BUNCOMBE COUNTY MEETING TRANSCRIPT
MONDAY, FEBRUARY 10, 2020
REDACTED PRESENTATION - COMMUNITY COMMENTS ONLY

Speaker 1:

What is the seller? Describe what that is. And will it just dissolve? Dogwood will be the seller entity. Thank you. Thank you for that, asking that clarifying question. I appreciate it.

Speaker 2 – Senator Van Duyn:

This is addressed to Mr. Ronald Winters and Mr. Thomas Urban with Gibbins Advisors. We are writing with deep concern regarding the state of Mission Hospital System since the purchase by the Hospital Corporation of America last year. We hope this description of concerns will provide helpful information to you in your work as the independent monitor. We realized that not all these concerns will fall directly under your purview, but think it is important that you are aware of the full scope of issues that have emerged over the last year. We also hope this letter serves as an invitation for a meeting with HCA and community leaders to address these issues. Concerns had been pouring in from distress patients, practitioners, and HCA employees to the offices of the attorney general, Western Carolina Medical Society, Western North Carolina Health Equity Coalition, North Carolina legislators, and the members of Asheville City Council. Some of these concerns, such as cuts to employee benefits, closing the Wheelchair Clinic, and closing satellite rehab clinics, we do not address here but we recognize. And to the growing dissatisfaction of Mission employees and patients, our focus here is on charity care, patient safety and decision disenfranchisement.

Charity care. HCA made a variety of forward-looking promises during the sale negotiations, including a more expansive charity care policy. Unfortunately, the implementation of this policy has fallen well short of this promise. The main concerns are following:

One, lack of transparency about public availability of the policy. The full written policy is not available to community providers and the public. We received the attached copy only with an open records request to the Attorney General's office. Providers with clinical questions about which medical conditions are covered by the policy are routed to the chief medical officer, who apparently is the only person with authority to address these questions, a problematic situation given the size and scope of the policy and the number of people seeking information about it. Or, they can access what is online. But it appears there's not much critical information that would enable providers and patients to understand what is covered and income eligibility requirements. This lack of transparency has resulted in confusion among providers and patients and, more importantly, in patients not receiving the care they should.

Number two, a change in the conditions covered by the policy for those under 200% of the federal poverty level from non-emergent to only emergent conditions. The policy is not clear about what constitutes an emergent condition and the CMO has indicated this will be decided on a case by case basis. We understand anecdotally that the policy's focus on emergent care is causing patients to seek care in the emergency department rather than less expensive care earlier that can keep them out of the ED.

Three, a change so the policy is only retroactive. The previous Mission policy allowed patients to be approved in advance for up to a year of care. The current policy does not allow for such preapproval and is only retroactive, meaning patients know whether their services are covered only after they receive them. This has resulted in patients being billed for services they thought would be covered and now cannot afford. Some of these patients are now the target of collection agencies.

Patient safety. With HCA heavily focused on the bottom line, there have been numerous aggressive staff cuts over the past year, putting patient safety at risk. Certified nursing assistants and unit secretaries have been cut dramatically or eliminated altogether, putting new pressure on nurses. Patient to nursing staff ratios have also increased and some departments have seen an exodus of nurses further stressing remaining nurses. Anecdotal accounts abound from Mission physicians and nurses on how these cutbacks have affected patient care and there is at least one documented example that resulted in the death of a patient in the ED. In the attached letter, a Mission employee states "Due to a mass exodus of nursing staff, each individual remaining nurse has been forced to take care of more patients at a given time. Way more than is considered safe for the patients" End quote. Patient satisfaction scores have dropped, and staff morale is poor. The same letter also notes that at Mission hospital, emergency room nurses can be seen weeping in the hallways, stress levels at their max. Medical staff who are this stressed simply cannot provide the level of patient care that we have experienced in the past and that we expect at Mission Hospital. I had a doctor tell me he has not seen anything like this since September 11th.

Physician dis-enfranchise. Numerous offices and physicians have contracts with Mission Hospital System that predate the sale. HCA has aggressively pursued contract renegotiations with multiple physician practices resulting in unfortunate outcomes due to HCA's insistence on significant cuts in physician pay. PML pathology and Cancer Center of Western North Carolina, both of which had long contracted relationships with Mission, have ended their contracts with Mission HCA. A similar dynamic is at work in negotiations with Asheville Hospitalists Group, a group of 50 hospitalists that represented the backbone of inpatient physician staff at Mission. As a result of HCAs unbending demand, six hospitalists have announced their resignations and at least five more are expected to turn in their resignation slowly. Shortly, I'm sorry. Two inpatient neurologists are known to be resigning as well.

Another issue is the increased regimented use of HCA protocol that reduces physician autonomy and input on the floors and in the ED. For example, historically an intensive care unit transfer was requested from a community hospital. The attending physician for Mission ICU would be included in that conversation. If no ICU beds were available at Mission, that patient would be placed on a waiting list until a bed opened up. Under HCA rules, any requests for a transfer from a community hospital is automatically granted without attending physician input or approval. If there is no ICU bed available, that transfer is directed to the ED with no notification to the attending physician until the patient

arrives. Accepting critically sick patient transfers is demanding of both time and emotional energy and depriving the attending physician of input only exacerbates the stress.

Note also that the nursing ratio in the ICU is two to one. In the ED, it is six to one. ED nurses, although highly talented, are not trained to take care of ICU patients and are already overextended. This has resulted in many critical care transfers lingering in already crowded and understaffed ED [inaudible 00:24:25] getting below standard of care for hours. We understand there has been a recent policy change on this issue, but it remains to be seen if that fully addresses these concerns. Experienced physicians are losing the ability to exercise their clinical judgment and use their training at Mission.

It is no surprise that a recent physician engagement survey resulted in an incredibly low approval rating of the administration. Of interest are the higher approval ratings for the pathology and hospitalist services, two of the service lines mentioned above that are casualties of HCAs aggressive renegotiations.

Conclusion. During the negotiations and public discussions leading to the sale, Mission officials were repeatedly asked if Mission is losing money, how will HCA make money by purchasing Mission? The only answer we've ever received was that HCA would make money through more efficiency, efficient purchasing power and staff reductions in redundant back office administrative positions. It is clear now that this was a lie. Instead, HCA has chosen to make its money by reducing charity care, eliminating medical and unit administrative staff to the detriment of patient care and safety, and sacrificing entire physician practice groups with longstanding contractual relationships by demanding significant reductions in pay. That wasn't the deal we were told about, and it wasn't the deal we made as a community. These outcomes that reduce care for low income patients, increase patient risk, and dismiss important practice groups that had provided outstanding service to Mission are simply unacceptable and must be corrected.

