Less than two short years ago, we introduced an ambitious new strategic framework for Dartmouth-Hitchcock’s future: a Mission, Vision and set of Goals that would serve to shape our pursuit of clinical and academic excellence for decades to come. As 2009 dawned, the volatility and uncertainty in our external environment underscored just how critical Dartmouth-Hitchcock’s commitment to a new blueprint for the future is to advancing the health of our region and nation. With our global and national economies slipping into recession and a newly-elected President challenging the nation to defy the status quo, it became startlingly clear that transformation is no longer just a compelling vision—it is an absolute necessity. The core themes of our Transforming Medicine campaign—Questioning Assumptions, Erasing Boundaries and Creating Solutions—are more pertinent than ever, serving as catalysts for innovation, collaboration, rigor and focus.

Like most healthcare and academic institutions, Dartmouth-Hitchcock Medical Center and Dartmouth Medical School are confronted with the enormous challenge to sustain essential patient care, education, research and community service missions at a time of economic upheaval. That said, we are confident that our Mission and Vision are focused and appropriate for these stressful times. Our strategic Goals are well-defined, and our long tradition of academic and clinical achievement give us the strength and resilience we will require as we weather the current environment and emerge a leader in transforming health care in our nation.

Advancing patient- and family-centered care now and decades from now remains our “true north”—the beacon that makes us passionate about our work and the journey ahead. Throughout the pages of this annual report, we invite you to join our journey with many of the inspirational physicians, nurses, faculty, researchers, residents, medical students, staff and volunteers who are the real healthcare leaders of today and tomorrow. These stories demonstrate just how we’ve put our strategic imperatives into action with tangible results that have dramatically changed the way we care for our patients and how we teach our future clinicians. We are proud that these individuals have chosen to make Dartmouth-Hitchcock and Dartmouth Medical School the focus of their commitment to caring, and honor them for their dedication to bringing our Mission to life.
Finally, we want to express our sincere gratitude to all of the compassionate and generous contributors who made gifts to Dartmouth-Hitchcock Medical Center, Dartmouth Medical School, Norris Cotton Cancer Center, Children’s Hospital at Dartmouth (CHaD) and all related partners and affiliates. We know and appreciate how difficult it may be to maintain or increase charitable giving during these difficult economic times, and want you to know how much we appreciate all that you do for the patients, families, students and communities we serve.

William Green, PhD
Dean
Dartmouth Medical School

Nancy Formella, MSN, RN
President
Mary Hitchcock Memorial Hospital

Thomas A. Colacchio, MD
President
Dartmouth-Hitchcock Clinic
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On the cover: Each summer, new residents and fellows join the Dartmouth-Hitchcock community. Their arrival brings hope for great contributions in all areas of our Mission—and the intensive curriculum to which they are subjected reflects the high expectations of their performance.
Stride through the corridors of DHMC with George Blike, MD, Professor of Anesthesiology at Dartmouth Medical School and Quality and Patient Safety Officer at DHMC, and he’ll likely show you a simple but powerful example of an initiative to prevent healthcare-associated infections. ¶ “We know from behavioral science that it takes about 80 times of doing something before it becomes automatic,” Blike says, stopping to clean his hands at one of the many Purell® hand sanitizer dispensers that are strategically placed throughout the medical center. “But once hand-washing becomes a habit, it becomes part of our everyday work. We estimate that we’ve had 115 fewer infections this year than last year due to this effort.” >>
George Blike, MD,  Professor of Anesthesiology, Quality and Patient Safety Officer
The hand hygiene campaign is just one example of many hospital-wide activities that Blike is helping to drive in support of Dartmouth-Hitchcock’s vision to become a leader in quality and patient safety. To provide a sense of the breadth of work under way, he offers another: “We recently received a letter from a grateful patient who had to go through the stressful ordeal of having her baby delivered by emergency cesarian section. She recounted the initial panic she felt, but then said that the tight coordination and quiet efficiency of her 12-person care team—including neonatal, surgical, nursing and anesthesia specialists—reassured her.”

“They were moving around me like I couldn’t believe,” wrote the patient. “They all had a job, and they really seemed to know what they were doing. In less than 10 minutes, my baby was delivered. I said to Dr. Lauria, my surgeon, ‘Wow, it’s like you guys practice that.’ She said, ‘As a matter of fact we do; we drill on it.’”

**A Place to Manage Change**

For a number of years, the medical center has been using high-tech simulator mannequins to give individual clinicians and medical teams hands-on training in a broad range of patient care scenarios. “It’s really the only way you can adequately prepare for events that don’t occur very often, like stat C-sections, and it allows clinicians to learn and practice skills in a safe environment that doesn’t put patients at risk,” Blike says.

With the opening of its newly-designed 8,000-square-foot Patient Safety Training Center last fall, the organization has significantly expanded its simulation training capabilities. “To me, it really represents an engine for change that’s going to help us keep pace with how quickly medicine is evolving,” says Blike, Medical Director of the new center. “It allows us to innovate and to explore new competencies, skills, techniques, and to test new equipment and environments. And it’s not just for clinicians—every employee can access the center for patient safety training.”

Set up like a virtual mini-hospital and clinic, the center is equipped with more than 30 video cameras used to record training sessions and debriefings, so that staff can review and reflect upon their simulation experiences. Other rooms provide stations for practicing skills such as giving injections, conducting physical exams, placing IVs, and using laparoscopic devices in simulated surgeries. In some sessions, clinicians learn how to interact with patients by practicing conversations with actors playing the roles...
of patients in different scenarios.

“Most organizations send their staff away for this type of training,” says Polly Campion, MS, RN, who as Director of Clinical Improvement and the Office of Patient Safety is Blike’s partner in helping to lead quality and patient safety efforts at DHMC. “Thanks to the operational leadership of Mike Ward (Vice President of the Center) and Fran Todd (Director of the Center), and the efforts and support of many others, we have the kind of space on site that allows nurses, doctors, and residents to go down for an hour and do a mini-course or to work in the skills lab and then to go back to what they were doing. This way, learning and training become part of the way that they work rather than something that occurs separately from it.”

Looking Ahead

In addition to being a place that can engage the whole hospital in meeting external standards set by organizations like The Joint Commission, Medicare/Medicaid and the National Quality Forum, the center allows Dartmouth-Hitchcock to target local opportunities for improving care.

“For example, when we say that one of our priorities as an organization is to eliminate healthcare-associated infections, and an important way of doing that is to make sure that we are exquisite about the frequency and quality of our hand hygiene, that theory can be embedded as practice in various scenarios in the training center,” says Campion.

Along with preventing healthcare-associated infections, DHMC is currently focused on increasing employee and community flu vaccination rates and enhancing acute pain services for patients and families. Future priorities will include developing initiatives that support the achievement of higher levels of excellence in rescue systems, patient- and family-centered care, high-alert medications, and communications.

