INDEPENDENT MONITOR
— MISSION HEALTH SYSTEM —

The following is a transcript of the community Webinar conducted by Gibbins Advisors, the Independent Monitor for Mission Health System, on April 7th, 2021

[00:00:00] Ronald Winters: Good afternoon, good evening, everyone. Welcome to the webinar for the Independent Monitor for Mission Health. My name is Ron Winters. I'm a principal of Gibbins Advisors. Gibbins Advisors is the independent monitor. Our firm is a professional services consulting firm, we work exclusively in health care. We specialize in community hospitals, both urban and rural. Before I review the agenda and then get into the heart of the presentation, I'd like to introduce our team.

We have five professionals from Gibbins Advisors working on this now. The people speaking today are the ones on the screen now. In addition to the five of us, we have a team of others who work with us, who specialize in media and logistics, also very helpful to our work. Let's talk about this page first. Clare Moylan, I mentioned myself I'm a principal of the firm, the guy at the left. Clare Moylan at right, she's the co-founder of our firm and a principal of our firm.

She leads the service design and engagement planning for our work on the independent monitor engagement. Tom Urban's at center. We're going to discuss a little bit more about Tom when we get to the part on our independence. I'll just summarize and say Tom is not a consultant. He's had a career of 40 plus years in health care, executive management, most of which was with the Mercy at the Mercy health system in Cincinnati. We can go to the next slide.

The other two members of the team are Ginger Smith and Brad Williams. The two principal reports that we get each year and evaluate and review for the parties that we report to are the annual report in the CapEx report. Ginger manages all aspects of the Cap-- We all help each other in this engagement but Ginger manages all aspects of the CapEx report, and Brad manage the aspects of the annual report. They're on our team, also, they're both accountants with many years of experience in health care.

Let's go to the next slide and we'll talk a little bit about the agenda this evening. The first part of the program is we're going to go through a slideshow presentation that we're doing now, those of you who came to the community meetings last year, this will look fairly familiar, we use that as a base and try to enhance a little bit. The second part will be a Q&A from you. We think our part of the presentation should take about 45 minutes.

We had planned for this presentation to go an hour and a half in total, but we're willing to go beyond that if we have questions to respond to. Let me talk a little bit about our side of the presentation. First, part one. I'm going to explain a little bit about the advisory boards and Dogwood and our role and how it all fits together. I'll also go through our independence, which is very important because we regularly get questions about that.

After that Clare's going to provide you some visibility on how we work in our processes, and that will give you a sense of how you can interact with us best and

both assist us and get information to us and ask us questions. After Clare, Tom is going to review the 15 commitments HCA made as part of the purchase of mission health. After that, I'll come back and summarize the calendar from last year and all our work last year, and I'll drill down on some of the things that we heard from the community.

After that, I'm going to go and explain the calendar for this year. We're about to get another annual report and CapEx report. Then we'll finish up by showing you how to contact us and also how to contact HCA for certain things that only they can respond to. When we're done with all of that will turn to the Q&A session, which again, I'm hoping is at least half the program. From here, we'll put up on the screen one more time how to ask questions during the program here.

We'll just pause here for just a moment so everybody can see it. If you have questions to ask, you can go hit the Q&A tab at the bottom, type it in, someone on our team is looking at it, we're collating them, and we'll present them at the end. We just wait a second here and then we'll go on to the next slide.

Let's talk about the independent monitoring role. When the determination was made that HCA would acquire Mission Health in 2019 or January 2019, in an order to get the consent of the attorney general which was required because it was a for-profit hospital, business acquiring a not-for-profit. It required a series of undertakings by HCA in order to provide quality health care services to the residents of West and North Carolina on a go-forward basis.

It further required that the seller or the party receiving the sales proceeds in this case Dogwood Health Trust, enforce compliance with those 15 undertakings and the AG further required that Dogwood hire an independent monitoring system in that regard and that's what we do, we are the independent monitor. We evaluate, look at the center box, light blue box. We evaluate on an ongoing basis that HCA is upholding its commitments, its obligations.

Their annual reports each year, but they're required to comply on a continuing basis. Then we advised Dogwood and the six advisory boards and we'll go into a minute how that all hangs together on matters relating to these reports and compliance, and under certain limited circumstances, we evaluate requests and we'll modify HCAs commitments. Before we get into how it all hangs together, let's spend a moment on our independence.

This is really important because we're asked about this regularly. We touched upon this when we were at the community forums last year, but I'll go through it again now. It's very important that the public understands that we are independent of Mission and independent of HCA. We are not paid by Mission, we are not paid by HCA, we are not paid by the AG, we are paid by Dogwood Health Trust.

Now, Dogwood Health Trust as I said before is the organization that was formed to receive the bulk of the proceeds from the sale transaction. I won't speak for Dogwood's mission, you can see that on their website, but basically, Dogwood's

purpose is to improve health and wellbeing for the people in 18 counties in West and NorthCarolina and that is what they do with the proceeds that they received.

In our context, they are also required to be involved in compliance here. We're paid by the foundation, again, not by HCA, and not by Mission. There is a real distinction here between this and many other corporate monitorships. In other cases, the party being monitored pays for it, in this case, we are crystal clear there is no misalignment of incentives or duties, we are paid by Dogwood and they have nothing to do with HCA or Mission.

One other point I'll make on independence and that is some of the requirements of us as a condition to being selected in this role. It was required that one of the members of our team and in this case, it's Tom Urban, who I mentioned before has had a lengthy career in executive management in major hospital system. It was required that that person have at least a dozen years of chief executive, chief operating officer, or chief financial officer experience in a hospital with 150 beds or more, Tom meets that easily.

It was also required that Tom never have been a director, officer, employee, or consultant of HCA or any of its affiliates and he is not. It was further required that any of the other members of our team have not worked for any of those same entities related to HCA over the past five years and we meet all of those requirements. With that addressed, let's go onto the next slide, the advisory board and the seller representing Dogwood structure.

You'll see here in the green boxes, those are all of the hospitals, the five furthest to right, Angel Blue Ridge, Highlands-Cashiers, McDowell and Transylvania, those are the local hospitals, the critical access hospitals. Then Mission, the major hospital in Buncombe County in Asheville, they're just to the right of Dogwood. Let's talk about how it all hangs together. We go to the next slide.

As I mentioned before, in addition to all of the important charitable work that Dogwood does with the proceeds from the sale, it is also required to monitor and enforce compliance with HCA's commitments. The advisory boards and there are advisory boards for each of the hospitals. They are eight members, half of them have been appointed by HCA. The other half were either appointed by-- In the case of Asheville, they're appointed by Dogwood. In the case of all the others, they were appointed by the board of the original hospitals' presale. We have the names of all of them, all of the advisory board members are on our website.

Their role is to either approve or contest modifications to HCA's commitments. They receive all the reports that we get and we speak to them and help them evaluate them and they're involved in resolving certain disputes in limited circumstances. Our role, again, is to advise Dogwood with respect to compliance and the other advisory boards with respect to their duties. In certain circumstances, our consent is necessary for certain approvals in limited set of circumstances none of which have occurred. With that out of the way, let me turn the program over to Clare and she will tell you a little bit about our work and our processes. Go on.

[00:12:08] Clare Moylan: Hello, everyone. My name is Clare. It's nice to have you all join us today. I'm going to take you through a few slides about how we actually deliver on the responsibilities that we have as the independent monitor. It can be broken down into two parts. The first part, we call our annual compliance evaluation process, then the second part relates to the activities that we undertake throughout the entire year in monitoring and evaluating HCA's compliance.

This slide here talks to the annual compliance evaluation process and all of these activities center around HCA submitting to us their annual report and their CapEx report and those reports relate to their compliance commitments and the APA. We receive those reports and review them but in addition, we get supporting documentation and evidence to substantiate that the commitments are being complied with.

We also undertake a pretty significant engagement exercise with the community, with representatives from the community, with representatives of the legislature state senators, local mayors, county representatives. We also engage closely with Dogwood Health Trust which is responsible for enforcing compliance. We have regular weekly meetings with Dogwood during this period of our evaluation which primarily takes place from the month or two before we receive the reports from HCA and that happens around the end of April, early May, through to when we need to complete our evaluation which is in around July or August.

