Mission
We advance health through research, education, clinical practice and community partnerships, providing each person the best care, in the right place, at the right time, every time.

Vision
Achieve the healthiest population possible, leading the transformation of health care in our region and setting the standard for the nation.
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Achieve the healthiest population possible, leading the transformation of health care in our region and setting the standard for our nation.
a message from leadership

As the pace of transformation accelerates in 2008, we are pleased to present you with Dartmouth-Hitchcock Medical Center’s 2007 Annual Report. The new Mission, Vision and Goals established by Dartmouth-Hitchcock’s leadership in 2007 are serving as a source of energy for our pursuit of clinical and academic excellence. Our Mission, Vision and Goals are also the catalyst driving a comprehensive strategic planning process that will shape the future of our organization over the next decade.

Our Annual Report brings you inside our far-reaching commitment to achieve the healthiest population possible, and illustrates how individual patients, families, donors, faculty, clinicians, nurses, research scientists, residents, medical students, volunteers and staff are all playing critical roles in creating our exciting future. As you read through these pages, you will realize that advancing health—advancing patient care now and decades from now—is at the core of who we are and everything we do.

Several of the milestones achieved in the past year are expected to be pivotal in positioning Dartmouth-Hitchcock Medical Center for success in advancing our Mission and pursuing our Vision in 2008 and beyond. These significant achievements include the following:

- Peter and Susan Williamson committed a gift of $20 million to Dartmouth Medical School and Dartmouth-Hitchcock Medical Center, the largest single gift ever made to the Medical School or Medical Center. The translational research building that will be erected as part of the C. Everett Koop Medical Science Complex will be named the Peter and Susan Williamson Translational Research Building in honor of the Williamsons' remarkable commitment to Dartmouth Medical School, the Transforming Medicine Campaign, and the future of medicine.

- The Center for Evaluative Clinical Sciences (CECS) became The Dartmouth Institute for Health Policy & Clinical Practice under newly-named Director Dr. James N. Weinstein, DO, Professor and Chairman of the Department of Orthopaedic Surgery for DMS and DHMC. Dr. Weinstein succeeded CECS founder John E. “Jack” Wennberg, MD, MPH as the leader of this preeminent health research, policy, and clinical practice improvement institution upon Jack’s retirement in July.

- Norris Cotton Cancer Center was again recognized by U.S. News & World Report as one of the Top 50 cancer care programs in the country. Norris Cotton Cancer Center is one of only 39 centers nationwide with the National Cancer Institute’s Comprehensive Cancer Center designation.

- Dartmouth-Hitchcock Medical Center and Dartmouth Medical School received a $1.24 million grant from the Health Resources and Services Administration (HRSA) to develop the Dartmouth-Northern New England Geriatric Education Center. The grant is expected to be the nucleus for a comprehensive network of educational, clinical and research centers at DHMC and DMS that will position us for leadership in addressing the healthcare needs of the rapidly aging population of New England and to directly address the severe shortage of healthcare and social service providers trained in the field of geriatrics.

- Dr. William Green, PhD, Chair and Professor of Microbiology and Immunology, was named Dean of Dartmouth Medical School. A distinguished scientist who has been at Dartmouth Medical School since 1983, Dr. Green succeeded Dr. Stephen Spielberg, MD, PhD, who stepped down from the Dean’s role to devote more time to his long-standing passions for pediatric research and international health initiatives.

Finally, we want to express our extreme appreciation to the more than 28,000 individual donors who contributed to Dartmouth-Hitchcock Medical Center and Dartmouth Medical School over the past year. Your confidence in us is an inspiration—one that underscores a strong belief in who we are and the Mission and Vision we live to fulfill every day.

Nancy Formella, MSN, RN
President, Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Alliance

Thomas A. Colacchio, MD
President
Dartmouth-Hitchcock Clinic

William Green, PhD
Dean
Dartmouth Medical School
GOAL

Provide Patient and Family Centered Care

Unwavering commitment to provide care that is coordinated, effective, efficient, compassionate and safe.
Pregnancy should be a time filled with joy and hope. But when a maternal complication or the risk of a genetic disorder threatens the health of a pregnancy, the experience can quickly become an anxiety-filled one for expectant mothers and their families. Until recently, women living within the region who were at increased risk for having babies with birth defects had to travel significant distances to other academic centers to receive the most advanced diagnostic testing.

With the arrival of Jeffrey R. Johnson, MD, at Dartmouth-Hitchcock, these services are now available much closer to home. Dr. Johnson, who is one of only a few Maternal-Fetal Medicine specialists in New England, offers many of the same highly specialized services to help patients and families improve the outcomes of their pregnancies. “These can involve maternal complications such as hypertension and diabetes,” he explains. “I also treat fetal complications and actually do procedures on fetuses, as well as expectant moms, for certain types of abnormalities.”

Only a few Maternal-Fetal Medicine specialists in New England offer this level of expertise. “I know patients and families really appreciate having access to procedures like CVS through the Dartmouth-Hitchcock system,” says Johnson. “It reduces the burden of having to travel long distances and makes the experience less stressful for them.”

Thanks to a highly specialized procedure called “transabdominal cerclage,” Wendy Estey Kirker’s pregnancy resulted successfully in the birth of her son, Thomas. “Wendy is a cervical cancer survivor and was at particularly high risk due to the surgical removal of her cervix,” explains Dr. Jeffrey R. Johnson, who is one of only a few Maternal-Fetal Medicine specialists in New England who perform the procedure. “But everything turned out very well.”

Successfully recovering from a serious injury or illness can make you feel like you’ve “got your life back.” But living with a chronic pain condition can be a debilitating experience, especially when you’ve tried many different treatment options that have proved ineffective. That was the case with Rich Letourneau, who ruptured a disc in his back in 2005.

