital level to include:
    - Service line analysis
    - Labor and staffing analysis
    - Evaluate physician contracts and relationships
    - Evaluate payer mix and payer contracts

Two CAH & Provider Based Departments Model

Two CAH & Provider Based Departments

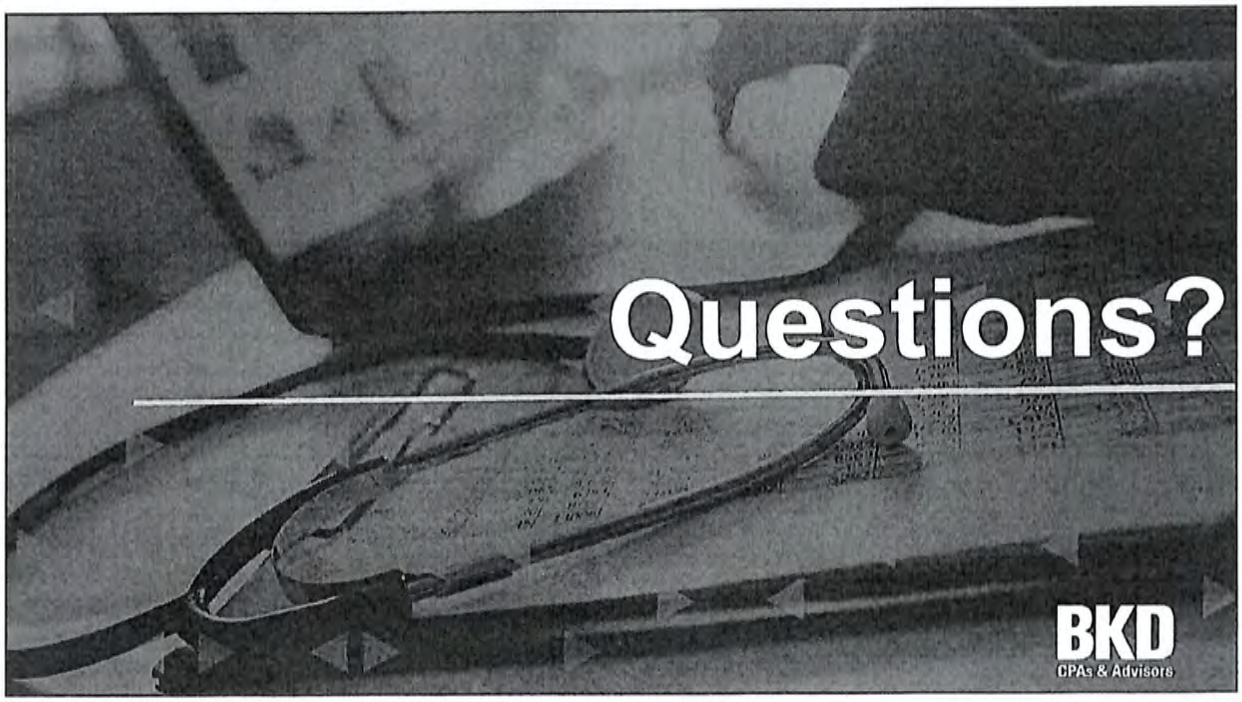
- CAH Provider based location provisions
  - CAH's off-campus provider-based location is more than a 35 mile drive (or 15 miles in the case of mountainous terrain or an area with only secondary roads) from another hospital or CAH
  - CAH must continue to meet the CAH distance requirements with the added provider-based location
- Above prevents putting provider based departments in Springfield, VT without jeopardizing the CAH status of Mt. Ascutney Hospital and Health Center and Valley Regional Hospital

Potential Future Roadmap



Potential Future Roadmap – Next Steps

- Run to ground the overhead administrative and general scenario for the three CAH's
  - Rerun cost reports removing the overhead of administrative and general and recast allocation of shared administrative and general services
- Assess/evaluate Springfield Hospital to create a micro-CAH operating model
- Assess impact of structure changes to Mt. Ascutney Hospital and Health Center and Valley Regional Hospital and create proforma revenue and expense summary



Rural Healthcare Challenges and the Mt Ascutney Journey

Valley Regional Healthcare

January, 2020

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MAHHC

- Purpose
- Joining the System
- Leadership Transitions
- Commitment to Quality and Patient Safety
- Culture Change
- Getting/Staying Lean
- Regional Strategy

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PURPOSE

To improve the lives of those we serve.

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Becoming a System Member

- Why affiliate?
  - Existential, needed stability
- After 14 months of due diligence, formal affiliation agreement signed in July, 2014
- Now what…?
- Early losses, later victories

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Early Work

- Number one priority in 2017 was to ensure a stable leadership transition
- *Re-establish our institutional commitment to Quality and Patient Safety*
- Look for small early victories
- Intense focus on employee and institutional wellness

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Leadership Role

- Alleviate the fears of losing autonomy and sense of place with affiliation into a larger health system
- Imperative to "stay on message"
- Manage the bumps/bruises
  - Loss of service lines
  - Search for and elevate local talent into management positions, whether at MAHHC or DHMC

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Leadership Transitions

- 2010- 27yr CEO Richard Slusky retires
- Kevin Donovan- CEO 2010-6/2016
- Gay Landstrom – Interim CEO 6/16-12/16
- Joe Perras – Inpatient Services Director 2013, CMO 2014, CEO 1/17
- New COO- 2012 (P. Calandrella)
- New CFO – 2012 (David Sanville)
- New CNO – 2016 (Deanna Orfanidis)

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And More…

- Yet another new CNO in 2019 (Amy Visser-Lynch)
- New primary care medical director, 2020 (Leesa Taft, DNP)

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What is most important?