We have a lot of activity happening through this period commencing in the last few weeks and going through until August on conducting this annual compliance. We also have a very detailed checklist of the compliance obligations and go through that in like an audit to satisfy ourselves that each and every requirement is being complied with and we deliver an evaluation report to Dogwood at the end of our review.

The next slide goes through the activities we undertake throughout the entire year in our compliance, monitoring, and evaluation. Similar to the engagement that we have specifically on the annual report and CapEx report, we're constantly engaging with the community and hearing from you via submissions through our website and email as to any feedback or concerns that you may have.

We continue our dialogues throughout the year with Mission and HCA to communicate with them around any areas of potential concern. We also check in with HCA on their intentions, with respect to the commitments, in a forward looking way, so we're not just looking back. We're looking forward. Part of our role is informing the public. You'll note, if you've taken a look at our website in the past few days, we've just released a lot of updates that provide more information and a lot of the information that we'll go through in today's presentation is now being updated, actually built into the website.

We engage with the media and answer questions, journalist questions, to make sure that the public is kept informed of our role, of our progress, and how we can be reached. How we can be contacted in case you have any information you'd like to share with us. When we can, we're also on site to take a look at the hospitals in the

communities that are served but as everybody knows with COVID the last 12 months have made that difficult but hopefully, in the next couple of months, we plan to be back on site, meeting with you all because that's one of the best things about this role is being out there and meeting the community.

Also, monitoring the media. We maintain regular monitoring of mainstream media but also social media. Click to the next slide. You might wonder what we do with the information we receive from you when we hear from you either through written letters, emails or phone calls or through that online form. By and large what we do is log everything in a central database, evaluate it against HCAs commitments and then advice Dogwood Health Trust around our evaluation.

We don't just consider direct compliance. We also consider indirect compliance but that'll come up again later in our presentation. There are two important things I'd also like to mention here. One of them is that we share the information that we receive from the public with HCA. We first redact for any personal identifiable information but we share with HCA and Mission, so that they are able to be aware of the concerns that are coming up in the community. Not everything that we hear we're actually able to resolve ourselves.

It's not necessarily within our agreement, but we share with HCA so that they can follow up any of the biggest issues. Additionally, we've recently updated our form so that you can elect to share your personal identifiable information with HCA and Mission so that specific complains or queries can be followed up by Mission or HCA. That's an election. Our normal course is to redact the personal identifiable information, but you can elect to have that shared with HCA.

The other important point here is that we endeavor and I hope we have been able to complete this already, is respond to everybody that reaches out to us with a response.

I think we can move on to the next slide. You might wonder then, if we find potential noncompliance, what's the process? What are we actually doing about it? There is a detailed process prescribed as a purchased agreement. We've simplified it for today. Where it says, "IM" that stands for independent monitor.

We would advise Dogwood Health Trust of the potential noncompliance. Dogwood Health Trust would then determine if they agreed and then notify HCA of the potential noncompliance. The parties then have an option to resolve by agreement, but if that were to fail, and they couldn't reach agreement on the dispute, there is a formal dispute resolution process that's laid out in the APA that involves arbitration or the court system depending on the nature of the dispute.

These talks about where we're looking at compliance issues. There is a different process and set of standards if HCA is seeking relief or modifications from its commitments and that's where we go back to the advisory board structure that Ron was mentioning earlier, where there are different set of approvals and consents related to modifying the commitments. I'll also note that with respect to the second

step that we've put here on Dogwood determining that there's been non-compliance or potential non-compliance and deciding to notify HCA.

There is a fail safe in the asset purchase agreement where the Attorney General has some powers to take action in the event that it disagreed with Dogwood Health Trust's determination. That's just something to bear in mind. Next slide, I'm going to turn now to Tom. He's going to take us through the 15 commitments on the HCA scope. Nothing has changed since last year in respect of the 15 commitments. They're still the same commitments, but we thought it would be helpful to do a recap of those today.

[00:20:53] Thomas Urban: All right, thank you, Clare and I'm happy to do that. Again, good afternoon, good evening to everyone joining us. As Clare just referenced, as I go through these 15 commitments that some of it will be refreshing of what some of you heard during the community forums a year ago, and some of you may be hearing this for the first time, but when one looks at the asset purchase agreement and all of the schedules and all the exhibits, it's a document that's over 3,000 pages long.

What we've done to make it more simple, that is to place the 15 commitments by mission HCA into these four categories as you see on the screen right here. Retaining services and hospitals, invest in facilities, invest in community health and wellbeing, and several other commitments that I'll review in a moment here. Regarding retaining services in hospitals.

There are four commitments included in this category.

As you can see them here on this slide, keeping the material facilities open for at least 10 years and the material facilities, no surprise and included the main Mission Hospital, the five local hospitals, Angel Blue Ridge, Highlands-Cashiers, McDowell, and Transylvania, as well as the CarePartners Rehab Hospital, and Mission Children's Hospital Outpatient Center. Continuing specified services for at least 10 years and I'm going to spend a little more time on this commitment in a moment.

Three of the local hospital advisory boards and Dogwood Health Trust have the right to bid if the hospitals are closed or sold and that should not happen for at least 10 years, and continue the long-term acute care services at St Joseph's campus for two years and that commitment has expired as of January 31st, 2021. If we move to the next slide, and this is a little more detail behind the commitment number two of retaining, in this case, protected services.

For Mission Hospital, CarePartners and Childrens, as you see on the side Mission Hospital, there are 10 clinical services that are specifically identified as protected services for the first 10 years. Included in that is also the graduate medical education program and the program for all-inclusive care of the elderly known as the PACE program. On the right side of the overhead, you see the CarePartners. We have hospital including inpatient, outpatient, rehab, as well as orthotics and prosthetics, home health, hospice and as I said, a moment ago, the pediatric specialty outpatient clinics.

This is referred to in the asset purchase agreement is 7.13[a]. When we move on to 7.13[b] that is specific to the local hospitals, and we'll move to that slide now. Five local hospitals, as you should see noted in this slide, all of them, collectively must retain emergency services, surgical services, and acute medicine services for all five of the local hospitals. In the case of Highlands-Cashiers, that includes the Eckerd Living Center, Mission McDowell includes OB-GYN and Transylvania, the Transitional Care Unit.

I think it's important to note that these services are not as specific as ones that we saw in the previous slide for Mission Hospital 7.13[a]. The services, as you see, are those specifically noted in the asset purchase agreement however, acute medicine services, surgical services and emergency services. Additionally, behind the list of these five local hospitals, is a definition of what is meant by each of these services, emergency, surgical and acute.

Part of our role is to carefully review these details and monitor whether HCA is compliant with these commitments. We just don't think about this in the form of a direct approach as Clare noted earlier. We also analyze whether HCA and certain activities that occur could result in an indirect violation of the commitments. I assure you that our review is very thorough. Moving on to the next set of commitments that are under the heading, investing in facilities.

There are also four included in this. One, as you can see is completion of the new Mission Hospital North Tower, which occurred in late 2019. Build a new 120-bed behavioral health hospital in Asheville within five years of obtaining the permits. That same requirement applies to building the replacement hospital for Angel Medical Center. Additionally, HCA is committed to spend $232 million in general capital expenditures within the five years. Part of the reporting process for Mission HCA includes a capital expenditure report that you'll hear referred to several times this afternoon.

We reviewed this closely because some capital expenditures count toward the $232 million requirement and others don't. We review this closely in our annual review and all the supporting documentation that goes along with it. Moving on to the next category is investing in community health and well being. Again, there are four commitments included in this heading. HCA is committed to providing $25 million over five years for an innovation in investment fund.

In addition, spending $750,000 per year in community contributions in years 2 through 10. That commitment just began last year and will be part of our review this year.

Certain community activities and programs were required to continue for at least 12 months and this commitment also expired January 2020. For 10 years, maintain the agreed upon uninsured and charity care policy. Thereafter, maintain policies for the treatment of indigent patients.