Our concern is for the wellbeing of our neighbors and holding HCA to the promises made to us that we would continue to see a high level of medical care for the people of this region. The time of patience in the transition has passed and the time for real conversation with HCA leadership about these problems has come. We thank Gibbins Advisors for your review of this letter and stand ready to work with you and HCA to address these concerns. And this letter is signed by myself, Senator Van Duyn, Representative John Ager, Representative Susan Fisher, Representative Brian Turner, Buncombe County Commissioner Chair, Brownie Newman, and Asheville Mayor, Esther Manheimer. Thank you for your patience. (applause)

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Speaker 3 – Jane Sutton:

Hi, and thank you for the opportunity to make a few comments. My name is Jane Sutton and I created the change.org petition in objection to HCA healthcare closing the CarePartners Wheelchair Fitting Clinic. I could recap those objections that literally thousands of people have made, but I know that HCA and Gibbins have read the petition, seen the signatures, read comments and I know they understand the tremendous toll, or at least they've told me they've heard the tremendous toll, that closing the clinic has taken.

Attorney General Josh Stein publicly stated on WLOS that he's committed to looking into the closure of this clinic. I would like to hear if we know where that review stands. Countless wheelchair users are awaiting an announcement to tell them that this clinic will not close. Some of these wheelchair users have used the clinic for only a short while, some for decades. Some are new patients in need of making appointments. These people are from all of Western North Carolina, not just Asheville. They range from young children to older adults. They are active, they are working, thriving vital members of our communities. They depend on this clinic to provide a lifeline for their day to day lives and to prevent life threatening conditions. Like the rest of us, wheelchair users, their parents, their guardians simply need to know how to plan for their crucial medical care. They are all in need of a definitive answer if this clinic will remain open.

Speaker 4 – Gwen Straub:

Thank you. My name is Gwen Straub. I live in McDowell County in Nebo, 27 Magnolia Drive. The story I have to tell is very personal. It's about me and my spouse diagnosed with myasthenia gravis, a terrible autoimmune disease that affects the head. She had been in the hospital at UNC Chapel Hill for a pituitary adenoma that had recurred after 10 years. That operation was very successful, but when she woke up from the anesthesia, she couldn't open her eyes. She couldn't hold her head up, she could barely breathe, she couldn't swallow. She had full blown myasthenia gravis from the trauma of that surgery, which went up through her nose into the pituitary gland to clear it of a soft tissue tumor, non-cancerous and very slow growing. They treated her at UNC hospitals in Chapel Hill. We were there for 42 days.

There is medicine, Mestinon, which helps to reduce the symptoms in the head. It doesn't attack the disease at all. And there was a procedure called PLEX, which is a plasma exchange, a catheter goes into the veins of the heart, separates blood, the red cells from the white cells, pulls out the white cells and puts back in pure albumin, which has no antibodies. They wanted to reduce the immune system because it was attacking the nerves in her brain that communicate with the muscles of her head, which included her tongue and everything.

She had some good days. She had terrible days. It's a very volatile disease. You never know what it's going to throw at you. We got there at around Christmas time from UNC Chapel Hill, to Asheville, because I don't think they knew what else to do. And she went into rehab because she was due to get another PLEX treatment and they were to be done closer to home, which was Asheville hospital, Mission Hospital, Asheville.

She came into Mission Hospital, she had a PLEX treatment, and now we're at January the 2nd, Friday, she had a wonderful day. All symptoms were gone. Her eyes were wide open. Her voice sounded normal. She said, I sound retarded. And she did. Her tongue is a muscle, in fact, all of the muscles of her head. She could swallow, she could breathe. We were ecstatic. We had friends there that day and a case manager came in, and she also had PT that day, and she walked up those steps sideways and back down again. And she walked with a walker down the hall because her arms and legs weren't ... Her arms were strong but her legs, she was just a little cautious on her walking.

Then that same day a case manager came in, a nurse, and said, "Susie, you're really doing well. And I think on Sunday or Monday we're going to discharge you." Now, this is Friday. And she's wonderful. She goes to bed that night, wakes up in the morning, and she had a PLEX treatment, the plasma transfer. And I think in the end, those plasma transfers were more harmful than good because after it was finished, she was right back with the symptoms all over again. Couldn't raise her head, couldn't open her eyes, the whole horrible thing. And she said to me, "Don't come today. I'm no good." The nurse that had said to her, you're doing great. You're going to be discharged Monday or Tuesday. She said, "I won't be here for the next two days, but someone else will take my place. And we arranged for CarePartners, you're going to have a PT and a nurse come in to the first two weeks." And then the next day she was horrible.

I'm not going to mention any names because I'm not even sure of them. There was a neurologist, I don't even know if it was a man or a woman. She'd been gone on vacation for a week, she came back that day, which is now Friday. And she said, "Call home and get someone to pick you up because you're discharged today." And she said, "I can't. I can't leave today. I'm horrible." They called me and said, you come and get her. And I said, "I'm not, there's no way I'm going to take her home." And that wasn't the neurologist that was saying this. She said, "I am representing a neurologist on your team. And these are what they want me to tell you."

She goes back to Susie, her name is Susie, and said, "If you don't get someone to pick you up today, we're going to put you in a taxi cab and send you home." And the trauma of that to this poor woman who was suffering these horrible symptoms and this disease cannot tolerate trauma, whether it's emotional or whether it's physical. I was frightened and I called her room, talked to the nurse on duty that night, and she said, "Don't you worry, she's right here in bed and I'm not letting anybody take her out of here tonight." I felt a certain amount of relief, but I wasn't going to wait till Monday or Tuesday when she was supposed to be discharged. I went the next day, which was Saturday and picked her up.

She was not doing well at all. We went home, she was home two days and now she's been in hospital for 70 days total, and I've been with her the whole time. She gets home and she sleeps in her bed twice. The dog is so glad to see her, and she had a little bit to eat. She was able to swallow a little bit. Next day was Sunday, she watched some political shows that she liked to watch on Sunday morning. And the next day she was due to see a home healthcare nurse. It was scheduled long before that. Monday morning comes and she's worse than ever and the nurse comes, lovely woman, RN. She was very nice, but she asked Susie, she said, "Are you able to swallow?" And Susie said, "No." She said, " Well, I'm sorry to tell you this, but if you can't swallow you can't be discharged. You should never have been discharged. You need to go back to the hospital."

I had to call 911, they had to get an ambulance to come in and go from our house in [inaudible 00:38:39] ... They thought they were taking her to Mission Hospital at McDowell. I'm glad I just set them straight, I said, "You're going to Asheville." They take her back to Asheville and I was right behind them and I almost got in the door with the ambulance guys, but once it closes you can't get in. So, I missed it. I ran down there, I couldn't get in. I had to go into the ER and I sat there for two hours. She never recovered. She died.

