

2026

Community Conversations: What We Heard





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First, thank you.

To the more than 300 community members who joined us across Jefferson, Berlin, Lancaster, Bethlehem, and Colebrook, and to those who submitted questions in advance, we are genuinely grateful. The time, honesty, and care people brought to these conversations made one thing very clear: our communities are deeply invested in the future of local healthcare. We see that as a strength.

This document is longer than a typical summary because the questions we received were thoughtful, specific, and important. People did not show up with surface-level concerns. They asked meaningful questions about access, workforce, communication, finances, local services, and the future of healthcare in the North Country. That level of engagement deserves more than a short recap. It deserves a real response.

Our goal in sharing this document is transparency. We want to communicate more clearly about what we heard, what we can answer today, and where work is still ongoing. We also want people to understand that these conversations matter. They help us identify where we need to do better, where we need to explain things more clearly, and where we need to keep listening.

We heard you. What follows is a reflection of what we learned, what we can clarify today, and where we are actively working to improve. While we may not have every answer to every question all at once, we are committed to continuing the conversation in good faith and sharing information as clearly and consistently as we can.

How We Heard Your Questions

This document contains questions raised during the listening sessions and information we want to share in response. While questions were asked in many different ways, the examples included below reflect how these concerns were commonly expressed. We grouped them by theme to provide clearer, more complete answers and to help community members see their words and priorities reflected in this work.

We are excited by this level of engagement, and we hope it continues. Please keep joining us, keep asking questions, and keep sharing your perspective. Strong rural healthcare depends on strong relationships, and that means staying in conversation with one another.

If you feel that something has not been answered, or if more questions arise, please do not hesitate to reach out to NCHListens@northcountryhealth.org. We look forward to continuing to work together to strengthen the health of our communities.



Access to Care, Communication & Coordination

Ensuring patients can access care reliably requires strong coordination across locations, systems, and communication channels.

How does NCH balance continuity of care with the use of rotating or temporary staff?

(e.g. “Why is it necessary to use a rotating staff when it is so impactful on patient care?”; “Why can’t we have consistent providers?”; “It’s hard when providers keep changing.”)

We agree that continuity of care is important, and short-term staff is not the ideal long-term model. However, the reality is that healthcare systems across the country, particularly in rural areas, are navigating significant workforce shortages. National projections from the Association of American Medical Colleges (2021) estimate a shortage of up to 124,000 physicians in the coming years, with rural communities experiencing the greatest impact.

In that context, rotating or temporary staff are often what allow us to keep services available locally. Without them, some services would be reduced or unavailable, requiring patients to travel greater distances for care. Our goal is always to transition from temporary coverage to permanent providers, and we continue to prioritize recruitment and retention to reduce reliance on rotating staff over time.

The preference is always to recruit and retain permanent staff, as continuity of care is important for both patient outcomes and patient experience. However, in a rural healthcare environment, there are times when vacancies, leaves, or recruitment challenges make it difficult to maintain full coverage with permanent providers alone. In those situations, the use of rotating or temporary staff becomes necessary to ensure that essential services remain available locally and that patients do not have to travel long distances to receive care. While this approach can create some disruption, it is a bridge strategy, allowing us to maintain access and safety while continuing to prioritize long-term recruitment and stability in our workforce.



What is the best way for patients to contact their provider or care team?

(e.g. “Why is it that when a person calls the hospital it rings over and over again? Sometimes no timely answer.”; “Want to understand why it is so hard to get someone on the phone for an appointment.”; “Have someone answer the phones when I call.”; “Why is it necessary to call so many times before getting someone?”; “Have you ever tried to call and speak to a person using the hospital number and gotten through on the first try?”)

You shouldn’t have to guess how to reach your care team, and if it has been difficult, we understand how frustrating that is.

There are a few ways to connect with your provider. The two most common ways are through the patient portal or by calling into the organization. The portal is often the fastest option for non-urgent questions, prescription requests, or follow-up communication.

If you have questions about using your patient portal, contact our Patient Portal Service Desk at (603) 788-5066 or email patientportal@northcountryhealth.org. To reach your provider for information or to make an appointment in Lancaster or Colebrook, please call (603) 788-5095. For more information, or to make an appointment in Berlin, please call (603) 752-2300.

How is NCH improving phone access and ensuring patients can reach someone in a timely way?

(e.g. “Why is it that when a person calls the hospital it rings over and over again? Sometimes no timely answer.”; “Want to understand why it is so hard to get someone on the phone for an appointment.”; “Have someone answer the phones when I call.”; “Why is it necessary to call so many times before getting someone?”; “Have you ever tried to call and speak to a person using the hospital number and gotten through on the first try?”; “Why is it so hard to reach someone local? Calling a local number does NOT get you a local person.”)

If you’re calling and not getting through, that is frustrating. That is not the experience we want for our patients or community members. Long wait times or not getting through are real concerns, and we are actively making changes to improve that. This includes adjusting how calls are routed so they reach the right team more quickly, reviewing staffing levels during peak call times, and setting clearer expectations for response times so messages do not sit unanswered. We are also working with our teams to reduce unnecessary handoffs, so patients are not being transferred multiple times to get help. Based on recent data regarding incoming calls, we have made



progress on reducing wait times and getting calls routed to the correct teams. Please keep sharing your experience with us so that we can be sure we dig into your concerns.

In addition to closely monitoring call data, we will be creating dedicated lines that patients can call for triage of urgent care issues and to call for medication refills. These changes are being implemented as a result of the concerns raised in the listening sessions.

Our expectation across North Country Healthcare is simple. When you call, you should be able to reach someone without it becoming a barrier to getting care or information.

In addition to the deep dive we have done regarding the phone lines, we are also taking a broader look at the patient experience through a newer initiative, our Patient Experience Team. This is a group of NCH staff from across the System who are focused specifically on identifying where the patient experience breaks down and working together to improve it. Challenges like phone access are exactly the kind of issues this team is helping us address in a more coordinated and intentional way.

How is NCH improving the timeliness and reliability of sharing test results across locations?

(e.g. "Tests taken at one NCH hospital do not arrive at other hospitals quickly. How can this be fixed?")

You are right; this is frustrating. You shouldn't have to think about where your test was done or whether it will follow you. That should be our responsibility, not yours. When results don't move quickly between locations, it creates unnecessary stress.

From our perspective, we don't look at this as a one-off issue; we look at it as a signal. In healthcare, we work to build systems that are reliable and consistent, and when something doesn't move the way it should, we step back and ask where the process is breaking down rather than putting that burden on patients or staff.

Part of the challenge comes down to how healthcare systems communicate with each other, something called interoperability. At North Country Healthcare, we participate in a Federally supported and mandated nationwide network called TEFCA (Trusted Exchange Framework and Common Agreement). This network is designed to securely connect hospitals, providers, public health agencies, and others so information can be shared when needed. It acts like a

highway for data, allowing information to move back and forth, but it does not store the data itself.

The key limitation is that for this system to work seamlessly, everyone involved, other hospitals, clinics, and partners, also need to be connected to the same type of network and have systems that are equally mature and compatible. Not all organizations are there yet. When systems don't align or aren't fully integrated, information may not move as quickly or automatically as expected, which can lead to delays.

We see it as an opportunity to improve. We are actively working to strengthen connections within our own system and with our partners, reduce manual steps, and move toward more real-time sharing of information so your care experience feels seamless. In the meantime, if something feels delayed, please reach out. That helps us address it in the moment, and it also helps us learn where we need to strengthen the system so it works better for everyone. Based on this feedback, we are looking at our current process to identify where we can improve and make changes.