As Clare mentioned earlier when she talked about the annual compliance evaluation process, HCA is required to maintain the charity care policy that is labeled Exhibit C

in the asset purchase agreement. Some of you may not be aware that at the time of the transaction, the HCA's charity care policy was compared with the existing Mission Hospital Charity Care Policy. As we understand it, a determination was made that the HCA charity care policy was overall better for the community at large.

That was the charity care policy that was chosen and included in the asset purchase agreement. It's something that you'll hear a little bit about later on in our program this afternoon. In the final commitments 13 through 15, includes providing graduate medical education for 10 years. This is important given the fact that main mission is a tertiary hospital that treats many complex patients. The fact that they have committed to continue the graduate medical education program, bodes well not only for the health system but for the community at large. Educating physicians in multiple specialties, hopefully to stay and serve the community. Participating in Medicare and Medicaid programs for 10 years is fairly straightforward. As you've heard and we'll hear more about each year, Mission HCA is to provide us with an annual report, in addition to a capital expenditure report, that summarize compliance with certain terms of the agreement, primarily focused on these 15 commitments that I've just reviewed. Our work begins now as HCA is intending to submit those two reports by the end of April or early May.

Then we will read again part of the process that Clare walked us through in terms of our detailed evaluation of what they provided. With that, I will happily turn the next part of the program over to my friend and colleague, Ron Winters.

[00:30:09] Ronald: Thank you, Tom, we can go to the next slide. I want to highlight here or go through the highlights of our work last year. This timeline goes through that. The transaction and it goes a little bit before that. The transaction, as I mentioned before, closed on January 31 2019. We were hired at the end of October, 2019 and the first gauging period for compliance, the reporting period for the annual report ended the end of 2019.

Right after we were hired in October, we went out in December and saw all of the facilities and met with local hospital leadership, as well as HCAs regional leadership in Asheville. In late January and early February, we went out in two tours to hold community forums, not at the hospitals, but in the towns where the local hospitals are and met with about 600 plus people in aggregate. Then at the end of April, HCA provided to us its CapEx report and its annual report simultaneously.

We then spent May and June reviewing that work as well as soliciting input from the community and speaking to a lot of people and at the same time, engaging closely with Dogwood and the covenant compliance committee at Dogwood, to keep them up to speed on our gauging of compliance. In July, HCA amended its CapEx report slightly which resulted in a favorable benefit for the community.

They reduce the amount of money that they accredited against the $232 million five-year commitment and then in July or early August, we completed our work with respect to the annual report and the CapEx report. Since then as Clare mentioned before, we've had ongoing compliance, monitoring, engaging with the community

and so on. Last year, as I mentioned, we went to see the hospitals in December. We went to see the communities really at the beginning of February, end of January.

COVID hit five weeks later and unfortunately, we weren't able to get back out to the communities and we're very much looking forward to doing that as soon as possible, hopefully as early as May this year. We'll go to the to the next step. Here's a couple of quick metrics. As I said, we met over 600 people in the seven community meetings last year. We had about 200 people register for this webinar and aside from our engagement with the community at the community forums last year, we had 263 other encounters with folks.

As Clare mentioned before, we used all that information in doing our work, and we also channeled all of it over to HCA so that they could act on it as appropriate. Let's go to the next page and talk a little bit about here, what we heard from the community. We've put up this slide, gives you a sense of what we're hearing. We present here what we call tiles, on this page. We show the issues that came up most frequently in what we were hearing from the community, and you can see that a large number of them having gone through the list of commitments that Tom went through.

Before you can see a number of things do not fall within HCAs commitments, but in performing our role, we need to always refer to the commitments that form part of the APA and that fall under the purview of the independent monitor. In evaluating compliance with the APA, we need to take a perspective that looks at policy, implementation of policy and service implementation patterns in the mission health organization.

This is by necessity, a high-level review. Individual cases when they all add up might result in trends that we'll be able to see that give rise to non-compliance, but a single lapse is not likely to result in a breach of a commitment. Last year at the community meetings, I asked the people not to spend a lot of time trying to figure out if their concerns fall within one of the 15 commitments. we ask you to just give us everything. we'll figure out if they give rise to a concern or if they indirectly give rise to concern and we'll channel everything over to HCA as we mentioned last year.

Please continue to provide us with your comments. All of the pieces of information, as I said, are part of our compliance and evaluation and inform our view. Your feedback is very important, and as I mentioned before, it's very possible that something that is not directly a violation may give rise indirectly to a violation. It's unclear, but we won't know until we examine. With that, let me then turn to the calendar for this year, and then we'll go on to how to reach us, and then we'll go on to the Q&A.

On this page, you can see our calendar for the current year again, this is the second anniversary, about two months ago of the transaction closing. We're holding this webinar now on April 7, we expect to receive the materials from HCA at the end of the month, the annual report and the CapEx report. That's was commitment number 15 in Tom's review, and it covers the items in I think five through eight.

Again, we're going to spend May through June this year speaking to the community, speaking to leaders, and speaking to anyone who would like to speak with us, anybody on this webinar, or anybody you know who wishes to speak with us, please reach out to us, we will arrange a call with you, a meeting with you. We'll do it individually, we'll do it in groups that will help inform our view. We expect to wrap up our evaluation in late July and make a determination of what to recommend to Dogwood at that point.

Again, just as we said in the calendar last year. From there, we continue to monitor ongoing compliance between the periods of the annual reports. With that, let me then turn to how to contact us. This is how you can contact us, we have an independent monitor website, independentmonitormhs.com. You can use the QR code in the right if you'd like to capture that with your phone. You can email us at independentmonitor@gibbinsadvisors.com.

On the website, you can leave comments or questions for us on a form that's on there. That's how to reach us. Again, there's a lot of good information on there. Clare mentioned before, we have just updated the website and we hope you'll go on there and spend some time. We think you'll find it useful. Next one, we also have just established a LinkedIn page for those of you who are LinkedIn users. It is the independent monitor for mission health system.

We're going to post much of what we post on the website on the LinkedIn page and if you are following us on LinkedIn, we urge you to hit the follow button and follow us. I think each time that we add something, it will be pushed to you and you'll get some notification by email presumably. If you are a LinkedIn user, please follow us on LinkedIn.

Lastly, before we turn to the Q&A, this is an email address that we received from HCA.[contactmission@HCAHealthcare.com]

We asked them if they'd like us to put up their ways that they can be reached so they can help people directly. One of the things that came up fairly recently in one of our conversations with the folks at HCA, when we have given them information that we've gotten from the community, they said it would be helpful if you gave us their contact information so that we can do something about and address it with them.

As Clare mentioned before, we recently changed our form so that people can opt to have us disclose their personal information to HCA but if you wish to speak to HCA directly, that's also fine, this is a special email address that they've set up for just this purpose. With that, we'll pause. I think we lived within our 45 minutes, notwithstanding our unfavorable rehearsal last night. We'll turn this over to the Q&A. I think Clare will moderate that.

[00:39:24] Clare: Thanks, Ron. We have received numerous questions, some really good questions during the webinar, and also, prior to the webinar, we received some questions that people submitted by email. What I'm trying to do is aggregate the questions and group them by theme. There are so many questions that in the time today, we won't be able to get through all of them, but we'd like to try and cover all of

the key things so that at least if you don't get a response to your specific question, in this meeting, you'll get an understanding of our own general response to that issue that comes up in different ways and in different questions.

Now, you'll appreciate from what Tom said earlier that the APA is 3,000 pages long. In case questions come up, and I've seen some questions just come up during the presentation. If they come up, and we don't have the answer for you during this meeting, please be patient that will take it offline and follow it up offline and get back to you directly or include it in an FAQ that we'll post on our website because we want to make sure that that we are able to be accurate and given the complexity of the APA, there are a lot of details in there that we have to navigate.

We might not be able to answer all the questions during today's meeting but thank you for submitting the questions and we'll get back to you offline. Now for all of them. We've got a lot that we can't answer today. I'll start off a couple of questions that have come in around the future of the hospitals, particularly the local hospitals. For example, question, do we have any assurances that HCA will keep regional satellite hospitals open at the end of a 10-year agreement and another question, is there any chance Pardee could take over Transylvania Regional Hospital? Ron, maybe you can address that question around the potential sale or takeover of the hospitals by other systems?