She died on the 12th of January. She had another PLEX treatment and during it she stopped breathing. I looked down at her, I knew she stopped breathing. I screamed out at the hall, they came in and did a very aggressive cardio-pulmonary resuscitation. And I watched her body going up and down from the hall and I thought they were going to break a chest bone, but they were doing their job. That was to get her to breathe. And from the calmness of lying and getting a PLEX treatment, which is not painful at all, she wakes up with a plastic tube in her mouth, down her throat and she can't make a noise, and she can't even talk, and her arms are tied down to the bed so she won't pull it out.

And she stayed that way for two days in agony. It was horrible. Finally, palliative care doctors I went to talk to, and I was with friends, and they tell a whole different story. The doctors, their goal is to keep you alive. Palliative care is to keep you comfortable. And they told me, being in a hospital immobile for 70 days at her age she could never withstand another resuscitation and she's suffering greatly, and this disease has really put her in a low state and it's only getting worse. They said, if you want to take the tube out of her mouth it's perfectly acceptable and probably the most compassionate thing you can do. So, we did.

She raised her hands up because they untied her arms too and she started to breathe on her own. She was carefully breathing, she wasn't gasping. And the reason why they had her in the tube is because her breathing on her own was not at full capacity after the resuscitation. She started breathing and I knew she was doing it carefully because she was blowing out through her lips like ... And she couldn't really talk because her tongue had lost its ability to get even sound to come out. But I heard one thing she said, it came out clear, and we had friends

there who were trying to understand her. She said to me, "This will be good for you." And she meant, because if she survived the care, I would have to give her would be extraordinary. I know they were willing to help me do that. She was telling me that if I go, it's better for you.

I stayed with her for 15 hours, her breathing stayed calm, but it got more intervals between them. And finally, 15 hours later, it was 1:00 AM on January 12th, she stopped breathing. And I just hope that this thing never happens to someone else because what I think is that neurologist, who was on vacation, came back, looked at the record and said, PT guy says, if I were you, I'd want to go home. You're doing so great. But she never looked into the patient and either she didn't know how myasthenia gravis changes on a whim, or she didn't care, or she was ordered to get that patient out of there. We need that room. Whatever it was, I hope to God it doesn't happen to anyone else.

Oh, and they sent her a survey of her experience and it was sent on November 11th and I had a sign for it, but I wasn't there in time. And the post office is closed for an hour and a half in the afternoon, and I went the wrong time. And she died the next day. And it says in here, you can fight a discharge. You're allowed to fight a discharge if you think it was improper. It was too late when this came. Thank you.

Speaker 5 – Monroe Gilmore:

Hi, thank you for sharing that, ma'am. My name is Monroe Gilmore. I live in Black Mountain. I'm part of the western North Carolina Health Equity Coalition and we, as Senator Van Duyn said, have been hearing these same types of concerns. And, in your presentation, you mentioned the advisory boards that each of the entities will have and that they can accept a change that HCA proposes. And I just want to know, who appoints those advisory boards? Who is on them? Is it a public entity and have they already been set up? It doesn't sound like an independent kind of decision then if HCA has half the members and they want to make a change. Where is the public protected? Is the hospital board, you mentioned, stockholders of the hospital? Yes. No, you said it was made up of four, one from the hospital and then you said there was a hospital board, that was the other four. [crosstalk 00:46:36] ... paid for by the hospital.

Speaker 6 – Cliff Johnson:

Good evening. My name's Cliff Johnson. I'm the western region rep of the State Employees Association of North Carolina, and I have a brief two-part question. Why is HCA Mission Hospital opposed to patient billing transparency as has been supported by Treasurer Dale Falwell and the State Employee's Association of North Carolina? Second, why are they opposed to the clear pricing project, which would save $300 million dollars in tax payer dollars and an additional 60 million for state employees and retirees while not causing them, HCA, any monetary loss, rather simply reducing the amount of profit they are realizing. They would realize no loss other than a little decrease in profit.

Speaker 7:

Yes, I contacted you via email. I have two questions. One related to the gentleman back here. I would like to know who, and I didn't get to hear the whole presentation, I would like to know how many Missions boards, how many of the appointees to these various committees have stock in HCA or Bain Capital? Bain Capital, which led into the [inaudible 00:48:52] foundation in getting HCA. I think it's in the public interest to know that and it should have been known before the hospital was sold.

The other thing that I would like to say is a personal story. I am a retired provider. I had a hip replacement in 2016, first I had a knee replacement in 2011, and I had excellent care. I don't know if it was because I was abroad or not. I hope not. In 2016, I had a hip replacement. The care had gone very bad. In 2018, I had to have my other hip replaced and I'm here to tell you that I had excellent care in the PACU. Excellent care in the preop, but the floor care was awful.

The food was terrible, and I was calling my husband, begging him to come and get me. They did not even know which side of the bed to help an orthopedic patient get out of. They didn't lower the seat and the portable toilets. I'm short, my feet were dangling. It was a nightmare. And I specifically asked my surgeon, who I love, did I need to bring a nurse with me? Oh no, we offer boutique care. Well, I'm here to tell you they don't.

Speaker 8 – Alexandra Kiefer:

If you don't mind, I'm going to come up front so people don't have to turn around. My name is Alexandra Kiefer and I'm here not only on my behalf but also my dad who was a doctor here in town, very well-known who's now deceased, but I was a patient for 11 days in November right after the new tower opened. And like this other lady, I had excellent care and the preop and I guess in the operating room, but by the time I got to my floor everything turned into a nightmare due to the lack of patient care.

I'll just read a couple of bullet points. First of all, when I was able to come around fully I noticed dried food on the floor on the left side of my bed, which indicated to me that housekeeping was not very thorough. That led me to wonder about what else I was going to find while I was there.

If I wanted a nurse and used the call button, it was approximately 25 minutes on average before anyone came to see what I needed. My husband stayed with me the first week, round the clock, after that I had to hire a ... what do you call those nurses that come in? Private duty

nurse, and she had to stay with me. At no time was I offered a bath. So finally, after five days, I asked if I could have one and the nurse, or CNA, looked at me like, what are you asking for? Twice my husband had to give me a bath while I was there.

One time my sheets were changed and one time my gown was changed. That was it. The nurses were excellent when they came in to help me, but the problem was they were harried and hurried, and just didn't have the time. I was a fall risk, when I was taken to the bathroom, they advised me to just stay there and wait for them to come back and pick me up, and they left the room. They told me to use the red cord, the emergency cord and call. The housekeeping, we saw twice in 11 days. That was it. Someone came in and emptied the trash every day. But as far as doing any cleaning, it was pretty much nonexistent.

I am here to say that I am also here on behalf of my father. He started the first women's clinic here in town in the early fifties, he was very prominent, well-known, did a lot for this community and I am not willing to let HCA pull down the work that my dad did. Thank you.

Speaker 9 – Kris Jennings:

Hi, my name is Kris Jennings. Ours is also a personal story. I'm going to share just some brief specific experiences that we had and then just a couple of general observations. I also have pictures. I have a timeline, if you folks want to talk to me. I do not want to be anonymous, and I am more than happy to share those with you.