How is NCH improving coordination and interoperability between systems so patient information can be shared more seamlessly?

(e.g. “Why don’t the computer systems at AVH and Coös Family Health work together?”; “Not getting proper info/referrals — coordination breakdowns internally.”)

Coös County Family Health Services and NCH are strong partners who serve many of the same patients, and like many healthcare organizations, we use different medical record systems that were selected to best support our individual operations. While that works well internally, it does create challenges when information needs to move between organizations.

Rather than focusing on having the same system, our shared priority is making sure patients experience coordinated care. We are continuing to work together to strengthen how information is shared, improve communication between care teams, and reduce the gaps that patients may experience. As technology evolves, there may be options to integrate, but it is not possible now.

This is an area where partnership really matters, and we are committed to improving how our systems and teams work together so that care feels more seamless, even when the technology behind it is different.

What payment options are available for patients, including those who prefer to pay in person?

(e.g. “I have paid my hospital bills at the hospital for years. Can I still do that?”)

Not everyone prefers or is able to pay online, and people should be able to handle this in the way that works best for them.

Medical bills can still be paid in person at our registration desks or front desk locations across NCH. We also offer additional options, including payment by mail, by phone, or online for those who prefer it. If you’d like to make a payment by phone, you can call 603-788-5679.

We also want to make sure patients know that support is available beyond just making a payment. Our Patient Navigators and Financial Counselors are available to meet with patients, help walk through bills, explore financial assistance options, and set up payment plans when needed.

To speak with our Financial Counselors: 603-912-1554, 603-912-1557, or 603-912-1664.

To speak with our Patient Navigators: 603-388-4234 or 603-788-5093.

If something feels unclear or difficult to navigate, we encourage you to reach out. You don’t have to navigate that alone, and we’re here to help make the process as straightforward as possible.



David Caplette, Volunteer Driver with the NEMT/CHET program.
NEMT Partnership highlighted in NH Hospital Association Community Benefit Report. (Foundation for Healthy Communities, 2025).

How is NCH addressing transportation barriers and distance challenges that impact access to care?

(e.g. “Transportation — how do we support this for access to quality care?”; “How do we get, offer, and maintain transportation options for all?”; “How could the distance of the PCP be handled differently so it didn’t undermine continuity of care?”)

We understand that in the North Country, getting to care can be just as hard as accessing it, especially for specialty services that may require travel outside of your immediate community.

There isn’t a single solution, but there are resources available that many people don’t realize they may qualify for. It is clear from the questions posed in the listening sessions that we, and our care partners, need to not only work together to improve transportation options in the region but also to do a better job publicizing the resources that are currently available to assist with transportation.

Depending on your insurance, transportation may be covered. Medicaid, for example, is required to provide non-emergency medical transportation (NEMT) for eligible members, which includes rides to appointments, pharmacy trips, or treatments. Additionally, Medicaid will provide mileage reimbursement for friends and family that drive Medicaid beneficiaries to medical appointments. More information on the options for New Hampshire



Medicaid beneficiaries can be found [here](#) (DHHS, 2026). Some Medicare Advantage plans also offer limited transportation benefits, although traditional Medicare and most private insurance plans are more limited in what they cover.

Locally, we are fortunate to have strong community partnerships that help fill these gaps. We work closely with organizations like Tri-County CAP and Coös County Family Health Services to support transportation services, particularly along the Colebrook to Lancaster corridor. We also collaborate with community partners such as local senior centers that provide transportation support in different parts of the region.

At the same time, we are continuing to look at how we can reduce the need to travel in the first place by expanding local services, bringing in visiting specialists, and using telehealth when appropriate. Telehealth has the potential to reduce the need for travel, especially in a rural region like ours. Today, it represents a small portion of our overall visits, but it continues to grow as we thoughtfully expand its use. Telehealth works best when the type of visit is appropriate and when both the patient and provider have the right tools and support to make the experience effective. It still requires a provider to deliver care, just in a different way, so we are focused on building these services intentionally, matching the right types of care with the right patients and ensuring our clinical teams are equipped to deliver high-quality care remotely.

If transportation is a barrier for you, please tell your care team. They can help connect you with available resources and work with you to find options that fit your situation. You don't have to figure that out on your own.



How are you focusing on ensuring the local workforce stays central to NCH's strategy?

(e.g. "What is NCH doing to grow our own? Nursing students, MAs, providers."; "How many people work at NCH or have family that work there?"; "Local jobs are important.")

Local jobs are critically important to the North Country, and as one of the largest employers not only in Coös County, but north of Franconia Notch, we take that responsibility seriously.

Every decision we make has to balance two things at once: supporting our workforce and ensuring that we can continue to provide care locally for the long term. In rural healthcare, those two are closely connected. If we are not financially stable, it puts both services and jobs at risk.

With the recent revenue cycle changes, our goal was to strengthen the overall system while minimizing disruption to our workforce. Many employees transitioned into new roles within NCH, including patient access, authorizations, and other support functions, and some of those transitions created new opportunities for growth.

We also recognize that change can be difficult, especially when it affects roles that have been part of our organization and community for a long time. That is not something we take lightly. Our commitment is to continue investing in a strong local workforce while making the decisions necessary to ensure that healthcare services remain available close to home.

How is NCH working to recruit and retain doctors to meet the needs of our communities?

(e.g. "How is the administration going to address the need for doctors?"; "We need more providers in this area."; "Why is it so hard to find and keep doctors here?"; "What are you doing to try and recruit, retain, and develop providers?"; "What is being done to bring in and keep providers?"; "How are you supporting providers so they stay in our community?")

Addressing the need for physicians is a top priority, and we are taking a multi-faceted approach to strengthen recruitment and build a sustainable pipeline of providers. We offer competitive incentives, including sign-on bonuses, to attract qualified physicians, and we actively recruit candidates from across the country to bring talent into our communities. At the same time, we recognize that long-term stability requires growing our own workforce. To that end, we are developing a primary



care residency program that will allow us to train new physicians locally, with the goal that many will choose to remain in the North Country after completing their training. Together, these efforts are designed to both meet immediate needs and create a more stable, long-term provider workforce.

We also utilize grant-funded initiatives—such as clinical workforce grants—to create pipelines into hard-to-fill roles. For retention and development, we are investing in career ladder opportunities that support professional growth and advancement within the organization. In addition, as discussed above, we are establishing a primary care residency program to train new providers locally, with the goal of building a sustainable workforce for the future. Together, these efforts are designed to attract new talent, support our existing staff, and create long-term stability in our provider workforce.

How does NCH recruit and retain specialists while ensuring high-quality, up-to-date care?

(e.g. “We need specialists that are current in their field.”; “Are there enough providers to meet the needs of the community?”; “What are you doing to bring more providers to the area?”)

When you see a specialist, you should feel confident that you are receiving care that reflects current standards and strong clinical qualifications. At NCH, that expectation is built into our credentialing process. Our threshold criteria require specialists to be board certified in their primary area of practice, or board eligible within five years of completing residency or fellowship training, with continuous maintenance of certification where required. Some providers hold multiple board certifications, and some hold lifetime certifications, while others renew on an ongoing basis.

In other words, this is not left to chance or preference. Maintaining high-quality, current care is part of how we evaluate and credential providers across the System.

We are proud of the specialty care available at NCH and of the providers who deliver it. At the same time, we want to ensure that those service lines are not only strong today, but also sustainable and able to grow in the future. Recruiting and retaining specialists in a rural setting is challenging, and we are competing nationally for a limited pool of providers. The Health Resources and Services Administration (2023)

identifies many rural regions as shortage areas for specialty care, which adds to that pressure.