[00:42:03] Ronald: Sure. I think there are specific--I hadn't been really thinking beyond 10 years at this point, but I think there are requirements after 10 years, at least with respect to Mission Hospital to my recollection. Responding to the question on party, somebody had asked, can Pardee take over Transylvania hospital? I'm not completely sure, It was a one-line inquiry. I'm not completely sure I know what the term take over means but let me try to respond just in a general way.

In order for the hospitals to be sold in the period, they would require the consent of both the local advisory board and of the independent monitor. I should mention also that Dogwood has the right to bid on that hospital if it wished to and it also has the right to assign the right to bid to a regional foundation, if it wishes. I think that sort of deals with the possibility of sales. There's a number of hurdles that one would need to go through and others that would have to be involved.

[00:43:28] Clare: Hopefully that's responsive to the question, but it's a good question and one that will make a note to put on the Q&A. Another theme, which seems to be coming up is around physician retention, physicians leaving HCA. There's a numerous questions here. I can't read all of them. There's 10 questions or so. I'm going to read out a couple of them so you get a flavor of the questions and then we can respond to that. Here's one question.

I thought the State Attorney's office was interested in knowing if HCA was keeping up their end of the bargain, meaning keeping all current services available. For example, we now have had both general surgeons leave Angel, I would like to hear the plan for hospital ED coverage for routine and emergency surgeries without surgeons. Way too many physicians or staff are leaving HCA hospitals. This is not a

coincidence. If this is not a breach of contract by eliminating services that I'm not sure what is?

Another question, what means exists to hold HCA accountable for the efflux of physician providers across the system. HCA's management style and contract negotiations has been off-putting to established providers who have served this region. There are numerous other questions. I won't read all of them but a similar flavor. Ron, did you want to respond to that?

[00:45:04] Ronald: Sure. I'll invite others on our team to supplement or correct me. I would break it into two groups. There are primary care physicians in a number of localities or all of them and then there are surgeons at the hospital. Let's talk about doctors, generally. The APA doesn't doesn't deal with or have any, none of the commitments relate to employing physicians and there's no commitment involved in that.

The commitments also don't touch upon primary care. Now having said that, all of that in some way affects the hospitals and the hospitals as Tom went through before in commitment number two, the local hospitals are each supposed to provide emergency care, acute medicine, and surgical services and then some of them have some additional ones.

To the extent that those departures impact services at the hospital, that's certainly something we're going to look at and inquire about.

We request data and inquire directly to HCA about this kind of thing. Certainly, to the extent that surgeons are leaving, that certainly is going to have an effect on their ability to provide surgical services for example. In the case of Angel, this was not something I had heard of before. We had heard about it in another instance, but not at Angel. It is certainly one of the things that we're going to follow up with HCA about.

[00:46:53] Thomas: I think that is a correct answer. As part of our in-depth review and analysis of the documentation that HCA provides us, last year and we'll do the same this year is take a look at service levels relative to those three categories, particularly as Ron said, acute, medicine and surgical and see if there's any trend or pattern that they can relate back to the physician retention issue.

[00:47:27] Clare: Right. Another theme we've got numerous questions on here is around charity care. Some of the questions, charity care has become more difficult since HCA took over, what are you doing about it? Is it true that HCA requires a patient to spend a certain amount of money upfront before charity care kicks in? If so, this is problematic, what can be done about it? Is it true that charity care or indigent care of patients must post 50% of their projected bills first?

I've been told that those who've failed to do so, their scheduled surgery has been canceled, then told that they have failed to fill out their forms properly. How are you ensuring that the charity care policy is transparent and fully understood by the public and providers? How are you monitoring the way in which the charity care policy is being carried out? Maybe, Tom, you could, look at that question in the first instance.

[00:48:31] Thomas: I'd be glad to. As I mentioned briefly, going through the 15 commitments as it related to the charity care policy when the Mission Health board was evaluating its policy for the uninsured against HCAs policy, it concluded that HCA's policy would provide charity care to more patients in greater amounts than the previous Mission charity care policy as we've been told.

That was the policy as I mentioned earlier, entitled exhibit C, the HCA policy relative to the uninsured and charity care that's included in the asset purchase agreement. However, we've come to understand that that change in this charity care policy was not well understood by the community and possibly not universally among physicians. Then as noted Clare in your questions, we've received several comments and concerns and questions about the policy.

We have found that some of the feedback indicated more of a lack of understanding of the new policy, or maybe even highlighting dissatisfiers in the new policy rather than hard evidence that HCA is not properly implementing the policy that was included in the APA. We're not experts in the former Mission charity care policy, but we do monitor whether HCA adheres to its commitment to deliver the policy that's included in the APA. It's something that we're going to continue to monitor very closely and it will continue to be one of our highest priorities as we review compliance this year and going forward.

[00:50:15] Clare: Right. With respect to the component around patients having to front up some of the cost, before getting charity to run, what are we aware of with respect to that issue?

[00:50:33] Ronald: I think as I read the policy last year, patients could qualify for charity care immediately under certain conditions, but it was difficult to comply immediately and HCA had the ability to ask you to be paid until they knew you qualified, if you were going to get treatment. I think that's what I would characterize as one of the dissatisfiers. I think that was all in the policy, as written, to my recollection when we reviewed it last year, but I think it is difficult to qualify immediately for charity care and until you do, I think they have the right to ask you to make a deposit, and I don't think you have the right to get it back.

[00:51:27] Clare: On the same topic, how are you ensuring that the charity care policy is transparent and fully understood by the public and providers? How are you monitoring the way in which the charity care policy is being carried out?

[00:51:47] Ronald: I'm going to let Tom jump in here too but I just want to mention it, the way we can determine in this item, that there's a lapse, that they're not complying with the policy is for people to tell us and when we reviewed it last year, we saw a great many people, or a number of people who were unhappy with the policy and no argument with being unhappy with policy. If I were in their position, I might be also but I think the issue is when we then went back and looked at the individual issues against the policy, it appeared they complied with the policy.

To the extent they're not we'd like to look at that. We'd like to hear people tell us exactly what has occurred. I know that in the case of, in many cases, we provided

information to HCA. There are people at every one of the community forums, and I know they address some of it but I mean, this is one of the things it's very hard to determine, absent input from the community. Tom, I'm sorry, you want to add anything to that?

[00:53:01] Thomas: I would agree with that 100%, but also reinforce part of that might be related to the fact that was a different policy. For people in the community that had used a prior Mission charity care or uninsured policies, they found it was different and we're concerned and there wasn't enough information about what that new policy is. I think that HCA has been very responsive to this in terms like you said, Ron, following up on their specific information, specific patient questions that are being asked relative to qualifying for charity.

I think as we move forward and that specifics of the policy become more understood within the community, perhaps some of these questions will diminish somewhat, but we'll stay on it and as you said, look forward to input from the community that allow us to follow up to make sure that compliance is occurring.

[00:54:09] Ronald: I think it was a different policy, it was administered by different people and I think, to me the most, the thing that's sort of different and I guess, folks in the community weren't really mindful of this because they weren't sitting around studying exhibit C, is that it was a different policy and only covered emergent non-elective care and that was sort of a starting point of difference. I think, to the extent that there was a better orientation, I think it would have been useful for people to understand that sooner.

[00:54:50] Clare: Real quick, some other questions coming in that they're related to changes in services at the hospital. A couple of questions that relate to an intellectual disability and developmental disabilities program. Capstone Behavioral Health unit asking the status around that, questions around primary care and if Family Support Network of Western North Carolina is the only example. What's the future of the Family Support Network with North Carolina and HCA and **[unintelligible 00:55:34]**?

Question about the Wheelchair Clinic, please explain what happened with the closing of several Mission My Care Plus clinics last Fall and how didn't that violate part of this agreement forcing thousands of individuals to find a new primary care physician? Another question here, please make sure you discuss any loss or change in available services particularly the original hospitals. There are some questions coming up around changes in services and how those are monitored. Perhaps, Ron, you could take that question.