First of all, the budget cuts are such that there are no basic supplies in either the rooms or the emergency room. My great aunt, this is who we're talking about, she was 80 years old, had pulmonary edema and congestive heart failure. They needed to start an IV in the emergency room. There was no IV pump. It took over an hour to get an IV pump to start an IV in the ER. In the room, once she was admitted, it was very common for the nurses to have to scavenge for basic supplies, including bed pads, when she would get up and they would replace them. Anything that they needed, it was very common for the nurses to have to go get them.

When she was in the ER, she needed help. We pushed the button for two and a half hours. No one came. When the nurse finally did come she was very nice. She apologized, but two of her other patients had coded so there was no one available to take care of my aunt. Once she was admitted, we sat in the ER for 15 hours on a Stryker gurney. We asked for the admin on call, they sent us everybody but the admin on call until I became, I will just say, persistent. When the admin on call came in she admitted that there was no excuse for leaving an 80 year old patient in her condition on a Stryker gurney for 15 hours and magically a bed appeared for her. Now, she still was not taken to a room for several hours. When your hospital is full, put up a sign, go somewhere else because that is ridiculous.

She was taken down for an MRI. She'd had no food since 5:30 the night before because it was an NPO situation. We understand that. She gets back to the room at 6:15, no food had been ordered. They forgot. Which was not uncommon, she missed several meals because they would forget to order them, which really wasn't all that bad because as someone else pointed, when the food did come it was typically in edible.

Later that night, about 12:15, the respiratory therapist came in because her 02 stats were alarmingly low. When she was brought back from the MRI no one plugged her OT back in, so for five and a half hours she had no oxygen. We also had the same experience with the trash not being dumped for over three days. I have photographs of that if you'd like to see them. The room was never mopped when we were there. Bed linens were only changed when we requested them, and once again, nurses and CNA's had to go scavenge for those.

These are just a few of our specifics that happened, but generally what I will say is what one of the other ladies said, when the nurses came in they were fabulous. We had one nurse that told us she cries every single night because she knows she is not giving appropriate competent patient care. We spoke to administrators and told them their hospital is understaffed and they said, "No, we are in compliance with the minimum patient to staff ratio." Well, if you want the minimum go to Mission Hospital because that's exactly what you're going to get.

But every single practitioner we talked to will tell you that hospital is understaffed and that it directly affects patient care and patient safety. Oh, by the way, my aunt passed away at Mission Hospital on November 27, 2019.

Speaker 10 – Jenny Kirby:

Hi, I'm sorry. I'm probably going to get emotional. I apologize. My name is Jenny Kirby. I've been a bedside nurse at Mission from almost 15 years. I've spent the last 10 years in the medical surgical intensive care unit as a bedside nurse and I want to second the things that were said in that letter. You're critically understaffed, it's not just nursing. I'm so sorry. It is in CNA's, it is in the phlebotomy, it is in the EVS department, which is the housekeeping department, which has been a hundred people short. That's why that trash doesn't get emptied. There's no one to do it. The radiology techs, that's why there's wait for CT scans and things like that because there's no one to run the machines. The SPD department, which is sterile processing, surgeons have had to cancel elective surgeries because there's no one in the SPD department to get the equipment and things ready for these surgeries. The respiratory therapists, physical therapists, every single department in that hospital that is designed to help the patient get out towards wellness is critically, and unethically, and inhumanely understaffed. I used to be really proud of where I worked and I'm not anymore. I'm really sorry. We leave every day and it's so hard because

I want to provide excellent care, I really care about what I do. We do not have what we need to do our jobs. HCA operates hospitals 20 years in the past. They are really good at running a mediocre hospital. They are not good at running an excellent hospital, and we used to be a really excellent hospital.

Speaker 11 – Richard:

My name's Richard [inaudible 01:00:27]. I'm bothered by the previous discussion of the advisory board, and I think that everyone in the room is wondering who's on it, what discretion do they actually have, and who appoints them? And I think it would be advisable to you as the monitor to be able to tell us precisely what that role is, how they will function, and how they will intermediate in all of the issues that I am listening to with great concern. Thank you. are any of them in the room presently? Are any of the members of the advisory boards in the room presently? Maybe they could stand up if they are there. [crosstalk 01:01:49].

Speaker 12 – Dr. Carole Saltzman:

Good evening and I appreciate everybody coming here. My name is Dr. Carole Saltzman. I've been in this community since 1994. I opened up a private practice. I'm currently retired and disabled. I have been a patient here as well as a member of the community, and I have grave concerns over what's happened since HCA has bought our hospital. I'm speaking from the aspect for those who cannot be here to speak and those who are frightened to speak because they're concerned about their jobs. I feel that the quality of care has been affected. The medical staff, the ancillary services, the nursing care, and it's been mentioned before, the people that are here are doing the best job they can, but you can't do a job for 10 people and be one person.

To give you some examples, in the ER, when they moved out of the old ER, they never bothered to clean up the old ER. And that wouldn't be an issue if nobody ever came through there, but we only have one MRI at our hospital because the other MRI broke down shortly after the sale of the hospital, and HCA did not feel that we needed a second MRI. Once they realized that we did need a second MRI, it takes six months for an MRI to be built. During this time, patients and our staff had to walk through that abandoned ER, and it looked like ISIS had been there.

It's not only embarrassing for us, but it's embarrassing for the patient as well. Also in the ER, sometimes it's been so overcrowded that patients were put on gurneys all over the ER and in the hallway. And one patient told me yesterday that her daughter was put up against the front desk where she heard the entire sign out of nurse to nurse about all the patients that they were signing off. And as a 15 year old girl she asked her mother, "Is this legal for me to be listening to all this?" I mean, a complete HIPAA violation.

The trash: Not only does the trash not get taken out, it doesn't get taken out in the ICUs. Patients are having to clean their own rooms or family members are. There are people sitting in here who have done that. Patients have been admitted to rooms where there is urine from other patients on the toilet seat, including trash that hasn't been taken out from a previous patient. We are not in a third world country. I came here from Stanford University, and when I came here, they were doing procedures here that we weren't even doing at Stanford yet. I was very proud to be a member of this community. The medical staff was strong, people cared about who was on medical staff, and as of January 31st they've eliminated the position for the chair of the credentials committee. Meaning, anybody who has any license, whether it's in America or not, can be on staff here. That's not how it was run in the past.

There are patients because of the ratio of lack of nursing, which you continually keep hearing, that are at risk and some have died because there was nobody to take care of them because the nursing staff was taking care of another critical care patient. Getting rid of the cancer center and saying, well, we'll just hire locum tenens. Is that what you want for your family member? When you have cancer and you're in the middle of a treatment or your family is? To be taken care of somebody who's just coming in the community to step in for a couple of weeks or a month who knows nothing about your care, and unfortunately, they may be one of only a few people that are available for you.