“We still have more work to do to truly become a leader in quality and patient safety,” says Blike. “But with our organization’s commitment to treating this as a priority, and with our recent accomplishments, we’re well on our way to becoming a culture that empowers everyone to embrace accountability for their actions without blame, to respect each other and speak up when needed, and to work in a truly engaged team environment that puts the safety of our patients first.”

“The patient care environment is complex, and quality and safety do not happen automatically,” says Polly Campion, MS, RN, Director of Clinical Improvement and the Office of Patient Safety. “The work that we do requires constant attention and continual improvement to reach the higher levels of excellence we aspire to in providing patient- and family-centered care.”
In 1994, when Paul B. Batalden, MD, was recruited to the faculty of Dartmouth’s Center for Evaluative Clinical Sciences—now known as The Dartmouth Institute for Health Policy & Clinical Practice (TDI)—he had already forged a brilliant and highly-distinguished career. The breadth of his accomplishments included helping to create a clinical research program at the National Institutes of Health, building an applied pharmaceutical doctoral studies program at the University of Minnesota, working as a COO and CEO of large private and public health systems, functioning as a governing board member of hospitals and colleges, serving as Assistant Surgeon General in the U.S. Public Health Service, and caring for the children of 1,000 families in Minneapolis, Minnesota as a pediatrician.
“I came to Dartmouth because I wanted to change the policies in use and the practices of professional education... a small group of us realized that, by taking advantage of Dartmouth’s Master of Public Health program and the Dartmouth–Hitchcock care setting which had an aligned strategy, we could meet a national need and be a model for others.”

Paul B. Batalden, MD
Yet, it would be at Dartmouth-Hitchcock that Batalden—while continuing his pioneering work and teaching about quality improvement in health care, and developing innovative approaches to the education of healthcare professionals—would make perhaps his most important contributions to medicine.

“I came to Dartmouth because I wanted to change the policies in use and the practices of professional education,” he explains. “At the time, there was no place where a person could go to finish his or her basic medical training and at the same time learn how to improve care. A small group of us realized that, by taking advantage of Dartmouth’s Masters in Public Health program and the Dartmouth-Hitchcock care setting which had an aligned strategy, we could meet a national need and be a model for others.”

One-of-a-kind Residency

In 2003, Batalden and his colleagues launched the Leadership Preventive Medicine Residency (LPMR)—a two-year program that combines an MPH degree from TDI with a mentored leadership practicum, offering residents in many different specialties the opportunity to develop a portfolio of experiences testing change and improving care in actual patient care settings.

“The LPMR is truly unique,” says Stephen Liu, MD, MPH, a hospitalist at DHMC who was the program’s first graduate in 2005. “It allows you to develop leadership skills that aren’t offered to residents anywhere else, and to think about systems-
based approaches to improving care. You have the chance to design and implement an intervention that can benefit not only the individual patient that you’re caring for but a whole population of patients that will receive the same kind of care.”

Liu, whose LPMR project yielded lasting improvements in care for patients hospitalized with community-acquired pneumonia at DHMC, continues to serve as a “coach” for others. They include the program’s most recent graduate Kirsten Weiser, MD, MPH.

“With the complexity and pace of medicine today, it’s easy to feel unempowered or disillusioned and to think, ‘I can’t fix this problem,’” says Weiser, a gastroenterologist whose LPMR project focused on introducing new quality indicators for screening colonoscopy at DHMC. “The LPMR allows you to move beyond the frustration to an energized place where, in fact, you believe change can happen. You get to reflect upon the practice of medicine and consider what is truly patient-centered. Then, the program provides you with the tools to make those ideas reality.”

The Ripple Effect

To date, the LPMR has had 22 graduates from 12 different departments and sections. “Many of the LPMR projects have continued to improve care here at DHMC well after the residents have graduated,” says Liu. “And because a lot of these graduates are going off and having careers in different places, they’re beginning to change the way that care is being delivered across the country—just as Paul had envisioned.”

“We’ve had a remarkable opportunity to have the world’s leading expert in the field as our mentor and leader in the program,” adds Weiser. “In fact, it meant so much to us as residents that, when we heard about his plans for retirement, we pleaded with him to stay on a bit longer.”

When Batalden steps down as Director of the Center for Leadership and Improvement at TDI in July, his successor will assume the newly-created, endowed Paul M. Batalden Chair for Clinical Improvement and Professional Development. He will continue to be actively involved at TDI with a specific focus on the LPMR. “In order to be sustainably successful, we need to manage successions of leadership well,” he says.

“The job will, in all likelihood, require the work of two or three generations. I’m very grateful for the interest and talent that have emerged, and I’m real proud of the work that these young men and women are doing.”
An Empowering Culture

Giving Every Nurse a VOICE

“It’s generating a lot of excitement amongst the nursing staff,” says Terri Rodee, RN, a nurse in DHMC’s Endoscopy Unit. “Those of us who provide direct patient care now have a voice in making decisions that affect not only our individual practice but also the day-to-day activities of our units.” She is talking about the medical center’s recently revised model for shared governance—a new framework that is designed to enhance decision-making and shared leadership throughout DHMC’s nursing community.

¶

The concept of shared governance has been in place at the medical center since the 1980s. “We’re working to build on that tradition, while expanding and improving upon our processes, as part of an overall effort to align our nursing strategic plan with the organization’s Mission, Vision, and Goals,” says Jo-Anne Dombrowskas, RN, a nurse in the Intermediate Cardiac Care Unit who was elected Executive Chair of Nursing to lead and coordinate the new structure. >>
Jo-Anne Dombrowskas, RN, Executive Chair of Nursing
A “Bottom-Up” Approach

One of the biggest changes on the hospital-wide level has been the transition from a single Nursing Practice Council (NPC), comprised of about 40 members, to six smaller Decisional Councils. These councils are focused on the areas of Practice, Quality, Research, Professional Development, Advanced Practice Nursing, and Management.

To ensure adequate representation from all nursing areas across the institution, the units are organized into districts—including Medical/Surgical, Critical Care, Perioperative Services, Maternal/Child, and Outpatient services—with an equal number of nurses in each district. Direct care nurses run for election to the Decisional Councils through their affiliation with a particular district.

Meetings for the six hospital-wide councils take place monthly. A Nursing Executive Steering Council—which includes the chairs of each of the Decisional Councils, as well as acting Chief Nursing Officer Linda von Reyn, RN, PhD, and Dombrowskas—then meets to hear the results from all of the councils’ decisions, to resolve any issues that come up, and to help move the work of the councils forward.

“It’s very much a ‘bottom-up’ rather than ‘top-down’ approach,” says Dombrowskas. “Whether our work involves helping to implement the organization’s new electronic health record or addressing our various quality initiatives, we believe that decisions are most effective when they’re closest to the point of care. This format is not only giving staff nurses an opportunity to have an active role in all decisions that are being made, it’s allowing ambulatory care nurses and inpatient nurses to work more closely together.”