[00:56:16] Ronald: Yes, these are all important services to the community and I don't know each and every one that was just mentioned. I'd have to go back and spend a little time looking at the agreement to see what it fell under. I know just listening to the ones relating to primary care, I know that certain clinics were closed, certain offices were closed.

Each of those because we did review them and we did discuss them with HCA, each of those was not required under the purchase agreement, they were not one of the 15 commitments, not to say they weren't important, but they weren't something that HCA had obliged themselves to continue and therefore, they were able to make those adjustments to their services.

[00:57:04] Thomas: We appreciate those questions coming in Clare and Ron because that gives us an opportunity to do follow-up and ask questions so we are educated ourselves in terms of what the service is and then can make the determination whether it falls under or it doesn't. As Ron said, these apparently don't but it's also good to know that information for our own benefit.

[00:57:31] Ronald: As we said a number of times during the discussion today, we're always looking to see if it indirectly affects compliance and we'll certainly look at that and if any members of the community have ideas on that we'd love to hear that also.

[00:57:51] Clare: Some questions coming in around how we judge compliance with the services so a similar theme to what we just spoke about during changes in services. How do we judge compliance with schedules 7.13[a] and 7.13[b]? How do you discern the difference between keeping a service open and reducing the staff to such a low level that in effect the service does not exist? Please define what it means to protect the service.

At what point does the service become unprotected and significantly compromised or essentially non-existent because of shortfall in staffing? These questions are around our process of evaluating whether the commitments that were made relating to the service were complied with. I'm happy to take these questions myself.

What we have to always refer back to is the commitments as written in the asset purchase agreement. We've got to very closely review the language.

There's a lot of detail and description in the APA. It's quite complex and we have to pay close attention to those details. Then we have a process of reviewing data so in addition to reviewing the annual reports from HCA and Mission around that compliance, we don't just take their word for it that says, "We comply with this section."

We submit a data request that asks for evidence that we can use in our evaluation to determine whether the services that are being provided are continuing as contemplated between the parties when they made the agreement. We ask for a lot of information and we review from multiple angles around volumes and different standards. We look at market trends and how it compares. What we're trying to do is build up a contextualized understanding of the activity and the level of service that's provided, and whether it accords with what was committed to in the Asset Purchase Agreement.

As Ron mentioned earlier, we look at it from a direct compliance and by direct we mean, is it written into the APA, for example, with respect to the specialty services? Is that specialty service written into the APA as a protected service? Has that been

complied with or in the case of primary care or physician retention? That might be considered ways that activities could change that have the ultimate result of a compliance breach, even though it's not direct. That's what we mean when we're talking about indirect or direct.

We use a factual basis for pulling together information, including information from the community and conversations that we have with community representatives and hearing from people on the ground. We use data that we receive from HCA, we use publicly available sources, and we pull all of that together in our evaluation process.

Hopefully that answers those questions, but please, if it's not a satisfactory response that you've heard today, please submit another question to us and we can follow up with you directly. In many cases here, if we haven't got to this specific question, we'll follow up after this meeting, but hopefully this exercise today is helpful in providing some more clarity around our work and how we go about holding HCA accountable.

There's some other topics, let me see here. We've got some questions coming in on areas that tend to fall to the side or outside of areas that are written into the 15 commitments. I'll give you a bit of a flavor of the questions, Ron and Tom, and you can then respond.

We've got questions around ER wait times and processing times, processes in relation to patients with dementia and Alzheimer's, stopping levels between nurse practitioners and nurses, case managers. Questions about cleanliness of the hospital and staffing around housekeeping, again, another one around, ER wait times, waiting eight hours in the ER. I'll start with those questions.

[01:03:40] Thomas: I might take a first stab at it and appreciate those questions. They certainly would fall into more of the realm of a little more operational when it comes to things like wait times, housekeeping services or staffing levels and the like.

I think it's important to note that, although we work primarily within the realm of the 15 commitments that we've referenced multiple times this afternoon, this evening, there are also a number of organizations and agencies and regulatory bodies that oversee hospitals in general, and certainly would be looking at and reviewing and inspecting and certifying Mission Hospital on all the five local hospitals as well.

The issues that just start bumping up against what might be considered quality or staffing or things such as that would certainly come to light under any of those many reviews and inspections and surveys that the Mission Hospital and entities undergo every year.

[01:04:57] Ronald: I would just add on that. Those issues, I think relate to regulatory compliance and quality, and I don't want it to sound like a cop out on our part to say, it's not part of what we do, but the commitments themselves really touch on the providing of services. I think as Tom just mentioned other governmental entities, the things that are brought up are very, very important, but there are other governmental entities and regulatory bodies that really have province over that.

Now, having said that we keep on circling back to the issues that indirectly affect compliance. To the extent that any of these things give rise to not providing the service effectively. That's something we need to carefully consider, but on a straightforward basis, I think those things are really under the umbrella of other regulators.

[01:06:04] Thomas: I'll make a final editorial comment. It's hard for me not to after spending 40 years as a Hospital Administrator. Clare, as you went through that list of those questions I suggested that many of them all, or most of them are more operational in nature. I think those are issues that hospital administration at all of those Mission Hospitals would want to know so that they can review, can follow up, can fix, can improve. That's the feedback that hospital administrators, hospital executives really, they don't like they're like that, but they want to have, so they can make their facility the best it can possibly be.

[01:06:54] Clare: The fact that we channel all of those or log all of those concerns and channel them through to Mission and HCA helps that transparency.

[01:07:10] Thomas: Yes. Exactly.

[01:07:14] Clare: Okay. There's few questions around how do we keep HCA accountable and enforcement of the APA, give you some examples of these questions that have come through. This is a long one. Last year Gibbons Advisors held several listening sessions throughout with North Carolina. Around that time many politicians also came forward to denounce conditions at HCA.

Also during that time a Facebook group entitled Mission Maladies is formed, and since its formation has welcomed over 11,000 concerned, members of the public. Members of the group have shared a myriad of both human relations and patient horror stories, yet here we are a year later with very little resolution.

We recognize Gibbins is limited in scope to the spirit of the 15-indicators in the transfer agreement. What is being done to keep HCA accountable to the community and to those indicators. Let me see some of the other questions as well. Actually, I'll ask those other ones as follow up questions. Perhaps, Ron, you can take this question to start.

[01:08:24] Ronald: I think this is similar to your questions on 7.13A and B. At the end of the day, all of those concerns are very, very, very valid. We understand why its so important to the community. From our perspective, the issue is, did it affect their performance of providing the services. Again, I don't want to sound overly narrow except that the thing that we can do something about, which is raise our hand and say, "They're not in compliance," only arises from when they are not providing the service.

Those are the key issues there. Those issues that were brought up, I think are being addressed by other people. I think they've been brought directly to HCA also. I think in each of those cases, I think we determined that they were providing the services, which is the only thing we could do anything about. When I say we, I say we in

conjunction with our client Dogwood Health Trust, that's in charge of enforcing compliance.

[01:09:45] Clare: A follow-up question then, give some examples of disputes that you've monitored through resolution. Have there been any disputes so far and have any gone through to resolution?

[01:10:07] Ronald: There have been no official disputes. If we're talking about a dispute where Dogwood would notify them the dispute compliance, that has not happened.

[01:10:25] Clare: In a formal capacity there have been no disputes. Then in our ongoing dialogue with HCA, we're constantly sharing concerns that the community share with us.

[01:10:44] Ronald: I'm sorry to interrupt, but let me let you finish up. I apologize.

[01:10:48] Clare: No. Go on. It's fine.

[01:10:49] Ronald: Are there informal basis? I think some things that happened that I think have been resolved. Let me give you maybe two examples, the Transylvania Transitional Care Unit is one example. I think we mentioned before, the Transitional Care Unit is a skilled nursing facility in a special unit within Transylvania Regional Hospital.