- Created position: Director of Quality, Patient Safety and Compliance
- Empowered and Resourced to build a team
- Growth in department from 1.5 FTE to 5 FTE with explicit goal of creating an environment for a high reliability organization

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- Mock surveys for every department and care location over 12 months with corrective action plans developed based on results.

- Development of an extensive quality dashboard to provide real time reporting on D-HH system metrics, ACO measures, Blueprint/PCMH requirements, Patient Satisfaction, and internal QI projects.

- **Ready for the next patient, not the next survey.**

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ROI

- Highest Quality and Safety metrics in D-HH.
- 500+ days without a serious safety event.
- Highest employee engagement scores in system-wide survey by Press-Ganey.
- On our D-HH System Employee Engagement Survey, 100% of MAHHC employees responded with Agree or Strongly Agree to questions regarding our institutional commitment to patient safety.

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Reduce Hospital Acquired Conditions

Category	Measure (bolded Measures are represented here and on the MAHHC Quality and Safety Goals)	Benchmark	QY18 Baseline	Target	Q1	Q2	Q3	Q4	YTD	YTD n
Hospital Acquired Conditions	**Patient Falls with Injury per 1000 patient days**	QY18 Baseline	0.78	0.78	0.4	0.4	0.6	0.5	0.5	5
	Pressure Ulcers per 1000 patient discharges	QY18 Baseline	0.00	0.00	0.0	0.0	0.0	0.0	0.0	0
Infection Prevention	CAUTI per 1000 catheter days	2015 Flex Monitoring Study	0.00	0.74	0.0	5.3	0.0	0.0	0.9	1
	CLABSI per 1000 catheter days	2015 Flex Monitoring Study	0.00	0.54	0.0	0.0	0.0	0.0	0.0	0
	C-Diff Infections per 10000 patient days	2015 Flex Monitoring Study	8.90	7.57	0.0	0.0	0.0	0.0	0.0	0

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2019 MAHHC Dashboard

MAHHC Quality and Safety Goals QY19				YTD	n
QY19 Performance Goals	Specific Key Performance Indicators	QY18 Baseline	QY19 Target		
Keep our Employees Safe	Reduce Total OSHA Recordable Injury Rate (TRIR) by 15%	3.3	2.8	2.1	7
	Standards program adherence - 90% or better (Mock Survey findings addressed within 60 days) -	89.0	90.0	99	144
Improve Patient Experience	**Increase "Overall Rating" of Hospital Score by 2%**	74.9	76.4	80.9	178
	Increase Provider Communication Score by 2% (Inpatient Acute Unit)	80.1	81.7	85.1	182
	Increase Nurse Communication Score by 2% (Inpatient Acute Unit)	77.3	78.8	82.2	187
Improve Patient Experience	**Increase "Overall Rating" of Provider Score by 2% (Windsor based Primary Care)**	82.5	84.2	79.6	898
	Improve Provider Communication Score by 2% (Windsor based Primary Care)	74.8	76.3	84.2	894
Improve Outcomes	**Reduce HAC Count by 15%**	17	14	6	--
	Hand Hygiene compliance > 90%	85.0	90.0	86.0	
	Reduce Preventable Falls Rate by 10%	2.65	2.39	2.78	29
	CDI - Improve appropriateness of inpatient testing	71	90	96	--
	Increase preventive screening by 10%	60.2	66.2	64.6	0
	Increase Colon Cancer Screening by 10%	64.9	71.4	65.3	-
	Increase Breast Cancer Screening by 10%	55.5	61.1	63.8	-
Build a High Reliability Organization	Reduce Serious Safety Events by 10%	2	0	1	--
	Increase near miss reports by 10% (monthly, YTD total)	54	59	189	--
	90% Events closed within 30 days	79	90	94	

Mt. Ascutney Hospital and Health Center
Dartmouth-Hitchcock

Dartmouth-Hitchcock Health FY19 Quality and Safety Goals and YTD Performance

Strategic Imperatives	Key Performance Domains	Performance Goals Within Each Domain	FY18 Baseline	FY19 Target	FY19 YTD	D-HH	APD	CMC/DHK	D-H	MAHHC	NLH
OUR PATIENTS	Inpatient Quality	Reduce count of Hospital Acquired Conditions (HACs) by 15%	298	253	300						
	Ambulatory Quality	Increase preventive screening by 10%	76.0%	83.7%	76.2%						
	Patient Safety	Standards program adherence at 90% or better	71.5%	90.0%	93.0%						
		Reduce count of Serious Safety Events by 10%	18	16	16						
		Increase count of Near Miss reports by 10%	1,439	1,583	2,106						
	Patient Experience	Increase "Overall Rating" of Hospital Score by 2%	75.9%	77.4%	76.2%						
		Increase "Overall Rating" of Provider Score by 2%	85.8%	87.5%	86.2%						
OUR PEOPLE	Employee Safety	Reduce OSHA Total Recordable Injury Rate (TRIR) by 10%	4.02	3.62	3.45						
		Increase count of employee submitted Unsafe Condition reports by 10%	281	309	307						
OUR COMMUNITY	Population Health	Implement Opioid Use Disorder (OUD) screening in at least one ambulatory setting and one inpatient unit or ED	N/A	2 types of locations for each member	8 of 10 locations						
		Screen 70% of eligible population where screening has been implemented	N/A	70%	68.2%						

