REPORT OF ATTORNEY GENERAL'S CHARITABLE TRUSTS UNIT

WITHDRAWAL OF LITTLETON HOSPITAL ASSOCIATION, INC. FROM NORTH COUNTRY HEALTHCARE, INC.

September 13, 2019

I. INTRODUCTION

The Charitable Trusts Unit received a notice with supporting materials, filed May 16, 2019, pursuant to RSA 7:19-b, regarding the proposed withdrawal of Littleton Hospital Association, Inc. (LRH) from North Country Healthcare, Inc. (NCH). NCH is the sole corporate member of LRH.

LRH exercised the withdrawal through an April 4, 2019 letter from the board chair and chief executive of LRH to the chief executive of NCH. The letter cited Section 8.2 of the June 30, 2015 Affiliation Agreement among LRH, Androscoggin Valley Hospital, Weeks Medical Center, and Upper Connecticut Valley Hospital (collectively, the four North Country Hospitals). The Affiliation Agreement contemplated the creation of NCH as the system parent of the North Country Hospitals. Pursuant to RSA 7:19-b, the Director of Charitable Trusts reviewed that transaction and issued a "no action" letter dated December 28, 2015.

In addition to the April 4, 2019 submission, the Charitable Trusts Unit received from LRH responses dated June 26, 2019 to requests for additional information. All of the documentation submitted will be referred to collectively as the "Notice". The Notice constitutes one of the requirements of RSA 7:19-b, II and III, which generally obligates the governing bodies of health care charitable trusts, including LRH, to satisfy certain requirements before they consummate a transaction.

The Charitable Trusts Unit has completed its review of the Notice. It has taken into consideration material discussed with the Director of Charitable Trusts at a meeting with the board of directors of NCH on August 7, 2019 and of LRH on August 21, 2019. The Director of Charitable Trusts discussed the withdrawal with groups of directors of LRH and NCH at additional meetings. NCH submitted written materials as to its position on August 16, 2019 and in other communications. The Charitable Trusts Unit retained the UNH Franklin Pierce School of Law Institute for Health Policy & Practice to assess the status of health care in the region served by the North Country Hospitals, to interview providers of health and social services, and to assess the impact of LRH's withdrawal upon NCH and health care in the North Country of New Hampshire. Representatives of the Institute in turn have interviewed 13 persons representing institutions including Ammonoosuc Community Health Services, Coos County Family Health Services, Indian Stream Health Center, North Country Health Care Consortium, Tri-County Community Action Program, City of Berlin, and the North Country Hospitals.

II. JURISDICTION OVER THE TRANSACTION

Both LRH and NCH are New Hampshire voluntary corporations and charitable organizations registered with the Charitable Trusts Unit. Because each organization provides health care services, each is also a "health care charitable trust". RSA 7:19-b, I(d). The withdrawal constitutes an "acquisition transaction" because the withdrawal of LRH from NCH creates a "transfer of control" within the meaning of RSA 7:19-b, I(a) – (c). A "transfer of control" occurs when control over more than 25% of the assets of a health care charitable trust changes hands. Here, LRH earns about 42% of the revenue of the North Country Hospitals, and its withdrawal will mean a loss of more than 25% of the assets of NCH. NCH is currently the sole corporate member of LRH and holds substantial reserved powers affecting LRH, and LRH's withdrawal will mean that LRH will regain full control over its assets.

Accordingly, the transaction is subject to the provisions of RSA 7:19-b, II, III and IV which require specific due diligence and notice by LRH, followed by a review of the transaction by the Director of Charitable Trusts.

This is the first instance of a health care charitable trust seeking to withdraw from an extant health care system after having previously received a favorable review by the Charitable Trusts Unit pursuant to RSA 7:19-b. LRH challenges the applicability of RSA 7:19-b to its withdrawal, since the structure of the statute seems to contemplate one health care organization acquiring another. But the language of the statute is clear that an acquisition transaction is defined by a 25% or greater change of control, and a change of control can occur in either an acquisition or a de-acquisition transaction.

LRH's counsel in a May 16, 2019 letter notes that the application of RSA 7:19-b to the planned withdrawal poses several practical challenges. The timing required for a withdrawal notice may does not mesh well with the timing of a contractual withdrawal right. The Charitable Trusts Unit's December 28, 2015 "no action" letter signified tacit approval of the terms of the Affiliation Agreement, and the Affiliation Agreement at Section 8.05 provided for a right of withdrawal. Those challenges are addressed in this report, but they do not prevent the Charitable Trusts Unit from exercising jurisdiction over this transaction.

III. RELATED LITIGATION

The withdrawal notice has triggered considerable acrimony between LRH and NCH. LRH filed for declaratory and injunctive relief against NCH, now pending in Grafton Superior Court (No. 217-2019-CV-00223). NCH quickly followed and filed a complaint filed under seal for breach of contract and various tort claims against LRH, four LRH directors and an LRH employee. That case is now pending in Coos Superior Court (No. 214-2019-CV-00059).

The parties are engaged in a mediation process in an attempt to settle the issues raised in the litigation, as well as matters related to the withdrawal payment and other issues. Retired Superior Court Judge Bruce E. Mohl was retained as the mediator. The Director of Charitable Trusts has also been actively involved with the parties to assist in reaching agreements on the many issues that divide them. While no agreement has been reached as of the date of this report, the parties have made much progress in resolving their differences.

IV. TRANSACTION REVIEW APPLYING REQUIRED STANDARDS

The board of directors of LRH must comply with its fiduciary duties in considering the proposed transaction. RSA 7:19-b, II sets forth in seven subparagraphs ((a) through (g)) the specific minimum standards that the boards must meet in order to approve an acquisition transaction. This report will address compliance with each of the standards but presented in a different manner than the statute and with reference to the applicable subparagraphs of RSA 7:19-b, II.

(b) Due Diligence

The Notice described the process that LRH employed to consider whether or not to withdraw from LRH. Specifically, LRH invoked Article 8 of the Acquisition Agreement. That section gave each of the North Country Hospitals the right to withdraw from NCH without cause within a 90 day window beginning on the third anniversary of the effective date of the NCH transaction. The transaction became effective on April 1, 2016, so the withdrawal period began on April 1, 2019. On April 5, 2019, LRH sent NCH a letter exercising its right to withdraw, although NCH learned of LRH's intention to so contemporaneous with the issuance of a press release by LRH dated February 19, 2019.

LRH's support for exercising its withdrawal focuses on its absolute contractual right under Article 8 of the Affiliation Agreement. It points to the fact that Article 8 does not require cause for withdrawal. While the Affiliation Agreement is likely an integrated agreement, LRH supports its reading of the document by referring to contemporaneous written notes taken of the negotiation process in 2015. A July 21, 2014 letter of intent among the parties contemplated there would be a limited right of withdrawal – with cause – at the two year mark after closing. That language changed during negotiations in May and June 2015 so as to permit the North Country Hospitals to withdraw without cause at the three year mark. The change was discussed in June 16 and 19, 2015 memoranda of counsel negotiating the transaction. The Charitable Trusts Unit then reviewed the transaction, including the Affiliation Agreement with the withdrawal cause, and issued a no action letter on December 28, 2015 allowing the deal to close.

Given the language of Article 8, LRH contends it need not express any reason to support its decision to withdraw from LRH. But the board of directors of a charitable organization must exercise its duty of care in any decision it makes. *See*, Guidebook for New Hampshire Charitable Organizations, p. 4. And that obligation is reinforced by RSA 7:19-b, II(b), which requires the exercise of due diligence in determining whether an "acquisition" transaction is in the best interest of the organization, among other factors.

Despite its stated position that no reason need be articulated, LRH provided with its Notice documentation to show that its board of directors did consider the withdrawal over a period of time and did articulate reasons for its decision to exercise its right to withdraw. Its chief executive presented to the LRH executive committee and the full board of directors a written analysis of the positive and negative aspects of the NCH affiliation, the cost of withdrawal, and opportunities for the future. The board of directors retained Hälsa Advisors to assist in the development of a strategic plan for LRH post-withdrawal. At a meeting with the Director of

Charitable Trusts, individual members of the LRH board of directors recounted the substance of discussions at meetings leading up to the vote to withdraw. Those discussions reflected concerns similar to those in the chief executive's written analysis and reflected future plans similar to those proposed by Hälsa Advisors.

The LRH decision to withdraw did not consider the effect it would have upon NCH and the other North Country Hospitals, except indirectly. In its response to an information request, LRH pointed to the contractually required withdrawal payment to NCH, which would "reflect an appropriate assessment of any detriment or damage realized by the System Parent [NCH] upon [LRH's] withdrawal". Affiliation Agreement, Section 8.3(a). LRH also contends that there has been little coordination at the hospital level since 2016, and so there will be little negative effect going forward. And LRH proposes that it could engage in a "clinical alignment strategy" going forward, which could be beneficial to NCH and the remaining North Country hospitals.

There will be further discussion of the detriment to NCH in the section discussing the best interest of the community, below.

(c) Conflicts of Interest/Fiduciary Duty

The Notice does not describe any conflicts of interest that involve any of its directors in undertaking this withdrawal. In a subsequent written communication dated September 3, 2019, LRH counsel confirmed that no LRH directors stood to gain any direct financial benefit, such as a performance bonus, as a result of its withdrawal from NCH.