Spreading Excellence

One of Dombrowskas’ major goals going forward is to improve communication within the nursing community at DHMC. “We’re using a variety of communication channels to keep everyone fully informed about what’s happening,” she says. “One key to enhancing communication is the ongoing development of the unit-based councils. Once they’re all up and running, we can better link the work we’re doing on the unit level with the work at the hospital-wide level. We would like to have more standardization with what we’re doing, while still allowing autonomy at the unit level, so that ‘pockets of excellence’ can be more easily replicated across the organization.”

“We’re in the process of setting up our bylaws and getting two councils up and running in Endoscopy,” says Rodee. “One great benefit of doing this work at the local level is the opportunity we have for collaboration and making the unit councils multidisciplinary. When you involve different members of the care team in the decision-making process, it increases staff morale and ultimately leads to better patient care.”

According to von Reyn, the Shared Governance model is an excellent example of the organization’s overall goal to build an empowering culture. “I think participating in the councils helps every nurse to develop their leadership abilities,” she says. “It also engenders a sense of ownership and accountability for their practice as they strive to provide our patients and families with the best care possible.”
DHMC’s revised model for shared governance is designed to enhance shared decision-making and shared leadership throughout the D-H nursing community, and is an excellent example of the organization’s goal to build an empowering culture. “Those of us who provide direct patient care now have a voice in making decisions that affect not only our individual practice but also the day-to-day activities of our units,” says Terri Rodee, RN, a nurse in DHMC’s Endoscopy Unit.
We don’t need statistics to know that our population is aging, but here are a few to consider. Over the next two decades, the number of people age 65 years and older in the U.S. is expected to grow to more than 71 million, comprising 20 percent of our population. At the same time, New Hampshire and Vermont are among the fastest aging states in the country, and future projections show a dramatic increase in the number of older adults who will need health services.
Stephen Bartels, MD, MS,  Director for the Dartmouth Centers for Health and Aging
“This ‘demographic tsunami’ will challenge us on a number of fronts,” says Stephen Bartels, MD, MS, Director of the Dartmouth Centers for Health and Aging. “Our healthcare system will need to shift from what has formerly been an acute-care model to one that is much more focused on chronic illnesses and long-term care needs. Right now, our guidelines for caring for the elderly, especially the oldest and frailest patients, aren’t as well-developed as they need to be. And currently, the numbers of clinicians and researchers with specific expertise in geriatrics are not adequate to meet future needs.”

In anticipation of these challenges, Bartels and many of his colleagues have been engaged for several years in a comprehensive planning effort—involving Dartmouth-Hitchcock Medical Center (DHMC), Dartmouth Medical School, local providers, and the community—to increase medical center and regional capacity to care for older adults. Their work has resulted in the formation of three centers focused on aging at Dartmouth that seek to integrate innovative programs in clinical care, education, and research.

Connecting People with Resources

The Dartmouth-Hitchcock Healthy Aging Center has been established to address the needs of older adults and their families through clinical programs and services. In a very active first year of operation, its accomplishments included: sponsoring an intergenerational music and movement workshop and performance at the Hopkins Center; helping to advance DHMC geriatric initiatives like The Bridge Program (a transitional care program for frail older adults discharged from the hospital); launching “Powerful Tools for Caregivers,” an evidence-based educational program for family caregivers; and offering a healthy aging lecture series for the community.

Starting in January 2009, the Healthy Aging Center and Dartmouth-Hitchcock’s Community Benefits program began sponsoring “Mapping the Aging Maze”—a series of events and communications that will bring together leaders in social services, health care, and government-based organizations—in an effort to promote more collaborative approaches to support people in aging well and accessing resources in their communities.

In the next year, the Healthy Aging Center will work to fill a critical need for patients, families and the community by establishing a resource center at DHMC. “Of the many excellent community recommendations we’ve received, this tops the list,” says Bartels. “It will increase our ability to help patients and families navigate the healthcare system. This center will provide free, open-access assistance with finding health information on topics related to aging, connecting with community services, and learning how to manage one’s health and make informed medical decisions.”

Expanding Education

Established in 2007, the grant-supported Northern New England Geriatric Education Center (NNEGEC) is focused on developing and expanding the capacity of the healthcare workforce to provide high-quality and safe, interdisciplinary care to older
adults in rural and underserved areas of NH and VT.

“To date, the NNEGEC has trained well over 700 healthcare professionals in a variety of disciplines,” says Suzanne Beyea, RN, PhD, Associate Director of the Centers for Health and Aging. “One of the unique aspects of our educational approach is our emphasis on experiential learning. This includes using ‘standardized patients’—a talented group of senior actors who take on the role of patients to give trainees a realistic, interactive learning experience.”

**Advancing Research**

The Center for Aging Research, which resides within The Dartmouth Institute for Health Policy & Clinical Practice (TDI), focuses on health services research that is aimed at improving health and health care for older adults. “We have a talented group of young investigators, and one of our priorities will be to help them develop their careers so they can be the foundation for our research center as we go forward,” says Bartels.

“At TDI, we’re fortunate to be surrounded by some of the best minds in the country,” he adds. “This will not only allow us to do research that can inform and help improve our clinical care and education programs—it will give us a unique opportunity to be leaders in thinking about what the healthcare system should look like for an aging America in the future.”

Suzanne Beyea, RN, PhD, is Associate Director of the Dartmouth Centers for Health and Aging which seek to integrate innovative programs in clinical care, education, and research to increase medical center and regional capacity to care for older adults.
In the Right Place, 
At the Right Time, 
EVERY TIME

To ensure that it can offer excellent access and service to its patients, as well as to referring providers in the community, Dartmouth-Hitchcock is focused on improving operational processes that directly support its Mission of providing each person “the best care, in the right place, at the right time, every time.” In an effort to make improvements in patient flow processes in the inpatient setting, the medical center implemented the Premise Bed Management System this past year. The new electronic system—which contains integrated modules for bed management, housekeeping, and transportation—is helping to make admission, transfer, and discharge processes run more efficiently and effectively. >>
Sandra Dickau, RN, *Vice President of Patient Care, Dartmouth-Hitchcock Medical Center*
A Visual Tool for Staff

“The Premise system is providing us with information that wasn’t as readily available in the past,” explains Sandra Dickau, RN, Vice President of Patient Care at DHMC. “For example, our placement coordinators and administrative coordinators on site can glance at their (color-coded) screens and tell immediately how many male or female beds are available in a particular unit. Having this type of information at their fingertips helps to provide patient-centered care in a timely fashion.”