“I could barely walk,” recalls Letourneau. “I was only able to work part-time and could do very little around the house. I got really depressed—I was afraid I was going to be a cripple for the rest of my life.”

Then his primary care physician told him about the Functional Restoration Program (FRP) at DHMC’s Spine Center, an intensive 3-week rehabilitation program which takes a dramatically different approach from mainstream medical practice. “We don’t emphasize pills, shots, and surgeries,” explains Rowland Hazard, MD, who directs FRP. “Rather than trying to cure pain, we try to teach people how to function better so they can do the things that they want to be able to do.”

FRP combines focused physical training, behavioral interventions, educational sessions, and self-care. As patients do exercises that they may have been afraid to try on their own, they gain more control over their pain and feel more confident about their capabilities. In the process, they receive invaluable support and encouragement from other patients in the group.

At the core of the program is goal setting. “It’s centered on listening very carefully to what is important to each person, understanding what they’re trying to accomplish, and helping them to safely progress toward their goal,” says Hazard. “We also involve family members who can provide the support patients need to do well with their self-care programs at home.”

FRP compares each patient’s results with those of 300 other program graduates as part of an effort to continually improve the program’s effectiveness. On average, FRP graduates report significant improvements in flexibility, strength, and endurance, as well as increased levels of pain relief and decreased depression.

“I recently had my one-year follow-up with Dr. Hazard and I’m doing great—my wife’s encouragement has been a key to my recovery,” says Letourneau. “I’m lifting things and moving the way I used to. I actually feel better than I did before my injury.”

“Patient and family centered care is when we truly put the patient and their family in the center of all we do—respecting each person within the holistic framework of their life. It means that they become partners in the delivery of their care and that they are actively engaged in our quality improvement efforts.”

Vicki M. George, RN, PhD, is DHMC’s Chief Nursing Officer.
Advance Our Academic Mission

Vigorously promote the education of tomorrow’s healthcare leaders as well as the creation, dissemination and application of new knowledge in support of our mission and vision.
Despite all of the advantages of modern medicine, cardiovascular disease is still the number one killer in the U.S., accounting for about one-third of all deaths annually. "When the heart goes bad, the only options we typically have for fixing it are medications that reduce the amount of work that the heart has to do, mechanical devices that open diseased vessels, or surgical procedures that bypass diseased vessels," explains Michael Simons, MD, A.G. Huber Professor of Medicine and of Toxicology and Pharmacology at Dartmouth Medical School (DMS), and Section Chief of Cardiology at DHMC. "Short of a transplant, we have no way of replacing the damaged tissue or rebuilding the damaged arteries."

As Director of the Dartmouth Angiogenesis Research Center, Simons is heading a comprehensive research effort to discover and understand the basic mechanisms underlying blood vessel formation. "What we're trying to do is find ways to make new vessels that can take the place of old ones—it's a fundamentally different approach to the treatment of coronary and critical artery diseases," he says.

In November, Simons and a group of his researchers published the results of an intriguing study in the Journal of Clinical Investigation. "We were able to induce a gene in adult mice that increased the vasculature, or number of blood vessels, in a normal heart and improved the heart’s output, even under conditions of stress," explains Daniela Tirziu, PhD, who co-authored the study along with Simons and other colleagues at DMS. "We were surprised to find that it also resulted in a hypertrophic (bigger) heart. That’s the beauty of science—you start with one idea and you end up with something unexpected."

In addition to offering novel treatment strategies for heart disease, the research is shedding light on how "we can potentially enhance the size of functionally damaged hearts and other organs—I think it has implications far beyond the vascular system," says Simons. "If we can create a new and healthy vasculature, it would mean a fundamental change in paradigm from trying to fix the old, leaky pipe with duct tape to putting in a shiny, new one, if you will. We could move from treating symptoms to changing the nature of the disease itself."

The groundbreaking research of Michael Simons, MD, and his colleagues at DMS may lead to novel treatments that allow heart disease patients to regenerate their own damaged arteries—something unexpected. That all began to change in 2005, when Vascular Surgery was designated a primary specialty by the American Board of Medical Specialties. "That made it possible for us to develop a separate, five-year Vascular Surgery Training Program which was approved by the Accreditation Council for Graduate Medical Education in 2006," says Cronenwett, who helped DHMC to become the first academic center in the country to have the new training model approved. "It allows us to focus on what we will actually do as practicing vascular surgeons, while providing the skills and training we need to provide exceptional care to our patients," says Joseph R. Dwaltby, MD, a second-year Vascular Surgery resident who is expected to be the first graduate of this type of training program in the nation. "It’s exciting to be part of such a progressive program. The Vascular Surgery Department here is world-class and its faculty is second to none."

The DHMC program is serving as a model nationally for other academic centers. "There are about 10 such programs approved, many more are in the process of applying, and they’ve all looked to us for guidance," says Cronenwett. "It’s really quite unique to have the opportunity to create a new training paradigm in medicine, especially one that will play such an important role in the future care of our aging ‘baby boomers.’

A few years ago, the burgeoning field of Vascular Surgery reached a critical impasse. Advancing technology and the rapid growth of catheter-based procedures like endovascular aneurysm repair and carotid artery stenting were propelling the field into a new realm of less-invasive treatments for patients. But traditional training programs weren’t keeping pace with how quickly the specialty was evolving. "We expanded fellowships from one year to two years to allow endovascular training to be accomplished more completely," explains Jack L. Cronenwett, MD, who held national leadership posts with the Association of Program Directors of Vascular Surgery and the Society for Vascular Surgery. "But trainees were still required to do five years of general surgery first, and many also did research years along the way. That stretched total vascular training to nine years in many cases. For the first time, the interest in Vascular Surgery fellowship started to decline."