At a time, I think last year, I'm not sure if it was in 2019 or 2020, HCA decided that it wished to provide those services at a different location in the physical structure. The community was very upset that the unit was closed. HCA at least the way they explained it to us, felt that they were still providing the services and they had complied. At the end of the day as a result of what the community said as a result of us bringing it to them, they decided to reopen that space again and it's operational.

Now, having said that that was immediately prior to, or at about the time of COVID. I would find that unsurprising on our own data on that, yet I would find it unsurprising that there was relatively light activity in the past year, but I understand that has been resolved. That's one example.

The other example, is the issues on physicians leaving. We've had several conversations probably over the last six months about that. I know, and I'm not sure it's because we did anything about it, but I know that HCA has-- I don't know if I say the right word is to accelerate the pace, but they have spent a lot of time making sure that the surgeons that were leaving are being replaced and we've kept track with that. I'm not sure we drove that. I don't want to take credit for that, but that's certainly something we brought up with them and others did too.

[01:13:03] Clare: A question around our independence, what assurance do we have that the Independent Monitor is acting in the public's favor and not HCA? Ron?

[00:03:17] Ronald: As I mentioned before, the role of the Independent Monitor is carefully prescribed in the asset purchase agreement. Then in an agreement that we have between us and our employer, which pretty much tracks that and it tracks exactly what the HCA commitments are. It requires that we be paid not by HCA, but by Dogwood and requires that our people not or have connections with HCA. I'm hopeful that's responsive, but we're paid by the guy who got the money out of that purchase, not the guy who is running the hospital now.

[01:14:05] Thomas: What I would add to that, Ron, is that our client is Dogwood Health Trust, our relationship with the board, which is a broad based community. They're a responsive board. The CEO of the leadership of Dogwood Health Trust, we work closely with the Covenant Compliance Committee that provides hands-on or review and oversight of our work. Again, different perspective on that like being independence that the community board provides that oversight in insistence on our independence and helps keep us on track.

[01:14:54] Ronald: I think I'll just add one thing to that. I completely agree, Tom. Dogwood, again focus principally on philanthropic operations in Western North Carolina 18 counties. They're also required to be in charge of compliance here. They have, and you can look at their website and speak to their people I don't want to speak too much for them, but they have established a lot of governance and machinery to make sure that the compliance occurs.

We meet with their Covenant Compliance Committee, we meet with other committees and the board to talk about all of this. Starting right about now each year, we have almost weekly meetings all the way between the time we get the annual report and the Capex report from HCA, all the way to the point where Dogwood has to make its determination. We're involved with them kind of in real-time.

[01:15:52] Clare: Great questions, aren't they? It's really impressive. COVID is coming up as a topic and will HCA be able to use the COVID excuse to get out of keeping up their end of the deal? Who wants to take that question?

[01:16:11] Ronald: I will do my best. When we started reviewing last year for compliance for the reporting period that ended the end of 2019 and asked a number of detailed questions with respect to data, HCA said to us, "Next year the numbers are going to be much worse," because this was right after COVID started, "because there's no elective surgery going on. People are avoiding the emergency room, all the numbers will be less favorable."

That doesn't mean they don't have to comply with the commitment, if people aren't coming in to do elective surgeries, I don't think they can be blamed for that. If they're not coming into the ED because they're scared, I don't think they can be blamed for that but they are all required to provide the service. There are other people around the country are going to say other people, other hospital systems including other HCA hospitals that provide these services.

I think we have the basis to do some kind of a gauging against others even if we don't gauge against the prior year. I don't think it's a simple waiver of any

responsibility for the year, I think they still have responsibility. They certainly can't be blamed for things they can't control, but they do have the responsibility for providing the services.

[01:17:40] Thomas: I'll just add, respective to that is, part of our ongoing review and evaluation we do, staying in touch with the communities, particularly the local hospitals we're serving. Some of the feedback we receive during this pandemic, certainly the first few months of the pandemic where all of us were trying to work to understand how to control it, how to live with it, how to deal with it.

A lot of positive feedback from local hospitals working with local communities together in a very collaborative, cooperative way to stop the spread, slow the spread, do all the things that we as a community have done over the past few months. It's just exactly the definition of a community hospital, to pitch in and be part of the community where there are so much uncertainly, there's so much fear and so much concern especially in the early stages of COVID.

[01:18:45] Clare: Great, there's a follow-up question that came up on that topic that we've just talked about on the instances of non-compliance. Did you say that there have been zero instances of non-compliance in, I think the mean greater than one year or they might remain in the first year? We've only reviewed the first year, so Ron, do you want to take that question just to clarify?

[01:19:14] Ronald: I think we need to evaluate their overall compliance. I'm sure there are going to be instances where something didn't comply precisely in an individual patient encounter but I don't think that would give rise to a purchase agreement violation if that's what you meant.

[01:19:34] Clare: Okay, but formally in our evaluation last year reviewing against the specific commitments.

[01:19:44] Ronald: We reviewed against the specific commitments and we believe that they were in compliance for the reporting year ended 12/31/2019 and 1/31/2020 with respect to the capex.

[01:20:00] Clare: There's some questions that are coming around the processes of Gibbins Advisors as an Independent Monitor. We can fire some of these off I think quite quickly. A few questions, does anyone at Gibbins follow Mission Maladies on Facebook? Does the Independent Monitor follow Facebook page Mission Maladies?

The answer to that is that we recently have started following Mission Maladies, so we can incorporate that in our work moving forward. Good question here, I see that your ongoing input includes that from physicians, but not from nurses, nurses are key to patient care and it suffered some of the most significant cutbacks in supporting staffing by HCA. Why are nurses not included? I think that's a great question. Ron, in our process last year, did we engage with nurses and if not, we'll absolutely make sure we do this year.

[01:21:08] Ronald: I think I'd love to engage with nurses. We'd like to engage with anybody. For the most part we engage with people who reached out to us. We went out to the community in order to encourage people to speak with us. We'll be doing that again shortly. We welcome the opportunity to speak to nurses individually or in groups.

If we could just scroll back for just a second, Clare, with respect to Mission Maladies. I know that there are probably a number of Facebook groups or Google groups that might be more local. We'd like the opportunity to follow as many of those as possible. If anyone would like to invite us or tell us the name of the Facebook page, they suggest we look at, we'd like to do that. We think that's a good way to efficiently get information.

[01:22:01] Clare: Question about our process, what's your process for soliciting community input on the HCA reports?

When we receive the HCA report at the end of April, early May, we post them on our website. The public has an opportunity to take a look at them and if you'd like to provide input, we really welcome your input. Please contact us using the online form or an email and we can receive your input and have a follow-up conversation if you'd like that.

Apart from just the general public, we have a number of community representatives and community groups that we've been directed to from Dogwood Health Trust that we should engage with as part of our review process. We actively seek out their input with respect to HCA's reports, as well as the advisory boards that were set up as part of the transaction.

We engage with those community members and Dogwood Health Trust and the Compliance Committee members as well. If you would like us to engage with you or you are representing a group or a part of a group that would like engagement with us, we'd be delighted. Please reach out to us and let us know.

A question, I'll have to summarize it because it's quite long. According to your presentation, you've received only 263 submissions from the communities, to the Independent Monitor as of the end of February. That's less than one a day, which is hardly insufficient relative to the degree of dissatisfaction means that in North Carolina around class and change with the HCA?

I'll take that question. We've received what we've received. We've logged all of the submissions that we've received through letters. We've received a few handwritten letters. We've received a few emails and most people contact us through the online form. We've logged all of them and we received 263. A lot of the activity took place after our community meetings last year when people were engaged pretty heavily. Then around March when COVID hit the whole world got distracted, I think, on the pandemic. The activity had that a little in subsequent months. We'd love to hear from you from the community as much as you'd like to communicate with us. We're just reporting too, the statistic that the number that we've actually received.

[01:25:16] Ronald: I would just add to that. I think we said on that page where the 263 was, Clare, that that did not include the people who were at the community of forums. We estimate over 600 people at the community forums. I would characterize those meetings as informative and spirited. People were not bashful about speaking up. Certainly didn't hear from all 600 of them, but I think if someone asked a question that was on the mind of someone else, they probably didn't also ask it.