Though staff at the unit level still need to enter information to keep Premise updated, the system offers some automated features that have improved the efficiency of communications. “Once a patient has been discharged and the information is entered into the system, Premise automatically pages Housekeeping to have someone come and clean the room,” says Dickau. “As a result, our turnaround time for room cleanings has improved.”

The system also utilizes text messaging. “Our patient placement coordinators and unit charge nurses used to communicate only by phone,” she says. “The new process has helped to decrease the number of phone calls that need to be made and has improved our efficiency in being able to communicate information more rapidly.”
Getting to “Yes”

For those monitoring and interacting with the system, Premise is a decision-support tool that helps to bring visual clarity to processes that are part of a complex academic care environment.

“Being able to see what the exact status of each patient is across the hospital at any given time is critical, especially when census is running very high as it often does here at DHMC,” says Dickau. “This not only helps us to minimize delays when, for example, patients move from the OR to recovery and then to an inpatient unit, it’s impacting our ability to say, ‘Yes,’ in accepting patients more readily from our partners in the community.”

Still, as valuable as the new system is, not all of its capabilities have been fully developed yet. “We still have a lot of work to do to really maximize the system and to further improve our patient flow processes,” she says. “But what we do know is that patients aren’t having to wait as long to get into the beds that they need.”
Debbie Ditommaso’s life had been full of challenges, but 2007 was shaping up to be her best year ever. “I thought, ‘Gosh, I’m on a roll now; I have my dream job and my kids are all doing great,’” she recalls thinking. But then in January of 2008, Ditommaso received the devastating news that she had breast cancer. “I’m not one to freak out and I’ve always been a very positive person, but when I got the call I just broke down,” she says. “More than anything, it made me mad.” Ditommaso quickly turned her anger into action. She asked her oldest daughter, who worked for a medical recruiting company, to help her find the best breast cancer surgery program in New England. “She said, ‘Go to Dartmouth, Mom,’” Ditommaso recalls. “‘They have the best of the best.’” >>
“There’s no question that TDI gives you a much more sophisticated understanding of the issues in health care—you gain such a wealth of knowledge that it can’t help but influence heavily the doctor you become afterwards. For example, implementing the SDM videos into our routine care process was completely the result of my experiences of working with Dr. Paul Batalden and thinking about how you redesign systems to support a better care process.”

E. Dale Collins, MD, MS
As a new patient in Dartmouth-Hitchcock Norris Cotton Cancer Center’s Comprehensive Breast Program, Ditommaso received a series of follow-up tests and visited the Center for Shared Decision Making, which helps patients and families make informed choices about their treatment options.

“At first, I thought, ‘I’m not a person who needs her hand held through anything,’” she says. “But we had a wonderful facilitator named Chuck Roswell, who later introduced us to my social worker Laurel Ludy and nurse coordinator Joann Frampton. He guided us through a session that included filling out a comprehensive survey on a laptop, watching a video about breast cancer, and reviewing materials that we could take home and share with the kids. I was very impressed with how thorough, informative, and helpful the process was.”

The laptop questionnaire—which gathers information on medical and family history, identifies emotional concerns such as depression, and checks the patient’s understanding of their diagnosis, treatment options and other factors that may affect their decisions—was developed by plastic surgeon E. Dale Collins, MD, MS, Director of the Comprehensive Breast Program.

“One of the things I’m very interested in is how health information technology can improve our care process,” says Collins. “Even the best, most dedicated and conscientious clinician occasionally forgets to ask a question, and that one question may be really important to address. This technology helps to prevent things from ‘slipping through the cracks,’ and provides crucial data to the care team to ensure that we’re meeting all of the patient’s needs.”

The shared decision-making (SDM)
process is designed to give patients the opportunity to consider unbiased information, as well as input from loved ones, while reflecting on their own beliefs, values, and circumstances. “That way, they come to their consultation more informed about the basics, and we can have more in-depth discussions about how different treatment options apply to them,” she explains. “I think it’s really important that we as caregivers not let our personal preferences or assumptions be part of this process.”

Collins credits this perspective to the Masters-level training she received at The Dartmouth Institute for Health Policy & Clinical Practice (TDI)—a preeminent research and education institution devoted to the ongoing reform of the U.S. healthcare system. Well over a hundred students and healthcare professionals from across the country are enrolled in TDI’s graduate degree programs each year. More than 50 of Dartmouth’s current faculty are graduates and are using what they’ve learned to change and improve the healthcare settings in which they work.

“There’s no question that TDI gives you a much more sophisticated understanding of the issues in health care; you gain such a wealth of knowledge that it can’t help but influence heavily the doctor you become afterwards,” says Collins. “For example, implementing the SDM videos into our routine care process was completely the result of my experiences of working with Dr. Paul Batalden and thinking about how you redesign systems to support a better care process. My SDM perspective was very much informed by the pioneering work of Drs. Jack Wennberg and Jim Weinstein, in trying to provide the information and support that patients need to make decisions that are truly the best ones for them.”

In Ditommaso’s case, it meant deciding to have a bilateral mastectomy in March of 2008, which involved infusion therapy a couple of months later, and then reconstructive breast surgery in November of 2008.

“For me, treating the cancer thoroughly and completely was more important than saving my breasts,” she says. “I’m very pleased with how everything turned out, and I feel fabulous now—the support that I received from my entire care team was phenomenal—along with my family and my positive outlook, it played a key role in my healing and carrying on as well as I have. I don’t think you could find a program that is better tuned to every aspect of care that a patient needs.”

Strong support from her family and care team at DHMC has helped Debbie Ditommaso make a full recovery from breast cancer. “I’m very pleased with how everything turned out and I feel fabulous now,” she says.
Most of us have been a patient at one time or another. But even if we’ve been asked to be a courier of our own medical information, we may not fully appreciate the activity and effort that take place behind the scenes to manage our medical records in support of our care.

“Medicine is inherently complex, and one of the most challenging aspects of our healthcare system today is the ability for there to be misinformation or inaccuracies exchanged between providers, between locations, and between patients and their care teams,” explains Thomas Colacchio, MD, President of the Dartmouth-Hitchcock Clinic. “This poses risks to both the quality and safety of care that is provided to patients.”

In support of Dartmouth-Hitchcock’s Mission, Vision and Goals—which include establishing a healthcare system supported by technology and processes that improve health outcomes, efficiency, access and continuity—Colacchio is co-leading a major initiative to implement an enterprise-wide electronic health record (EHR). The organization recently completed a year-long vendor selection process involving the participation of more than 1,500 staff, ultimately choosing to partner with Epic Systems Corporation for the implementation of the EHR at Dartmouth-Hitchcock.

“This is the biggest transition we’ve ever made as an organization, even bigger than when we moved from the facility in Hanover to here, because it really involves transforming how we think about and do our work,” says Colacchio.