The hospitalists, as have been mentioned, are the backbone. They are the people who are in the hospital when you are there. No longer are the community physicians attending to you while you're in the hospital. It's been felt all over the country that it was better continuity of care to have a hospital team that was in there every day with you than have your doctor being pulled out of their office, or their partner who's covering, who doesn't know anything about you. Well, guess what? Those hospitalists are leaving in droves. Their contracts had been renegotiated. Their salaries have been cut in half, and they've been asked to do more work. Anybody who doesn't have to be here can elect to leave. Asheville's been a place that has always recruited the best, but now it's just a warm body.

They're bringing in a residency of internal medicine residents. Well, guess what? Residents are people that are just out of med school. They need guidance. Who do you think is going to be guiding them when there's nobody available for them to talk with who has more experience? Not only that, you have things that they've taken away from this community. Volunteer programs. Children who are interested in becoming interested in medicine don't even have a local hospital who cares to let them a) shadow or b) volunteer. What makes people in this community want to stay here?

Patients are screaming into the hallway, please help, help. They're not in a nursing care facility. They're at a hospital where they're supposed to have assigned nurses, but these nurses are so overworked they can't come to get patients out of their bed to take them to the bathroom.

So, guess what? People don't want to crap or pee on themselves, they attempt to get out of bed, they fall over their oxygen tubing and then they fracture their tibia and fibula. True story.

The other issues are: patients are being put on floors with nurses who have no idea how to care for them. Instead of being in an ICU setting, they're put up on a cardiac ward, their bowels eviscerate, they have a surgical life-threatening emergency, and the nurse doesn't know how to find the surgeon. I, myself, have been called in to help somebody before their loved one died, try to find their doctor. People come in with a routine ruptured appy and ended up leading two months later, 15 surgeries later, losing their bowel, having a colostomy bag, being intubated, trached, and then have a lifetime worth of surgeries that they continue to have because somebody didn't recognize that something had gone wrong. Things go wrong. I'm a surgeon, things happen. That's not the problem. It's recognizing it. We are not in a third world country.

Most recently, like I said, they have a eliminated the chair of the credentials committee. I don't know what's going to be coming here. Their answer is to take locum tenens. Locum tenens are not people who are invested in their community. They're not here to stay. They don't have the connections. And truthfully, they're just clocking in and clocking out to fill a void. I feel like what's happened is a travesty. I feel that with all the lack of professionals, they've also lacked ancillary people like social services. So, mother/baby and pediatrics used to have four social workers. You have people coming in, they have babies that are premature, there's a ton of babies that are coming off of drugs because their parents are heroin or meth addicts. And there's nobody here to transition them to make it out in the community.

It's not just about money. This is a place where every caretaker used to be proud to work and now they're running out of here in droves. The smart ones got out early. The dedicated ones are having to seek psychiatric services because they're being asked to do things that really just aren't ethical.

Speaker 13:

Hi. I am here to represent a younger crowd. I work at a pediatric office that serves 12,000 patients in Henderson and Transylvania counties. And while they are a small portion of our current population, they are 100% of our future. And one of the things that the providers that I work for are concerned about is the cost of care and access to care. Mission Children's is one of the few resources that we have, even up to Cashers and Highlands, which we still serve. And when we don't get records back from abnormal MRIs of the brain for 10 days, that not only puts our children at risk, but that further delays their treatment because there's very few pediatric neurologists that we can refer them to.

We are also on the verge of Medicaid Transformation. While that got delayed in 2020, that doesn't mean that the 2021 docket won't make that difference next year. And one of the things ... I do all the quality reporting, the clinical quality reporting, so I'm the ones telling the doctors, hey, did you remember to click that button? And while I can do my job and I can submit that data, that doesn't mean that the kids that we serve don't go to the ER and we aren't responsible for the cost of care for referring them to specific facilities. And at the end of the day, HCA is Hospital Corporation of America. They're not concerned about private practice or specialists, but once you leave the hospital you go back to your primary care, and they're the ones responsible for keeping your costs low, and they're the ones that try to keep you out of the hospital. And we can't do that when we're being docked and we're being punished for the cost of care being provided at HCA.

My point being, the cost, the fact that it's a hospital, and that they're jacking the prices higher and higher for less and less, as demonstrated tonight. The fact that we don't get records on a regular basis. If we did not have a contract with HCA that provided us direct access to their medical records, we would be, and were for a long time, struggling to get radiology reports, lab reports back on patients and the abnormal MRI of the brain is a real story. That's putting our kids at risk, but we're responsible. And at the end of the day, HCA needs to partner with Mission Children's Specialists and the pediatric providers within the community to provide the best care possible.

Speaker 14 – Jeff Paul:

Hi, my name's Jeff Paul and my family, we live in north Asheville. And first of all, I just want to thank the folks who came out from Mission tonight. I think it's really amazing and I hope next time you'll bring your friends. I guess I have a couple of questions for you all. The first relates to the four corners of the contract and the first slide that you put up there, you mentioned what is a material service or facility they can't close for the first 10 years, right? And I guess I'm curious what constitutes material service or facility? Is it closing the ER? The wheelchair clinic? Is it hollowing out the nurses' station? What does it take, number one, and let me just give you the second. The second is, we've got a whole ecosystem of accountability actors here. We've got the health equity network, we've got [inaudible 01:16:51] legal, we've got our representatives. Have you thought about sitting down with them and maybe thinking about how your roles complement each other so that you can plot and scheme a little bit and get this thing back on track? it's just limited to those that are up there?

Speaker 15 – Winnie Pace:

Hello, I'm Winnie Pace. I'm a retired social worker. I'm also a licensed sign language interpreter, and I'm coming tonight with information that I've gleaned from conversations in the deaf community in western North Carolina about the changes at Mission Hospital in the past year since HCA took over. Primarily the use of video remote interpreting equipment rather than live, onsite interpreters. They use small screens. If any of us here have a tablet, hold it up. These are supposed to be on dedicated internet lines but often are not. At least 30 to 40% of the time, the equipment malfunctions, is blurry. The view of the deaf person is blocked so they cannot see the interpreter and participate in their

medical treatment. HCA's unwritten policy of primarily using video remote interpreting equipment and their lack of staff training means if staff don't know how to use the equipment, it results in inappropriate, ineffective communication with deaf patients, endangering their lives.

Communication with deaf patients is mandated by several federal laws. HCA's own assurances say that they will provide high quality patient centered care. They have a written communication policy that "ensures this" and yet use of this VRI equipment primarily is endangering these deaf lives because they're not able to know what the provider is saying. They're not able to communicate to the provider their symptoms, their concerns. The VRI provider status even says on their website that indiscriminate use of a VRI results in inadequate communication for the deaf patients.

