Dear Dr Hamory,

I am sure that you have heard from several of my colleagues regarding our dismay at the final report presented to the Green Mountain Care Board. I am adding my voice to those. I will ultimately concentrate on your statements about obstetrics at North Country Hospital, but I also question some other assertions in your presentation. I would contend that you did NOT speak with or interview a thousand or so people in the state of Vermont. You held several meetings at which maybe that many people in total were present, but you did not speak with them. You spoke to them. And, you obviously did not listen to them. If you wanted to really understand how healthcare functions in this state, you should have spoken with the people who are directly responsible for delivering it. I would have certainly made time in my busy schedule to meet you in my office to discuss how obstetrics functions at NCH. And, I would have been more than happy to show you our "small" and "outdated" ORs. By the way, they are neither. But, you wouldn't know that, because you did not see them.

You recommend severely limiting what we do at NCH, yet it would seem that our productivity is at least at the 50th percentile, since we were not on the list of underperforming institutions. If our gross revenue is up $14MM this year, yet expenses are only up $700k and we are still losing money on operations, there are some conclusions that could be drawn. Either we have a problem with our revenue cycle or we are not reimbursed well enough for the work we do. We made clear to you, and to the GMCB, that Cerner has posed significant problems with revenue cycle. But, also, since we have the highest proportion of Medicaid and Medicare in the state, it is likely that our reimbursement is lower than other institutions. It also means that we care for the most vulnerable population. You are proposing that we make it more difficult for this population to get care. I understand that most of the state of Vermont has no idea how things function in the real Northeast Kingdom. They might prefer that we go away, but the healthcare professionals here would like to keep caring for our people.

You already know that I take exception to your interpretation (or misinterpretation) of the JAMA article regarding obstetric volume and severe maternal morbidity (SMM) at rural and urban hospitals. I think that you take liberties in order to try to make a point. What you may recall from the article is that there was NO difference in SMM between rural hospitals that delivered between 111 and 240 babies and those that delivered between 241 and 460 babies per year. The incidence was 0.55 in each. The decrease occurred above 460 births per year. And then it was only to 0.47. This would imply that there would be 8 more incidences of SMM per 10,000 births. At our hospital, that would take 50 years. Plus, as you may know, just because there is a SMM, it does not mean that it is handled inappropriately. There is no evidence that an SMM is better handled at a larger institution. I am not sure why you continue to press the 240 births number. It is a misleading statement. The other clear point made in the article is as follows (taken directly from the article):

"In rural counties, closure of hospital-based obstetric units, which are at greater risk

of closure when they are lower volume and located in more remote areas, is associated with

increases in emergency birth and preterm birth, and travel distances are associated with adverse

infant and maternal outcomes."

The article next states that this should not be used as an excuse to consolidate or close rural OB units. Rather, it suggests a need for tailored quality improvement programs for rural hospitals, improved training, and even enhanced reimbursement. We also should establish transfer and referral networks and participate in perinatal quality initiatives at a statewide or regional level, per the article. We have an excellent relationship with the MFM physicians at UVMMC. We are almost always able to transfer there, or at least to DHMC. We also participate in NNEPQUIN (Northern New England Perinatal Quality Initiative Network) and in the AIM initiatives sponsored by UVMMC's MFM department. I specifically asked you when you spoke to the NCH Board (of which I am a member) if you had spoken with anyone at NNEPQUIN or in the MFM group at UVM. You told me that you had not. I assume that statement still holds true. How can you make statements without having done the work? Any good physician knows that they should evaluate all available data before making a diagnosis. Is it possible that one of your inexperienced New York City associates made these determinations?

At the community meeting in Newport, when I met you in person for the first time, you stated to me that we were not going to discuss obstetrics at all. I took that to mean that closing our unit was off the table. But, obviously you had already made up your mind and you did not want to take the heat from the community. You knew how they would respond.

As my good friend Dr Walker says, the most efficient way to save money in healthcare is to deny the care. This of course means that people will die. And, with them, so will our community.

Sincerely,

Peter Stuart, MD, FACOG

Vice President of the Medical Staff at North Country Hospital

Medical Director of OB/GYN