The EHR initiative will provide a number of benefits to providers and patients, says Linda von Reyn, who as Acting Chief Nursing Officer and Co-Chair of the Clinical Transformation Governance Group is helping Colacchio lead this effort.

“Today, clinicians commonly work in settings where there is variation in practice and a dependency upon both paper-based and computer-based systems,” she explains. “As a result, they often have to rely on memory and manual processes when taking all of the steps that are involved in providing care. This increases the chance of a step being missed or an error occurring.”

“Using this technology, we’ll be able to automate our care process so that our workflow is more consistent, the accuracy and completeness of the patient’s medical information is improved, and efficiencies and reminders are built into the system to enhance quality and patient safety,” she adds. “Whether they’re being seen in Nashua, Concord or Lebanon, this project will help us to ensure that patients and their families continue to feel like they’re receiving excellent care but in an even more seamless, well-coordinated, and timely fashion.”

Once fully implemented, the EHR initiative will directly support Dartmouth-Hitchcock’s research and education activities, and is expected to help the organization realize enhanced efficiencies between its clinical operations and areas such as credentialing and billing.

“We’ve now selected the Clinical Project Team—40 leaders within the organization who will work closely with Epic and be dedicated full-time to the EHR implementation process over the next three years,” says Colacchio. “There’s a lot of learning and work to be done, but you can feel the energy and excitement that people have around this project.”
“This is the biggest transition we’ve ever made as an organization, even bigger than when we moved from the facility in Hanover to Lebanon, because it really involves transforming how we think about and do our work.”

Thomas Colacchio, MD
President of Dartmouth-Hitchcock Clinic
Chair of the Clinical Transformation Governance Group
One of the keys to Dartmouth-Hitchcock attaining its Vision of achieving the healthiest population possible within the regions it serves is continued development of needed programs and services in Southern New Hampshire—where the majority of the region’s population resides. “We have a tradition of partnering with providers in the southern part of the state, and we have developed large, multi-specialty group practices in communities like Concord, Manchester, Nashua, and Keene,” says Stephen LeBlanc, Chief Operating Officer of Dartmouth-Hitchcock. “We’ve established a strong foundation of primary and specialty care services. Increasingly, we’re exporting sub-specialty services—which are linked to our tertiary-level capabilities here in Lebanon—in an effort to provide people with care as close to home as possible. We need to continue to build on those efforts to more fully meet the needs of these communities.”

Dartmouth-Hitchcock is working to align its operational and clinical activities between Lebanon and southern locations to establish a regionalized, integrated approach to care that will provide better coordination and overall management of patients’ healthcare needs. “Our project to implement a common, highly-functional electronic health record will play a key role in this process,” says LeBlanc. “Whether a patient is being seen, for example, by a primary care physician in Nashua, a GI specialist in Manchester, or an oncologist in Lebanon, we want them to feel like they’re part of the same system of care.” >>
Stephen LeBlanc, Chief Operating Officer, Dartmouth-Hitchcock
Christine Schon, Vice President of Community Group Practice Operations
To achieve its Vision, the organization must also continue to build essential partnerships by attracting and engaging others. “That means developing strong, integrated relationships with not only hospital partners but also others who play a vital role in meeting the full spectrum of healthcare needs within the southern communities,” says Christine Schon, Vice President of Community Group Practice Operations.

“This kind of collaboration occurred recently when everyone came together as a coalition to create the Manchester Sustainable Access Project, which will expand care to this area’s most vulnerable patient population with the opening of the West Side Neighborhood Health Center,” she adds.

Continuing growth in Southern New Hampshire will also help Dartmouth-Hitchcock, as the state’s only academic medical center, to meet its goals of educating tomorrow’s clinicians and contributing to research efforts that advance medicine.

“In order to enhance our research opportunities and to offer adequate training experiences for our residents and medical students, we need to serve a population base that is large enough in terms of incidence of disease and also diversity,” LeBlanc explains. “A great example is the ER residency program that we’re pursuing. We don't have enough volume here in Lebanon to support that particular program. But through a partnership with another institution in Southern New Hampshire, we’re hopeful that we can make this training available to our residents.”
When you’re caring for a child with a chronic illness, you never know what tomorrow will bring. “You just take each day as it comes, and you try as much as possible to have a normal household,” says Paula Garvey, whose 10-year-old daughter Rosie has Cystic Fibrosis (CF), a genetic disease that causes the buildup of thick, sticky mucus in the lungs and the digestive tract which can result in chronic, life-threatening lung infections and serious digestive problems.

A “typical” school day for the Garveys starts with Rosie rising extra early to eat a large breakfast. “She requires 4,000 calories a day (twice as many as her sisters) and needs to take a lot of medications, including enzymes to help digest her food,” explains Paula. “In the evening, she does her vest—a machine that vibrates and gets rid of any mucous in her lungs—and also does two nebulizer treatments. We have a good routine, but it’s a time-consuming process. And, I never know when I might get a call from the school nurse, saying, ‘Rosie’s sick.’”

But since the Garveys moved to Amherst, NH four years ago and began taking Rosie to the Children’s Hospital at Dartmouth’s (CHaD’s) CF outpatient clinic in Manchester, she hasn’t had a hospitalization. The CF program, one of 115 CF centers in the country accredited by the national CF Foundation, is part of CHaD’s regional system of care. The Garveys receive multidisciplinary care that includes doctors, nurses, physical and respiratory therapists, and nutritionists—and also have access (if needed) to a full array of tertiary-level services at CHaD in Lebanon.

“To be honest, when we moved here from Boston, we weren’t expecting the same level of care,” admits Paula. “But, Rosie’s pediatric specialists Dr. Pamela Hofley (gastroenterology), Dr. Steven Grandgeorge (pulmonology), and her entire care team have been fantastic. The care we receive is second to none. Rosie’s even involved in a clinical study there. And, you can’t beat the convenience. The fact that we only have to go a half hour down the road to the clinic, and can avoid the stress of having to drive into the city, is a godsend to us.”

With love and support from her family and top-notch care from her CF team at CHaD, Rosie is thriving. “She’s doing great in school,” says Paula. “She dances, plays basketball, and does track and field. And we have her playing the clarinet now, in hopes that it might offer a bit more exercise for her lungs. CF isn’t the best thing to have, but we truly feel fortunate to be where we are.”
Building Dynamic Partnerships

Developing Regional CONNECTIONS

Being diagnosed with cancer can be one of life’s most difficult and challenging experiences. Access to the latest research-based cancer care can make a critical difference, and getting that care close to home—with the support of family and friends nearby—can be a source of great comfort.

“For example, we have a patient who lives in Manchester who needs a bone marrow transplant (BMT),” says Amy Stansfield, Administrative Director of Hematology/Oncology at Dartmouth-Hitchcock’s Norris Cotton Cancer Center. “Our BMT program can match the services of any other BMT program in the country.”