Imagine if you yourself were deaf and you knew that 50% of the time communication was going to be inadequate with your provider. Would you go to Mission? Another major VRI provider in Plainville, Massachusetts states, "And even though there are the VRI providers ..." They say, "VRI is not appropriate when there is high turn talking exchanges, complex dialogue, communication with visually impaired deaf people, high risk medical, and mental health settings."

HCA has a regional hospital in Portsmouth that in 2010 was sited with an Office of Civil Rights consent decree for not providing appropriate axillary aids and services for deaf patients. HCA knows better.

The 11th circuit court of appeals in 2017 sited three hospitals in Miami, Florida for indiscriminate use of VRI equipment with deaf patients. Several of whom suffered permanent physical harm from miscommunication. There have been seven OCR voluntary agreements, voluntary resolution agreements in other states that have become [inaudible 01:23:29] law that state that indiscriminate use of VRI equipment is discriminatory.

At Mission, when the equipment does not work, staff have turned to family members of patients. These family members are not skilled in language and so the patient is left out. I asked that Dogwood Health Trust proceed with an in-depth community needs assessment, within the deaf community in western North Carolina, to find the horror of their experiences over the past year at Mission.

Speaker 16 – (Ron Winters reads a handwritten note given to him):

I'm going to read one that was given to me earlier in the evening, I was asked to read this. I'm greatly concerned about the closing of the CarePartners' wheelchair seating clinic. As a person born with cerebral palsy, the wheelchair clinic has been an invaluable, necessary resource for me. The clinic is where I've been properly fitted by a specialized physical therapist for each wheelchair I have used since I was five years old. I'm now 28 years old.

Each particular part of my chair, footrest, back, back seats, etc. have been fitted and customized to my individual body alignment in order to provide proper positioning, minimize scoliosis, prevent pressure sores, and maximize my independence as a human being. I'm not able to drive and therefore every appointment, and or social outing, requires securing a driver for my wheelchair van. With the closing of CarePartners' wheelchair clinic in Asheville, I have to find someone to drive me round trip to Charlotte or Greenville, South Carolina. This is an incredible inconvenience to me and all disabled people who rely on wheelchairs for independence. What is the rationale for this closure? I know we are a really small minority group, but we are part of this community and therefore expect our hospital system to value us as consumers of healthcare. I would strongly ask HCA to reconsider its decision and keep the Asheville wheelchair seating clinic open.

Speaker 17 – Bill O'Connell:

Thanks. I'm Bill O'Connell. I'm with the Communities for Older Adult Health, which in turn is a member of the Health Equity Coalition that you heard alluded to earlier. I think Senator Van Duyn did a great job and lots of other points in support of the opening letter that we heard here. The problem I see, for what it's worth, is that the points we're raising are not outside of the list of basic services that HCA is committed to have within the contract they purchased. What we need to understand is we had 133-year-old community institution here in the form of Mission Health, which led to the kind of quality this doctor over here alluded to. And we've sold it to a profit-making corporation. Now, nothing wrong with the profit- making corporation, but that is, as this person said, their middle word in their name, corporation. If you look up the earnings calls that HCA has with the investor community, you will see that they're extraordinarily pleased with their first year of performance. Why? Because they turned in, or at least were targeted to turn in, a 4% return on investment to their stockholders.

That's their job. They're selling healthcare as well. And unfortunately, we're not going to have the kind of hold on them that we had with a community institution before we had Mission here. That's under the bridge, that's done. That shipped sailed for us. What a lot of what we're sharing with you tonight, and here in your other venues that you've heard, which I gather are rather similar feedback, hopefully you will take and glean from it, look guys, there's a lot of things here we're hearing, they're not part of our job to monitor the contract. What I'm hoping you will be able to take back to the HCA executive suite is that you guys have been here for a year. You've had an opportunity to have shakedown

time for your operation. People are expecting you now to start performing not unlike what Mission Hospital used to deliver. And they're not happy. And they're not going to take it for a long time.

There are other institutions that do want to serve this community. They may not be at the scale Mission is now, but they could be if people begin to wander down the road elsewhere. If physicians took their business elsewhere. And one way or the other, HCA's going to have to understand they're going to need to be accountable for quality care.

Because that's going to tie back to continuing to have the kind of bottom line results, they want to assure the stockholders that they will show in their second year of ownership and on into the future. That's their game. Keeping their stock price high. And there's nothing wrong with that, this is America as it is, but they've got to deliver a quality product if they want that. And what you've heard here, and will continue to hear, if we don't bring to bear some market forces on this institution, we'll continue to see exactly what we got.

As this nurse pointed out, HCA's known for running a very good mediocre hospital, if they're allowed to get away with that. If it has an impact on their bottom line, they'll belly up. They'll do what they need to do to offer more quality, but we've got to be able to show that as a consumer group and our elected representatives need to be able to get their shoulder behind that wheel as well with us. Thank you.

Speaker 18 – Kitty Kelly:

Hi, my name is Kitty Kelly and I came here tonight mostly because of my husband who really has had excellent health his whole life, and my daughter in law both experienced situations of inpatient care and ... I will not go over time, I think simply will say, very much a ditto to the complete lack of housekeeping. To the complete lack of food service availability after laboring for 12 hours, to the point where my daughter in law chose to leave the hospital, and she did choose too early, and fortunately did not have serious issues from doing that, but it was clear that the floor care was simply not available. It wasn't. It's exactly what everyone has said.

Nurses were great, nurses are in tears, nurses are covering way too many patients and you just don't get the floor care that you're paying for. And I really, really hope that HCA will address that. I do want to mention something no one else has brought up yet, and that is the overall change in CarePartners hospice. I'm very well acquainted with that. There are many changes, the chaplains, as they retire, I am married to a retired chaplain, who really, really loved and dedicated a good number of years to CarePartners hospice. Chaplains are not being replaced. Chaplains, you cannot bill Medicare for chaplains, they don't bring in money. All they try to do is help you with end of life care.

They pray, they do way more than pray, they are there with families sometimes for years. Actually, you can stay on hospice rolls for a long time. They are vitally important as a link with home health nurse, social worker, doctors. It was a very, very tight knit professional, top-notch group. These people are educated at Duke, Columbia, Emory, all over the place. Wonderful folks. They have left in droves. My husband still does part-time PRN and what's happening, he said, he thinks he has probably finished his last PRN. It's too heartbreaking. And home health nurses are no longer able to afford the time to stay with the family. Think about it HCA. If this is you and your family, they can no longer stay until the funeral home people come to get the body. So you are left there without support and resources except among your family. Some people don't have family, or they have families who are at war with one another. So my understanding is, it could certainly be wrong, is that HCA has very little experience in owning and running hospice. So if that is indeed true, personally, if you can't run it because you don't know how to run it, then let it go back to being not for profit, but the thought of an advisory committee or board simply saying, okay, Western North Carolina, no more hospice. And again, folks I'm talking about hospice care is not just the last month, there are many, many patients who received palliative care. That it's critical, as the lady up front was saying, for months or years through hospice. I hope we can keep it. Thank you.