I thought we had a pretty good representation, based upon the meetings and the follow-up on the website and emails. Again, had we been able to be in the field, be in the communities more, I think we would probably be hearing a little bit more. At the end of the day, we relied a little bit more on inbound, and our engagement with media to get comments in. This year, again, Tom and I are hoping to get out to at least one of the hospitals maybe more in May this year and we would like to do that regularly.

[01:26:26] Clare: Another question about our process. I believe that last year, the IM said that there were concerns to the right organization if it fell outside your remit. Are you still doing that? I guess I can answer that. In terms of our process, what we do is log the concerns and evaluate them against the 15 commitments and share them with HCA.

Our role is not really extended to triaging and directing the traffic of the content of the complaint or concern and directing it to all the different governmental and regulatory organizations out there, but we do respond to everybody that submits a question to us and we share it with the HCA / Mission. Additionally, where there's specific questions, we now have the opportunity to ask the submitter if they'd like to opt in to have their contact details so that HCA say that specific things can be followed up. Anything to add Tom or Ron?

[01:27:52] Ronald: I think a good way to look at this is, we fit within a suite of part of entities that have some province here. The government and the regulators have patient safety and medical and healthcare standards. We have the contract and I think we don't really overlap with each other. I'm not sure it would be appropriate for us to be providing information about what happened at a hospital that we heard indirectly to a regulator. I don't think that really is our role.

[01:28:31] Clare: Yes. Another question about our engagement. What are your obligations for better outreach and communication to ensure you receive appropriate submissions for the community, when clearly the occasional news stories are good enough and getting it done? What are our obligations for better outreach and communication?

[01:28:50] Ronald: I don't know what our obligations are, Clare. What we are definitely doing is we are trying to step up our outreach. We've always been out there. Maybe we didn't speak to everybody on this webinar all the time, all year but we did speak to somebody, some people all during the course of the year. We'd like to encourage people to see us.

I think when we go into the community, it usually causes people to come find us, either while we're there or afterwards, and we're going to try to continue to do that. Again, we're trying to and we've beefed up our website presence, our LinkedIn presence. We were responsible last year to the press and will continue to be, I think those are all things we're working on all the time and we welcome the opportunity to speak to you the press, and everyone.

[01:29:50] Clare: Okay. Another question, I know that we're at time, did you want to keep going?

[01:29:59] Ronald: It's about and a half now, but I think if we still have some questions, so let's keep going. I think we still have a good number of participants on the webinar.

[01:30:08] Clare: Okay. Do you have any direct connection to the Attorney General or is it only through Dogwood Health Trust?

[01:30:18] Ronald: Well, I guess it's through Dogwood Health Trust, but we do engage with them. After we were hired in October, 2019, we met with them almost immediately. We have spoken to them from time to time and I know that in collaboration with Dogwood, we are having a series of meetings with the AG's office this year. We've also had some one-off conversations with them, but most of it is in concert with Dogwood.

[01:30:58] Clare: Okay. Here's another question. Interesting one. Is it true that HCA has certain control or veto authority over the use of Dogwood Health Trust endowment and grant making?

[01:31:17] Ronald: I've never heard of that. I'm not one who could speak to that?

[01:31:23] Clare: That's something I've never heard of as well. I'd be alarmed and surprised if that were the case. I'm quite sure that it isn't, but we'll double check with Dogwood on that question. Okay. Let me see. I'll go back to the topic list. We've got about a hundred and something questions. What I try to do is go through, in the first hour-and-a-half, all of the different theme. We'd touch on all of the different themes and then I can go back through the list now and target some other specific question that will come through.

[01:32:05] Ronald: Can I just add one more thing on the last thing that you mentioned Clare. I'm not sure what the HCA can do or not do with respect to Dogwood's endowment but I know and I've heard this before, Dogwood has a mission to improve healthcare in West and North Carolina and these 18 counties, which are also the counties that Mission serves. I think I have heard perhaps informally that there is a desire for some collaboration so that everyone is supporting each other in advancing healthcare generally.

[01:32:52] Thomas: Just to attach on to that and you referenced it earlier, in reference to Dogwood Health Trust, they also have a very informative website. They also have a very informative newsletter, an annual report that is full of information

regarding the programs and services the agencies, the organizations, the causes that fall within their purview to support. It really has been quite impressive to follow that. I urge your people that are with us today in this webinar to do the same thing and see what their community Dogwood Health Trust Foundation is doing to improve the health and wellbeing of their communities.

[01:33:44] Clare: Okay. Great. Thanks, Tom. Another question. Has HCA given you all the data you requested including staffing levels, to make your determination about compliance with the APA?

[01:33:58] Ronald: This year, since we've now gone through one cycle of the reporting period, one cycle of annual reports and Capex report and we know what to expect, at least if we can use last year's example. We thought we'd get on it a little bit earlier and make our questions known before we get those reports because now we know what we're likely to get. We provided a series of questions to HCA for the annual report and the Capex report last week.

We haven't gotten that yet, but we didn't expect to. We asked to get it at the same time, if possible, the same time we get the annual report and the Capex report. We did not specifically ask, to my recollection, about staffing levels. I don't think that is part of gauging services, which is I think where is the closest I can think of where that will touch. Last year we asked for a lot of information about it.

[01:35:06] Clare: There's another question, it touches on the question of formal disputes around compliance and related to physicians retention, physicians leaving. Here it is. "I find it perplexing that there have been no formal disputes between Dogwood and HCA in regard to physicians leaving as stressed by Gibbins. There ought to be much more formal discussion on these issues sooner rather than later. This situation is clearly problematic." I guess this touches on formal versus informal discussions and whether something is seen as an issue to be addressed, or followed up, or a formal dispute.

[01:36:00] Ronald: I would like to have a conversation. I know our group have a conversation with the individual provider that question in order to explore that further so that we can understand that. I think that's important to know.

[01:36:14] Clare: Let me see those we haven't covered yet. "How are you diversifying staff and is your staff required to take racial equity training to better serve people of color and black individuals in the community? What about language barriers including Spanish in areas served?"

[01:36:48] Ronald: That's a question I did not expect to get. We're a very small firm and we specialize in this kind of work. We have not had policies like that at this point. With respect to language barriers, the folks that we engage with thus far at HCA have been English speakers. The people who have come to us with questions and comments have been English speakers. We would be happy to arrange for language support if others would like to speak to us. We'll arrange that. That's no problem.

[01:37:40] Clare: I agree. That won't be a problem. There's a lot of languages not just Spanish. Any language where they'd like to communicate with us but feel like they can't, that language barrier we can always arrange an interpreter to facilitate the conversation. We don't want that to be a barrier.

A question around Graduate Medical Education requirement. "The GME commitment is tied to availability of similar GME funding. Does this mean only the Medicare funding stream or other funding?" Response, in terms of the APA from what I recall, the language in the APA is generic around requiring funding to a similar level compared to what was current at the time of the transaction. Doesn't specify whether it's Medicare or other funding.

[01:38:56] Thomas: That's correct, Clare. It just states that support should be provided for 10 years, no less than the current levels.

[01:39:05] Clare: "Is HCA's GME commitment only related to the existing MAHEC relationship or is HCA seeking other GME partners?" From what I recall in the contract again, HCA was required to stay through to the end of the contract that was in place. I don't think we know unless Tom or Ron have other information what HCA's activities are. If it's seeking other GMA partners at this time.

[01:39:43] Ronald: I don't have any answer to that.

[01:39:45] Thomas: Oh, no.

[01:39:47] Clare: Okay. We covered those questions. A follow-up on the charity care policy says I think the question was how are you getting the information out to people about the new policy? How are we getting people the information about the new policy?

[01:40:19] Ronald: At the end of the day, it's HCA's policy and it's my understanding it's on the website. I think we checked that at least a couple of times last year. On our website, in response to some inquiries that the AG, the Attorney General made last year, HCA provided a fairly thorough response on April 30th, to the AG. I believe it's on the AG's website. We have posted it on our website.