That said, this is not just about filling a role. It is about making sure patients have access to qualified specialists who are engaged in their field and prepared to practice in a rural environment for the long term. We also rely on partnerships where appropriate. Our cardiology, ophthalmology, and oncology services are examples of areas where we work with other hospitals and provider groups to help ensure specialized care remains available close to home.



Launching our Family Medicine residency program will also strengthen our ability to recruit specialty providers. Physicians across specialties are often drawn to academic environments where there are opportunities to teach, mentor, and engage in a culture of continuous learning. By building that academic infrastructure, NCH becomes a more attractive destination not only for primary care trainees, but also for specialists who value education, collaboration, and professional development.

We continue to evaluate how we supplement local care through visiting specialists, telehealth, and regional partnerships so patients can access the right level of expertise without always needing to travel far from home. We also know we need to do a better job communicating these options clearly so patients and community members understand what is available.



How many people work at NCH, and how is our workforce connected to the communities we serve?

(e.g. “How many people work at NCH or have families that work there?”; “How many local people are employed by NCH?”)

NCH currently employs 1,058 individuals. That makes NCH not only a major healthcare provider, but also one of the largest employers in Coös County.

We are proud of the role we play in both the health and economic wellbeing of the region. In a community like ours, healthcare is not just a service; it is deeply personal. Many of our staff were born and raised here, and it is not uncommon to see multiple generations of the same family working within NCH. That kind of connection shapes how care is delivered, because our employees are caring for their neighbors, friends, and family members.

We understand that decisions we make as an organization ripple outward. They impact not only our workforce, but also the broader community. That is something we take seriously, and it is part of why we work to balance sustainability, access to care, and local employment as we plan for the future.

This legacy of service is something we are incredibly proud of. It reflects the strength of our organizations, the commitment of our staff, and the trust placed in us by the communities we serve.

How does NCH determine entry-level wages, and how do those wages compare within the organization and the broader market?

(e.g. “How much do entry level staff make? What are you doing to recruit & retain staff & providers? Why are provider salaries being cut when there are shortages?”)

At NCH, one of the standards we are most proud of is our implementation of a socially responsible minimum wage. We are proud that we were among the first, if not the first, in the region to implement this standard. Our minimum starting wage is currently \$17.00 per hour for entry-level positions with no prior experience. That includes roles like Patient Access, which are often an entry point into healthcare careers.

As responsibilities and training increase, so does compensation. Licensed Nursing Assistants (LNAs) start at approximately \$18.21 per hour, and Registered Nurses with an associate degree begin at

around \$33.38 per hour in our hospitals. In addition to base pay, we offer add-on payments that reflect the realities of healthcare work, including \$7 per hour for night shifts, \$3 per hour for weekends, and time-and-a-half for holidays.

We also look closely at how those wages compare nationally. For roles similar to Patient Access, entry-level wages across the country typically fall in the \$15 to \$17 per hour range, depending on the market (Indeed, 2026). For nursing assistants, national data shows wages around \$16.82 per hour at the lower end and \$18.36 at the median (U.S. Bureau of Labor Statistics, 2024).

For Registered Nurses, including those with an associate degree, national data shows a broader range. Entry-level nurses earn an average of about \$28.89 per hour, increasing to approximately \$33.47 per hour within 5 to 9 years of experience, with overall wages ranging from roughly \$25 to \$45 per hour depending on experience, location, and specialty. The national median for all Registered Nurses is approximately \$45.00 per hour, reflecting the full range of experience levels (U.S. Bureau of Labor Statistics, 2024).

When you look at those comparisons side by side, our starting wages are at or above entry-level national ranges for several roles and aligned with early-career benchmarks for clinical positions, particularly in a rural setting.

Like executive compensation, staff wages at NCH are not set informally. We conduct a national market compensation analysis annually to ensure our pay is fair, equitable, and competitive, and we have made adjustments each year over the past several years as part of that commitment.

We also see these roles as starting points, not endpoints. Many of our team members begin in entry-level positions and grow into higher-paying roles through training, certification, and internal advancement opportunities.

In a rural market, being competitive isn’t optional, it’s how we sustain both our workforce and our services.





How is NCH supporting provider well-being and reducing administrative burden to prevent burnout?

(e.g. “How do we create an environment where there is not so much pressure on medical providers? Ex: reports, documentation, burnout, focus provider well-being”; “Providers seem overwhelmed.”)

Creating an environment with less pressure on medical providers starts with recognizing that burnout is not just an individual issue; it is often a system issue. The National Academy of Medicine (2019) emphasized that reducing clinician burnout requires changes to workflows, administrative burden, and organizational culture, not just individual resilience efforts.

We are actively evaluating administrative burden, including documentation, reporting requirements, and prior authorizations. We are working to streamline processes so providers can spend more time with patients and less time navigating systems. That includes improving workflows, better use of technology, and ensuring providers are practicing at the top of their license.

As part of that effort, we have implemented ambient voice AI tools to support clinical documentation, with the primary goal of reducing the burden on providers so they can focus more on patient care. This type of tool improves both efficiency and documentation accuracy, which also supports downstream operations such as coding, billing, and care coordination. In addition, we are piloting the use of AI for summarizing incoming medical records and identifying key clinical information, as well as opportunities to assist with workflows like order entry when appropriate. While these technologies offer meaningful potential, they are being thoughtfully and

responsibly implemented to ensure they align with clinical workflows and maintain high standards of care. Early research shows that ambient documentation technologies can significantly reduce documentation time and cognitive load for clinicians (Shanafelt et al., 2023).

We are also strengthening team-based care models so that responsibility is shared across care teams, not carried by one person alone. Studies have shown that well-supported team-based care can improve both patient outcomes and provider satisfaction (Bodenheimer & Sinsky, 2014).

Additionally, establishing a Family Medicine residency program will help create a more supportive and sustainable clinical environment, which can reduce stress and burnout for providers. Residency programs naturally foster collaborative care, where responsibilities are shared among attending physicians, residents, and care teams, helping to distribute workloads more effectively. They also create a culture of learning, collaboration, and mentorship, which many physicians find professionally rewarding. In addition, having learners in the environment encourages more structured workflows, clinical discussion, and peer support, all of which contribute to a stronger sense of purpose and connection. Together, these factors can improve day-to-day work experience, increase job satisfaction, and support long-term provider retention.

At the same time, we continue to focus on recruitment and retention to help distribute workloads more evenly. Workforce shortages, particularly in rural areas, remain a significant challenge. National projections from the Association of American Medical Colleges estimate a shortage of up to 124,000 physicians in the coming years, with rural communities experiencing the greatest impact (Association of American Medical Colleges, 2021).

We offer emotional support and professional development opportunities for all staff, including providers. Supporting well-being is not just about reducing workload; it is about making sure people feel supported, valued, and able to grow in their roles.

In addition, our Employee Experience Team is currently leading a systemwide survey focused on employee well-being and burnout. This work is complemented by both a Systemwide Wellness





Group and a provider-specific Wellness Group, recognizing that different roles experience pressure in different ways and need tailored support to be successful. These are important steps in making sure we are not assuming we know what our teams need but actively listening and using that feedback to guide meaningful changes moving forward.

We are also integrating High Reliability Organization principles into this work, creating an environment where staff are empowered to speak up about pressures, identify inefficiencies, and help improve the systems they work within.

Ultimately, provider well-being and patient care are directly connected. Supporting our workforce is not separate from delivering high-quality care; it is foundational to it. This is work we are committed to continuing over time.