Key:
- Better than Target
- Not at Target, Better than Baseline
- Not at Target, Worse than Baseline
- Data collection not available yet

Reporting Month: Jun 2019
Data Last Updated: 07/26/19

Mt. and Dartmouth-Hitchcock Health

Dartmouth-Hitchcock Health

VRH000215

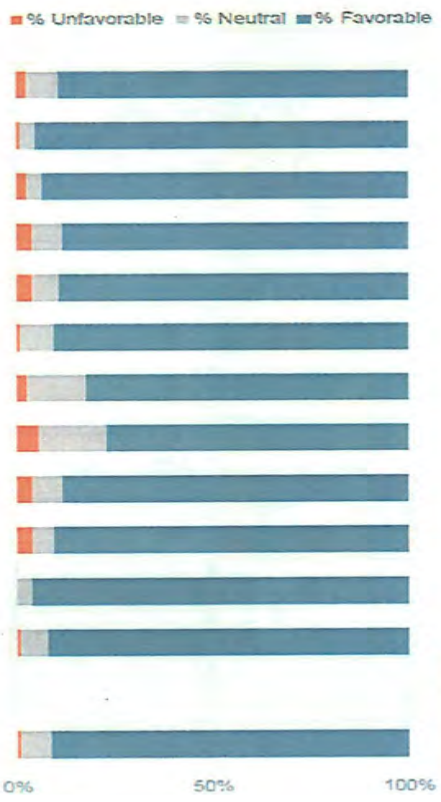
Culture of Safety and Employee Engagement

2019 Employee Engagement Survey - Mt. Ascutney Hospital and Health

Safety Dimension **326 respondents**

		MAHHC Score	D-HH Score
Safety		4.28	4.11
Patient safety is a priority in this organization.		4.57	4.34
Employees in my work unit make every effort to deliver safe, error-free care.		4.41	4.41
I can report patient safety mistakes without fear of punishment.		4.30	4.20
In my work unit, we discuss ways to prevent errors from happening again.		4.23	4.18
We are actively doing things to improve patient safety.		4.32	4.17
Mistakes have led to positive changes here.		4.04	3.96
When a mistake is reported, the focus is on solving the problem, not writing up the person.		3.96	3.81
Employees and management work together to ensure the safest possible working conditions.		4.15	4.00
I feel free to raise workplace safety concerns.		4.24	4.15
This organization makes every effort to deliver safe, error-free care to patients.		4.45	4.17
Senior leadership provides a work climate that promotes patient safety.		4.33	3.99
Our executive leaders provide a work climate that promotes patient safety.			3.97
Clinical and administrative leaders provides a work climate that promotes patient safety.		4.31	4.04
		Better than D-HH	Worse than D-HH

Distribution of Responses



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Institutional Wellness

- Employee health and fitness
- Social determinants of health AND workplace dysfunction
  - Expanded EAP
  - Work United
- Provider Burnout a persistent issue
- Leadership Development Curriculum
- System wide succession planning completed

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Culture Change

- Existential questions began prior to affiliation.
- What do we want to be?
- Can we be what we want/need to be and keep the lights on?

- Peri- affiliation: Does Dartmouth-Hitchcock agree with our goals and do they serve the greater needs of the System

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What can we offer the System

Rehabilitation Center of Excellence

- 1 of 2 Acute Rehabilitation centers in Vermont and closest in NH is Concord.
- Full suite of inpatient and outpatient rehab services, including a therapeutic pool.

BEDS/Hospital Medicine Expertise

- Significant inpatient capacity of CAH and Acute Rehab Unit in 2010-13.

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Goals

- Attain accreditation by Commission on Accreditation of Rehabilitation Facilities (CARF).
- Multiyear process, but signals to payers and patients our commitment to quality and patient safety with the highest possible outcomes.
- We are now the only CARF- accredited facility in VT and closest in NH are in Manchester and Salem.
- Renovation of Nursing home into state-of-the-art Acute Rehabilitation Center.

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"Just Fill It"

- CAH average daily census (ADC) in 2013 – 16
- Acute Rehab ADC in 2013 – 7

- We have beds, D-H needs post acute beds
  - Hire hospitalists, 24/7 coverage
  - Simplify referral process, allow weekend and evening swing admissions
  - Take MDs out of the admissions workflow for most admissions
  - Conversion to ALL private rooms to enhance capacity

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Since 2014

- 400-500 post acute and acute rehab admissions yearly, most from DHMC
- ADC increased to 21+ in CAH and 8.5 on Acute Rehab
- Focused efforts on more complex swing and acute rehab patients
- Significant growth of ancillary services (and revenue) to support the influx of patients

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Challenges

- Significant financial risk in filling the hospital with post-acute patients
  - CFO/finance team meets weekly with Care Management to discuss individual cases and payer issues.
  - CMO review of all extended stays, all readmissions
- Would not be possible without institutional commitment to expense management and growth of non-operating revenue