The Blood and Marrow Transplant Program, under the direction of Dr. Kenneth Meehan, is the only National Marrow Donor Program (NMDP) transplant center in northern New England and is recognized as a specialized center for unrelated donor transplants.

“We’re able to provide pre-transplant chemotherapy for the patient at Norris Cotton Cancer Center in Manchester, and greatly reduce the time the patient will have to spend in Lebanon for the tertiary care, which involves highly-specialized treatments and monitoring,” she says. “If all goes well, we’ll also transfer post-care back to Manchester. The patient and his family told us that being able to receive expert care and support services close to home is making a big difference.”

With a focus on building an integrated system for advanced cancer care through regional locations and strong relationships with community providers, Dartmouth-Hitchcock’s Norris Cotton Cancer Center is meeting the needs of cancer patients and their families throughout the region. Two major partnerships, established in the last year and a half by Norris Cotton Cancer Center, underscore this effort.

In February 2008, the Cancer Center moved its medical oncology and infusion services from Dartmouth-Hitchcock Manchester to the new Notre Dame Pavilion, in partnership with Catholic Medical Center (CMC). In December 2008, the Cancer Center strengthened its relationship with Cheshire Medical Center/Dartmouth-Hitchcock Keene and established Dartmouth-Hitchcock Norris Cotton Cancer Center at the Kingsbury Pavilion.

“We are committed to excellence in research, and to building dynamic partnerships throughout our region that connect new discoveries in cancer to improved care for patients,” says Cancer Center Director, Mark Israel, MD. “Our recent collaborations with Cheshire and the Kingsbury Pavilion, like our partnership with Frisbie Memorial Hospital on the Seacoast, are great examples of this. We’re able to bring the knowledge and expertise of a National Cancer Institute (NCI) Comprehensive Cancer Center directly to people in their communities, helping patients to stay close to home in New Hampshire even if they require specialized care or treatment in a clinical trial.”

Of the thousands of cancer treatment programs across the country, the National Cancer Institute recognizes only 40 Comprehensive Cancer Centers. In 2008, it approved an additional five years of support for Norris Cotton Cancer Center as an NCI-designated cancer center, a distinction that it has earned continuously since 1978. Norris Cotton Cancer Center is the only cancer center in northern New England to hold the NCI Comprehensive Cancer Center designation.

According to Michael Ward, Vice President of Cancer Services, continued expansion of Norris Cotton Cancer Center programs and services in Southern New Hampshire is key to Dartmouth-Hitchcock’s role as a tertiary and quaternary care leader in the region. “The NCI’s grant funding supports many of our innovative research programs and it is particularly interested in reaching large and diverse populations with advanced cancer care and prevention programs,” explains Ward. “In our region and particularly in Southern New Hampshire, it’s important for us to provide robust clinical programs, which in turn enhance our research and our efforts to improve cancer medicine for patients here—and around the world.”
Michael Ward, *Vice President of Operations, Norris Cotton Cancer Center*
After a tumultuous start, Dartmouth-Hitchcock finished Fiscal Year (FY) 2008 with strong financial results, producing a positive operating margin of $21 million (and surpassing the $17 million operating margin it achieved in FY2007). One of the keys to improved performance was a financial action plan initiated mid-year. “The most significant component of our shortfall in operating margin early in the year had been lower-than-budgeted patient activity, so an important area of focus for us was to improve patient access in both the inpatient and ambulatory settings,” explains Daniel P. Jantzen, Chief Financial Officer for Dartmouth-Hitchcock. “Through a number of initiatives, we were able to improve access for patients who really needed our care, and at the same time we improved our financial results.”
Daniel P. Jantzen, Chief Financial Officer, Dartmouth-Hitchcock
Strong financial performance is directly linked to Dartmouth-Hitchcock’s organization-wide strategic planning process. Approved by the Boards of Trustees in June of 2008, the goal of this process has been to establish a single, unifying vision for Dartmouth-Hitchcock that will provide a framework for strategic and operational planning and decision-making over the next five years. “While largely directional in nature, the plan provides a course of action for aligning our Mission, Vision and Goals and for directing the investment of our resources,” Jantzen says.

Importantly, the strategic planning process is designed to be dynamic and adaptive to unforeseen changes in the environment. This has proven critical in helping Dartmouth-Hitchcock weather the financial “storm” that arrived at the beginning of the new fiscal year (2009), when highly volatile, sharply declining investment markets signaled one of most severe economic downturns in U.S. history.

“In a very short period of time, the world has changed dramatically,” says Jantzen. “We’ve responded by focusing on areas over which we have the most control. For example, we’ve had to be flexible and modify our capital plans, putting some projects and purchases on hold to help us conserve and rebuild lost liquidity. At the same time, we’re continuing our efforts to become more operationally efficient and to produce operating margins that will give us the resources we need to invest in our future.”

The organization is moving ahead with two major projects which are considered priorities in this regard. The first is the system-wide Clinical Transformation project, which will establish an electronic health record that will directly support Dartmouth-Hitchcock’s goals of creating an integrated system of care within its region and transforming the way in which care is delivered. The other is the construction of an outpatient surgery center on its Lebanon campus to meet an increasing need for operating room space. As a leading tertiary and quaternary referral center responsible for caring for the sickest and most complex patients, the demand for Dartmouth-Hitchcock’s services not only remains strong, it is expected to grow in the future with our aging population.

Still, the organization recognizes that as it continues to cope with the uncertainties created by the economy and the investment markets, there are many factors—such as reduced payments from Medicaid—that could further challenge its ability to meet multiple missions as New Hampshire’s only academic medical center.

“Because we’ve been prudent financial managers over the years, we headed into this economic ‘storm’ with a relatively strong and healthy financial position,” says Jantzen. “And with our strategic planning efforts under way, we’re more focused than ever on meeting our financial stewardship goals, and making sure that Dartmouth-Hitchcock will continue to be a growing, vibrant organization that will be here for our patients and our communities in the future.”
### Operating Expenditures (in thousands of dollars)

<table>
<thead>
<tr>
<th></th>
<th>FY2008</th>
<th>FY2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dartmouth Medical School</td>
<td>$229,632</td>
<td>$209,135</td>
</tr>
<tr>
<td>Dartmouth-Hitchcock</td>
<td>1,031,940</td>
<td>969,765</td>
</tr>
<tr>
<td>Veterans Affairs</td>
<td>134,486</td>
<td>123,847</td>
</tr>
<tr>
<td>Medical Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$1,396,058</td>
<td>$1,302,747</td>
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</table>