(i) LRH Director Fiduciary Duty to LRH

NCH alleges in its Coos County Complaint and in its comments to this Notice that several of the directors of LRH suffered from conflicts of interest with LRH in that they have a direct or indirect financial interest in the withdrawal. The apparent focus of the financial interest is the potential growth in certain LRH staff salaries following this transaction. Several of the directors are management or medical employees of LRH, or are related to them. But New Hampshire's statute governing conflict of interest transactions, RSA 7:19-a, exempts from its ambit the compensation of both the executive director and hospital medical staff, so long as the medical staff does not exceed 25% of the membership of the board. RSA 7:19-a, I(c)(1) and X. Apart from the salary amounts exempted from RSA 7:19-a, there are no disclosed conflicts of interest.

NCH also alleges there may not have been a proper quorum of unconflicted and eligible directors to vote on the withdrawal. LRH counsel in its September 3, 2019 letter provided documentation to support the presence of a voting-eligible quorum. Moreover, the LRH board of directors took a vote on April 9, 2019 to ratify its earlier vote. That April 9th vote took place four weeks before the delivery of the formal withdrawal letter. Accordingly, there is no serious issue that LRH observed the formalities of the voting process for the withdrawal.

(ii) LRH Director Fiduciary Duty to NCH – as NCH Directors

NCH also alleges in its Coos County Complaint and in its comments to this Notice that two LRH directors owe a duty to NCH by virtue of also serving as an officer or director of NCH.

NCH alleges that they committed breaches of the duties of loyalty and care owed to NCH. NCH also alleges that those two directors, along with another director of LRH, committed interference with contractual relations and fraudulent misrepresentation against NCH.

Only one of those two LRH directors is a voting member of the LRH board. The vote of the other LRH director in favor of the withdrawal was not the decisive vote. That director's vote, along with allegations against the other two LRH directors, are the subject of NCH's ongoing lawsuit seeking monetary damages. The claims include additional conduct distinct from the LRH board of directors' consideration of the withdrawal. The claims are also fact-intensive, and some are beyond the expertise of the Charitable Trusts Unit. Accordingly, the allegations against those three directors are best resolved through the litigation process and the Director declines to consider them in this report.

(iii) LRH Director Fiduciary Duty to NCH – as Subsidiary of NCH

Finally, NCH alleges that the LRH board of directors as a whole owes a duty to NCH, given that LRH is a "subsidiary" of NCH and NCH is the sole corporate member of LRH, holding certain reserved powers. NCH in its comments to this transaction points to the Opinion of the Attorney General dated February 13, 2017, which states that the Charitable Trusts Unit will apply limited fiduciary duties to the corporate member of another charitable organization. *See, e.g., Lifespan Corp. v. New England Medical Center*, 731 F.Supp.2d 232, 236 – 41 (D.R.I. 2010). But the Opinion was limited to the downstream duty of a corporate member to its membered organization; it is silent as to the claim made by NCH: that the membered organization, LRH, owes an upstream fiduciary duty to its corporate member, NCH.

The Attorney General is not prepared to extend the Opinion to cover that opposite situation, i.e. fiduciary duties do not extend generally to the membered organization for the benefit of its member. The membered organization is junior to its member due to reserved powers in favor of the member described in its articles of agreement and bylaws.

Still, a written agreement may create a fiduciary relationship, and there is a written agreement here that requires greater scrutiny. In one section, the Affiliation Agreement imposes an upstream duty on the directors of the North Country Hospitals. In Exhibit G, Governance Principles, LRH and the other North Country Hospitals agreed to certain competencies for hospital directors, including a "[p]ledge to mission", which means that he or she "[e]nsures attainment of the mission, vision, values and ethical responsibilities to 1) the communities the Hospital serves and 2) regionally through [NCH]."

The Governance Principles recognize that LRH directors owe a duty of loyalty and a duty of care toward LRH. The Principles extend those duties "regionally through [NCH]". Assuming that phrase contractually establishes a fiduciary duty upon LRH directors toward NCH, that duty in turn must be circumscribed by LRH's right to withdraw without cause as described in Article 8 of the same Agreement. The Attorney General's Opinion notes that a corporate member's fiduciary duty to its membered organization may be defined by written documents. Similarly here, LRH's duty to NCH is defined and limited: in time, to the period that it remains a member of NCH; and in scope, to matters not otherwise laid out in the Agreement. The Governance Principles may be evidence in favor of NCH in its case against the three LRH director

defendants, but the Principles do not define the duty of the LRH board as a whole in its consideration whether to exercise LRH's contractual withdrawal right.

(d), (e) and (f) Proceeds of Transaction

The withdrawal involves two New Hampshire voluntary corporations, whereby NCH will no longer be the corporate member of LRH. LRH and NCH will retain their own assets. There is no "acquisition price" as such in this transaction.

However, Section 8.3 of the Affiliation Agreement requires LRH to pay NCH a withdrawal payment, which is defined in a formula, but which cannot be less than 3% of the withdrawing hospital's net patient service revenue for its most recently completed fiscal year. LRH tendered to NCH the 3% payment to NCH in the amount of $2,546,961 along with its April 4, 2019 withdrawal notice. LRH supports that amount with a report from Quorum Health Resources. NCH contests the amount of the withdrawal payment, relying upon a study from Stroudwater Associates. NCH and LRH are engaged in mediation over the amount of that payment along with the issues pending in the litigation. It the parties fail to reach an agreement, the parties must resort to binding arbitration to determine the amount of the payment.

The amount of the withdrawal payment does not mesh well with the "fairness" and other language of RSA 7:19-b, II(d) and (e). Subsection (d) expects that the proceeds will "constitute fair value". Here, Section 8.3 sets the contractual price for withdrawal. That price is the subject of mediation, and failing that, arbitration. Therefore, this review will not weigh in on the value of the withdrawal payment. It is important to note that the formula in Section 8.3 attempts to place some value on the loss to be suffered by NCH from the withdrawal of any of the hospitals. That concept will be discussed further in the section on the best interest of the community.

(g) Notice and Hearing

LRH has not provided extensive outreach to the communities affected by its withdrawal. It did not make any public statement prior to its February 18, 2019 vote to withdraw. LRH issued a press release on February 19th and made other public statements about its plans prior to its April 4, 2019 withdrawal notice letter. There has been some press coverage of the litigation between LRH and NCH over the withdrawal.

The Director has elected not to hold a public hearing on the withdrawal pursuant to RSA 7:19-b, IV. The reasons are threefold: the Charitable Trusts Unit conducted four public hearings concerning the 2015 affiliation, which included consideration of the Affiliation Agreement; the withdrawal right is contained in Article 8 of that Affiliation Agreement; and there is litigation and confidential mediation ongoing between the parties. Still, the Director and the UNH Institute for Health Policy have reached out to individuals and organizations in the North Country to learn their views and their assessment of the consequences of the withdrawal.

LRH decided it was in its best interest to keep deliberations quiet until it had taken its withdrawal vote on February 18, 2019. The announcement came as a fait accompli. It was met with great surprise and anger from NCH leadership and with surprise from many in the North Country. At the least, LRH handled badly the messaging to NCH of its withdrawal. But that failure of itself does not affect this analysis.

(a), (b) and (e) Best Interest of the Organization

The chief executive's written analysis and the Hälsa Advisors presentation describe both the challenges LRH perceived in remaining with NCH and the opportunities offered by becoming independent once again. The board of directors remain enthusiastic that withdrawal will lead LRH to a more successful future.

Based on the limited materials offered, LRH has presented enough information to support its belief that the transaction is in its own institutional best interest.

(a), (b) and (e) Continuation of Charitable Purposes

After the withdrawal, LRH will continue to operate as a New Hampshire voluntary corporation and a charitable organization registered with the Charitable Trusts Unit. It will retain its status as a public charity classified under Section 501(c)(3) of the Internal Revenue Code.

LRH's articles and bylaws will be amended to reflect that it is no longer a part of NCH. The proposed amended articles show no change of purpose for LRH, which is to operate a critical access hospital and to supply health care services to its community.

(b) and (e) Best Interest of the Community

As stated above, LRH did not consider directly the effect a withdrawal would have upon NCH and the other North Country Hospitals. LRH believes that its contractually required withdrawal payment to NCH will "reflect an appropriate assessment of any detriment or damage realized by the System Parent [NCH] upon [LRH's] withdrawal". Affiliation Agreement, Section 8.3(a). LRH also contends that the North Country Hospitals initiated little coordination at the operational level since 2016, and so NCH will suffer no negative consequence from withdrawal. As one LRH director stated: "[NCH] people wanted to be affiliated but not connected" and "[NCH] people wanted the patch, not the job." NCH disputes that, pointing to tangible efforts at non-clinical integration. And LRH proposes that it could engage in a "clinical alignment strategy" going forward, which would benefit NCH and the remaining North Country hospitals. At present, NCH sees little value in further cooperating with LRH on clinical matters.