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Maximizing Non-operating Revenue

- 340B- optimizing pharmaceutical rebate programs

- Grants- $2 million++ yearly in grant funding for (un-reimbursable) community health efforts

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Expense/Cost reduction

- 340B (again)
  - Mail order pharmacy benefits, offset expense- $100K
  - Inpatient/Swing, expense reduction- $75K

- GPO pricing for major equipment
  - $200K savings in last 12 months by leveraging capital purchasing power with D-HH
  - NEAH pharmacy/materials management

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- Locums & Travelers Strategy
  - Focus on employee engagement, professional development, wage growth
  - Minimal traveler presence (currently 4)
  - 11-20 positions vacant in 400 person workforce

- Limited Consulting – Important matters/opportunities, and only if we had the will and bandwidth to make recommended changes.

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Harder Calls

- Closing nursing home (2012-13)
  - Improved bottom line $1.4m
  - Care management implications…
- Repurposing NH for private IP Rehab rooms
  - Increased ADC 1.5
  - Added 30+ Admissions; $1.5m revenue
- Closing unproductive practices- plastic surgery and a podiatry location
- FTE reductions, getting lean
  - 6 FTE reduction in Finance alone
    - Leveraged technology and efficiencies
  - 2012 = 356; 2018 = 326
  - Position Control – Weekly study of FTEs across institution

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Moving Forward

- Regional Strategy
  - It is imperative that hospital leadership build a sustainable model of healthcare delivery for southern Windsor County and Sullivan County.
  - Care needs to be efficient with quality and safety driven by higher volumes, possibly with hospital specific service lines
  - Full hospitals are healthier than empty hospitals
  - There are potential savings with leadership consolidation across multiple sites

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System Strategy

- Tight
  - Quality Safety and Compliance, Risk Management
  - Finance/Materials Management
  - Service line coordination
  - Credentialing
  - Care management
- Loose
  - Building programs to meet individual community's needs

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First Pancake

- Moving Belinda Needham-Shropshire to role of Director of Rehabilitation Services for both VRH and MAHHC.
- She brings a long history of excellence in building rehab programs, change management, and operational success.
- We have steadily brought our hospital leaders together in numerous forums so we can start to use common language/taxonomy with quality and patient safety and finance.

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Open Discussion and Questions

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VRH and MAHHC

The Case for Integration

August, 2021

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D-HH and MAHHC Regional Strategy

- Timeline:
  - Peter Wright, CEO of VRH, leaves 3/19 to take position in Maine.
  - He was under a D-HH management contract to serve as CEO.
  - Deanna Howard, long time D-HH employee and MAHHC Trustee, appointed interim CEO under ongoing management contract in early 2019.
    - VRH Board had expressed interest in joining D-HH.
    - VRH had experienced financial difficulties with persistent but manageable losses on operations for a number of years, but has a strong balance sheet.
    - At the time of Wright's departure, VRH did not have a CMO or COO.
    - Long history of intermittent clinical cooperation and sharing of resources between MAHHC and VRH over prior administrations.

- Early discussions with D-HH senior leadership regarding VRH's entry into System and consolidation of MAHHC/VRH leadership teams.

- Deanna Howard and I would review service lines and operations to determine feasibility.

- Initial plans to have a non-binding letter of intent by Summer of 2019 that signaled VRH/D-HH plan.
  - Single CEO, CMO, CFO
  - Operations leads at both sites
  - HR directors at both
  - Quality directors at both
  - Other leadership roles tailored to needs of "microsystem" (Southern Windsor County and Sullivan County)
    - Flexibility to respond ever-changing needs

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2 Curveballs

- Springfield Hospital, under interim leadership from Quorum, enters bankruptcy on 6/26/2019.

- Their interim leadership reaches out to D-HH and requests urgent consideration to enter D-HH System.

- D-HH's measured response is "come to the table" as we look at regional rationalization of care across MAHHC, VRH, and now Springfield.

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- NDAs signed in August, 2019, and a steering committee is established with CEO/CFO from 3 hospitals, D-HH strategic leadership, and a 3rd party consultant (BKD) to investigate the current financial positions of each institution and to study 3 different models of regional care delivery with all 3 hospitals acting as a microsystem under D-HH umbrella. 3 Options were investigated:

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- 1) consolidate leadership teams as previously described but leave other administrative structure and clinical service lines intact.
  - Minimal impact on operations
  - Some savings in executive leadership
  - All current "warts" remain visible/untreated

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- 2) "skinnied down" Springfield with minmal inpatient capacity, focus on outpatient procedures and maintaining ER presence.
  - Inpatient capacity at Springfield 5-15 beds
  - Increased ADC at VRH and MAHHC
  - Service lines expand at MAHHC and VRH

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- 3) Springfield Hospital closes
  - Attains designation as Rural Emergency Hospital
    - Requires VT legislative rule-making
    - Substantial transformation funding (Adirondack Model)
  - Springfield loses CAH designation and all inpatient capacity
  - VRH and MAHHC expand accordingly

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- Any model for Springfield would involve significant financial support from D-HH and cooperation from creditors, the State of VT, and CMS– all of whom were owed close to $20 million from SMCS.

- In parallel to financial analysis, I was responsible for development of a service line plan for the 3 institutions.
  - Informed by D-HH service line chiefs who all agreed that consolidated specialty care should be the model for DH outreach moving forward.
  - Focus on historical strengths of each institution.