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The teaching of medical and graduate students, staff, nurses, physicians, and administrators is critical to our mission. At D-H, we have a commitment to continued learning and improvement at all levels. At the center of it all is the patient—and they may be the best teachers of all.”
Close the Quality Gap
Lead the way in discovering and closing the gap between the best that can be and where we are today.
at the forefront of transparency

HONEST, ACCURATE & ACCOUNTABLE

Across the country, hospitals and healthcare organizations are facing increasing pressure from payors and the public to report on the quality, outcomes, satisfaction, and costs of their services. In 2004, DHMC became one of the first providers to begin sharing this information with consumers, and is now a national leader in the transparency of quality and cost information. The medical center’s Quality Reports website currently provides over 470 measures of quality about 24 different procedures, conditions, and services.

“These efforts have not gone unnoticed. ‘Patients tell us that they appreciate being able to see results like our C-section rates; what percentage of women have epidurals, and how other patients rate the quality of care they’ve received,’ says Foster. ‘They feel more informed about their options and more actively engaged in their care. And it gives us insight into what’s most important to them. We rely on patient feedback to make sure that our data is presented in an understandable and useful way.’

‘Transparency also has an important role to play in helping providers to identify gaps in quality and make changes in practice that are needed to improve care. This was one of the major topics covered in a transparency symposium hosted by DHMC last October. The conference—the first of its kind—included almost 200 people from around the U.S. and Canada who gathered to discuss the value of transparency in health care.

“It was a great opportunity to share our knowledge and vision about transparency and to learn from other national experts,” Foster says. “It’s exciting to see how much interest there is around this topic now. There’s a growing realization that this is not only information that people should have, it can also help us to continually improve the care we provide to patients.”

According to Tina C. Foster, MD, MPH, MS, an OB/GYN specialist at DHMC who serves on the operations committee for the website project. “Our focus has been to provide honest, accurate, and timely data to our patients, their families and the public—in a way that is educational and provides resources—to help them make more informed decisions about their health care.”

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George T. Blike, MD, is the Medical Director of DHMC’s Office of Patient Safety.

responding early, saving lives

SPECIALIZED TEAMS READY TO RESPOND

Kelly Vincent had a feeling that something wasn’t right with her 10-year-old son, Ian, the day before that snowy morning one April. “He’d had a respiratory infection for a few days and his symptoms had gotten worse, so I’d made an appointment for him at the Pediatric Clinic at DHMC,” recalls Vincent, an RN in DHMC’s Post-Anesthesia Care Unit.

When the Vincents arrived, the Pediatric nursing staff quickly assessed Ian’s condition and activated Pedi HERT (Hitchcock Early Response Team). Though he had no history of asthma, Ian was suffering from a life-threatening asthma attack. Working in concert with the pediatric nurses, the HERT team placed him on a nebulizer, administering continuous medication to open his airway, and rushed him to the Pediatric Intensive Care Unit (PICU). While en route, they called ahead to have helium waiting to further aid Ian’s breathing.

“The rapid response team’s efforts saved him from going into respiratory failure and from having to be intubated,” says Vincent. “He spent two nights in the PICU and recovered quickly. Today, he has very minimal effects from his asthma—he’s a healthy, active kid.”

DHMC first began looking into the rapid response team concept in 2004, before it became popular nationally. At that time, review of DHMC data demonstrated that nearly half of patients who had cardiac arrests had signs and symptoms of something going wrong long before they actually had the arrest. “Hospitalized patients who suffer cardiopulmonary arrest have always had a very high mortality rate,” says Stephen Surgenor, MD, Chief of Critical Care Medicine. “We realized that deploying a rapid response team had potential to prevent some of those deaths.”

DHMC launched adult and pediatric HERT programs in 2006, helping to reduce our annual number of “codes” by more than half in two years. The HERT teams are trained to recognize problems, and assist communication and planning when a problem is detected. “Activating HERT early and often is the key to helping our gains and continuing to improve,” says Surgenor. “Research is telling us that the more these teams are called, the better the outcomes are for our patients. We’d prefer several activations that end up ‘false alarms’ rather than fail to rescue one patient that goes on to code.”

Above, HERT team members Tina Smith, RCP, and David Fedor, DO, respond to a call, and below, assist Sam Strong, RN, in stabilizing a patient.

When we look honestly at the gap in quality between what’s currently happening in medicine and what’s possible, it’s much larger than we thought. But therein lies the exciting opportunity. We now have the science we need—as well as the experience gained from creating pockets of excellence—to close that gap.”
Attract and Engage Others

Build essential partnerships and convene group and community resources at the local, regional and national levels to achieve our vision.
Helping to spearhead this effort was a highly successful public education program offered last year by the Dartmouth Community Medical School (DCMS) entitled, “The New Thinking About Aging.” More than 750 members of the public participated in the eight-week programs, held in Hanover, Lebanon and Manchester and led by faculty from our institutions and other community leaders and physicians. “Our sessions included presentations on new advances in geriatrics and successful aging, interactive panel discussions about healthcare options and resources for families, and forums on designing senior-friendly communities,” says Donald L. St. Germain, MD, who as Director of the DCMS curriculum developed the program along with Dr. Stephen Bartels and other faculty at Dartmouth’s Center for Aging. “In our community forum events, participants lent their ideas to our planning efforts and those of other institutions involved in eldercare programs in the region.”

For the first time, in addition to holding its spring series on Tuesday evenings on the DMS campus, the DCMS program held sessions at the Lebanon Senior Center on Saturday mornings. “It proved to be a wonderful venue that helped us to reach a broader, more diverse audience,” says St. Germain. “As part of the program, we also featured the ‘Young @ Hearts Chorus,’ an internationally known group of primarily 80-year-olds who showed everyone an inspiring facet of aging.”