RSA 7:19-b, II(b) requires hospitals engaged in a transaction to determine "that the transaction is in the best interest of the [hospital] and the community which is serves." The statute does not define "best interest", but it likely includes issues identified in the health needs assessment and addressed in the community benefits that the organizations measure and report to the Charitable Trusts Unit pursuant to RSA 7:32-c – 32-*l*. The 2016 NCH Community Health Needs Assessment identified the following as the top five serious health issues: substance use disorder, alcohol abuse, obesity, mental health and poverty.

The UNH Institute for Health Policy has identified several issues that may emerge with access to health care services as a result of the withdrawal. Its analysis starts with the major public health issues mentioned above. The Institute created a Summary of Health Needs and Public Health Data, which is attached to this report. It notes that the North Country is a rural region with an economy that has declined in the recent past. Compared to the rest of the state, it

has higher unemployment, lower life expectancy, higher poverty rates and an older, sicker population. More mental health and substance use disorder treatment is needed.

To cope, North Country institutions are exploring ways to collaborate more, whether it be through merged school districts or municipal services. Community providers of health and social services looked with hope over the past three years that NCH would develop more efficient, higher quality care. Employers had begun to use NCH as a community resource in their recruitment of employees to the North Country. There is disappointment that the promise of a unified system will not develop as planned. Unfortunately, except for improved access to some specialty services, UNH also found that NCH remained a promise for yet-to-be realized improvements in health care.

In deciding to withdraw, LRH did not fully consider factors such as those identified by the UNH Institute for Health Policy. The Notice shows that LRH did not consider the serious health issues identified in the 2016 NCH Community Health Needs Assessment, although it now plans to expand its behavioral health treatment capabilities. Therefore, LRH did not fully consider whether its decision would be in the best interest of the communities served by NCH, of which LRH is a part. The Notice shows that LRH did not examine whether its withdrawal payment in fact "is an appropriate assessment" of the detriment to NCH and to the communities it serves. But for the contractual nature of LRH's withdrawal right, LRH's failure to consider the best interest of the NCH communities could form the basis for the Charitable Trusts Unit to object to the proposed withdrawal.

CONCLUSIONS AND DETERMINATION

The withdrawal of LRH from NCH is an "acquisition transaction" pursuant to RSA 7:19-b, but it is not the sort of transaction that easily fits within the rubric of the statute. Apart from its failure to give full consideration to the best interest of the NCH community, LRH has complied with the minimum standards set forth in RSA 7:19-b, II for an acquisition transaction. LRH's failure to address fully the "best interest of the community" standard is premised on its belief that RSA 7:19-b does not apply to a withdrawal transaction, that LRH has an absolute right to withdraw from LRH under the Affiliation Agreement, and that LRH is required to pay a substantial withdrawal payment to NCH. LRH believes the withdrawal payment should address the detriment that NCH, and by extension the North Country, may face from LRH's decision.

The Notice described LRH's contractual right to withdraw from NCH without cause. Still, the Notice articulated reasons for LRH's withdrawal that showed the board of directors considered that decision to be in the organization's best interest.

With respect to the best interest of the community, LRH is obligated to make a substantial withdrawal payment to NCH. That payment will at least help to compensate NCH for the detriment to NCH as it attempts to continue to deliver health care services to the North Country. The proper amount is the subject of ongoing mediation. Beyond that, and considering the findings made in this report, LRH must further address the best interest of the NCH community, particularly with respect to needs identified in the health needs assessment for substance use disorder and mental health services. LRH can do so by following the

representations and conditions below. With those representations and conditions in place, the best interest of the community standard of RSA 7:19-b is satisfied.

Accordingly, the Director of Charitable Trusts will take **no further action** with respect to the transaction, subject to the following representations and conditions.

Representations

LRH represents that the statements below will be true and correct as of the withdrawal date:

(i) The withdrawal will comply with the terms of the Affiliation Agreement and the statements made in the Notice.

(ii) There are no conflicts of interest or pecuniary benefit transactions involving directors of officers of LRH contemplated as part of the withdrawal.

Conditions

LRH assents to the following post-withdrawal conditions:

(i) Payment of a withdrawal fee to NCH as determined through mediation or arbitration in an amount not less than $2,546,961.

(ii) Continue support for North Country Home Health and Hospice Agency, and not develop a competing home health agency. LRH will negotiate with NCH to create a new governance framework for the Agency. The framework, below, is the initial template for a governance model.

(iii) Develop by July 1, 2021 a behavioral health treatment area adjacent to the LRH emergency department with two dedicated rooms and two flexible treatment rooms for behavioral health patients, both to meet demand and to allow appropriate spaces for extended holding of behavioral health patients as necessary.

(iv) Continue as the regional hub for substance use disorder services, so long as that program is available to LRH by contract with NH Department of Health and Human Services. In doing so, LRH will use its best efforts to continue to use and pay promptly for the services of Weeks Medical Center (WMC) professional staff at the Littleton Doorway.

(v) Provide nursing and physician support at no cost to the North Country Health Care Consortium for a period of no less than three years so that it may operate up to four detox beds at its Friendship House facility.

(vi) In order to support the ability of NCH to continue its delivery of services in Coos County, for a period of four years, LRH and its affiliates shall not from this date

co-locate practices or establish facilities in Coos County for services currently offered by NCH or its affiliates, without the express consent of NCH. LRH has an expectation that NCH will likewise refrain from similar activities in LRH's Grafton County primary service area.

(vii) Upon request from the other North Country Hospitals, LRH will use its best efforts to enter into arrangements to provide call coverage, for which LRH has available staffing, to those hospitals for a period of four years, at rates comparable to those currently charged in Northern New Hampshire for such services.

(viii) Continue to participate, with NCH and the other North Country Hospitals, in currently organized accountable care and community care organizations working toward value-based care and payment.

(ix) For a period of five years, provide up to $50,000 to fund an independent, third party organization to identify health care access issues in the North Country.

(x) In its governance, use best efforts to recruit and retain on its board of directors "community" directors without business or employment connections with LRH.

LRH will deliver annual reports to the Director of Charitable Trusts as to its compliance with the above conditions. The reports will be due on the first anniversary of the effective date of LRH's withdrawal, and thereafter for a total period of five years. LRH will submit any dispute with NCH concerning any of these conditions to the Director of Charitable Trusts for informal dispute resolution.

This no further action report concerns the review of the Charitable Trusts Unit pursuant to RSA 7:19-b and does not implicate the jurisdiction of any other section of the New Hampshire Department of Justice which may also have a role in reviewing this proposed transaction, including the Consumer Protection and Antitrust Bureau.

NORTH COUNTRY HOME HEALTH AND HOSPICE AGENCY

GOVERNANCE MODEL TEMPLATE

- NCH and LRH will be the exclusive members of NCHHHA and will hold 58% and 42% respective membership interests therein;
- NCH and LRH understand that successfully operating a single home health care and hospice facility for their communities is in the best interests of those communities;
- Accordingly, NCH, its affiliate hospitals and LRH will work together to maximize the benefits and efficiencies of NCHHHA in providing services to the communities served by all four hospitals.
- NCHHHA's business plan, operations and budgets will be tailored to meet the needs of all of four hospital service areas and communities, with input from each hospital.

- Business plans and annual operating and capital budgets will be reviewed and approved by the Boards of NCHHHA, NCH and LRH. Management of NCHHHA will work with the management of NCH and LRH to facilitate this review and approval.
- In the case of an annual deficit or reduction of surplus, the NCHHHA President, working with NCH CEO and LRH President, would recommend to the two members as to how the deficit should be funded, or not. In the case of a capital project approved by the NCHHHA, NCH and LRH boards, the NCHHHA President, working with NCH CEO and LRH President, would recommend to the two members whether to seek member financing, third-party financing or request a capital contribution from the members.
- The current Board of Directors of NCHHHA consists of 8 voting members with replacements appointed by the NCHHHA Board and approved by the NCHHHA Board and the NCH Board, with the NCHHHA President and NCH CEO serving as ex officio non-voting members. The current board membership would be maintained, with the added the requirement that LRH's Board must also approve replacement board members and add the LRH President or his designee as an ex officio non-voting member.
- The NCHHHA President will report to NCH CEO. The NCHHHA President will have decision making authority over NCHHHA personnel decisions.
- Any disputes between the members of NCHHHA will be resolved by discussion, then mediation using the offices of the CTU if the parties cannot resolve the issue, and then, if still unresolved, by submission to the CTU for a binding decision after submission of positions.
- A restriction on LRH and NCH and its constituent hospitals forming any other home health agency or supporting through agreement, financial means or otherwise, any other home health agency or hospice provider, unless approved by the NCHHHA Board.

Franklin Pierce School of Law
Institute for Health Policy & Practice
Health Law & Policy

North Country Health: Withdrawal of Littleton Regional Healthcare

COMMUNITY IMPACT REPORT -2

SUMMARY OF HEALTH NEEDS AND PUBLIC HEALTH DATA

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Updated September 13, 2019

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This updated and revised Community Impact Report, Summary of Health Needs and Public Health Data contains public information gathered from community benefit reports, hospital health needs assessments, community health improvement plans, and public health data.