System Model, Local Control & Future Stability

The NCH System is designed to strengthen long-term sustainability while maintaining local input and community connection.

What does it mean to be part of the NCH System, and how does working together actually benefit our local hospitals and communities?

(e.g. “NCH says that we are ‘better/stronger together’ but I am not sure what that means or how that helps us.”; “What does being part of a system actually do for our hospital?”; “How does this help our community directly?”)

We are glad you asked, because we love to explain this NCH strength! When we say North Country Healthcare is “better/stronger together,” we mean that operating as a single, coordinated system allows us to provide a level of stability, access, and care that would be very difficult—if not impossible—for three small, independent Critical Access Hospitals (CAH) to achieve on their own.

NCH functions as a 66-bed regional healthcare system, rather than three separate CAHs operating in isolation. That scale matters. It allows us to share staff across facilities when there are shortages or surges in demand, which is especially important in a rural area where recruiting can be challenging. It also allows us to share specialized resources—whether that’s clinical expertise, equipment, or support services—so that patients benefit from a broader network of care without needing to leave the region.

Just as importantly, being a system allows us to move patients between sites when appropriate, ensuring they receive the right level of care at the right time, while still staying as close to home as possible. Instead of each hospital trying to do everything independently, we can coordinate care across the region in a way that is more efficient and higher quality. In short, “stronger together” means more stability, more flexibility, and better access to care for our communities than any one hospital could provide on its own.

Behind the scenes, the system structure allows key functions like IT, supply chain, finance, quality, and compliance to be supported centrally. This reduces duplication and allows local teams to focus more of their time and energy on patient care.

This work did not happen overnight. NCH began this journey in 2016 with the goal of building a more sustainable model for rural healthcare. Along the way, we experienced both the loss of an early affiliate and a global pandemic. While those moments created challenges, they also reinforced the value of operating as a coordinated system. During times of disruption, the ability to share resources, support one another, and adapt together proved to be a strength.

How is NCH ensuring long-term stability and communicating clearly about rumors or concerns related to the future of the organization?

(e.g. “I was told a group is looking for NCH to be dissolved — rumor or potential fact?”; “We want to feel assured the hospital is here to stay!”; “Is AVH closing? How are they doing financially? What will we do if our local hospital closes?”; “There was discussion about a group wanting to dissolve NCH. Is that true? Or just a rumor?”)

To be clear, there is no plan or effort underway to dissolve North Country Healthcare; nor is there a plan to close any of our three hospitals or our home health and hospice agency. In fact, the very opposite is true. Our affiliation is what allows our hospitals and home health and hospice agency to operate from a position of strength today and into the future.

The NCH affiliate hospitals could not operate as independent, stand-alone entities over the long term. Independence is not a viable option given the financial and operational realities of rural healthcare today. The financial pressures facing rural healthcare—including reimbursement constraints, workforce shortages, and rising operational costs—are simply too great for small, rural hospitals to



absorb on their own. As part of the NCH system, these hospitals can share resources, infrastructure, and expertise that are essential to maintaining access to care in the communities they serve. Without that system support, their long-term viability would be at significant risk.

NCH and its Affiliates remain focused on providing care close to home and strengthening services for the long term. The changes we have made recently ensure that our hospitals remain open, services lines can grow, and for those patients who want or need care at home, our home health and hospice services are available to them.

We are here. We continue to invest in our System. Our goal is to ensure that high-quality care remains available in the North Country for years to come.

How is NCH working to sustain local hospitals, and how will communities be informed about the financial health and long-term stability of each affiliate?

(e.g. “Is AVH closing? How are they doing financially? What will we do if our local hospital closes?”; “Are North Country hospitals at risk of closing due to Medicaid budget cuts? What can citizens do to help?”; “We want to feel assured the hospital is here to stay!”)

There is no plan to close any of our hospitals. NCH is committed to keeping care local and strengthening services across the System. One of the core strengths of a multi-hospital system like NCH is its ability to balance financial performance across its affiliates. When one hospital experiences a period of financial difficulty, the System can absorb those challenges while improvement work is underway. This is not theoretical; it is something NCH has done. For example, the system was able to support Weeks Medical Center (WMC) through a sustained period of financial strain while a comprehensive financial improvement plan was implemented from 2023 to 2025.

Because WMC was part of the NCH System, it had the stability and time needed to improve its performance. If WMC had been operating independently, it likely would have exhausted its cash reserves and faced the very real risk of closure or significant debt. We are proud to say that today, because of the collaboration and support available to WMC as part of the system, WMC is operating from a position of financial strength.



This system model is also what allows NCH to maintain and expand critical—but often financially challenging—services across the region. Services like behavioral health and substance use disorder (SUD) treatment are essential to our communities but are not always self-sustaining. Because NCH operates as a system, we can support and subsidize these services through overall financial performance, ensuring that patients in the North Country continue to have access to the care they need close to home. In other words, services that may not be financially self-sustaining at one location can continue because they are supported by the strength of the System as a whole. In short, the system structure is what preserves—not threatens—the long-term viability of our hospitals and the services they provide.



Why is central supply located in Littleton, and how does that decision support our hospitals and communities?

(e.g. “What was the thought process of supply chain/central supply in Littleton?”)

That’s a fair question, especially when you look at it from the perspective of individual hospital locations. This approach was shaped by what we experienced during the COVID-19 pandemic, when supply chains were disrupted nationwide and rural hospitals faced real challenges accessing even basic supplies. That experience highlighted the need for a more coordinated and reliable system.



The decision to base central supply in Littleton was made with a system-wide view in mind. While it may not feel “central” to any one hospital, it is central to the broader region we serve. From Littleton, we are able to efficiently support a large geographic footprint, from the Canadian border down to Plymouth, and from the Vermont border across to Maine. Littleton is close to major roadways, which allows for more efficient transportation and distribution, and it is also in close proximity to several of our neighboring partner hospitals. By consolidating distribution in one location, we are also able to

reduce reliance on multiple long-haul deliveries, which have become increasingly expensive for rural areas.

A centralized model helps us improve consistency, manage inventory more effectively, and reduce duplication across sites. In a rural healthcare system, those efficiencies matter, because they allow us to stretch resources further while maintaining reliable access to the supplies needed for patient care. It also allows us to respond more quickly to shortages or changing needs across the system, rather than each site managing those challenges independently.

Governance, Leadership & Accountability

Clear governance structures and accountability mechanisms ensure responsible leadership and decision-making.

What is NCH’s organizational structure, and how does its nonprofit status shape how decisions are made?

(e.g. “Is the hospital for profit?”; “NCH has lost its nonprofit way. Executive compensation is not nonprofit.”; “Who does Tom Mee answer to?”)

North Country Healthcare and its Affiliates are all nonprofit organizations. That distinction matters. In a nonprofit health system, the fiduciary responsibility is to deliver on the mission and serve the community. In a for-profit system, the fiduciary responsibility is to maximize shareholder value.

That means we do not have shareholders or owners who receive profits. Instead, any revenue generated is reinvested into the System to support patient care, staff, facilities, technology, and services for the communities we serve. There are no distributions to individuals or owners. Resources stay within the organization to support care and operations.

Being a nonprofit also means we are accountable to significant oversight at both the state and federal level. In New Hampshire, charitable healthcare organizations are subject to oversight by the New Hampshire Department of Justice Charitable Trusts Unit, which reviews matters related to charitable governance, reporting, and community benefit. At the federal level, nonprofit hospitals must qualify under Internal Revenue Code Section 501(c)(3) and comply with additional hospital-specific requirements under Section 501(r), including conducting a Community Health Needs Assessment every three years, maintaining a financial assistance policy, limiting



charges for eligible patients, and following specific billing and collections rules (Internal Revenue Service, 2025a, 2025b; New Hampshire Department of Justice, 2025).