“We’re very pleased with how well the program was received and that so many others share our commitment to provide exceptional care to older adults and their families,” he adds. “It was a wonderful example of the growing public recognition that we’ve all got to work together to support a healthy aging environment in the future.”

“By 2030, the number of people age 65 and older in the U.S. is expected to swell to 71 million and comprise 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.

In anticipation of this demographic shift, a geriatrics initiative has been underway over the past three years—involving a collaborative effort between Dartmouth-Hitchcock, Dartmouth Medical School (DMS), local providers, and the community—that is focused on raising awareness and planning for programs that will increase medical center and regional capacity to care for older adults.

Power of Many
Dartmouth Medical Community Reaches Out

Attracting and engaging others is the catalyst—and the fun part—of academic medicine. Growing programs, providing new services, listening to and learning from the expertise of others, enhancing connections that lead to innovations in care and expansion of knowledge. These synergies provide the core energy that drives improvement in care.”

“...”

Lyn F. Butterly, MD, Director of Colorectal Screening at DHMC, has served as Chair of the New Hampshire Comprehensive Cancer Collaboration (CCC) since its inception in 2003. The CCC is comprised of hundreds of individuals and organizations from all over the state who are volunteering their time and expertise in a focused effort to reduce the incidence and effects of cancer on all New Hampshire residents.
Create Systems that Work
Establish a population based healthcare system supported by technology and processes that improve health outcomes, efficiency, access and continuity.
reshaping health care

BEST PRACTICES AT THE DARTMOUTH INSTITUTE

How well do medical procedures actually work?
How are healthcare resources distributed and used? How do patients value medical interventions and their consequences? These are some of the thought-provoking and important questions that Epidemiologist and Health Services researcher John E. “Jack” Wennberg, MD, MPH, and his colleagues at The Dartmouth Institute for Health Policy and Clinical Practice (TDI, formerly the Center for the Evaluative Clinical Sciences) at Dartmouth Medical School (DHMC) have been asking and providing answers to for nearly two decades.

Known for his pioneering work in evaluating medical practice and promoting patient involvement in healthcare decisions, Wennberg founded what is now the Institute in 1989. Over the years, he recruited a team of internationally-recognized researchers and practitioners—from disciplines as diverse as economics, sociology, and psychology—who helped build it into one of the preeminent institutions in the field of health service research, education, and the reform of clinical practice.

When Wennberg stepped down as Director of CECS last July, he handed over the reins of leadership to a former student and close colleague who is one of the most highly respected physician researchers in the world—Dr. James O’Connor, PhD, ScD, Associate Dean, Dartmouth Medical School.

“The work that Jack has pioneered along with many brilliant and accomplished colleagues is now being recognized and heeded,” says Weinstein. “As a result, we have been presented with an unprecedented opportunity to change the delivery of care for our nation. Whether it’s in helping to improve healthcare practice, promoting shared decision-making to foster patient choice and satisfaction, sharing knowledge gained through research and professional study, or influencing healthcare policy—we will continue to ask, ‘How can we make health care continually better?’”

Working in an enhanced collaboration with DHMC, The Dartmouth Institute will focus on taking “best of class” programs—in medical practice evaluation, patient informed choice, healthcare improvement and quality leadership development, and post-graduate/undergraduate education in the clinical evaluative sciences—to the next level of widespread application. The Institute’s new home will be part of the C. Everett Koop Medical Science Complex.

TDI students have the opportunity to learn about the evaluative clinical sciences from national leaders like James N. Weinstein, DO, Professor and Chairman of the Department of Orthopaedic Surgery for DMS and Dartmouth-Hitchcock Medical Center (DHMC). With the strong support and backing from DHMC and Dartmouth College leaders, Weinstein reorganized CECS into the Institute.

for the benefit of patients
SUPERIOR PAIN CONTROL, FASTER DISCHARGES, HIGHER PATIENT SATISFACTION

At DHMC, anesthesiologists have radically changed the effectiveness of performing nerve blocks and can now offer patients a virtually pain-free experience for complex procedures such as ankle/foot reconstruction, shoulder surgery and hand surgery.

“Using advanced ultrasound imaging, we’re able to guide the needle to the exact spot where we need to be and deposit local anesthetic around the nerve in a consistent and safe fashion,” explains Brian D. Sites, MD, Director of Regional and Orthopaedic Anesthesia.

The DHMC approach offers dramatic improvements over previous techniques. “In the past, we had to use the needle positioning on anatomical landmarks that were variable,” he says. “There were multiple needle pokes, which caused discomfort for patients, and the blocks frequently failed. Now, our success rate is above 90%.”

The advantages of regional nerve blocks are well documented and include superior pain control (reducing the need for IV narcotics which cause side effects), faster discharge from the hospital, and higher patient satisfaction.

“Knowing how effectively nerve blocks are performed here gave me added confidence about undergoing surgery,” says Samuel Bakhoum, a medical student at Dartmouth Medical School who recently had ACL reconstruction knee surgery following a soccer injury. “The block worked very well and lasted for about 24 hours after surgery. It kept me comfortable when I left the hospital and it allowed me to start my physical therapy right away. Being able to recover quickly and resume an active lifestyle was very important to me.”

DHMC, which performs between 2,500 and 3,000 ultrasound-guided nerve blocks per year, has been a pioneer in perfecting the technique and is one of only a few centers nationally to offer a fellowship program dedicated to ultrasound-guided regional anesthesia.

“We now have a dedicated six-bed, fully-equipped block area which is staffed by a team of specially trained nurses, physicians, fellows and residents,” says Sites. “We’ve been able to create a very efficient process that works seamlessly for both patients and providers that will ultimately become a new standard of care.”