Speaker 19 – Karen Sanders:

Hello. My name is Karen Sanders and I'm a patient advocate working in Western North Carolina. Tonight, listening to all of these horrific cases about the quality of patient care, the lack of staff, there are 300 traveling nurses now in Mission taking up vacancies of nurses who have left in droves. We've heard about not enough. They've downsized unit secretaries, they've done away with unit secretaries, nursing assistants and they have also stopped using security employed by Mission and those are contracted out. So now we're hearing security fiascos like people who have drug seeking behaviors on vacant floors at St. Joseph's Hospital. That all being said, patient care is a right and it is a privilege that we deserve to give to our patients. And we have a regulatory agency right here in North Carolina. We don't have to wait for boards, we don't have to wait for committees, we don't have to wait for anyone. And you can call the North Carolina Division of Health Service Regulation, and they have a hotline to receive all of your patient complaints. I do not understand why the Centers for Medicare and Medicaid have not shown up here to evaluate this. The other thing for those of us who've been in this community for at least 30 years, lots of us remember when CMS came in and closed down Haywood County Regional Hospital. Do you all remember that? That was because they had some deplorable healthcare situations going on. So, the number is 1-800-624-3004. It is a hotline that's open, it's only open 9:00 to 1:00, 9:00 to 12:00, they're off for lunch and then 1:00 to 4:00. But that's 1-800-624-3004, and they're there to help us get this attended to immediately.

Speaker 20 – Steve Schoeller:

I have a quick independent monitor procedural question. My name is Steve Schoeller. I'm a retired physician, current patient member of various organizations. These have been very upsetting stories, hard to hear. I understand your dilemma, that you're not here to fix them. But

should you find that HCA is out of compliance, will the public know that you have found them out of compliance and if so, how will that be communicated to the public?

Speaker 21 – Deborah Miles:

Thank you. My name is Deborah Miles, and I'm here on behalf of the Health Equity Coalition. Thank you to everybody for all the things that you've said tonight. I understand very clearly that you are only... You're actually not responsible for a lot of the issues that we faced tonight. And so, somebody needs to be responsible, and we don't just sit around and let do our rates increase and not holler and fuss about that. And that's got to happen with this as well. The Health Equity Coalition may not be able to do all of that, but we certainly want to be a part of that. As I understand Gibbins is putting together a portal so that the things that have to do with the availability of services can be reported on that. But the quality of services or the employee situations that have been discussed tonight, that's not necessarily something that's going to be able to be fixed on that portal, and that's where I think... That's great. That's a good add on to that. We do want to especially point out the charity care policy that was promised in the Asheville Citizen Times and Mountain Xpress that it was going to be far better than the Mission Health charity care policy. And as it turns out, that policy is actually considered proprietary. And that's why our legislative folks had to get a freedom of information act to find out what that was. And I believe that is in your purview to evaluate that. And I, I really encourage you to take as broad a statement of that as you can. And then it's not just that and the issues of availability of services has to also have a racial and a gender and an LGBTQ and a disability lens to that. It's not just what's the overall care on this, but how are those particular individuals and communities affected in much harder ways than many of us in this room. There are a bunch of members of the Health Equity Coalition. We are welcoming other people to join us as it's an enormous job. It's going to go on for years and years and years. So if you're interested, check out the website at Health Equity WNC, and we'll do this all together. Thank you.

Speaker 22:

Hi, I'm not here on behalf of my organization, but I worked for a primary care clinic in the area. We are a federally qualified health center, which means that we see uninsured folks regardless of their ability to pay and I'm really happy this lady brought up the charity care policy prior to the HCA transition. We were informed that the care would remain accessible through the Mission Health System. So prior to HCA, [crosstalk 01:41:58] prior to the HCA transition, if we referred a patient to any Mission associated facility and they were under 200% of the federal poverty guideline as well as several other things, they could have their services covered at 100% of costs, which meant if I sent someone to Mission Neurology or Victoria Urology for a specialist consult, that could then be applied for the charity care program to have that covered.

After HCA, that slowly got it phased out and now our patients are required to pay 20% of the cost of every visit upfront. Now when you serve a population that is uninsured and is earning low to no income, often these can be $100 to $200 for a specialist visit which means we have resorted to using the ER to get our patients the care they need for things that could have been managed out by the ER. It could be as simple as we see someone for suspected pneumonia and we want an X Ray but now we can't send them to Mission Imaging, because Mission Imaging is going to ask them for $120 before they even provide the procedure. We have to send them to the ER, which clogs up the ER and prevents people with actual urgent care need from getting the care they need.

Our only other alternative is to use a program called Project Access, which they are absolutely wonderful, and I have no complaints with them, but they have limitations as well. You have to have been in Buncombe County for a year, which if you work with the indigent population sometimes that's not the case, nor is it easily provable, and as well, they have to turn in paperwork. And when you have someone who doesn't have an address or is constantly moving around or people that are unstably housed and being kicked out of where they're being housed, they can often miss the deadline for this paperwork and then they're deferred for six months from reapplying. Which means, if we want a diabetic with early stage kidney disease to see a nephrologist and they get denied for this program, we have to wait six months to send them, at which point they get worse, and maybe they get so worse at that point we have to send them to the ER for further care. So, I don't know if this is in the purview, but I really wish someone would look into this charity care program because it has made primary care very difficult to do for a really vulnerable population.

Speaker 23 – Barbara DeLoach:

Hi, I'm Barbara DeLoach, and I have been an RN for over 40 years. yes. I have worked in Atlanta in various hospitals. I also worked for Mission for 14 years. I am retired basically now. I just work one day a week in a clinic. When I first moved here 23 years ago, I started working for Mission, and I had just come out of some pretty nice hospitals, but I was very impressed with Mission when I came here. The staff was wonderful. We all really got along well. We cared. We were proud of where we worked, and I was happy that I had moved to a beautiful place like this, like Asheville and it just happened to have a fabulous hospital and wonderful providers, and I just, it breaks my heart to see what's happened.

I no longer work for Mission, but boy do I hear the stories. I have lots and lots of friends that work for Mission. They are miserable. I'm speaking for them and the patients as well. The staff is miserable. They are... And they're trying so hard. These are good people. They're people that really want to do a good job for Mission. They're working with a lot of people they don't know that come in and out because they're travelers, and it's pretty well known in the nursing community – particularly in the OR nursing community and I am an OR nurse – that most of the hospitals in our country that have to use lots and lots of travelers are a bad place to work. And that's why they have to be travelers. When you

have travelers, traveling nurses, first of all, they pay the traveling nurses very big salaries. They also provide for the place that they are staying, and all that goes back into the budget of the hospital.