### Revenue Sources Summary (in thousands of dollars)

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<thead>
<tr>
<th></th>
<th>FY2008</th>
<th>FY2007</th>
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<tbody>
<tr>
<td>Payment for Patient Services from Third Parties and Patients</td>
<td>$987,292</td>
<td>$939,417</td>
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<td>Federal Budgets for Veterans Affairs Services</td>
<td>131,406</td>
<td>119,928</td>
</tr>
<tr>
<td>Funded Research</td>
<td>123,922</td>
<td>130,723</td>
</tr>
<tr>
<td>Tuition Income and Fees</td>
<td>19,267</td>
<td>18,448</td>
</tr>
<tr>
<td>Gifts, Bequests and Endowments and Investment Income</td>
<td>5,577</td>
<td>61,374</td>
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<tr>
<td>Other Income</td>
<td>117,459</td>
<td>85,106</td>
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<tr>
<td><strong>Total</strong></td>
<td>$1,384,923</td>
<td>$1,354,996</td>
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</table>

### Revenue Sources Detail (in thousands of dollars)

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<tr>
<th></th>
<th>FY2008</th>
<th>FY2007</th>
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<tbody>
<tr>
<td>Payment for Patient Services from Third Parties</td>
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<td>Federal Budgets for Veterans Affairs Services</td>
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<td>131,406</td>
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<td>Funded Research</td>
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<td>3,080</td>
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<tr>
<td>Tuition Income and Fees</td>
<td>19,267</td>
<td>18,448</td>
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<tr>
<td>Gifts, Bequests and Endowments and Investment Income</td>
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<td>61,374</td>
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<tr>
<td>Other Income</td>
<td>44,307</td>
<td>73,152</td>
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<tr>
<td><strong>Total</strong></td>
<td>$221,821</td>
<td>$1,028,616</td>
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### FY2007

<table>
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<tr>
<th></th>
<th>DMS</th>
<th>D-H</th>
<th>VA</th>
<th>TOTAL</th>
</tr>
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<tbody>
<tr>
<td>Payment for Patient Services from Third Parties</td>
<td>$12,156</td>
<td>$977,261</td>
<td></td>
<td>$987,417</td>
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<tr>
<td>Federal Budgets for Veterans Affairs Services</td>
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<td></td>
<td>119,928</td>
<td>119,928</td>
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<tr>
<td>Funded Research</td>
<td>126,804</td>
<td>3,919</td>
<td></td>
<td>130,723</td>
</tr>
<tr>
<td>Tuition Income and Fees</td>
<td>19,267</td>
<td>18,448</td>
<td></td>
<td>18,448</td>
</tr>
<tr>
<td>Gifts, Bequests and Endowments and Investment Income</td>
<td>5,577</td>
<td>61,374</td>
<td></td>
<td>61,374</td>
</tr>
<tr>
<td>Other Income</td>
<td>28,128</td>
<td>73,152</td>
<td></td>
<td>101,278</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$206,201</td>
<td>$1,028,616</td>
<td>$123,847</td>
<td>$1,354,996</td>
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</table>
OPERATIONAL AND PATIENT REPORT

**Patients Discharged**

<table>
<thead>
<tr>
<th>Location</th>
<th>FY2008</th>
<th>FY2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Hampshire</td>
<td>12,288</td>
<td>12,290</td>
</tr>
<tr>
<td>Vermont</td>
<td>9,509</td>
<td>9,238</td>
</tr>
<tr>
<td>Other States</td>
<td>1,144</td>
<td>1,063</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>22,941</td>
<td>22,591</td>
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</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>FY2008</th>
<th>FY2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Days of Service *</td>
<td>112,694</td>
<td>107,534</td>
</tr>
<tr>
<td>Average Daily Census</td>
<td>308</td>
<td>295</td>
</tr>
<tr>
<td>Operations Performed</td>
<td>18,064</td>
<td>17,100</td>
</tr>
<tr>
<td>Births</td>
<td>1,187</td>
<td>1,131</td>
</tr>
<tr>
<td>Emergency Dept. Visits</td>
<td>31,871</td>
<td>30,891</td>
</tr>
<tr>
<td>Volunteer Hours</td>
<td>54,325</td>
<td>50,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,033</td>
<td>1,030</td>
</tr>
</tbody>
</table>

* Includes patients admitted for observation and intensive care nursery bassinet patients.

**Outpatient Visits**

<table>
<thead>
<tr>
<th>Location</th>
<th>FY2008</th>
<th>FY2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dartmouth-Hitchcock Northern Region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lebanon</td>
<td>416,108</td>
<td>462,262</td>
</tr>
<tr>
<td>Dartmouth-Hitchcock Community Practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concord Offices</td>
<td>181,040</td>
<td>183,731</td>
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<tr>
<td>Manchester Offices</td>
<td>372,037</td>
<td>354,229</td>
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<tr>
<td>Nashua Offices</td>
<td>211,504</td>
<td>208,604</td>
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<tr>
<td>Keene Offices</td>
<td>338,222</td>
<td>333,980</td>
</tr>
<tr>
<td>Other</td>
<td>111,953</td>
<td>129,217</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>1,212,756</td>
<td>1,209,761</td>
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<tr>
<td><strong>Total</strong></td>
<td>1,628,864</td>
<td>1,672,023</td>
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**DHMC PHILANTHROPIC CONTRIBUTIONS**

**FY2008**

<table>
<thead>
<tr>
<th>Category</th>
<th>FY2008</th>
<th>FY2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Philanthropic Contributions (in dollars)</td>
<td>26,353,447</td>
<td></td>
</tr>
<tr>
<td>(July 1, 2007 – June 30, 2008)</td>
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<td></td>
</tr>
<tr>
<td>Current Operations</td>
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<td></td>
</tr>
<tr>
<td>Unrestricted and Annual Funds</td>
<td>1,597,805</td>
<td></td>
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<tr>
<td>Restricted Funds</td>
<td>16,788,221</td>
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<tr>
<td><strong>Total Current Operations</strong></td>
<td>18,386,026</td>
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<tr>
<td>Endowment</td>
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<tr>
<td>Total Endowment</td>
<td>4,649,838</td>
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<tr>
<td>Plant and Equipment</td>
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<td></td>
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<tr>
<td>Total Plant and Equipment</td>
<td>3,317,583</td>
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</table>
COMMUNITY BENEFITS REPORT

Dartmouth-Hitchcock is uniquely positioned to work with the communities we serve to promote wellness, prevent illness, and remove barriers that hinder access to health care. Dartmouth-Hitchcock continues to maintain a vision of achieving the healthiest population possible through investing in research, clinical care, health education, and community partnerships that result in improved health for all residents in the communities we serve.

We demonstrate our commitment by providing outstanding healthcare services even when a patient’s financial resources are not adequate to pay for that care. In FY 2008, D-H provided a total of $18.4 million in direct financial assistance to more than 13,000 people in the region to ensure they received proper medical care.

In addition, Dartmouth-Hitchcock remains committed to providing care to patients enrolled in the Medicaid program, regardless of being fully reimbursed for the cost of these services. In FY 2008, D-H provided care to more than 50,000 Medicaid patients while absorbing $47 million in unreimbursed fees.