Brian D. Sites, MD, Director of Regional and Orthopaedic Anesthesia, has led efforts to perfect ultrasound-guided nerve blocks at DHMC, which offer superior pain control, faster discharge from the hospital, and higher patient satisfaction.

As health care is evolving, we’re seeing greater specialization, more complexity, and a major infusion of technology that can provide the tools we need to become more efficient and to continually improve care. Creating systems that work will allow us to best meet the unique and changing needs of the population of patients we serve.”

Michael B. Sparks, MD, is the Director of Perioperative Services at DHMC.
Build an Empowering Culture
Enable people to attain ever-increasing levels of excellence by establishing environments of continuous learning and accountability.
How does an organization create a “culture of health” that actively encourages employees to make positive lifestyle changes? “It involves not only providing the resources individuals need to improve their health, but also an empowering environment that supports those kinds of changes,” explains Robert K. McLellan, MD, MPH, Medical Director, DHMC Employee Health and Safety.

McLellan and his colleagues have been working towards that goal since DHMC received a multi-year grant from the Centers for Disease Control in 2003 as part of the Health Care Worker Health Promotion (HCWHP) project. The effort has included campus-wide screenings, education classes, and promotion of existing disease prevention programs, as well as the addition of an on-site exercise room, healthier cafeteria menu options, and a 100 percent smoking cessation benefit. The project has yielded some positive results to date. “We identified a number of employees who were at higher risk for cardiovascular disease, diabetes, and hypertension, and have helped many to sustain significant improvements in key health measures,” says Marion Cate, Director of DHMC’s Health Improvement Program (HIP). “Participants report improved productivity and overall participation in our programs has grown up nearly 34 percent.”

Last May, HIP received an Outstanding Achievement Award from the Governor’s Council on Physical Activity and Health for efforts to improve the health of employees, their families, and the community. The program is part of a broader strategic effort underway at Dartmouth-Hitchcock to promote a healthier workforce as one way to support the organization’s vision to achieve the healthiest population possible. Related initiatives include the creation of a Population and Health Management Task Force whose focus includes employee health; the completion of a new 2008 benefit plan by the Benefits Work Group that provides an affordable set of benefits focusing on the health and wellness of employees; and an organization-wide effort to make DHMC’s Lebanon campus tobacco-free by July, 2008.

“The unique opportunity we have to significantly improve the health of our region starts ‘at home’ with our own employees and their families,” says Nancy Formella, MSN, RN, President of Mary Hitchcock Memorial Hospital. “As each of us takes steps to become healthier, it will not only help to ensure that we continue to provide the highest quality care possible, it will also show our patients that we practice what we preach.”

Raising the Bar

When Tracey Rapp was hired in 2005 to become the new manager for Central Sterile Reprocessing (CSR)—a 24/7 operation responsible for cleaning, disinfecting, and sterilizing all reusable instruments in the medical center—staff morale was low.

“The lines of dirty case carts and instruments used to get backed up and we didn’t have a consistent process for handling our workflow, any breakdowns that might occur, or for training new staff,” recalls Alan DuBeau, a six-year veteran of CSR who is now second-shift supervisor. “We always got the job done, but the work was often grueling and thankless.”

As soon as she arrived, Rapp—who has 30-year career in health care has included working in ORs, trauma centers, medical sales, and the military as a naval hospital corpsman—began applying her experience and leadership skills to bring a new structure and atmosphere to the department. She focused on directly involving staff in problem-solving and decision-making, infusing them with a new sense of ownership and empowerment.

She also worked tirelessly to build relationships with perioperative and clinical staff outside of CSR, making possible through collaboration many evidence-based changes for enhancing the quality and safety of patient care.

As a result, Rapp and her staff have created an environment for rapid process improvement and transformed CSR into a model department for the entire organization. “While we don’t physically touch the patient, our efforts have a direct impact on the quality and safety of the care that is provided here, and we take that responsibility very seriously,” she says.

“But without the buy-in from my staff and their willingness to do things differently, the many progressive partnerships from other areas, and the strong support from leadership we wouldn’t have been able to accomplish what we have to date.

“I think together, we’ve demonstrated that when we collaborate we are very powerful, and there’s really no barrier to making us the best of the best. Our patients deserve nothing less.”
GOAL

Practice Careful Stewardship
Steadfast dedication to create the highest value given the resources available.
Reducing our ecological footprint

Reconciled for Environmental Leadership

With its reliance on rapidly advancing technologies, high energy consumption, and trend toward disposability of supplies and devices, health care is leaving one of the largest “ecological footprints” of any industry.

“We have a materials usage industry and we’re dependent upon manufacturing, transportation, and other processes that not only cause damage to the environment but also, ironically, compromise human health,” says John Leigh, Manager of Waste and Recycling Programs.

“We’re challenged above and beyond where other businesses might be when it comes to reducing the amount of resources that go into the services we provide.”

In recognition of this dilemma, DHMC has been focusing on environmental sustainability for a number of years and has become a leader in greening the healthcare industry. “Protecting the health of our environment is a critical part of protecting the health of the communities we serve, and we have a responsibility to practice careful stewardship,” says Gail Dahlstrom, Vice-President of Facilities Management. “Because of this, we’re committed to continually decreasing our environmental impact which will make DHMC safer and healthier for our patients, staff, and community, and the environment.”

In 2007, DHMC earned two prestigious environmental awards for its efforts. In May, it received (for the fourth time in five years) the national “Environmental Leadership Award” from Hospitals for a Healthy Environment for the significant progress it continues to make in areas such as waste management, recycling, and source reduction. For example, DHMC cut the amount of cardboard waste it generates by 35% last year, and was one of the first hospitals in the country to utilize reusable plastic sharps containers.