From a governance perspective, the CEO is accountable to the Board of Directors, which is responsible for oversight of strategy, performance, and adherence to the organization’s mission. Our mission is to improve lives by assuring consistently excellent, integrated healthcare, and our nonprofit status, along with these accountability structures, helps ensure that mission remains the primary driver of decisions across the organization.

What do the NCH and Affiliate Boards do, and how do they stay focused on oversight without getting involved in day-to-day operations?

(e.g. “What is the role of the NCH and hospital boards?”; “Are they governance or are they also involved in operations?”; “Does the board cross the line between governance and operations?”)

The role of the NCH Board and the affiliate Boards is firmly rooted in governance, not operations. Board members have fiduciary duties of care, loyalty, and obedience, which require them to act in the best interests of the organization, ensure financial stewardship, and uphold the mission and strategic direction of the system. In fulfilling these responsibilities, boards provide oversight of executive leadership, approve strategic plans, monitor organizational performance, and ensure compliance with legal and regulatory obligations. Day-to-day operations, however, are the responsibility of management. While effective boards ask thoughtful questions and maintain appropriate visibility into operations to inform their oversight role, they do not engage in operational decision-making or management functions. Maintaining this clear distinction is essential to strong governance and organizational effectiveness.

How much local control does each Affiliate retain?

(e.g. “We seem to be experiencing a loss of local control and input of each hospital; how do we stop or prevent this?”; “Are decisions being made locally or at the system level?”; “How are community voices included in decisions that affect our hospital?”)

Maintaining strong local control and input is essential to the success of NCH. Each hospital serves a unique community with distinct needs, and that local insight

is critical to ensuring care remains responsive, relevant, and effective.

At the same time, operating as a system allows us to share resources, coordinate strategy, and strengthen long-term sustainability across all affiliates. The goal is not to replace local decision-making, but to align it within a broader framework that supports the whole system.

One of the ways we do that is through active engagement of local affiliate boards, which bring forward community perspectives, identify emerging needs, and help ensure that decisions reflect what is happening locally. These structures are essential to maintaining strong local input while benefiting from system-level coordination.

Part of what is evolving is how we think about “local.” In the past, that often meant a single hospital and its immediate community. Today, it also includes the broader region we serve across the North Country.

That does not replace local perspective. It expands it. It allows us to consider both the needs of individual communities and the needs of the region, so we can make decisions that strengthen access to care across all of our communities, together.

How does NCH ensure executive compensation is appropriate, transparent, and aligned with comparable organizations?

(e.g. “How does Tom Mee’s salary compare to others in his position?” “Salary discrepancies”; “High level paid a lot”)

At NCH, executive compensation is not set informally or by individuals. It is governed by a Board-adopted compensation philosophy and reviewed through a structured, independent process designed to ensure fairness, accountability, and alignment with our mission. In simple terms, no one sets their own pay. Compensation is reviewed and approved by an independent Board committee using external data and established benchmarks.

It is also important to clarify that the NCH CEO role is a system-level position, responsible for leading a healthcare system that includes three hospitals and a home health and hospice agency. This is different from leading a single hospital, and compensation is evaluated accordingly.

In nonprofit healthcare across New Hampshire and the United States, compensation is guided in part by IRS regulations, which require organizations to use



comparable market data when setting pay. This means looking at similar organizations based on size, geography, complexity, and financial performance, and using that data to inform decisions.

This process, often referred to as benchmarking, is a standard best practice across nonprofit health systems (Internal Revenue Service, 2023). That means looking at what leaders in comparable roles are paid and making sure compensation at NCH falls within a reasonable range.

At NCH, this work is led by a Board committee, supported by an external firm which specializes in healthcare compensation benchmarking. The firm uses research on nonprofit hospital compensation and provides measures that are commonly used to align leadership incentives with both operational performance and patient care outcomes. They do not work for NCH leadership, and their role is to provide objective, market-based data to the Board committee.

It is also important to note that incentive compensation is not automatic. It is tied to organizational performance, including financial stewardship, patient safety, quality outcomes, and system-level goals. The Committee reviews market data annually and documents all decisions through a formal process to ensure consistency and objectivity.

Remaining competitive is an important part of setting compensation. In the North Country, where recruiting healthcare professionals is already challenging, offering competitive compensation helps ensure we can attract and retain the leadership needed to support access to care, maintain quality, and build long-term stability for our communities.

Ultimately, this structure is in place to ensure that compensation decisions are not subjective, but instead follow established nonprofit standards, are independently reviewed, and reflect the scope and responsibility of leading a complex, multi-entity rural healthcare system.



How are executive incentives determined, and how do employee performance and organizational goals factor into that structure?

(e.g. “Bonuses for executive leadership are based (to my understanding) on the performance of the employees. Meeting meters, quality etc. Would it be better to include employees in that system?”; “What % did management bonuses decrease after outsourcing?”)

Executive variable compensation (sometimes referred to as bonuses) is established through a structured, board-governed process designed to ensure it is fair, performance-based, and aligned with the organization’s mission and strategic priorities. Variable compensation opportunities are set in advance and tied to clearly defined performance metrics, including financial performance, quality and patient safety outcomes, operational goals, and strategic initiatives. At the end of each performance period, results are evaluated against those established goals, and any incentive payout is determined based on actual performance. If those goals are not met, incentives are reduced or not paid. This process is designed to meet the requirements of the Internal Revenue Code, ensuring that compensation decisions are made by independent decision-makers, informed by appropriate data, and properly documented.

At NCH, performance-based incentives extend beyond the executive team. Providers, select nursing positions, and other non-clinical leaders also have performance-based compensation tied to a combination of organizational goals. Many of those measures are directly connected to the work happening across teams, because healthcare outcomes are inherently collective. No single role determines those outcomes on its own. That said, the intent is not to place pressure on employees, but to ensure that leadership is accountable for creating the conditions that support strong performance across the organization.

Additional differentials apply, including an additional \$7 per hour for night shifts, \$3 per hour for weekends, and time-and-a-half for holidays. This is not unique to clinical leaders, but part of how healthcare organizations ensure consistency, safety, and accountability across different functions.

We also recognize the spirit of your question, which at its core is about fairness and shared success.



There is a growing body of research that supports aligning incentives across teams and organizations. 2024 survey data found that 93% of health systems reported utilizing incentive-based compensation (Beckers Hospital Review, 2024). When done thoughtfully, shared incentive structures can strengthen engagement, improve collaboration, and reinforce a sense of collective ownership (Pink, 2009).

At NCH, we are continuing to evolve how we recognize and reward our workforce more broadly. One example of that is our implementation of a socially responsible minimum wage. We are proud that we were among the first, if not the first, in the region to implement this standard. We recognize that many of our employees live and work in the same communities as our patients, and ensuring a livable wage is an important part of promoting financial stability and overall well-being. This step reinforces our values as a mission-driven organization and demonstrates our commitment to being a responsible and supportive employer in the North Country.

Ultimately, our goal is to create a culture where success is shared, best practices are promoted, where people feel valued for their contributions, and where leadership is accountable not just for outcomes, but for how those outcomes are achieved.

Does the NCH CEO live near the hospitals and understand our communities?

(e.g. “Does NCH CEO even live here? How much time does the CEO spend in northern NH?”; “All of the men in suits should have been introduced by name/position and where they live.”)