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Hospital Assumptions

Beds	MAHHC	VRH	SH
Post Acute/Swing/Inpatient Care	25	25	15
Acute Inpatient Rehab	10	-	-
Geri Psych Inpatient	-	-	-

Average Daily Census	MAHHC	VRH	SH
2018 (Adjusted)	19.56	15.00	15.68
2019 (Adjusted)	19.75	15.00	15.00
2020 (Budgeted)	19.67	20.00	4.00

Other Hospital Services	MAHHC	VRH	SH
Emergency Department	Full Service	Full Service	Full Service
Operating Rooms	Actual/Budget	Actual/Budget	-

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Intermediate Model

	Current Service Lines			Proposed Service Lines			
Service Line	MAHHC	VRH	SH	MAHHC	VRH	SH	comments
Post Acute/Swing/ Inpatient Care	25 beds*	21 Beds*	25 Beds*	25 beds	25 beds	15 beds	VRH increase 4, SH reduce 10
Acute Inpatient Rehabilitation	10 beds			10 beds			no change
Adult Day Care							close adult day care
Cardiology	DH	DH	Cheshire				remove MAH and SH
Emergency Room							no change
Ear, Nose, Throat							remove SH
General Surgery							no change
Hospital Medicine							no change
Gastroenterology							no change
Womens Health							no change
Infusion							no change
Neurology							no change
Oncology	DH	DH	DH				remove MAH and SH
Ophthalmology							no change
Operating Room							no change
Orthopaedics							no change
Pain Management							no change
Physical Medicine & Rehabilitation							no change
Podiatry							no change
Psychiatry Inpatient			SMCS			GeriPsy	geri psych
Pulmonary							no change
Rheumatology	2/days mo.						no change
Urgent Care							no change
Urology							remove VRH and SH
Total Service Lines	17	15	14	15	14	9	

*Employed Hospitalist coverage

11/25/2019

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Early Observations

- Where clinical service lines existed really did not effect financial picture.
- Springfield needed to keep CAH designation in order to preserve reimbursement benefits, no other model would allow for financial success.
- According to BKD, MAHHC had the ideal service line mix and operational structure for a rural CAH (largely driven by core service lines and high utilization of inpt beds) , Valley was close, and Springfield offered the most opportunity for improvement and was further afield from where a CAH "should be."

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Springfield

- D-HH submitted proposal to Springfield BOT with conditions to creditors (state, FEDs, vendors, banks) that would allow SH to enter D-HH as a distressed hospital.
- Springfield decided to choose their own path out of bankruptcy, refusing virtually all of D-HH's conditions.
- In losing the weakest organization, it becomes harder to generate significant operational/financial gains in MAHHC/VRH.
- Of note, since emerging from bankruptcy, SH has continued to lose money.
  - Down to 6 days cash recently prior to cash infusion from State

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Early 2021

- Renewed focus on MAHHC/VRH financial analysis with BKD
- Service line plans unchanged
- Some early movement to integrate leadership roles
  - Director of Rehab services for both institutions (Belinda Needham-Shropshire)
  - Lab Director (Lara Moody) serving VRH and MAHHC
  - Closer Quality and Safety coordination
  - No real clinical integration (yet)
  - Opportunity to elevate internal resources to "microsystem" leadership

- Financial Performance in FY20-21
  - MAHHC- $4+ million ahead of "covid" budget
  - VRH- currently close to budget but expect to keep PRF and get close to break-even

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Current State

- Per D-HH, they cannot signal intent to bring another hospital into D-HH until a ruling on the D-HH/GO combination agreement by the NH AG.
- The timeline continues to extend
  - Realistically, could 12+ months to have clarity
- Jocelyn and I are both working with Boards eager to make progress
- D-HH leadership has agreed to re-focus on VRH/MAHHC
- Further BKD analysis of finances of 2 hospital System with plans to bring to the D-HH Board for approval in September
- Hoping for a letter of intent between VRH and D-HH soon after

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Big Issues

- Does the imperative to bring MAHHC/VRH closer together still exist?
- Does the potential financial improvement of a microsystem justify the work/resources required to bring 2 hospitals closer together.
- Governance of the 2 organizations