In October, DHMC was recognized by New Hampshire Governor John Lynch for achieving excellence in energy efficiency through its partnership with National Grid, an international energy delivery company. DHMC saves an estimated 2 million kilowatt hours a year through initiatives that include innovative building design, compact fluorescent lighting, and programmable heating and cooling systems.

“There is a real sense of shared responsibility here,” says Leigh. “People realize that it’s the small things we can all do each day in contributing to this important ideal that are going to ensure long-term success.”

Maximizing our value

Responsible for Fiscal Stewardship

In today’s healthcare environment, academic medical centers face a unique set of challenges. They are charged with meeting multi-faceted missions that include providing quality patient care, educating tomorrow’s clinicians, and contributing to research efforts to advance medicine. As tertiary centers responsible for caring for the sickest and most complex patients, they need to attract highly-skilled physicians, nurses and clinical staff while investing in the latest medical technologies.

Yet, they must accomplish these things at a time when the numbers of uninsured are growing, healthcare costs are continuing to rise, and reimbursements from payors such as Medicare and Medicaid have leveled off.

Despite these challenges, Dartmouth-Hitchcock has continued to maintain a position of financial strength and stability and closed the 2007 Fiscal Year accomplishing a key organizational goal. “We set out to improve our overall financial performance over Fiscal Year 2006 and we achieved that, producing a positive operating margin of $17 million,” says Daniel P. Jantzen, Chief Financial Officer of Dartmouth-Hitchcock. “As a result, we were able to take those resources and make some significant investments that we haven’t been able to make in the past.”

As a growing, vibrant organization, Dartmouth-Hitchcock recognizes that strong financial performance is critical to the long-term fulfillment of its patient care, teaching, research, and community service missions. “That’s why it’s so important for us to practice careful fiscal stewardship,” Jantzen says. “I think we’ve done a good job historically of managing our costs in a way that has been consistent with the growth we’ve experienced.”

This will be even more important in the future, as resources become more constrained and the aging population places a greater demand on Dartmouth-Hitchcock’s services. “We have a responsibility to help control the costs of health care, and through our strategic planning efforts we’re focused on finding ways to become more efficient in how we deliver care,” says Jantzen. “Being careful stewards of our resources and staying focused on quality will help us to ensure that we are maximizing the value of our services that we provide to our patients and our communities.”

Practicing careful fiscal stewardship is critical to the long-term fulfillment of Dartmouth-Hitchcock’s patient care, teaching, research, and community service missions, says Daniel P. Jantzen, Chief Financial Officer. “I think we’ve done a good job historically of managing our costs in a way that has been consistent with the growth we’ve experienced,” he says.
peter and susan williamson

$20M GIFT ADVANCES VISION FOR THE FUTURE

In a magnanimous gesture intended to inspire others to make record-breaking gifts, Dr. Peter D. Williamson and his wife, Susan, of Lyme, NH, made a $20 million gift commitment to Dartmouth Medical School and Dartmouth-Hitchcock Medical Center in 2007. Dr. Williamson is Chair of the Transforming Medicine Campaign. The commitment from the Williamsons is the largest ever to the Medical School or the Medical Center and will support facilities projects that are high priorities within the Campaign.

“Susan and I believe in the excellence of Dartmouth medicine and its ability to truly transform medicine. We feel this is exactly the right time to make a contribution of this magnitude to support the academic mission of DMS and hope this will inspire others to contribute as well. This is a record... and records are meant to be broken!”

Peter Williamson, MD, Director, DHMC Epilepsy Program

In recognition of their landmark gift, the Boards of the Hospital/Clinic, Medical School, and College voted to name the translational research building that will be part of the C. Everett Koop Medical Science Complex in honor of the Williamsons. The Peter and Susan Williamson Translational Research Building on DHMC’s Lebanon campus will house research scientists, clinicians, medical students, and others engaged in innovative collaborative research in cardiology, the neurosciences, and immunology.

Dr. Williamson believes that investing now in academic medicine and translational research is critical to the future of the Medical School and DHMC: “We must make this investment in our future, so we can continue to meet the challenges and expand our knowledge and our ability to care for patients. This is a pivotal moment for Dartmouth medicine and we are thrilled to be part of its future. The academic medical mission is every bit as important as the clinical mission. The research and teaching allows us to deliver the very best care we are able to for patients.”

Dr. Williamson is a world-renowned neurologist known for his pioneering work in epilepsy. A 1958 graduate of Dartmouth College, he returned to Hanover in 1969 to establish and lead the Dartmouth-Hitchcock Comprehensive Epilepsy Center, building it into a nationally and internationally-recognized program. Under his leadership, the National Institutes of Health has designated the Center one of the nation’s top epilepsy referral centers.

Susan Kettering Williamson is a 1959 graduate of Skidmore College in Saratoga Springs, NY. She has served on Skidmore’s Board of Trustees since 1973, and she received the Denis B. Kemball-Cook award for exemplary service at Skidmore. She received an honorary Doctor of Humane Letters in 1998 from Skidmore, and in 1999, the Surrey Williamson Inn on the Skidmore campus was named in her honor. Mrs. Williamson is also a volunteer at David’s House, a home-away-from-home for children receiving treatment through Children’s Hospital at Dartmouth, and she has served on the David’s House board.

“Susan and I believe in the excellence of Dartmouth medicine and its ability to truly transform medicine,” explains Dr. Williamson. “We feel this is exactly the right time to make a contribution of this magnitude to support the academic mission of DMS and hope this will inspire others to contribute as well. This is a record... and records are meant to be broken!”