He sure does! Our CEO, Tom Mee, is a full-time New Hampshire resident and has been a registered NH voter since 2019. He spends his time in the North Country, regularly traveling across our Affiliates to stay connected to staff, providers, and the communities we serve. That includes time in our hospitals, clinics, and community settings, not just in meetings.

Tom has made a personal commitment to this region, and cares deeply about the quality of care people in the North Country receive. Believing that we could be an organization that provides the safest care through a journey towards High Reliability is just one of the reasons Tom chose NCH.

Outside of his workday, Tom can be found exploring local rivers or woods. As an avid hunter and former-professional fisherman, he appreciates the White Mountains region and all there is to explore. Tom genuinely values being part of the North Country community, meeting the people across the region, caring for both the staff he is privileged to see in action and the patients they care for.

If you want to get to know him a bit more, we recommend checking out our official organization podcast, Rural Roots: A Road Less Travelled, which highlights the unique roles, paths, and opportunities that make rural healthcare what it is. Tom has joined the podcast twice so far, [Season 1, Episode 11](#) and [Season 2, Episode 4](#) with plans to join each season to share updates and his perspective.

Operations, Outsourcing & Financial Processes

Operational decisions, including outsourcing and financial processes, are designed to improve efficiency, sustainability, and access to care.

How is NCH defining and communicating the scope of outsourced services, including which functions are impacted?

(e.g. “I was aware of billing and coding but unaware that authorizations, referrals, and scheduling may also be involved?”; “Why does scheduling and billing have to be outsourced?”; “What is the impact of outsourced leadership tools at NCH?”; “Do people have to give personal information to outsourced functions?”)

That is a fair question, and we understand how this can feel broader than expected.

To be clear, most health systems today outsource all or part of their revenue cycle. As billing, coding, and insurance requirements have become more complex, this work has required specialized expertise, advanced technology, and constant adaptation to regulatory and payer changes. It is no longer something most hospitals can effectively manage on their own. Industry data shows that nearly 70% of hospitals and health systems have moved to outsource all or part of their revenue cycle operations because of the growing complexity of billing, coding, and payer requirements.

The changes we made were focused on specific parts of the revenue cycle, including areas such as billing,



coding, authorizations, referrals, and scheduling. Across most health systems, they are treated as a single, integrated process rather than separate functions. Revenue cycle management spans everything from scheduling and insurance verification to billing and final payment, all of which need to work together for the system to function smoothly (Healthcare Financial Management Association [HFMA], 2026).



The patient-centric revenue cycle roadmap. (Healthcare Financial Management Association [HFMA], 2026).

The changes made in revenue cycle were not a full outsourcing of hospital operations. Care delivery, clinical decision-making, and the overall patient experience remain local and are led by NCH teams. Even within the areas that were realigned, NCH continues to provide oversight, set expectations, and remain accountable for how those services are delivered.

We also recognize that the scope of these changes may not have been clearly understood at the time. We should have done a better job communicating that up front, and that is something we are actively working to improve.

How does NCH ensure that vendor selection processes are fair, transparent, and compliant with applicable state and federal requirements?

(e.g. “Was there an unfair bidding process?”; “If NCH affiliates receive federal funds, did this contract meet requirements for that?”; “Was there defined [unclear] in place for selection?”; “Was there an arms-length procedure in place for procure, review, select-proposal for outsourcing revenue cycle?”; “What is COI policy with regard to independent contractors?”)

The selection process followed a structured and compliant approach. Fairness was not an afterthought; it was built into the process from the beginning. NCH conducted a structured evaluation over a number of years that included reviewing multiple options, assessing experience and performance in healthcare revenue cycle operations, and ensuring the selected partner could meet the specific needs of a rural health system. The process included internal review, expert input, and documentation to support decision-making.

Our responsibility as a nonprofit healthcare system is to be good stewards of both public and community resources. That means making decisions through a process that is fair, consistent, and compliant while also ensuring we select partners who can support the long-term sustainability of care in the North Country.

What process did NCH use to evaluate and select an RCM partner?

(e.g. “How was the external RCM consultant selected? What was the decision process?”; “With respect to proposals received — how many others were there?”; “Was there an arms-length procedure in place for procure, review, select-proposal for outsourcing revenue cycle? What was the process? Who was involved?”; “Was decision to go with the external RCM consultant made by parties with no interest?”)

At NCH, our revenue cycle management (RCM) work is guided by established policies and a structured operational process focused on accuracy, compliance, and the patient experience.

Over the past five years, NCH has worked with national experts to evaluate opportunities to strengthen our revenue cycle operations. One consistent finding across multiple reviews was that billing and payer requirements have become significantly more complex, and that strengthening the systems supporting accuracy and timeliness is critical to sustaining local healthcare services (Guidehouse, 2024).

Based on that guidance, NCH made the decision to further align certain RCM functions with an external partner. This was not a new concept for NCH, as portions of revenue cycle work had already been supported through external partnerships for several years. The goal of this transition was to improve consistency, reduce avoidable claim issues, maximize patient insurance coverage, and better manage increasing insurer requirements, while



allowing NCH teams to remain focused on patient care and local service continuity.

The partner was selected through a structured evaluation process that included expert input, multiple rounds of review, and consideration of how well the partner could adapt to NCH’s rural environment. A key priority was avoiding a one-size-fits-all approach and ensuring that any partner could work within the realities of rural healthcare delivery.

More broadly, many healthcare organizations use some level of external partnership support for revenue cycle functions due to the growing complexity of billing and payer systems (Cass, 2024). NCH’s approach reflects that broader trend, while remaining focused on strengthening sustainability and reducing avoidable friction for both patients and staff.



How did NCH evaluate internal improvements versus outsourcing when making decisions about revenue cycle operations?

(e.g. “Can you explain why you didn’t choose to fix the process/system instead of outsourcing?”; “Why did RCM outsource instead of internal creation?”; “Why does scheduling and billing have to be outsourced?”)

That is a fair question, and it’s one we spent several years working through.

Before making any changes, NCH made multiple efforts to improve these processes internally. That included recruiting for open positions, investing in training, and working to strengthen workflows across

billing, authorizations, scheduling, and follow-up. Despite those efforts, some of the same issues, including delays, inconsistencies, and challenges navigating insurance requirements, continued to persist over time.

The decision to realign certain revenue cycle functions was made after those internal efforts had been in place for years. It was not about replacing that work, but about stabilizing areas where improvement had been difficult to achieve and creating a more consistent experience for patients navigating scheduling, insurance approvals, and billing.

We also want to be clear that this was not a reflection on the commitment of our staff. Our teams were working hard within a system that had growing complexity and limitations. This change was about strengthening the system itself so that both patients and staff are better supported.

What has been the impact of recent operational changes, including outsourcing, on employees and local jobs?

(e.g. “How many people lost their jobs with these changes and outsourcing? Berlin, Lancaster, Colebrook.”; “How many people have lost jobs because of outsourcing collectives?”; “How many staff have been impacted by the layoffs?”; “Local jobs are important.”)

We understand why this matters, especially in a community like ours where people know each other.

As part of these changes, one (1) employee left the organization because their position was eliminated as part of the workforce reduction.

In addition, between August 2025 and January 2026, 30 employees in revenue cycle-related roles chose to leave NCH prior to position eliminations or in anticipation of potential changes. We understand that those who chose to leave were navigating uncertainty, and that is an uncomfortable place to be. As we worked through next steps for each individual, we recognized the weight of that experience and truly wish them the best moving forward.