NCH Health Needs Assessment Summary

In 2016, NCH completed a Community Health Needs Assessment (the "Assessment") for the North Country. The Assessment includes five separate health needs assessments, four from the four partner hospitals' service areas as well as one overarching assessment, that address the health issues facing the North Country.

As part of the Assessment, NCH surveyed 181 key informants and 528 community members to gather information.[1]

North Country Health 2016 Needs Assessment	
Community Survey Issues	**Key Informant Survey Issues**
1. Substance/drug abuse	1. Substance abuse
2. Obesity	2. Obesity
3. Cost of healthy food	3. Alcohol abuse
4. Alcohol abuse	4. Tobacco use
5. Tobacco use	5. Physical inactivity
6. Lack of dental insurance	6. Mental health problems

As noted above, the NCH healthcare system assessment shows many serious health challenges, such as access to healthcare, affordable health and dental insurance, barriers to healthy living, healthcare workforce capacity, and inadequate behavior health services. Moreover, the Assessment noted that the North Country population is generally poorer, older, and has consistently worse health outcomes than the rest of the state. Although there are many challenges, the Assessment identified programs or services that could improve the North Country population's health. These include additional educational programs regarding healthy living, more healthcare services, and improvements to the environment. Specifically, the Assessment noted that expanded substance use and mental health services and more education surrounding drug abuse could improve the health of the residents. It further identified environmental enhancements such as improved public access to recreation and increased public transportation would significantly benefit the North Country.[2]

[1] NCH, Community Health Needs Assessment, 2016, http://avhnh.org/images/uploads/littletonlancastercolebrookcommunityhealthneedsassessment1216.pdf
[2] *Id.*

Relevant Comparisons of North Country Health Issues to NH and United States:[3]

Chronic Diseases – Geographical Comparison[10]

Risk Factor	North Country 18-64	North Country 65+	NH 18-64	NH 65+	United States 18-64	United States 65+
Diabetes	8%	24%	7%	22%	6%	20%
Hypertension	27%	63%	24%	61%	24%	61%
Angina or Coronary Artery Disease	4%	15%	2%	13%	2%	13%
Heart Attack	4%	12%	2%	12%	3%	13%
Stroke	1%	6%	1%	7%	2%	8%
Overweight (Obese)	34% (33%)	43% (28%)	34% (28%)	39% (39%)	34% (27%)	40% (26%)
Smoking	23%	9%	19%	7%	17%	9%
Physical Activity in last 30 days	75%	58%	82%	69%	76%	67%

Regional, State and National Comparison of Health Status Indicators[11]

Indicator	*North Country Region*	*NH State Rate/Percent*	*National Benchmark Rate/Percent*
Premature Mortality (Under 65 Years)[12]	234.7	180.1	[13]
Percent Elderly (65 & older)	19.4%	12.0%	12.4%
Age Adjusted Diabetes Prevalence	11.1%	7.1%	6.5%
Percent Overweight	38.6%	36.5%	35.8%
Percent Adult Obese	31%	25.8%	25%
Asthma Prevalence	15.6%	11.4%	9.1%
Hypertension Prevalence	36.7%	30.6%	30.8%
Heart Attack Prevalence	7.4%	4.1%	4.4%
High Cholesterol Prevalence	43.6%	38.7%	38.3%
Low birth weight	6.3%	7.6%	
Currently smoking	22.8%	16.9%	17.3%
Heavy alcohol use risk factor	6.1%%	6.4%	4.9%
Always wear seat belt	73.3%	81.1%	
General Health Status			
Fair	15.3%	9.9%	12.4%
Poor	4.9%	3.8%	3.8%

[3] NCH, Community Health Needs Assessment.

The North Country Public Health Region Community Health Improvement Plan: 2018-2020[4]

The North Country Health Consortium completed a Community Health Improvement Plan (CHIP) based on the North Country's public health needs.

The Executive Summary and the plan highlight the need for coordinated and collaborative health care initiatives and interventions in the North Country.

> Executive Summary
>
> New Hampshire is regarded as one of the healthiest states in the nation. However, regional disparities exist within the State, including in the northernmost region of the state, inclusive of Coos and Northern Grafton County, referred to as the North Country. This rural population suffers geographic and economic barriers to accessing health care as well as higher rates of mortality and morbidity than the state and national averages. In the rural North Country of New Hampshire, residents disproportionately have higher rates of chronic disease or disability than the State as a whole. North Country health behavior data for youth and adults reveal a population that is more likely to use tobacco and engage in other risky health behaviors that contribute to poor health outcomes. North Country residents are less likely to have insurance or to have seen a doctor in the last 30 days. Family and individual incomes in the North Country are, on average, lower than in NH and the US. The travel distance from most North Country communities to a health care provider is 25 miles or more. People are less able to afford the health care they need. Shortages of health care providers, dentists, mental health clinicians and other health professionals in the North Country compound these problems. Overall, people in the North Country are more likely to be sick and less likely to have the care they need to treat or manage their illness. It is clear from the table below that the North Country population is older, less educated, and earns substantially less than other residents in the State and the Nation. The data below, depicting rates substantially higher than New Hampshire and, in many cases, the United States, are known risk factors for having a population at greater risk for premature death and with a higher prevalence of chronic diseases.

http://www.nchcnh.org/images/NCHCuplds/NCHC_Community_Health_Improvemen.pdf

Outlined within the CHIP are six priorities specific to the North Country's health needs:

- Obesity
- Oral Health
- Public Health Emergency Preparedness
- Substance Misuse
- Heart Disease and Stroke
- Mental Health

[4] North Country Health Consortium (NCHC), North Country Public Health Region Community Health Improvement Plan (CHIP), 2018-2020, http://www.nchcnh.org/images/NCHCuplds/NCHC_Community_Health_Improvemen.pdf

The North Country Hospitals

Littleton Hospital Association d/b/a Littleton Regional Health Care ("Littleton")

Littleton is a critical access hospital located in Littleton, NH.[5] Originally, established in 1906.[6] It is located in Grafton County, and its service area covers a majority of northern New Hampshire and the Northeast Kingdom of Vermont.[7] Currently, Littleton has 25 licensed beds and a mission "[t]o provide quality, compassionate and accessible healthcare in a manner that brings value to all."[8] It employs 500 people, making it the largest hospital in the North Country.[9] As of June 27, Littleton licensed a new walk-in center called Urgent Care at Littleton, located at 600 St. Johnsbury Road.[10]

Its core services include emergency care, birthing, general surgery, rehabilitation, and intensive care. Littleton's specialty services include advanced technology, such as 24-hour Cardiac Monitoring, 64-Slice CT Scan, Bone Density Scanner, 3-D Ultrasound Imaging, Multi Slice Spiral CT Scanner, iCAD Second Look Mammogram, and Newborn Hearing Testing.[11]

Listed below are the Net Patient Service Revenue totals for the fiscal years ending in September 2015 through September 2018:[12]

- fiscal year ending Sept. 2018: $84,898,699
- fiscal year ending Sept. 2017: $85,164,572
- fiscal year ending Sept. 2016: $87,274,990
- fiscal year ending Sept. 2015: $87,169,612

Littleton has the largest Net Patient Service Revenue in the Affiliation. Despite this, Littleton is the only hospital in the Affiliation whose Net Patient Service Revenue has decreased since 2015. In 2017, the operating margin of the hospital was 0.97%, the lowest margin of the four hospitals.[13]

Littleton has a payer mix that is less dependent upon government payers than the other North Country hospitals. Medicare and Medicaid typically reimburse at or below cost for health care services and at a significantly lower rate than commercial plans. Littleton depends on 39% of

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[5] Critical Access Hospitals ("CAHs") are designated as, "small, rural hospitals which provide key services, including 24-hour emergency care, inpatient and outpatient care, community wellness activities, and frequently act as the primary employer (for rural communities)," and cannot be licensed for more than 25 beds. https://www.dhhs.nh.gov/dphs/bchs/rhpc/critical-access-hospitals.htm

[6] Littleton, History of Littleton Hospital, https://littletonhealthcare.org/LRH_history.php

[7] NCH, Community Health Needs Assessment.

[8] Notice Pursuant to NH RSA 7:19-b, August 31, 2015.

[9] New Hampshire Hospital Association (NHHA), 2017 Health System Report, https://nhha.org/images/Data/2017_Health_System_Report.pdf

[10] *See* Littleton, Littleton Urgent Care at Littleton Regional Healthcare, http://www.littletonhospital.org/urgent_care.php. It's unclear what notification Littleton provided pursuant to the Affiliation Agreement or due under RSA 151:2, II (7).

[11] Littleton, Littleton Regional Healthcare Department Directory, http://www.littletonhospital.org/department_directory.php

[12] ProPublica, Littleton Hospital Association, https://projects.propublica.org/nonprofits/organizations/20222152

[13] NHHA, 2017 Health System Report.

revenues from government health plans, including Medicare (30%) and Medicaid (9%).[14] A majority (61%)[15] of Littleton's patient revenue is from commercial insurance coverage or from those who self-pay for their care.

Littleton's Community Health Needs Assessment was completed in 2016.