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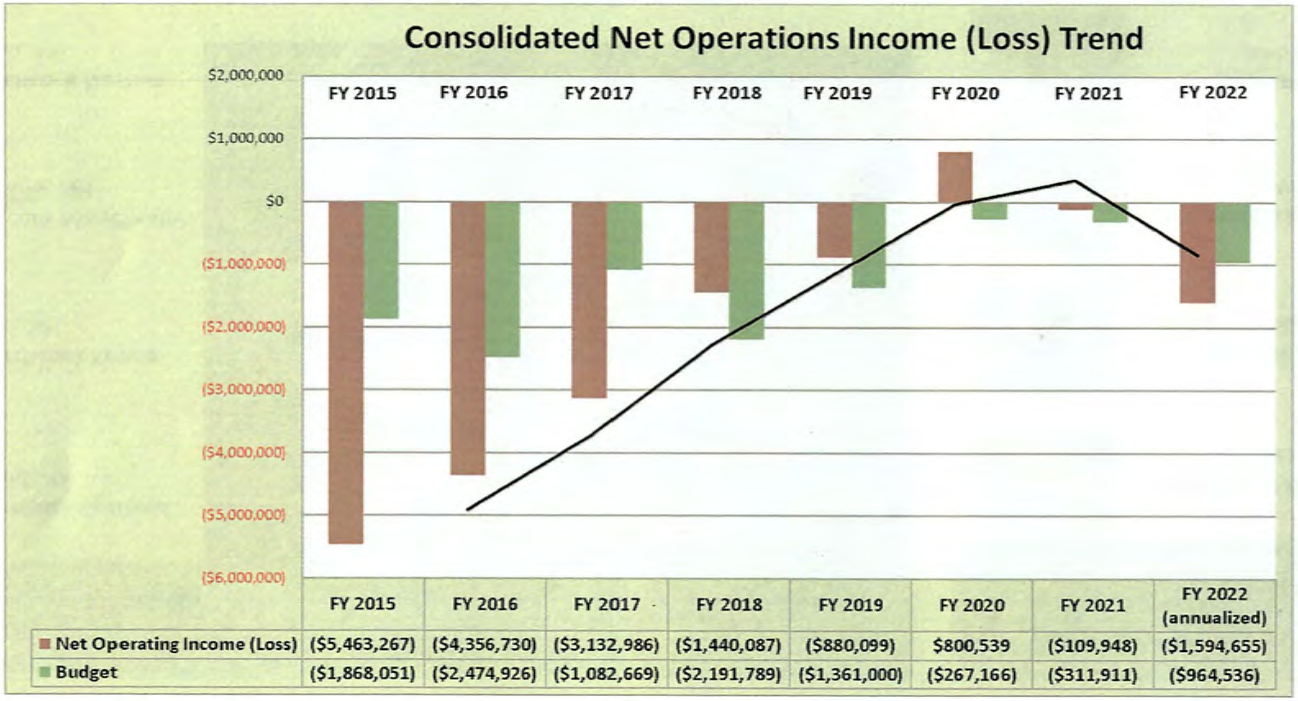
Dartmouth Health

Past and Present



	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022 (annualized)
Net Operating Income (Loss)	($5,463,267)	($4,356,730)	($3,132,986)	($1,440,087)	($880,099)	$800,539	($109,948)	($1,594,655)
Budget	($1,868,051)	($2,474,926)	($1,082,669)	($2,191,789)	($1,361,000)	($267,166)	($311,911)	($964,536)

FY2020 - $4.9m stimulus dollars included in Net Operating Income
FY2021 - $4.0m PPP funds removed from Net Operating Income
FY2022 - $2.0m DSH Reserves removed from Net Operating Income

Dartmouth Health

Dartmouth-Hitchcock Health System – Today

Dartmouth-Hitchcock Community Group Practices

Dartmouth-Hitchcock Concord
Concord, NH

Dartmouth-Hitchcock Keene
Keene, NH

Dartmouth-Hitchcock Manchester
Manchester, NH

Dartmouth-Hitchcock Nashua
Nashua, NH

Dartmouth-Hitchcock Putnam
Bennington, VT

Dartmouth-Hitchcock Medical Center
Lebanon, NH
Mary Hitchcock Memorial Hospital/Dartmouth-Hitchcock Clinic Lebanon