At the same time, 31 employees transitioned into other roles within NCH, including positions in patient access, authorizations, clinical pathways, and other support functions. Several of those transitions created opportunities for growth and advancement within the organization.



Our goal throughout this process was to minimize disruption and support our employees through the transition wherever possible. We recognize that any change like this has a real impact on people and on the community, and that is something we took seriously throughout the process.

Community Impact, Services & Future Planning

Planning for the future includes expanding services and aligning care with the evolving needs of the communities we serve.

Is NCH considering future growth or partnerships, including the addition of new Affiliates?

(e.g. “Is NCH acquiring another affiliate e.g. Spear, Cottage”; “Is the hospital for profit? Purchased by a bigger ‘shark’ (MaineHealth, Dartmouth)? What would happen?”; “What changes are coming next?”)

Our focus right now is on strengthening the services we provide across our existing System and continuing to improve access, quality, and the patient experience in the communities we already serve.

That said, as a rural healthcare organization, we are always looking for thoughtful opportunities to expand services or partnerships in ways that support long-term sustainability and improve access to care. Any future decisions of that nature would be guided by our mission, the needs of our communities, and a structured governance process.

If and when there are developments to share, our commitment is to communicate clearly and directly with our communities.

Is NCH considering being acquired by or affiliating with a larger healthcare system, and what would that mean for local care?

(e.g. “Is the hospital for profit? Purchased by a bigger ‘shark’ (MaineHealth, Dartmouth)? What would happen?”; “Is NCH acquiring another affiliate e.g. Spear, cottage”; “What is the long-term plan for healthcare here?”)

There is no plan for NCH to be purchased by a larger health system. Just the opposite. The work we have done and continue to do is to ensure that we can remain a strong, independent rural healthcare system without a large, tertiary care hospital that dominates the affiliation.

We understand why people ask this. Rural hospitals across the country are under pressure and communities have seen closures, consolidations,

and service reductions elsewhere. The American Hospital Association reported that 136 rural hospitals closed between 2010 and 2021, including 19 in 2020 alone. More recently, the Chartis Annual Report noted that 417 rural hospitals were vulnerable to closure in 2026 (Chartis, 2026). We have seen examples nationally and regionally where large, for-profit systems have reduced or eliminated certain service lines, including behavioral health, when those services are not financially sustainable. Those decisions can be difficult for communities, especially when access is already limited.

That is exactly why NCH’s model matters. North Country Healthcare was built as a nonprofit rural system designed to help community hospitals stay open by sharing resources, reducing unnecessary duplication, and strengthening long-term sustainability. In practice, that means shared support for functions like finance, HR, compliance, quality, IT, and supply chain, while care remains rooted in local communities. The goal is not to make our hospitals less local. The goal is to make them more resilient and ensure that care remains available in the communities we serve.

As a nonprofit health system, we strive to provide care regardless of a patient’s ability to pay. In the emergency department, this obligation is mandated by the Emergency Medical Treatment and Labor Act (EMTALA), which requires that anyone who presents for care be medically evaluated and stabilized, regardless of insurance status or ability to pay. Outside of the emergency department, we are not subject to the same federal mandate; however, as part of our commitment to community benefit, we provide reduced costs and when possible, free care through our charity care programs.

At the same time, providing this level of access does have financial implications. Care is often delivered without full reimbursement, particularly in rural communities where a higher percentage of patients rely on Medicare, Medicaid, or have limited ability to pay. That makes financial stability more complex and requires careful planning, strong operational management, and a system structure that allows resources to be shared and sustained over time. That commitment is an important part of how we think about long-term sustainability and access to care in the North Country



This approach matters because rural hospitals face many of the same fixed costs as larger facilities while serving fewer patients and frequently being paid less than the cost of care by major government payers. The American Hospital Association has noted that Medicare makes up nearly half of rural hospital revenue and that Medicare and Medicaid often reimburse below the cost of providing services.

National research also suggests that affiliations and partnerships can help preserve access to care rather than drive closures. The AHA’s Future of Rural Health Care Task Force found that strategic alliances and partnerships can help strengthen rural hospitals, prevent closures, and preserve local availability of care when they are designed thoughtfully. The system model is part of how we work to avoid becoming the next rural closure story.

How much Financial Assistance does NCH provide each year, and how is that care delivered across our services?

(e.g. “What is the percent of charity care provided by NCH annually?”; “How much free or reduced-cost care is provided?”; “Where does charity care show up across services?”)

NCH is deeply committed to providing care and delivering meaningful community benefits across the region each year. This includes care provided to eligible patients regardless of their ability to pay, as well as a range of programs and services that support community health.

Financial Assistance, previously often referred to as charity care, is reported at the hospital level, not at the NCH parent organization level. For North Country Healthcare, that means this information is reported separately by Androscoggin Valley Hospital, Upper Connecticut Valley Hospital, and Weeks Medical Center.

In 2024, Weeks Medical Center reported \$1,121,882 in Financial Assistance at cost, Upper Connecticut Valley Hospital reported \$180,184, and Androscoggin Valley Hospital reported \$621,098. Together, those three hospitals reported \$1,923,164 in Financial Assistance at cost.

Because this information is reported through each hospital, it is not broken down by individual provider type, such as primary care physicians, nurse practitioners, physician associates, specialists, or nurses. Instead, it reflects hospital-level Financial

Assistance provided to eligible patients under each hospital’s policy, across the services those hospitals deliver.

What ophthalmology services are available at AVH, and are there plans to expand access in the future?

(e.g. “Tell us more about ophthalmologist services at AVH.”; “What eye care services are available locally?”; “Will there be more access to specialists like ophthalmology?”)

In early 2026, NCH partnered with an ophthalmology physician practice to bring this care to the North Country. We recognized that this was a much-needed service for the region and worked to find a partner that could deliver quality care in our clinics. So far, the practice is busy, and we are thrilled to say it is expanding. In June 2026, the group will add surgical services to the care available to our patients. This partnership is a great example of NCH partnering with other healthcare providers to ensure that our patients get excellent care close to home.

Are there plans to offer services like pharmacy and social support in one location to make care easier to access?

(e.g. “Can you have pharmacy and social services on site?”; “Can services be located together so it’s easier for patients?”; “Is there a way to make care more coordinated in one place?”)

We have retail pharmacies at both Upper Connecticut Valley Hospital and Weeks Medical Center where community members can fill prescription medications and purchase over-the-counter medication.

Currently, NCH has financial counselors available at all our hospitals, but we do not have external social services available on site. NCH is exploring opportunities to collaborate with external partners to expand access to essential support services within the communities we serve.

While these services are not currently provided within our hospitals, NCH recognizes the significant role that social services, legal assistance, and other community-based resources play in overall health and well-being. To better meet these needs, NCH is evaluating models to bring trusted partners to our affiliates and into accessible, community-centered locations, such as local libraries, schools, and other



shared spaces, where individuals can more easily connect with the support they need. Through these partnerships, NCH aims to help strengthen the broader network of care that supports individuals beyond the walls of our healthcare facilities.

How is NCH planning to support the needs of our aging population, including services like a senior health center?

(e.g. “Would NCH offer a senior health center to support the aging population?”; “What services are available for seniors in our community?”; “How is NCH planning for an aging population?”)



NCH is not currently planning to develop or operate a dedicated senior health center. However, we recognize that access to fitness, social engagement, and community-based activities is essential to supporting the health and well-being of our patients. NCH remains committed to advancing the overall health of our communities and will continue to explore opportunities to collaborate with community partners, local organizations, and existing programs that promote active, connected, and healthy aging.