Dartmouth College President James Wright recognized the Williamsons at DHMC’s Annual Donor Appreciation Reception in September, where the gift was announced. “Peter Williamson has committed himself to Dartmouth medicine since day one, from serving as one of the founding members of the Medical School’s Board of Overseers, to arranging for the first $1 million commitment to the school, to establishing a world class epilepsy center at the Medical Center, to chairing the Transforming Medicine Campaign. Susan Williamson has been a full partner in the family’s philanthropic work at Dartmouth, in the local community, and more broadly,” said President Wright. “Peter and Susan’s latest generosity will have enormous impact for generations. This is a transformational gift for Dartmouth medicine and accelerates our ability to advance knowledge quickly and for the benefit of us all.”

The extraordinary generosity of the Williamsons, and many others since the Campaign’s launch in 2005, has helped to propel the Transforming Medicine Campaign to within $55 million of its $250 million goal, through December 2007.
2007 was distinguished by the extraordinary breadth and depth of support for Dartmouth-Hitchcock Medical Center and Dartmouth Medical School on the part of our growing philanthropic community. An unprecedented 28,000 donors made gift commitments totaling more than $65 million to the Transforming Medicine Campaign during calendar year 2007. The year was also marked by a leadership gift commitment of $20 million—the largest-ever single gift to the Medical School or the Medical Center. Large and small, these gifts brought us to within reach of our $195 million goal at year end, putting us on track to exceed our target by $10 million within three years.

We deeply appreciate all of our donors—patients, community members, faculty, staff, alumni, friends, and foundation partners—for your generosity and our confidence in our future for the philanthropic support is felt throughout our medical enterprise and beyond. Every gift, whether $20 or $20 million, is an investment in our ability to advance patient care, medical education, and scientific research—and in doing so to transform medicine.

On these pages, we respectfully recognize those donors whose gifts totaled $1,000 or more in calendar year 2007.

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The Dartmouth-Hitchcock Medical Center Fund

Alston, Laboratories
Acme, Inc.
Alder, Inc.
Alois, Inc.
Amnion, Inc.
AmeriCorps, Inc.
Amborella, Inc.
Abbott Laboratories
Acme, Inc.
Alder, Inc.
Alois, Inc.
Amnion, Inc.
AmeriCorps, Inc.

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heart of our mission

As an academic medical center, Dartmouth-Hitchcock is uniquely positioned to be a leader in partnering with communities to serve us to promote well-being, prevent illness and remove barriers that hinder access to health care. Our new vision—to achieve the healthiest population possible, lead the transformation of health care in our region and setting the standard for our community—will serve as a catalyst for taking that commitment to an even higher level.

Charitable care and community health improvement have always been at the center of Dartmouth-Hitchcock’s mission. We provide a wide array of community benefits, including free and reduced cost medical care, professional training for healthcare providers, partnerships with community organizations, and residents to plan and develop resources to long-term and emerging healthcare needs such as substance abuse, and health care to meet the needs of an aging population. While the value of Dartmouth-Hitchcock’s community’s 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:

- The total value of community benefits provided by Dartmouth-Hitchcock in Fiscal Year 2007 was $87.4 million.

- Since we believe that a person’s financial situation should never determine whether or not they receive adequate medical care, we provided a total of $102.2 million in direct financial assistance to more than 13,000 people in our region to ensure they got the medical care they needed.

- Dartmouth-Hitchcock absorbed $42.7 million in uncompensated costs for providing medical care to more than 15,000 Medicaid patients, from both Vermont and New Hampshire.

- We provided more than $134.4 million in uncompensated teaching time and uncompensated teaching time to teach medical students, residents, uncompensated time to teach medical students of medicine and other health professions, and uncompensated time to provide continuing education for healthcare professionals.

Financial Assistance to Patients

Patients Receiving Financial Assistance

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper Valley and North Country</td>
<td>6,807</td>
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<tr>
<td>Total</td>
<td>13,594</td>
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</table>

Cost of Financial Assistance $20.2 million

Trends in Patient Financial Assistance (dollars in millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>15.2</td>
</tr>
<tr>
<td>2005</td>
<td>16.5</td>
</tr>
<tr>
<td>2006</td>
<td>17.0</td>
</tr>
<tr>
<td>2007</td>
<td>20.2</td>
</tr>
</tbody>
</table>

Value of FY 2007 Community Benefits at Cost

Uncompensated Medicaid

Cost of Financial Assistance to Patients

Support for Medical & Other Professional Education* $13,463,926

Cost of Financial Assistance

In-kind Support for Research & Other Grants $2,890,455

All Other Community Health Activities 8,021,378

Total FY 2007 Community Benefits Value $87,396,457

*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.
### Operating Expenditures (000s omitted)

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dartmouth Medical School</td>
<td>$259,335</td>
<td>$203,198</td>
</tr>
<tr>
<td>Dartmouth-Hitchcock</td>
<td>$96,765</td>
<td>$92,850</td>
</tr>
<tr>
<td>Veterans Affairs Medical Center</td>
<td>$123,847</td>
<td>$110,535</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$1,304,267</td>
<td>$1,286,333</td>
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### Revenue Sources (000s omitted)

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<thead>
<tr>
<th></th>
<th>2007</th>
<th>2006</th>
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<tbody>
<tr>
<td>Payment for Patient services</td>
<td>$12,156</td>
<td>$9,272,841</td>
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<tr>
<td>from third Parties</td>
<td></td>
<td></td>
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<tr>
<td>Federal Budgets for Veterans Affairs services</td>
<td>$119,928</td>
<td>$119,928</td>
</tr>
<tr>
<td>Funded Research</td>
<td>$126,804</td>
<td>3,919</td>
</tr>
<tr>
<td>Tuition Income and Fees</td>
<td>$18,448</td>
<td>18,448</td>
</tr>
<tr>
<td>Gifts, Bequests and Endowments</td>
<td>$20,665</td>
<td>$40,709</td>
</tr>
<tr>
<td>Other Income</td>
<td>$28,128</td>
<td>56,978</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$206,201</td>
<td>$1,024,948</td>
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### Operating Expenditures (000s omitted)