Investing in the education of our clinical workforce is also a top priority, providing more than $13.4 million in uncompensated teaching time and other resources to support physician residency programs, nursing education, and other education activities.

Key partnerships with a wide array of community organizations and residents enhance our ability to plan and develop responses to long-term and emerging healthcare needs. Examples of these urgent needs include addressing high rates of substance abuse through prevention programs and enhanced treatment services; promoting healthy eating habits and a more physically active lifestyle as ways to help reduce the sharp increase in obesity and weight-related health issues for children and adults; and helping organize medical providers and community organizations to more effectively meet the healthcare needs of an aging population.

While the value of Dartmouth-Hitchcock’s community benefits doesn’t adequately tell the full story of the lives we impact, the numbers below provide a tangible measure of the magnitude and diversity of our commitment to the communities we serve.

### Financial Assistance to Patients

<table>
<thead>
<tr>
<th>Patients Receiving Financial Assistance</th>
<th>FY 2008 Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper Valley and North Country</td>
<td>23,828</td>
</tr>
<tr>
<td>Southern Region</td>
<td>27,063</td>
</tr>
<tr>
<td><strong>Cost of Financial Assistance</strong></td>
<td><strong>Cost of Uncompensated Medicaid</strong></td>
</tr>
<tr>
<td>$18.5 million</td>
<td>$47.2 million</td>
</tr>
</tbody>
</table>

### Value of FY 2008 Community Benefits at Cost

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost (in $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncompensated Medicaid</td>
<td>47,176,115</td>
</tr>
<tr>
<td>Cost of Financial Assistance to Patients</td>
<td>18,458,609</td>
</tr>
<tr>
<td>Support for Medical &amp; Other Professional Education*</td>
<td>13,427,663</td>
</tr>
<tr>
<td>In-kind Support for Research &amp; Other Grants</td>
<td>2,908,084</td>
</tr>
<tr>
<td>All Other Community Health Activities</td>
<td>6,871,395</td>
</tr>
<tr>
<td><strong>Total FY 2008 Community Benefits Value</strong></td>
<td><strong>88,841,866</strong></td>
</tr>
</tbody>
</table>

*This category includes financial support to DMS, uncompensated time to teach medical residents, uncompensated time to teach students of medicine and other health professions, and uncompensated time to provide continuing education for healthcare professionals.
“Bold, visionary, innovative, strategic, and efficient.” These are all words that industry experts have used to describe C&S Wholesale Grocers and the remarkable growth and success it has had in a highly competitive business. Based in Keene, New Hampshire, C&S is the nation’s second largest food wholesaler, serving 5,000 independent supermarkets, regional and national grocery chains, and military bases across the U.S. The company delivers 53,000 food and nonfood items from 70 distribution warehouses located in 12 states. With annual sales of $19 billion, C&S is the 12th largest privately held company in the nation, and the largest in New England.

But ask those who work for the company or live in the areas where it operates, and you'll likely hear about C&S’s “compassion, caring, and generosity” in its many community-oriented efforts to stop hunger and to support health care and children. Nowhere is this more strongly felt than in Northern New England, where the C&S Charity Golf Outing has a tradition of raising funds and awareness for organizations that are dedicated to improving and saving the lives of children with cancer.

At last summer’s two-day event in Vermont and Massachusetts, C&S brought together nearly 1,000 people—including C&S customers, vendors, and food industry leaders—to raise a record $1.185 million to support Children’s Hospital at Dartmouth (CHaD) and seven other organizations that work to address children's health care and hunger. C&S' $500,000 gift to CHaD's Pediatric Oncology Unit, part of a total pledge of $750,000 to Dartmouth-Hitchcock, was the largest ever single corporate donation to the children's hospital. The company has raised a total of $1.6 million for CHaD over the past 11 years.

“We have a long-standing partnership with CHaD that was initiated by retired President Ron Wright,” says Gina Goff, Director of Corporate Giving for C&S. “He had a deep passion for helping people afflicted by cancer, especially children, that is shared by so many here. Our business is run by very driven people, but whether I'm talking to an executive vice president, a clerk, or a forklift operator—their hearts will all melt when the subject turns to kids with cancer.”

One of the biggest hearts of all is that of Chairman and CEO Rick Cohen, grandson of Israel Cohen, who founded C&S in Worcester, Massachusetts in 1918.

“The family values that shaped us early on still run deeply through our company; with all of the success we've experienced, we feel a strong obligation to give back,” explains Cohen. “We're very pleased to have reached a new level of support for CHaD which provides unparalleled medical services to pediatric cancer patients and their families. The bravery shown by these kids, the sacrifices made by their families, and the dedication shown by CHaD's care teams is truly inspiring.”

“The employees and leadership of C&S should be commended for their passionate generosity,” says Nancy Formella, President of Mary Hitchcock Memorial Hospital. “Their unwavering devotion to our pediatric cancer program enables our young patients and their families to endure the toughest fight of their lives. C&S is an example to all of us of how one employer can truly make a difference to the community.”
“The family values that shaped us early on still run deeply through our company,” says Rick Cohen, Chairman and CEO of C&S Wholesale Grocers. “With all of the success we’ve experienced, we feel a strong obligation to give back. We’re very pleased to have reached a new level of support for CHaD.”
On these pages, we are pleased to present those who made gifts to the Transforming Medicine Campaign during calendar year 2008 totaling $2,500 or more. In recognizing those listed here, we seek to express our gratitude for each and every contributor, of any amount. Together, your support surpassed $30 million for the year, bringing the Campaign total to more than $225 million.

2008 was notable not only for the sustained commitment of thousands of donors, but also for continued growth in the breadth of support for the Campaign. A record-breaking 31,000 donors made gifts to Dartmouth-Hitchcock Medical Center and Dartmouth Medical School—the highest ever participation in a single year.

The energy and excitement driving the Transforming Medicine Campaign were exemplified by The Gala 2008. Capping off a weekend of special events in May, The Gala brought together more than 500 supporters to celebrate and advance the Campaign's success, raising over $1.1 million and pushing the Campaign past the $200 million mark.

Sadly, the year was also marked by the passing of Campaign Chair Dr. Peter D. Williamson, who had led the Transforming Medicine Campaign both in word and deed. In 2007, he and his wife, Susan, made an extraordinary gift to the Campaign. His passionate commitment to Dartmouth medicine and its vision for the future made a lasting impact and inspired us all. He is ably succeeded in leading the Campaign by co-chairs Peter Fahey and Al Griggs.

To all of our donors, we thank you for your participation and your partnership, for your generosity and your confidence in our vision for the future. Your philanthropic support is felt throughout our medical center and beyond. Your investments in patient care, medical education, and scientific research are transforming medicine for today and tomorrow.

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