Littleton Community Health 2016 Needs Assessment[16]

Top Five Issues	Leading Contributors
1. Substance misuse (drugs, opioids, heroin, etc.)	1. Drug abuse
2. Mental health problems	2. Cost of prescription drugs
3. Obesity/overweight	3. Lack of physical exercise
4. Alcohol abuse	4. Lack of dental insurance
5. Smoking and tobacco use	5. Cost of healthy food

Androscoggin Valley Hospital

AVH is a nonprofit, 25-bed, critical access hospital in Berlin, NH.[17] Berlin is the only city in Coos County and the largest community in the County with an estimated population of 10,638.[18] Established in 1971, AVH's charitable mission is to deliver "the best healthcare experience for every patient, every day."[19] It employs 383 people.[20] AVH operates the only labor and delivery unit in Coos County.

Its core services include emergency care, birthing, rehabilitation, and general surgery. New England Heart & Vascular Institute, which specializes in cardiology, cardiovascular disease, and echocardiography, provides services at AVH.[21]

Listed below are the Net Patient Service Revenue totals for the fiscal years ending in September 2015 through September 2018:[22]

- fiscal year ending Sept. 2018: $54,598,460
- fiscal year ending Sept. 2017: $57,308,823
- fiscal year ending Sept. 2016: $45,381,806
- fiscal year ending Sept. 2015: $54,486,055

[14] Payer Mix NH Hospitals.xlsx (BOX)
[15] Payer Mix NH Hospitals.xlsx (BOX)
[16] NCH, Community Health Needs Assessment.
[17] NHHA, 2017 Health System Report.
[18] NCH, Community Health Needs Assessment.
[19] AVH, AVH Mission and Vision Statements, http://avhnh.org/about-us/mission-and-vision-statements
[20] NHHA, 2017 Health System Report.
[21] AVH, Medical Services, http://avhnh.org/services
[22] ProPublica, AVH Inc, https://projects.propublica.org/nonprofits/organizations/20280367

In 2017, the operating margin of AVH was 5.68%, the highest operating margin of the four hospitals.[23] Yet over half of AVH's revenue (51%) is from government payers Medicare (43%) or Medicaid (8%),[24] leaving 49% of patient revenues from private or commercial payers.[25]

AVH's Community Health Needs Assessment was completed in 2015.

Androscoggin Valley Hospital (AVH) 2015 Needs Assessment[26]

Top Five Issues	Leading Contributors
1. Substance misuse (specifically drugs)	1. Drug/alcohol abuse
2. Alcohol abuse	2. Unemployment
3. Mental health problems	3. Poverty
4. Smoking and tobacco use	4. Cost of healthy food
5. Obesity/overweight	5. Lack of dental and health insurance

Upper Connecticut Valley Hospital

UCVH is a nonprofit, licensed acute care, 16-bed, critical access hospital in Colebrook, NH.[27] It was originally established in 1970.[28] UCVH provides inpatient, outpatient, emergency (stabilize and refer), and specialty care to residents of northern Coos County. It employs 120 people, making it the smallest hospital in the Affiliation.[29]

The mission of UCVH is "to improve the well-being of the rural communities we serve by promoting health and assuring access to quality care." Its core services include emergency care, general surgery, and rehabilitation. Specialty services include access to neurology, orthopedic, urology, pulmonology, OB/GYN, podiatry, and cardiology.[30] UCVH does not have a labor and delivery unit or an emergency department.[31]

Listed below are the Net Patient Service Revenue totals for the fiscal years ending in September 2015 through September 2018:[32]

- fiscal year ending Sept. 2018: $17,057,897
- fiscal year ending Sept. 2017: $16,690,820
- fiscal year ending Sept. 2016: $15,707982
- fiscal year ending Sept. 2015: $15,616,811

UCVH has the lowest Net Patient Service Revenue in the Affiliation. In 2017, its operating margin was 2.38%.[33] Most of its revenues (50%) comes from Medicare, and an additional 11%

[23] NHHA, 2017 Health System Report.
[24] Payer Mix NH Hospitals.xlsx (BOX)
[25] Payer Mix NH Hospitals.xlsx (BOX)
[26] NCH, Community Health Needs Assessment.
[27] Notice Pursuant to NH RSA 7:19-b, August 31, 2015.
[28] UCVH, Our History, https://www.ucvh.org/index.php/about/our-history
[29] NHHA, 2017 Health System Report.
[30] UCVH, Services, https://www.ucvh.org/index.php/hospital-services
[31] *Id*.
[32] ProPublica, UCVH Association, https://projects.propublica.org/nonprofits/organizations/20276210
[33] NHHA, 2017 Health System Report.

comes from Medicaid.[34] Essentially, a substantial part (61%) of UCVH's revenues are from treating patients are covered by government plans – more than any other in New Hampshire. The remaining revenue (39%) is from commercial insurance and self-pay.[35]

UCVH's Community Health Needs Assessment was completed in 2016.

Upper Connecticut Valley Hospital 2016 Needs Assessment[36]

Top Six Health Issues	Leading Contributors
1. Low income/poverty	1. Drug abuse
2. Substance misuse (drugs, opioids, heroin, etc.)	2. Poverty
3. unemployment/lack of jobs	3. Lack of dental insurance
4. Smoking and tobacco use	4. Unemployment
5. Alcohol abuse	5. Lack of jobs
	6. Lack of physical exercise
	7. Cost of healthy food

Weeks Medical Center

Weeks is a nonprofit, tax-exempt corporation that is the owner of a licensed acute care, 25-bed, critical access hospital located in Lancaster, NH.[37] Weeks was established in 1919 as the Lancaster Hospital Association, and in 1947 the Beatrice D. Weeks Memorial Hospital opened, which is where Weeks continues to reside today.[38]

The charitable mission of Weeks is: "Weeks Medical Center's compassionate staff is committed to providing high quality and efficient health care to ensure the well-being of our patients, families and communities."[39] It employs 336 people.[40] The hospital's core services include emergency medicine, general surgery, and rehabilitation. The specialty services of the hospital include hyperbaric oxygen therapy, PET/CT scans, and bone mineral densitometry.[41]

Listed below are the Net Patient Service Revenue totals for the fiscal years ending in September 2015 through September 2018:[42]

- fiscal year ending Sept. 2018: $46,193,888
- fiscal year ending Sept. 2017: $45,698,141
- fiscal year ending Sept. 2016: $42,797,847
- fiscal year ending Sept. 2015: $42,167,196

[34] Payer Mix NH Hospitals.xlsx (BOX)
[35] Payer Mix NH Hospitals.xlsx (BOX)
[36] NCH, Community Health Needs Assessment.
[37] Notice Pursuant to NH RSA 7:19-b, August 31, 2015.
[38] Weeks, History of Weeks Medical Center, https://weeksmedical.org/about/history-of-weeks-medical-center/
[39] Weeks, Mission Statement, https://weeksmedical.org/about/mission-statement/
[40] NHHA, 2017 Health System Report.
[41]Weeks, Weeks Medical Center Services, https://weeksmedical.org/services/
[42] ProPublica, WMC, https://projects.propublica.org/nonprofits/organizations/20222242

In 2017, the operation margin of the hospital was 2.93%.[43] Much of Weeks' revenue comes from Medicare (49%), and 9% of it comes from Medicaid.[44] The remaining 42% is from commercial insurance and self-pay.[45]

In 2016, Weeks's Community Health Needs Assessment was completed.

Weeks Medical Center 2016 Needs Assessment[46]

Top Five Health Issues	Leading Contributors
6. Substance misuse (drugs, opioids, heroin, etc.)	6. Lack of dental insurance
7. Obesity/overweight	7. Drug abuse
8. Unemployment/lack of jobs; poverty	8. Unemployment
9. Alcohol abuse	9. Cost of healthy food
10. Smoking and tobacco use	10. Lack of physical exercise
	11. Alcohol abuse