<table>
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<tr>
<td>Dartmouth Medical School</td>
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<td>$203,198</td>
</tr>
<tr>
<td>Dartmouth-Hitchcock</td>
<td>$96,765</td>
<td>$92,850</td>
</tr>
<tr>
<td>Veterans Affairs Medical Center</td>
<td>$123,847</td>
<td>$110,535</td>
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<tr>
<td><strong>Total</strong></td>
<td>$1,302,747</td>
<td>$1,226,333</td>
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### Revenue Sources (000s omitted)

<table>
<thead>
<tr>
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<th>2006</th>
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<tbody>
<tr>
<td>Payment for Patient services</td>
<td>$939,417</td>
<td>$878,999</td>
</tr>
<tr>
<td>from third Parties and Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal Budgets for Veterans Affairs services</td>
<td>119,928</td>
<td>119,928</td>
</tr>
<tr>
<td>Funded Research</td>
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<td>3,919</td>
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<td>Gifts, Bequests and Endowments</td>
<td>20,665</td>
<td>40,709</td>
</tr>
<tr>
<td>Other Income</td>
<td>28,128</td>
<td>56,978</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$1,354,996</td>
<td>$1,242,330</td>
</tr>
</tbody>
</table>

### Selected Financial Information

- **44 45**
### Operational and Patient Report

**2007** vs **2006**

#### Patients Discharged
- **New Hampshire**: 12,290 vs 11,548
- **Vermont**: 9,228 vs 9,030
- **Other States**: 1,063 vs 1,015
- **Total**: 22,581 vs 21,593

#### Current Operations
- **Unrestricted and Annual Funds**: 1,710,611 vs 1,639,882
- **Restricted Funds**: 17,327,734 vs 15,044,055
- **Total Current Operations**: 19,038,345 vs 16,683,937

#### Endowment
- **Total Endowment**: 9,461,853 vs 6,585,937

#### Plant and Equipment
- **Total Plant and Equipment**: 567,385 vs 4,743,012

---

**Outpatient Visits**

<table>
<thead>
<tr>
<th>Region</th>
<th>2007</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Region</td>
<td>462,262</td>
<td>443,609</td>
</tr>
<tr>
<td>Lebanon</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Community Practices**

<table>
<thead>
<tr>
<th>Location</th>
<th>2007</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concord Offices</td>
<td>183721</td>
<td>177750</td>
</tr>
<tr>
<td>Manchester Offices</td>
<td>354229</td>
<td>344885</td>
</tr>
<tr>
<td>Nashua Offices</td>
<td>208664</td>
<td>221318</td>
</tr>
<tr>
<td>Keene Offices</td>
<td>333980</td>
<td>349319</td>
</tr>
<tr>
<td>Other</td>
<td>123217</td>
<td>125715</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>1,259,761</td>
<td>1,243,987</td>
</tr>
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</table>

**Total**: 1,672,023 vs 1,699,596

---

**Dartmouth Medical School**

<table>
<thead>
<tr>
<th>Department</th>
<th>2007</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans Affairs Medical Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients Discharged</td>
<td>2,429</td>
<td>2,566</td>
</tr>
<tr>
<td>Patient Days of Service</td>
<td>14,465</td>
<td>15,269</td>
</tr>
<tr>
<td>Average Daily Census</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td>Operations Performed</td>
<td>2,429</td>
<td>2,566</td>
</tr>
<tr>
<td>Outpatient Visits</td>
<td>179,253</td>
<td>173,985</td>
</tr>
<tr>
<td>Same Day Procedures</td>
<td>4,623</td>
<td>4,611</td>
</tr>
<tr>
<td>Home Health Visits</td>
<td>3,004</td>
<td>3,144</td>
</tr>
<tr>
<td>Volunteer Hours</td>
<td>58,117</td>
<td>58,151</td>
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</table>

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**DHMC Philanthropic Contributions**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Contributions (in dollars)</th>
<th>Dartmouth-Hitchcock</th>
<th>Dartmouth Medical School</th>
<th>Veterans Affairs Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>29,067,583</td>
<td>6,620</td>
<td>1,077</td>
<td>895</td>
</tr>
<tr>
<td>2006</td>
<td>28,012,905</td>
<td>6,414</td>
<td>1,105</td>
<td>649</td>
</tr>
</tbody>
</table>
MARY HITCHCOCK MEMORIAL HOSPITAL
AND DARTMOUTH-HITCHCOCK CLINIC
2007 BOARDS OF TRUSTEES

Emily R. Baker, MD
Trustee, Dartmouth-Hitchcock Clinic
Lahaina, HI

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Board Vice-Chair
Dartmouth-Hitchcock Clinic
Trustee, Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital
Concord, NH

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Trustee, Dartmouth-Hitchcock Alliance
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Trustee, Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital
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Alfred L. Griggs
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Trustee, Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital
Northampton, MA

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Board Treasurer, Mary Hitchcock Memorial Hospital
Trustee, Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital
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Hanover, NH

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Hugh C. Smith, MD
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Rochester, NH

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Dean, Dartmouth Medical School
Trustee, Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital
Hanover, NH

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President, Dartmouth-Hitchcock Medical Center
Trustee, Mary Hitchcock Memorial Hospital
Port Washington, WI

Diana J. Weaver
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Vermont, VT

William W. Wyman
President, Dartmouth Medical School
Hanover, NH

Barry P. Scherr, PhD
President, Dartmouth College
Hanover, NH

Stephan P. Spielberg, MD, PhD
Dean, Dartmouth Medical School
Vice President for Health Affairs
Dartmouth College
Hanover, NH

James W. Wright, PhD
President, Dartmouth College
Hanover, NH

Oglesby H. Young III, MD
Alumni Council Representative
Concord, NH

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