So it just, it really pays a hospital to be good to their employees so they'll stay. It is so expensive to have to train people, and also you don't want all brand new nurses that just come out of nursing school. I worked for a hospital in Atlanta that was bought by HCA so I have experience in this. And it was horrible when I found out that HCA had taken over Mission or were going to, my heart sank and it sank because of what all these wonderful people have said, and I appreciate everyone that spoke up. I know there'd be a lot of Mission employees here, but they're scared to death to say anything because there's no other place to work around here. The other two main hospitals here are full of Mission employees. They have stacks a mile high, and the VA for heavens sake, it's really jammed up with all these people that want to work there because they get benefits when they retire, but there's no other place to work. I mean, we have people that were nurses here that are going to Greenville every day because they don't want to work at Mission.

I'm afraid to be a patient there. I've already told everybody I know: don't send me to Mission unless I'm having a heart attack, a stroke or multiple traumas. I have experience with friends that have recently gone and had surgery at Park Ridge and Pardee, which are much smaller hospitals, because they did not want to go to Mission. That is so sad for our community. It is heartbreaking, and the thing is, as several people have said here, I don't know how this can get fixed. How? Because it's Hospital Corporation of America and it is for profit and their first thing they do – they did it in the hospital down in Atlanta and they're doing it here – they get rid of as much staff as possible because that's the quickest way to help your bottom line. And I hate it, because I very much believe that we need to get the profit out of healthcare in our country.

I can't possibly believe that people are getting the best care they could possibly get when there is a corporation scraping as much as they possibly can off the bottom line. They make these huge [unclear], they can get some of their medical supplies cheaper cause it's a huge corporation, but corporations, once again, they are not people. They're corporations. They don't really... they don't see the individual, whether they be the patient or the person working there. And so, I don't know the answer. I don't know how we can make a corporation accountable. Not really. So that's what scares me. I don't know how it's going to, I don't know how we're going to make a change, and I appreciate so much the monitoring, but then comes the accountability. And we've got to go somewhere. But I don't know what we're going to do. I wouldn't want to have to go there today. I'm sorry, but it sounds like bad news, but that's, that's just, that's my opinion.

Speaker 24 – Jeff Heck:

Hi, I'm Jeff Heck. I'm a physician and the CEO here at MAHEC where you're all seated. MAHEC trains the future generation of providers for Western North Carolina. And in fact, we've been here 50 years and in those 50 years, of the 600 or so primary care physicians, over half have been trained here or worked here.

We have 60 medical students here at any given time. We have pharmacy students and residents and training. We train dentists, we train public health people, we train nurses, we have three family medicine programs. We have a psychiatry program, a surgery program, a dental residency, and we'll continue to add more residency programs for the future of Western North Carolina. We are not part of, we are not owned by, Mission or under the governance structure of Mission. We have our own 501(c)(3). I report to a board. We work closely with UNC, which is where all of our schools are affiliated with, and we also work really closely with all the hospitals, not just Mission, but all the hospitals, and we have residencies in Pardee. We have a residency program up in Boone that we just started, and we send residents actually to all the rural communities so that they can actually learn to train and work here.

And although we're not part of Mission, Mission is vital for MAHEC. It's vital for our community to be a successful tertiary hospital where we can train students and residents in the best possible care that can be provided. We're a very competitive place for people to train. We've always attracted some of the top medical students and physicians in the country and continue to work and publish papers about best practices, how to provide integrated behavioral health care, etc. But it's really, really important for us to have a successful Mission. And it's been actually wonderful for me to sit here and listen to all of this. I've heard things, of course, in the community, and I appreciate everybody's boldness and speaking out. We have to work as a community to help Mission be successful. I can't point to what the core problems are, what the root is, but I'm committed to working with Mission, with the Dogwood Trust, with our partners in the community, and those of you who are working out in the rural areas to make sure that we do this well, we serve our community well. And, in my regular meetings with Mission administration, I will continue to advocate that we do our very best to train the right people and provide the right care for our region. So, in a sense, although I'm not a Mission employee, you can hold me accountable too. Thank you.

Speaker 25 – Stuart Smith:

Hello, my name's Stuart Smith [crosstalk 01:53:55]. Hello, my name is Stuart Smith and does HCA ever sit down with the stakeholders to solve any of these issues? And if they don't, why not? Yes. Do you know of any examples where they've ever met with local doctors? The community? After all, they are the only hospital in Buncombe County. I mean besides the VA.

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REDACTED PRESENTATION - COMMUNITY COMMENTS ONLY

Speaker 26 – Ann Jennings:

Thank you. My name is Ann Jennings. I'm a cancer survivor and I have been at cancer care of Western North Carolina. I went in for an appointment at the beginning of January. My doctor was not there. That's a very weird experience to go see your doctor and they can't tell you where your doctor is, and they don't seem to care. They gave me a little piece of paper, said "here's their phone number." I said, "I've called that number but I can't get through." I said, "I need to speak to someone, this is a mess."

The manager of the office came out and talked to me and she said, "yeah, they're not here anymore. They did not want to join the hospital or stay with the hospital so they have gone somewhere else, but you can have a doctor here." I said, "I want my doctor." I said, "where can I find this? Where can I find my doctor?" They finally told me where to go. It's now called Messino Cancer Center, and they told me where it is. I went there and I was just mad, then as I was with the lady at the former place and I said, "what's going on?" And she said "our phones are ringing off the hook. We have had to hire people just to return phone calls because people are trying to call in to find out what's going on." And she said "they are so mad at us for not signing on with them and for wanting to stay independent. They would not give us our records, our patient records, so that we could send you all notices to give you our address." They couldn't call me on my phone cause I didn't have my phone number, because that belongs to HCA. They have built up this practice over all these years that doctors and nurses in this practice built up that practice. HCA now owns the records, and they wanted me to come to their new doctor at HCA at Mission.

I said, "if I didn't have a job, I'd volunteer to come in here and answer these phone calls." I'm a cancer survivor. I'm not someone who just got my diagnosis. I'm not someone who doesn't know what to do with this. Mine's being handled, but this is a cancer place of all places. I am telling you guys, the tears fell from my eyes, and I realized HCA doesn't care about their patients. They really don't. If they are acting this way to a provider, and I ask the provider, "are you still working with Mission?" They said, "yes, we have rights to work at the hospital." And I said, "are you happy with the choice you made?" And they said, "I got to tell you, yeah, we are." I mean as someone I am speaking as a patient who has gone with a practice, who was strong enough to stand up and say, we can't do this and we're going to do whatever it takes to not be part of HCA. And I feel for cancer patients and anyone else that is trying to find their doctor's office and is having to live in this city and can't afford to go somewhere else for a higher level of care. With what I've heard tonight, I am humbled. I almost didn't stand up tonight, because what you've shared is so much worse than what I'm saying. Mine is nothing. This was just finding my doctor, but the things I've heard tonight, this is a stain on Asheville. This is unbelievable.