Dartmouth-Hitchcock Health System Members

Alice Peck Day Memorial Hospital
Lebanon, NH

Cheshire Medical Center
Keene, NH

Mt Ascutney Hospital & Health Ctr.
Windsor, VT

New London Hospital
New London, NH

VNH

Visiting Nurse and Hospice of VT & NH
White River Jct., VT

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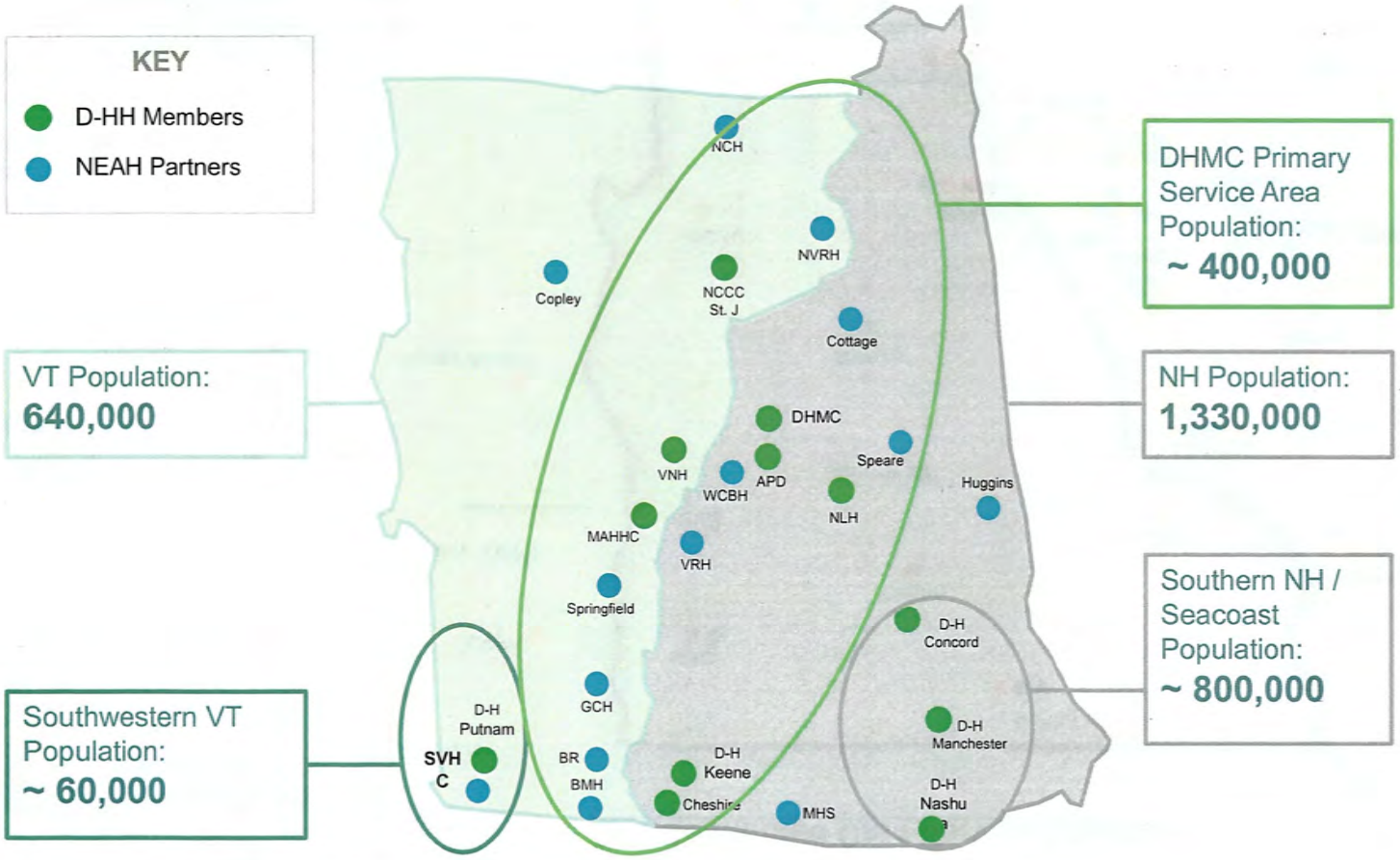
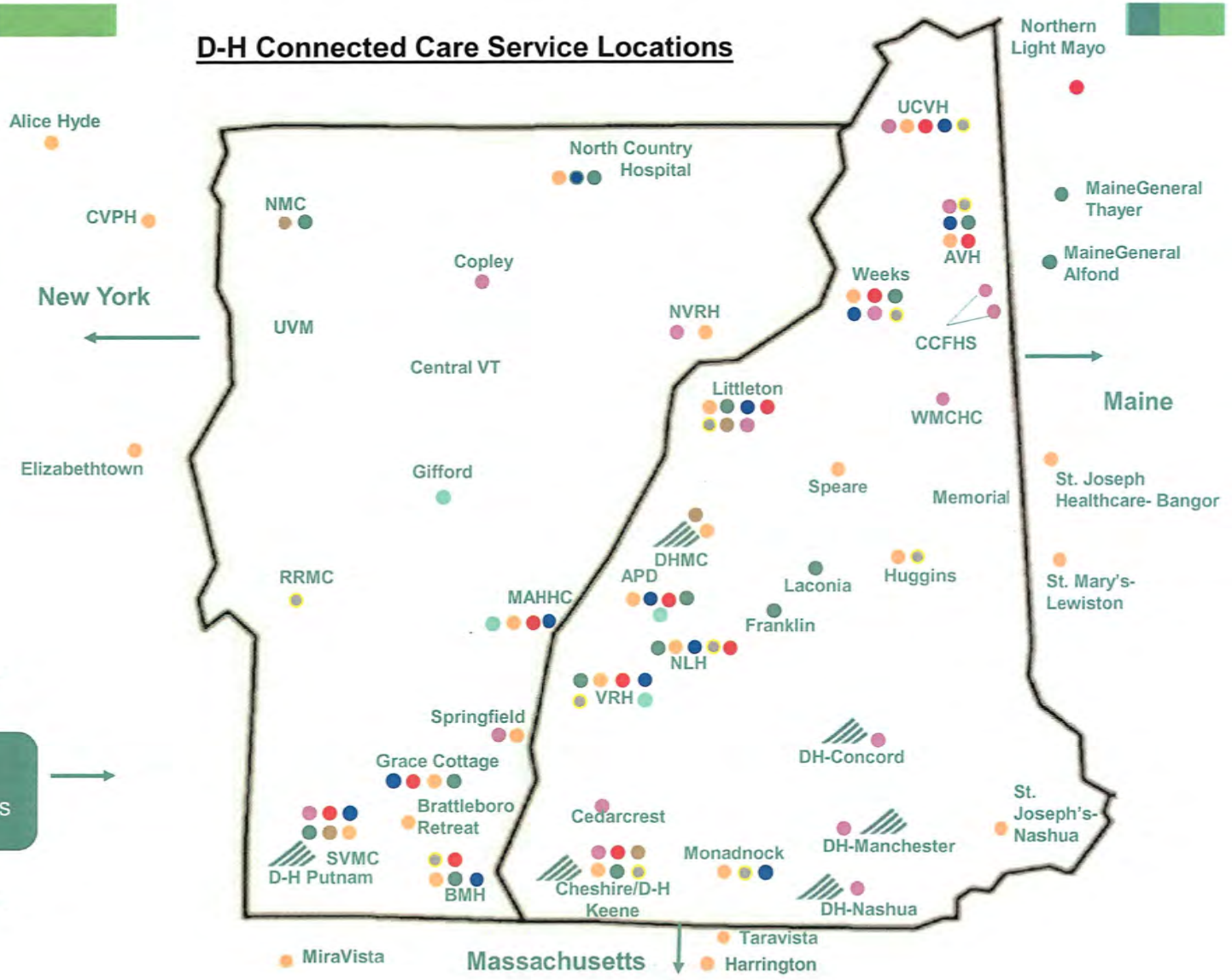
Rural Network