Access to Labor and Delivery

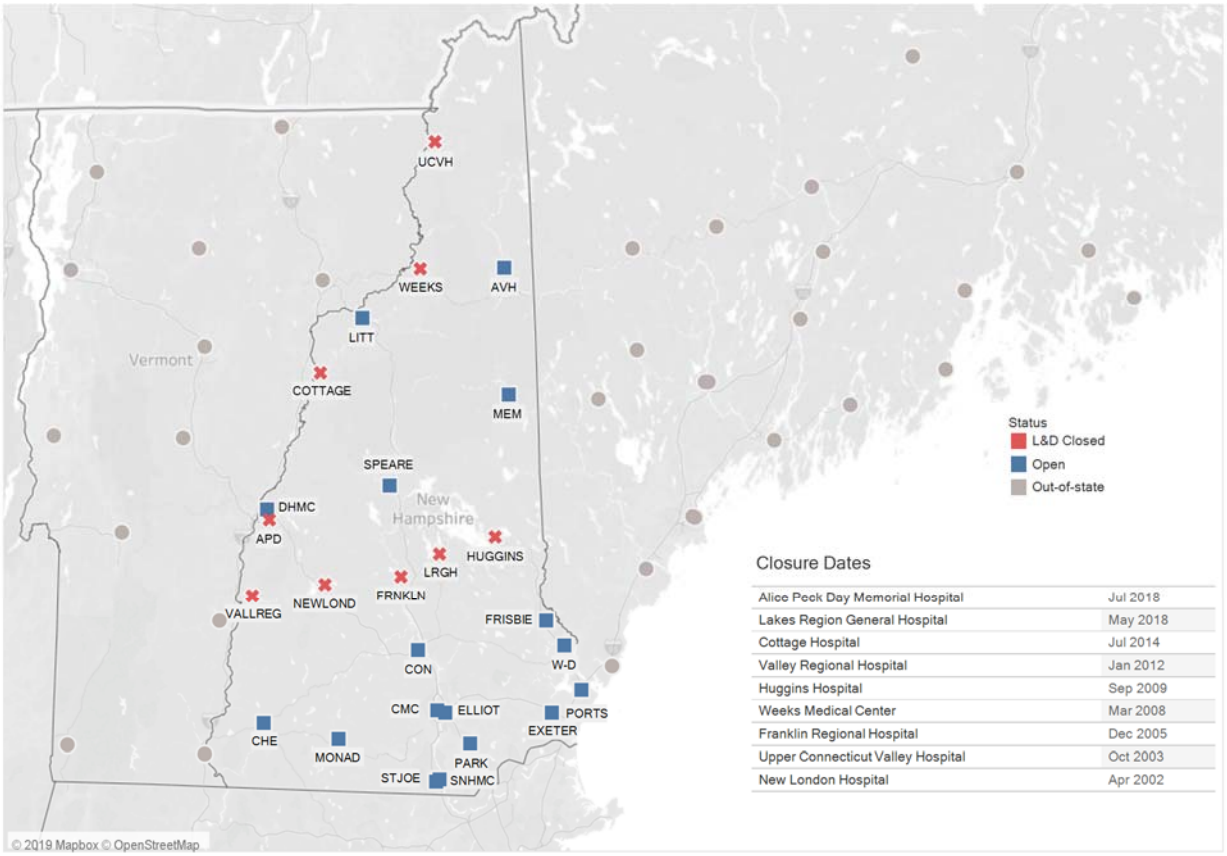
In North Country there are three open Labor and Delivery units. Two units are located in Coos County at Androscoggin Valley Hospital and Memorial Hospital, and the third unit is in Grafton County at Littleton Regional Hospital. Previously, North Country had three more Labor and Delivery Units that have since been closed. Upper Connecticut Valley Hospital closed their labor and delivery unit in October of 2003. Weeks Medical Center closed their labor and delivery unit in March of 2008. Cottage Hospital closed their labor and delivery unit in July of 2014. Improvements in maternal and newborn health have been important global priorities over the past decade.[47] Pregnancy and perinatal outcomes are closely linked to health, nutritional and educational outcomes of the child. Id. Achieving Millennium Development Goal targets for maternal and child survival are an integral part of the UN Secretary General's Global Strategy for Women's and Children's Health. Good outcomes during pregnancy and childbirth are related to availability, utilization and effective implementation of essential interventions for labor and childbirth. The majority of the estimated 289,000 maternal deaths, 2.8 million neonatal deaths and 2.6 million stillbirths every year could be prevented by improving access to and scaling up quality care during labor and birth. *Id*. New Hampshire is no different.[48] Access to reproductive health services and safe labor and delivery services is critical to a population's overall success and to the health of women and children. A review of the recommended

[43] NHHA, 2017 Health System Report.
[44] Payer Mix NH Hospitals.xlsx (BOX)
[45] Payer Mix NH Hospitals.xlsx (BOX)
[46] NCH, Community Health Needs Assessment.
[47] Sharma, Mathai, et al, "Quality care during labour and birth: a multi-country analysis of health system bottlenecks and potential solutions" (2015) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4577867/
[48] https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality/state/NH

Medicaid core maternity health measures is useful to show the depth of services required to maintain maternal health. [49]

A full discussion of the importance of maternity care to the health and wellbeing of a population is beyond the scope of this review. However, the ability of any hospital to sustain the costs associated with maintaining a high-quality maternity care, which supports prenatal and post-partum care, is a significant challenge. Yet access is critical to the sustainability of the community. The number of births at AVH is declining because the demographics of the region are shifting. The loss of another labor and delivery center could be catastrophic.

New Hampshire Labor & Delivery Closures



By: David Laflamme (David.Laflamme@unh.edu)

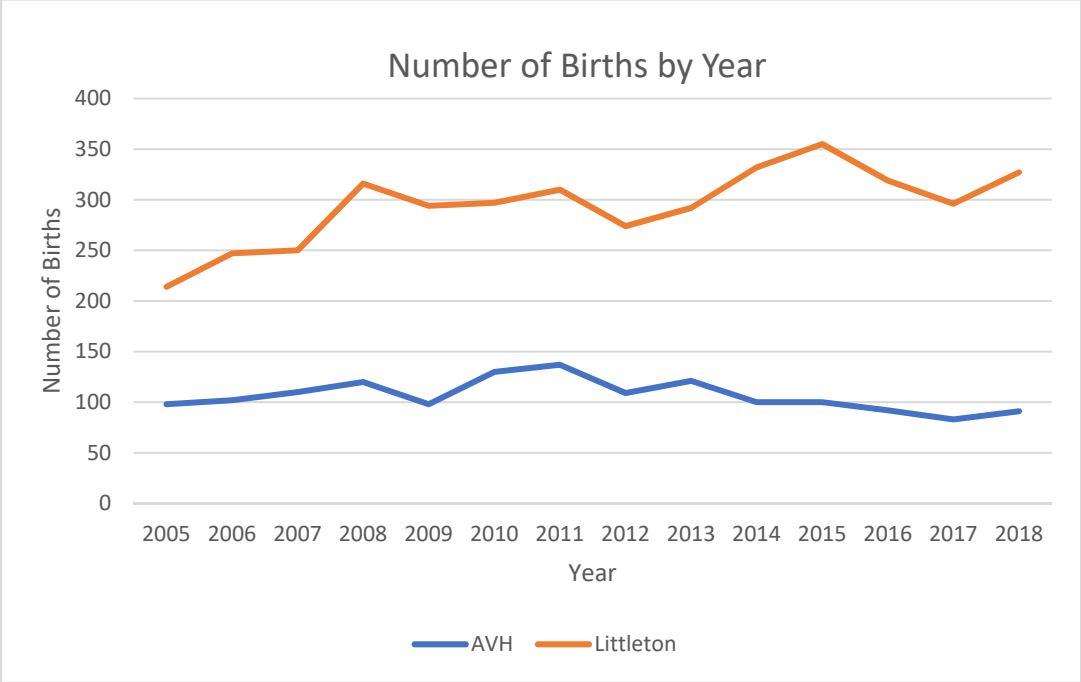
Birth Data- Littleton and AVH

Androscoggin Valley Hospital has seen a decline in the number of births since 2011. From 2005 to 2011, there was a gradual increase in the number of births which peaked in 2011 at a total of 137 births. Since 2011, the number of births at AVH has steadily fallen. In year 2018 there were only 91 births. Although there has been a gradual decline of the number of births at AVH, Medicaid/CHIP has increasingly been the payor for births. In 2018, the payor for 63.7% of births

[49] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-maternity-core-set.pdf

was Medicaid/CHIP. It is also noted that almost all of the mothers who give birth at Androscoggin Valley are New Hampshire residents.

Littleton Regional Hospital has seen a steady increase in the number of births since 2005. In 2005, Littleton had the lowest number births at a total of 214 which climbed to a peak of 355 births in 2015. In 2018, there were 327 births at Littleton Regional Hospital. There has also been a gradual increase in the percentage of births covered by Medicaid/CHIP at Littleton. In 2018, the payor for 49.5% of births was Medicaid/CHIP.



Androscoggin Valley Hospital Number of Births by Year and Payor			
Year	Not Medicaid/ CHIP	Medicaid/ CHIP	Total Births
2005	43	55	98
2006	35	67	102
2007	41	69	110
2008	50	70	120
2009	36	62	98
2010	57	73	130
2011	60	77	137
2012	43	66	109
2013	62	59	121
2014	39	61	100
2015	32	68	100
2016	36	56	92
2017	33	50	83
2018	33	58	91

Littleton Regional Hospital Number of Births by Year and Payor			
Year	Not Medicaid/ CHIP	Medicaid/ CHIP	Total
2005	139	75	214
2006	158	89	247
2007	142	108	250
2008	182	134	316
2009	146	148	294
2010	149	148	297
2011	166	144	310
2012	136	138	274
2013	134	158	292
2014	187	145	332
2015	160	195	355
2016	174	145	319
2017	159	137	296
2018	165	162	327

The North Country

Three of the North Country hospitals are in Coos County, including AVH, Weeks and UCVH. Littleton is in Northern Grafton County. The region in New Hampshire north of Franconia Notch identifies itself a common area and uses the term the "North Country". Many key data points are collected by county and town, however. It's important to understand that the North Country is uniquely characterized by its beauty but inaccessibility due to the prominence of the White Mountains.

Coos County is New Hampshire's largest, spanning over 1800 square miles, but has the smallest population, with a population of 31,589 as of July 2018[50]. The town of Littleton, located in Grafton County, has a population of 5,895 as of July 2018[51]. The North Country collectively includes about 37,484.