Appended to their letter, is that I believe is Charity Care Policy along with it there are other two companion policy. One is a Patient Liability Limitation Policy, and I think another one is a Patient Financial Assistance Policy. They're all appended to that letter and they're on our website. We have not taken it upon ourselves to provide patients with a policy because it's not our policy, we're not providing health care, but it is available, both from us and from HCA.

[01:41:38] Clare: Okay, around charity care, again, regarding charity care, are you asking for feedback from the community? What specifics are you looking for in regard to feedback to demonstrate problems experienced with charity care? What feedback would be useful for us to hear from the community with regard to charity care?

[01:42:04] Ronald: I would like to hear that people feel that the policy wasn't complied with, to the extent that they did not comply with the policy, we'd like to understand specific instances about that so that we can gauge compliance. Also, if you'll allow us, we'll provide that information with your name attached to HCA so they can maybe do something about it, but either way, we're going to look at that to gauge compliance.

[01:42:37] Clare: We have a statement from Dogwood that's come in, thankfully, from Janice Brumit, the Board Chair of the Board. He says with respect to that question, we had around HCA's potential veto powers, she's confirmed. “HCA has absolutely no control over Dogwood or any of its assets. Dogwood is completely independent.” Good to know.

[01:43:07] Ronald: Thank you, Janice.

[01:43:09] Clare: Yes, thanks, Janice. Okay, let me see what else we've got. It's around primary care again. “With respect to the closure of NMCPs, those are clinics specifically were not addressed. How can you say this wasn't a reduction in service capability? There were thousands that lost their doctors and the remaining NMCP did not have the capability to accept them. I checked with several that said they were full.”

[01:43:50] Ronald: I would just say that there's no doubt that those services are very important to the community. I certainly understand the community being upset with that and concerned about it, but at the end of the day, when we look at the purchase agreement at the commitments, the commitments don't deal with primary care. Now to the extent they affect surgical services, acute medicine services, emergency services, those are things we want to know if that there is an indirect effect on the hospitals for our work, but notwithstanding how important those services are to the communities they were not promised under the commitments of the APA.

[01:44:38] Clare: Another question about our process. The data from the community is largely anecdotal. When does enough anecdotal data become hard data and evidence in your opinion?

[01:44:52] Ronald: It's a hard thing to answer. It's hard to quantify that. We're certainly looking to hear if there's a significant amount of it. I don't know that I would say, 100 or 50 or 20, what number becomes significant. It's hard for me to say on the webinar here now.

[01:45:17] Clare: Yes. I think what we do is, we receive all of the submissions from the community. Where there's consistency or certain things keep coming up, that really puts it on our radar to follow up the issue. Like I mentioned, we're not just taking HCA's word for its compliance with the commitments under the APA, we're citing documentation and evidence.

It's helpful to get the information from the community because where a theme comes up more frequently, we can probe a bit harder with the evidence to substantiate the

facts. Then based on the facts, we make our evaluation of compliance and recommend that to Dogwood. That's a good question.

The next question around quality of care, “is quality of care part of your mandate? Or, is quality of care not part of your mandate?”

[01:46:41] Ronald: It's not specifically prescribed in the APA. I think we've mentioned earlier in the webinar. Quality is certainly something under the province of governmental bodies and regulatory bodies. It would only relate to us to the extent that affected services that are part of the commitments. [silence]

[01:47:19] Clare: Sorry about the delay. I'm just trying to review these live and see which ones we've covered and which ones we haven't.

[01:47:24] Ronald: Just while you're looking, again, to the extent anyone feels that quality or anything gives rise to indirectly affecting the provision of the committed services, we'd like to understand that so we can evaluate it.

[01:47:45] Clare: There's an interesting comment that someone's put forward as a comment, not a question. It's helpful for our considerations. It's good feedback. "The way you're approaching public feedback biases toward people who are more sophisticated in professional interactions and against people who are more poorly educated or less sophisticated in such interactions. These very people most vulnerable to falling prey to and for failing to navigate system cuts and changes relevant everywhere, including the discussion about charity care."

I think that's a good question because we've been taking the approach that the community representatives and community nonprofits and groups that we're engaging with are representing those cohorts of people rather than us directly targeting to engage with those cohorts. It's a good question. We'll talk about this among ourselves as team as to whether it continues to be the right approach or whether we should actually consider widening our engagement to directly interface with some of those people in the community. We'll take that question offline.

[01:49:13] Ronald: I will just say, Clare, that I think that's one of the reasons we want to get back out into the communities which we couldn't. Again, maybe less than five weeks after our last community forum, we were all locked down since then. I personally think that being in the community at a indoor or outdoor event, at a restaurant or something, talking to people will be very helpful in that regard. I'd like to do it as soon as possible.

[01:49:50] Clare: Another question that I'll process for this view and you might not be able to answer it, but I'll put the question out there. “When you say you're going to be visiting communities in April and May, are you going to host open meetings?”

[01:50:07] Ronald: We haven't developed the logistics of that. I think we're there and we're going to, I think to the extent we're certainly certainly going to be open. The question is how formal will they be? We haven't gotten that far, but able to plan

for that yet. It doesn't necessarily only have to be in April and May, we can be there as often as necessary.

We're up against the reporting deadline with respect to the annual report in this second quarter, beginning of third quarter, but it doesn't mean we're not watching compliance the rest of the year. Any meeting we have out there, we're going to welcome the public. The question is how much advanced time do we have to plan it out?

[01:51:03] Clare: Question, can Dogwood hire consultants who can examine quality of care?

[01:51:14] Ronald: We're going to channel that question to Dogwood and let them respond to that. If it's okay with the person who provided that question, we'll provide your name to Dogwood and they can respond to that.

[01:51:29] Clare: Some other questions around the Hispanic population in communications with them. I think we've covered that already. Another question around quality of care and indicators and quality of care, I think we've covered that a few times. Exactly who is monitoring Gibbins. We could probably cover that again.

[01:52:05] Ronald: Who's monitoring Gibbins?

[01:52:08] Clare: Who's monitoring Gibbins, yes. We've got the governance structure around the APA. We were appointed the independent monitor. Then we report and advise into Dogwood Health Trust, and then there are six different advisory boards that we report to as well. When you actually tally up the number of people, there are six advisory boards with eight people on each advisory board, plus the Covenant Compliance Committee of Dogwood and the broader board.

Were engaging with a good number of people who are really our client. They're people that we're accountable to in delivering our services. We've got a lot of eyes on us as the Independent Monitor to make sure that we're doing a good job and fulfilling our role. I think that answers that question about who's monitoring us. We've got a lot of people that we're accountable to.

[01:53:18] Ronald: We're, of course, we're mindful of the Attorney General also and our hiring required the approval of the Attorney General back in 2019.

[01:53:30] Clare: Right. Good point. We're coming up on two hours now and I think for the large majority of the questions, we've covered most of the key themes that are coming up from different people. There are other questions that we haven't made it to specifically, but we will take the questions like we take each question or submission that we received through our website.

We'll take each of your questions that you've put into the webinar format and treat it in the same way. We'll log it and respond directly where we're possible and in a Frequently Asked Questions section of our website where the questions are more frequent. I think it's probably time that we need to start to wrap up the meeting.

[01:54:23] Ronald: Right.

[01:54:25] Clare: Ron, do you have any other closing comments or so?

[01:54:27] Ronald: We wanted to thank everyone for coming out tonight. Appreciate it. Appreciate all the thoughtful questions. I say the same thing I said when I was out at all the community meetings. I think we can add a lot to this effort here in working with you and working with Dogwood. I am mindful that we can frustrate the public because of the limitations of what we have province over, but the things we have province over are really important. I'm hopeful that each time I said, "Well, that's under government regulator or another body," I'm hopeful it didn't frustrate you too much. We have a very specific set of requirements to work under but we think they're really important and really important to the communities.

We thank you again. We urge you to come and look at our website and see all the useful information. We urge you to come and follow us on LinkedIn, then you'll get the information more actively. We urge you all to reach out and contact us through the website or through our email address. Lastly, of course, we will look forward to seeing you when we're out in the community in the coming weeks and months. Thank you very much again and we look forward to continue this work.

[01:56:05] [END OF AUDIO]