Service	Sites	Icon
TelePharmacy	29	
TeleEmergency	13	
TeleNeurology	16	
TeleICU	5	
TelePsychiatry	13	
Telemedicine Clinics	16	
TeleICN	11	
TeleGeriatric ED	4	

Virtual Urgent Care Across the United States

D-H Connected Care Service Locations



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Dartmouth Health

PURPOSE:

Dartmouth-Hitchcock Health's purpose is to **Guide, Grow and Enable** our members' success to improve the lives of **our patients, our people, and our communities.**

PRINCIPLES

- Ensure exceptional collaboration and integration across the system and the continuum of health promoting teamwork because we are stronger together than on our own.
- Embrace and grow diversity, demonstrate respect, and value the unique perspectives and contributions of every employee and their communities in which we are caregivers, leaders and patients.
- Translate the cutting-edge research in discovery, delivery science, and health professions' education, which we undertake as an academic health system, into high-quality patient care for all patients of every member organization.
- Care for our colleagues and undertake positive intention in our actions.
- Be accountable, responsible and transparent in stewardship of our financial, human and natural resources in all aspects of our work.

Dartmouth Health

MAHHC

Purpose

To improve the lives of those we serve.

Principles

- Every action, every day, deepens our commitment to our patients, our people and our community.
- MAHHC continues to expand D-HH's presence across the region. MAHHC will grow as a center of clinical and operational excellence within D-HH and the communities we serve in VT and NH. Extending the reach of MAHHC in Southern Windsor County and Sullivan County, our goal is to stabilize our healthcare delivery system. We improve the health of our communities by building a more coordinated and resilient network that will keep appropriate care local.
- MAHHC establishes the necessary infrastructure to optimize our role within D-HH and allows for rapid response to proposed and future initiatives around workforce development, increasing system capacity and deepening system integration. We expand access to high-quality care with investments in primary care and population health management.
- MAHHC partners with Dartmouth-Hitchcock Medical Center to train the next generation of our healthcare workforce. We translate the cutting edge research in discovery, delivery science and health professions' education into high-value patient care for our patients.
- MAHHC embraces and grows diversity, demonstrates respect, and values the unique perspectives and contributions of every employee and their communities in which we are caregivers, leaders, and patients.
- MAHHC is accountable, responsible and transparent in stewardship of our financial, human and natural resources in all aspects of our work.

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MAHHC

- Why affiliate?
  - –Existential, needed stability
- After 14 months of due diligence, formal affiliation agreement signed in July, 2014
- Early alignment of System and Local Needs/Resources

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- Alleviate the fears of losing autonomy and sense of place with affiliation into a larger health system

- Manage the bumps/bruises
  - Loss/gain of service lines
  - Search for and elevate local talent into management positions, whether at MAHHC or DHMC

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- Number one priority in 2017 was to ensure a stable leadership transition
- ***Re-establish our institutional commitment to Quality, Patient Safety, and Improving the Patient Experience***
- Intense focus on employee and institutional wellness

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- Building transparency in a FLAT organization
- Development of an extensive quality dashboard to provide real time reporting on D-HH system metrics, ACO measures, Blueprint/PCMH requirements, Patient Satisfaction, and internal QI projects.
- **Ready for the next patient, not the next survey.**

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ROI

- Highest Quality and Safety metrics in D-HH.
- 500+ days without a serious safety event, although post-pandemic we have struggled on this front
- Highest employee engagement scores in every system-wide survey by Press-Ganey for the last 4 years with lowest staff turnover rate in the DH System
- On our D-HH System Employee Engagement Survey, 100% of MAHHC employees responded with Agree or Strongly Agree to questions regarding our institutional commitment to patient safety.

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Institutional Wellness

- Employee health and fitness
- Social drivers of health AND workplace dysfunction
  - Expanded EAP
  - Work United
- Provider Burnout a persistent issue
- Internal opportunities for advancement
- Financial stability and reinvestment in staff

Dartmouth Health

Together in the Community

Valley Regional Hospital

What does this mean for you?

Valley Regional Hospital will keep:

- Name
- Mission & Community Spirit
- Employees
- Physicians
- Local Board

As a member of Dartmouth Health the community will get:

- More convenient, cost-effective care options
- Access to high-quality, multi-specialty care
- Expansive career opportunities for employees
- Resources of an academic health system

Dartmouth Health

What's Happening Now?

Due diligence – we're learning about each other's organizations and writing our formal agreement

Internal education – speaking to all our employees

External education – meeting with patients, neighbors, employers, elected officials and others

Public forums – we will hold official comment sessions this fall, after filing our agreement