Age demographics as of (2018)[52]

The age demographics for Coos County are detailed in the table below. Coos County's population of 65 years and older is 23.7%, which is 5.6% higher than the state of New Hampshire. The population below the age of 18 years old is 16.3% in Coos County compared to 19% for the state of New Hampshire.

Age and Sex	Coos County	New Hampshire
Below 5 years	4%	4.7%
Below 18 years	16.3%	19%%
65 and older	23.7%	18.1%%

Age Demographics (2018)[53]

The information found in the table below breaks down the age demographic by decade in Coos County and in New Hampshire. 15.7% of Coos County are between 60-69 years old, which is a larger percentage than the state of New Hampshire which is 12.8%. Coos County also has a higher percentage of residents over the age of 70.

[50] https://www.census.gov/quickfacts/fact/table/NH,cooscountynewhampshire
[51] https://www.census.gov/quickfacts/fact/table/littletontowngraftoncountynewhampshire/AGE295218
[52] https://www.census.gov/quickfacts/fact/table/NH,cooscountynewhampshire
[53] http://www.towncharts.com/New-Hampshire/Demographics/Coos-County-NH-Demographics-data.html

Age Group	Coos County	New Hampshire
<20	18.5%	22.7%
20s	10.5%	12.7%
30s	11.1%	11.5%
40s	12.9%	13.3%
50s	16.5%	16.4%
60s	15.7%	12.8%
70+	14.8%	10.7%

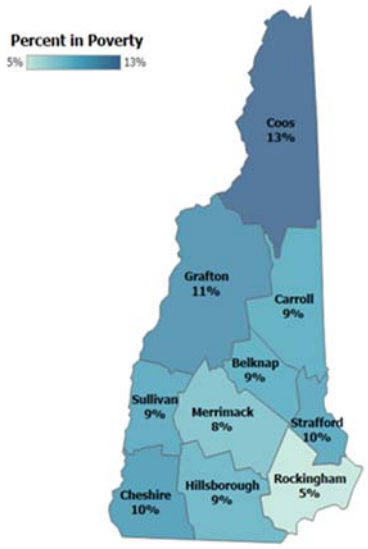
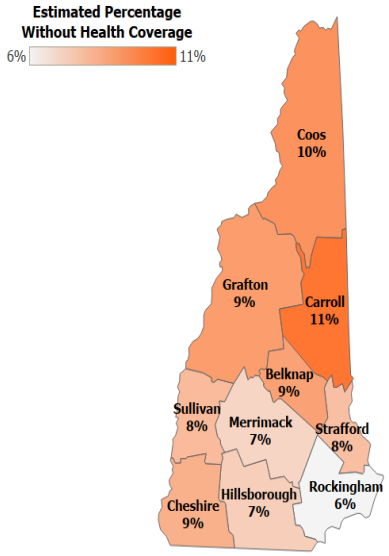
*The source of the data is from Town Charts. Town Charts reports this data is from the 2018 Community Survey.

Race (2017)

The majority of Coos County is Non-Hispanic white. The percentage of races, other than Non-Hispanic white are lower in Coos County compared to the state of New Hampshire. [54]

Race	Coos County	New Hampshire
Non-Hispanic African American	0.8%	1.3%
American Indian and Alaskan Native	0.5%	0.3%
Asian	0.6%	2.8%
Hispanic	1.8%	3.7%
Non-Hispanic White	95%	90.5%

[54]https://www.countyhealthrankings.org/app/newhampshire/2019/rankings/coos/county/outcomes/overall/snapshot

Estimated Poverty Rates by County	Percentage of Population Without Health Coverage: NH Counties
Source: U.S. Census Bureau, American Community Survey, 2013-2017	Source: U.S. Census Bureau, American Community Survey, 2013-2017
	
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Economic and Social Factors (2013-2017)

Coos County is generally more vulnerable to poverty and unemployment which in turn impacts whether individuals have or access health insurance.

The prevalence of economic factors is detailed in the table below. The unemployment rate in Coos County is higher than the state of New Hampshire. The percentage of children in poverty and the percentage of children eligible for free or reduce lunch is also higher in Coos County. See Fn 5.

Economic Factors	Coos County	New Hampshire
Unemployment	3.4%	2.7%
Children in Poverty	19%	10%
Children in Single-Parent Households	39%	28%
Children Eligible for free or reduced-price lunch	47%	27%
Median Household (2017)	$43,800	$73,600

[55] Created by NH Fiscal Policy Institute, Aug 2019

Education (2017)[56]

Level of education attainment are shown in the table below. Coos County has a lower percentage of residents with a high school education, and/or a bachelor's degree compared to New Hampshire. The dropout rate in Coos County is 5% higher than New Hampshire.

Education	Coos	New Hampshire
High School Education or higher	88%	93%
Bachelor's Degree or higher	18%	38%
School Dropout rate	12%	7%

Health Care Coverage (2017)[57]

Health care coverage in Coos County is detailed below. Medicare is the reported payer for 31% of Coos County compared to 22% for New Hampshire. Medicaid is the reported payer for 14% of Coos County compared to 8% for New Hampshire. Employer-based coverage is 17% lower in Coos County than New Hampshire. This means that the percentage of individuals covered by government sponsored health care, reimbursing providers at or below cost, is significantly higher when compared to New Hampshire as a whole.

Insurance	Coos County	New Hampshire
Employer-based	48%	65%
Direct Purchase	19%	14%
Medicare	31%	22%
Medicaid or Public	14%	8%
No coverage	13%	10%
Children Without Health Insurance	3.8%	3.4%

*The source of the data is from Town Charts. Town Charts reports this data is from the 2018 Community Survey.

Clinical Care (2016)

Rates and percentages relating to clinical care are detailed in the table below. The uninsured rate in Coos is 2% higher than New Hampshire. Coos county has a lower Patient to Primary Care Physician ratio compared to New Hampshire. Coos County does have a higher Patient to Mental Health Provider Ratio compared to New Hampshire. In Coos County, there is a lower percentage of mammography screenings and flu vaccinations. See Fn 5.

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[56]https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_S1501&prodType=table

[57] 2017 American Community Survey- http://www.towncharts.com/New-Hampshire/Healthcare/Coos-County-NH-Healthcare-data.html

**As of 2017, the uninsured rate is reported to be 6% in New Hampshire- https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-hampshire%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

	Coos County (2016)	New Hampshire (2016)
Uninsured**[58]	9%	6%
Patient to Primary Care Physician Ratio	940:1	1,100:1
Patient to Dentist Ratio	1,760: 1	1,370:1
Patient to Mental Health Provider Ratio	610:1	350:1
Mammography Screening	41%	49%
Flu Vaccinations	31%	48%

Health Behaviors (2015-2017)[1]

The health behaviors in Coos County are detailed below. Adult obesity is reported to be 4% higher than New Hampshire. Food insecurity is also reported to be 2% higher in Coos County compared to New Hampshire. Based on anecdotal evidence and witness interviews, food insecurity is a major issue for residents of the North Country. There are very few grocery stores and those that do exist may not be within travel range or commuting patterns of many residents. Most residents shop for food at the Dollar Store, Walmart, gas stations or other small food shops or mini marts. See Fn 5.

Health Behaviors	Coos County	New Hampshire
Adult smoking (2016)	17%	18%
Adult obesity (2015)	32%	28%
Physical inactivity (2015)	26%	20%
Excessive drinking (2016)	17%	20%
Alcohol-impaired driving deaths (2013-2017)	29%	31%
Food insecurity	11%	9%

Health Outcomes (2015-2017)

Health outcomes in Coos County are detailed in the table below. The average life expectancy in Coos County is 2.7 years shorter than New Hampshire. The diabetes prevalence is also 4% higher in Coos County compared to New Hampshire. See Fn 5.

Health Outcome	Coos County	New Hampshire
Life Expectancy	76.8	79.5
Diabetes Prevalence	13%	9%

[58] As of 2017 NH uninsured rate was 6%. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-hampshire%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Health Data (2014) Rates per 100,000 population, age standardized

The data below shows the mortality rates based on specific causes. Ischemic Heart Disease has, Tracheal, Bronchus, and Lung Cancer, and Diabetes, Urogenital, Blood, and Endocrine Diseases mortality rates are higher in Coos County compared to New Hampshire[59].