Trust, Transparency & Communication

Building trust requires consistent, transparent communication and a commitment to being a reliable source of information for the community.

How does NCH manage provider transitions while supporting continuity of care and patient trust?

(e.g. “Why did you let a trusted practitioner leave?”; “When we finally received information that [Provider] had gone, it was communicated very poorly.”)

We understand how impactful it is when a trusted provider leaves, especially in a rural community where those relationships matter deeply. In many cases, provider transitions are driven by personal or professional decisions outside of NCH’s control. That said, our responsibility is to create an environment where all our staff feel supported and want to stay.

While we cannot comment on the departure of any one provider, know we are actively focusing on retention through improved onboarding, peer support, and workload balance, while also working to recruit providers who are committed to building long-term relationships in our communities.

How will NCH serve as the source of truth so patients, staff, and community members can clearly understand care processes and decisions?

(e.g. “How do we get to understanding all sides of issues/processes for patient care? Includes all levels of staffing.”; “Mixed or incomplete information — how do we get the right info from you (ideally in advance)?”; “So much different info out there (conflicting) how do we get the right info from you (ideally in advance)?” “So much different/conflicting info out there. How do we get the right info from you (ideally in advance of big changes)?”; “There is too much conflicting information.”; “How will we know what is actually true?”)

We hear you. We heard throughout the listening sessions that we need to communicate better. These are very real concerns, and honestly, it’s something we know we need to keep improving. When information feels mixed or incomplete, it creates frustration and uncertainty, especially when it involves your healthcare.

We are committed to communicating more clearly and more consistently. That includes strengthening our website as a central source of information, increasing direct communication with patients, and using local media and social platforms to share timely updates.



Our local affiliate boards play a critical role in ensuring that NCH remains closely connected to the communities we serve. As trusted community leaders, they bring forward real-time feedback, local perspectives, and emerging needs helping to inform decision-making at both the affiliate and system levels. They also serve as important ambassadors and surrogates for the community, providing insight into how decisions may be experienced locally and helping to build understanding, trust, and transparency between the organization and the people it serves. In many ways, they serve as a direct link between NCH and the communities we serve, helping ensure that local voices continue to shape how decisions are understood and implemented.

We are working to create additional avenues to receive feedback from our patients and the community. One of the ways we are doing that is through the development of our Patient and Family Advisory Council (PFAC), which creates a direct partnership between patients, families, and hospital leadership. The goal is to ensure that the voices of those receiving care are not just heard but actively integrated into how we design and improve services.

PFAC is designed to bring forward real experiences and perspectives to help inform decisions related to patient experience, safety, communication, and access. It allows us to move beyond assumptions and better understand what is working well and

where we need to improve, directly from the people we serve. This is one of the ways we ensure that the information we share reflects real experiences, not assumptions.

In addition to PFAC, we rely on multiple feedback channels, including patient experience surveys, frontline staff input, and community listening sessions like the ones that informed these questions.

We are also working to make it easier to know where to go for accurate information. That includes strengthening how we use our website, patient communications, and community updates so that there are clear, consistent sources people can rely on. Internally, we are putting more structure around how information is shared so that staff across our System are receiving the same, aligned messaging. That helps ensure that when you ask a question, whether it is at a front desk, on the phone, or in a clinic, you are hearing consistent and accurate information.

We encourage you to join us at Community Conversations, attend upcoming events like hospital open houses and Butterfly Releases, or consider getting involved in our Patient and Family Advisory Council (PFAC). You can also always reach out to us directly by email with questions or concerns at nchlistens@northcountryhealth.org.





References

- Association of American Medical Colleges. (2021). The complexities of physician supply and demand: Projections from 2019 to 2034. <https://www.aamc.org>
- American Hospital Association. (2022, September 7). Rural hospital closures threaten access: Solutions to preserve care in local communities. <https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf>
- American Hospital Association. (2021, May). Final recommendations: Future of rural health care task force. <https://www.aha.org/system/files/media/file/2021/05/final-recommendations-future-of-rural-health-care-task-force-may-2021.pdf>
- Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: Care of the patient requires care of the provider. *Annals of Family Medicine*, 12(6), 573–576. <https://doi.org/10.1370/afm.1713>
- Cass, A. (2024, September 10). How health system leaders feel about their revenue cycle outsourcing partners. *Becker's Hospital Review*. <https://www.beckershospitalreview.com/finance/how-health-system-leaders-feel-about-their-revenue-cycle-outsourcing-partners/>
- Chartis. (2026, February 10). 2026 state of the state: Rural health. <https://www.chartis.com/insights/2026-rural-health-state-state>
- Council of Nonprofits. (n.d.). Executive compensation. <https://www.councilofnonprofits.org/running-nonprofit/governance-leadership/executive-compensation>
- DHHS. (2026). Medicaid Transportation. <https://www.dhhs.nh.gov/programs-services/medicaid/medicaid-transportation>
- Foundation for Healthy Communities. (2025), “Coös Non-Emergency Medical Transport (CNET/NEMT) Program.”
- Guidehouse. (2024, August). 2024 revenue cycle management report: Making every claim count [Report]. <https://guidehouse.com/-/media/new-library/industries/health/documents/2024/2024-revenue-cycle-management-report-guidehouse.ashx>
- Indeed. (2026). Patient access representative salaries in the United States. <https://www.indeed.com/career/patient-access-representative/salaries>
- Internal Revenue Service. (2023). Intermediate sanctions: Excess benefit transactions (Section 4958). <https://www.irs.gov>
- Internal Revenue Service. (2025a, July 1). Requirements for 501(c)(3) hospitals under the Affordable Care Act - Section 501(r).
- Internal Revenue Service. (2025b, July 1). Community health needs assessment for charitable hospital organizations - Section 501(r)(3).
- Internal Revenue Service. (2025c, July 1). Charitable hospitals: General requirements for tax exemption under Section 501(c)(3).



National Academy of Medicine. (2019). Taking action against clinician burnout: A systems approach to professional well-being. National Academies Press.

New Hampshire Department of Health & Human Services. (2026). Medicaid Transportation. <https://www.dhhs.nh.gov/programs-services/medicaid/medicaid-transportation>.

New Hampshire Department of Justice, Charitable Trusts Unit. (n.d.). Health care organizations.

Healthcare Financial Management Association. (2026, February 27). Healthcare revenue cycle management (RCM) – What it is & how it works. <https://www.hfma.org>

Health Resources and Services Administration. (2023). Health professional shortage areas (HPSAs). <https://data.hrsa.gov>

Shanafelt, T. D., Dyrbye, L. N., & West, C. P. (2023). Addressing physician burnout: The role of technology and workflow redesign. *JAMA*, 329(12), 1017–1018. <https://doi.org/10.1001/jama.2023.2742>

National Rural Health Association. (2026). About rural health care. <https://www.ruralhealth.us>

New Hampshire Medicaid, Non-Emergency Medical Transportation <https://www.dhhs.nh.gov/programs-services/medicaid/medicaid-transportation>

Office of the National Coordinator for Health Information Technology. (2020). Connecting health and care for the nation: A shared nationwide interoperability roadmap. <https://www.healthit.gov>

U.S. Office of Management and Budget. (2024). Uniform administrative requirements, cost principles, and audit requirements for federal awards (2 C.F.R. Part 200). <https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200>

U.S. Bureau of Labor Statistics. (2024). Occupational employment and wage statistics: Nursing assistants. <https://www.bls.gov/oes>

U.S. Bureau of Labor Statistics. (2024). Occupational outlook handbook: Registered nurses. <https://www.bls.gov/ooh/healthcare/registered-nurses.html>