	Gender	Coos County	New Hampshire
Ischemic Heart Disease	Female	141.3	108.4
	Male	215.3	164.0
Cerebrovascular Disease (Stroke)	Female	33.6	38.9
	Male	40.4	39.9
Tracheal, Bronchus, and Lung Cancer	Female	50.6	48.6
	Male	67.9	64.6
Breast Cancer	Female	22.6	23.7
	Male	0.3	0.3
Malignant Skin Melanoma	Female	2.4	2.1
	Male	2.4	4.5
Diabetes, Urogenital, Blood, and Endocrine Diseases Mortality	Female	56.2	42.0
	Male	63.7	57.0
Self-Harm and Interpersonal Violence Mortality	Female	9.4	8.4
	Male	36.6	26.0
Transport Injuries Mortality	Female	10.2	6.2
	Male	22.2	13.6
Mental and Substance Use Disorders Mortality	Female	8.9	9.4
	Male	34.1	24.4
Cirrhosis and Other Chronic Liver Diseases Mortality	Female	14.2	9.5
	Male	19.6	17.3

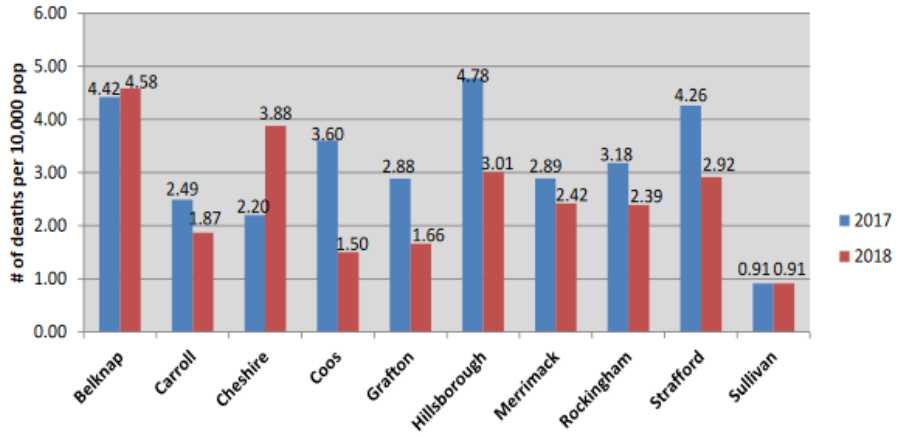
Substance Use

The rate of overdose deaths in New Hampshire have been the highest in the country. Coos County's experience is similar to other regions in the state, with an appreciable improvement in 2018 over 2017 for incidents involving deaths and opioid use, but a consistent rate of hospital admissions due to drug use.

[59]http://www.healthdata.org/sites/default/files/files/county_profiles/US/2015/County_Report_Coos_County_New_Hampshire.pdf

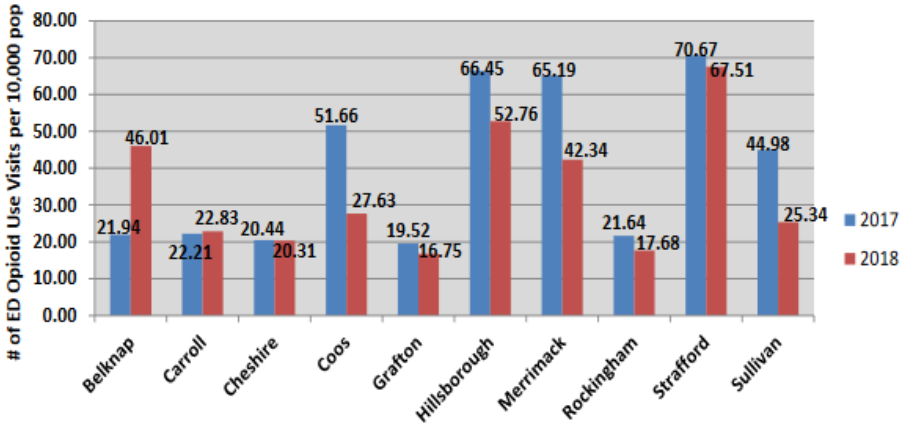
2017 vs. 2018* Overdose Deaths by County per 10,000 Population

Data Source: NH Medical Examiner's Office



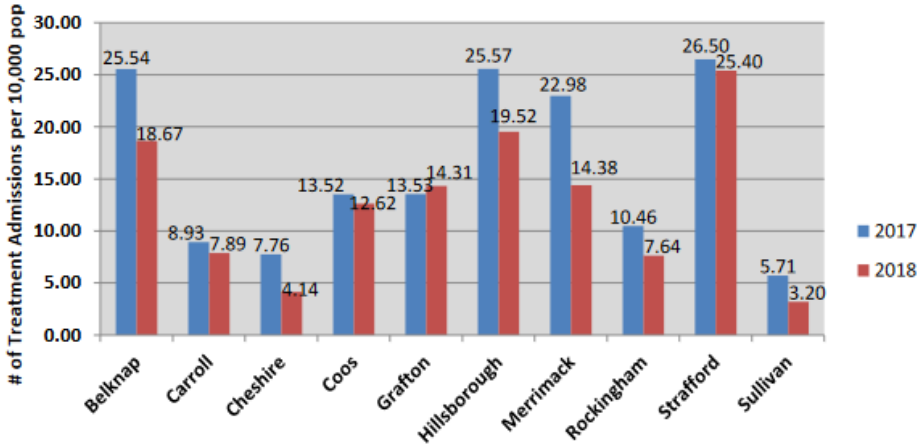
** 2018 Numbers are based on analysis as of 16 January 2019 - 77 cases pending*

2017 - 2018 Emergency Department Opioid Use Visits by County per 10,000 Population



Source: NH Division of Public Health Services

2017-2018 Opioid/Opiate, Methamphetamine, & Cocaine/Crack Treatment Admissions by County per 10,000 Population



Source: NH Bureau of Drug & Alcohol Services

CONCLUSION

The North Country, a rural area with scarce economic resources, relied on the Affiliation's promises and vision for a sustainable and collaborative service delivery model. The withdrawal is not only a costly distraction to the community, but it jeopardizes the collective opportunity for mutual aid and sustainability. This report highlights this effect by examining the North Country's community needs as defined by common economic, health, and public health markers. It then highlights the key characteristics of the North Country, summarizes their Community Needs Assessment, and identifies key risk areas of the North Country population. The report highlights the critical nature of several key risk areas: (1) mental health and substance use disorder; (2) an aging population; and (3) labor and delivery capacity.

The DOJ-CTU's review should take into consideration the broader needs of the North Country community and the impact this withdrawal will have on the North Country community's ability to meet those needs.

Exhibit A

Licensed Facilities in North County[60]

Below is a table of the licensed facilities in Coos County as of August 23rd, 2019.

Type	Facility	Address	City	State	County	Effective Date
Assisted Living/ Residential Care Facility	On the Green Residential Care Facility	412 Dartmouth College Highway	Haverhill	NH	Grafton	7/1/2019
Community Residence (4+ beds)	Becket Adult Services	2444 Main Street	Bethlehem	NH	Grafton	2/1/2019
Community Residence (4+ beds)	Columbia House	18 Stoddard Road	Columbia	NH	Coos	2/1/2019
Community Residence (4+ beds)	Gilpin Residence	145 High Street	Littleton	NH	Grafton	8/1/2018/
Community Residence (4+ beds)	Verdun Street Community Residence	85 Verdun Street	Berlin	NH	Coos	7/1/2018
End-Stage Renal Dialysis	Fresenius Medical Care of Lancaster	173 Middle Street	Lancaster	NH	Coos	8/1/2019
Home Care Service Provider	Alpine Home Health Services	105 West Main Street	Littleton	NH	Grafton	9/1/2019
Home Care Service Provider	J & S Home Care Services	2 First Street	Gorham	NH	Coos	2/1/2019
Home Health Provider	Androscoggin Valley Home Care Services	795 Main Street	Berlin	NH	Coos	5/1/2019
Home Health Provider	Coos County Family Health Services	193 Pleasant Street	Berlin	NH	Coos	3/1/2019

[60] https://www.dhhs.nh.gov/oos/bhfa/documents/licensedfacilities.pdf

Type	Facility	Address	City	State	County	Effective Date
Home Health Agency Hospice	North Country Home Health & Hospice Agency	536 Cottage Street	Littleton	NH	Grafton	9/1/2019
Hospital	Androscoggin Valley Hospital	59 Page Hill Road	Berlin	NH	Coos	4/1/2019
Hospital	Littleton Regional Healthcare	600 St Johnsbury Road	Littleton	NH	Grafton	1/1/2019
Hospital	Upper Connecticut Valley Hospital	181 Corliss Lane	Colebrook	NH	Coos	9/1/2019
Hospital	Weeks Medical Center	173 Middle Street	Lancaster	NH	Coos	1/1/2019
Laboratory	AVH Laboratory	2 Broadway Street	Gorham	NH	Coos	6/1/2019
Laboratory	AVH Laboratory	133 Pleasant Street	Berlin	NH	Coos	7/1/2019
Non-Emergency Walk In Care Center	Urgent Care at Littleton	600 St Johnsbury Road	Littleton	NH	Grafton	6/27/2019
Nursing Home	Coos County Nursing Home	365 Cates Hill Road	Berlin	NH	Coos	6/1/2019
Nursing Home	Coos County Nursing Hospital	136 County Farm Road	West Stewartstown	NH	Coos	4/1/2019
Nursing Home	Grafton County Nursing Home	3855 Dartmouth College Highway	North Haverhill	NH	Grafton	1/1/2019
Nursing Home	Morrison Nursing Home	6 Terrace Street	Whitefield	NH	Coos	1/1/2019
Nursing Home	St Vincent De Paul Rehab & Nursing Center	29 Providence Avenue	Berlin	NH	Coos	6/1/2019
Supported Residential Care Facility	Summit by Morrison	56 Summit Drive	Whitefield	NH	Coos	6/1/2019

For More Information

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