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—Contributor.....Joyce Marcel

—Contributor email.....joyrand@sover.net

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BMH deficit could take up to three years to fix

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Interim CFO David Sanville says all aspects of the hospital's operation are under scrutiny for cost savings

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TEXT BODY:

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Since October 2025, questions at the state level have been raised about Brattleboro Memorial Hospital's financial viability.

Now, after the loss of its two top executives, an influx of hospital administration experts, multiple budget revisions, and an energetic, ongoing top-to-bottom examination of costs and

services, there won't likely be many easy fixes for the hospital. And some of the difficult fixes might be very hard to take.

"We're kind of changing the tire as we roll down the road," said Interim Chief Financial Officer David Sanville at a Feb. 10 news conference.

"So we're having to rework some of the financial reporting systems [and] make them more accurate, easier, and faster to use," Sanville said. "At the same time, we're looking at service lines as we speak."

Once the hospital gets the financial systems "performing at a very high level — maybe not perfect, but a high level — then we'll be able to begin to work in more areas more quickly," he said.

Nonprofit BMH, the town's third-largest employer, is not the only hospital in the region. Nor is it the only hospital in Vermont with financial problems.

But for people in Brattleboro and the surrounding area, BMH is a necessity.

The 61-bed inpatient hospital provides a large number of essential medical services, including a 24-hour emergency department. It is where patients from the outlying clinics can go for blood work. It has surgical suites. It is where people get their colonoscopies. Its cardiology department monitors pacemakers. Cancer patients go there for chemotherapy. Patients can get an X-ray or a CT scan there. It is a vital part of the southern Vermont community.

BMH also has a $14.5 million budget deficit.

The story to date: In June 2025, the Green Mountain Care Board (GMCB), an independent five-member board established by statute, looked at BMH's proposed 2026 budget.

The board — charged with improving the health of Vermonters while "controlling health care costs, increasing access to high-quality care, and ensuring greater transparency and accountability in the state's health system" — bristled at what

Sanville described as a "$250,000 positive margin," suspecting the figure was aspirational instead of accurate.

It asked BMH to submit a more realistic budget. "Stated as directly as possible, we are deeply concerned about BMH's solvency," the board wrote in an Oct. 1, 2025 Hospital Budget Decision and Order.

That is when Sanville was called in.

"I went through the financials along with another consultant, and we revised the budget in three weeks," he said. "It's normally a three-month process."

Instead of a positive balance, the working group announced a $14.5 million deficit, which Sanville wants to cut in half this year and eliminate entirely in three years.

"I believe that most turnarounds of this size will take two to three years, if everybody sticks to it and there's an organizational commitment to get there and to make the changes that are necessary," he said.

"We believe that its leadership must make big strides to adjust course," the GMCB wrote in its budget decision.

That leadership the GMCB was talking about? Mostly gone. Its CEO, Christopher J. Dougherty, and its CFO, Laura Bruno, ultimately resigned.

Today, the hospital is run by two acting CEOs — Dr. Elizabeth McLarney and Dr. Tony Blofson — who are also physicians at the hospital. Sanville, the interim CFO, moved to Vermont in 1997 and has worked at the Central Vermont Medical Center, Gifford Medical Center in Randolph, and Mount Ascutney before coming to BMH in October 2025.

"David is not operating by himself in this recovery process," said BMH Chief of Staff Gina Pattison. "He is working along with the board of the hospital, senior leadership, and other managers to right the ship. There are many people contributing to this turnaround effort."

Sanville told the press that "there are a number of cultural norms that are going to need to be shaken up, and the way we do business in certain areas is going to need to change."

In a typical rural hospital like BMH, certain operations subsidize others, he said.

"I think it's important for people to understand that," Sanville said. "If you're lucky, inpatient becomes close to breaking even. Your ancillary services are the big contributors. So radiology and the imaging laboratory, physical and occupational therapy, and surgery are the ones that kind of carry the day financially for an organization.

"So it's not going to be a matter of looking at whether we make or lose money in a particular service line. It is going to be, is this part of our mission? Is this part of our charge? Is this our obligation to the community? Should we right-size it, or make it more efficient, or find another way to fund it?

"Those are the types of decisions that we're in the process of making, going department by department," Sanville said.

'BMH works because we do'

Sanville is encountering some resistance: Two hospital unions have recently protested having the ship righted with their members' money. On Feb. 12, Brattleboro Healthcare United (BHU) authorized a strike vote to "protect patient care and [the] community hospital."

BHU, a local of AFT Vermont, represents 280 support staff, technical, clerical and maintenance workers at the hospital and its associated clinics. It began bargaining its first contract last May.

Since then, its leadership said in a press release, "negotiations have been repeatedly delayed, bargaining sessions cancelled, and key questions left unanswered. At a Jan. 28 bargaining session, management proposed a three-year wage freeze, along with cuts to healthcare and retirement benefits,

reductions to night and weekend differentials, and cuts to earned time."

While BHU remains committed to BMH and patient care, its members cannot "make ends meet as community members ourselves" with a wage freeze like that, said John Gibbs, an orthopedics certified medical assistant and a BHU bargaining team member.

"Through months of stalled contract negotiations and administrative upheaval, Brattleboro Healthcare United members have continued to show up for our patients, each other, and this institution," stated Gibbs. "We remain committed to providing care to our patients and this community. [...] We are simply asking for the same commitment to us that we have shown to BMH. BMH works because we do."

Also, the Brattleboro Federation of Nurses (BFN) union has agreed to proceed to mediation as part of ongoing collective bargaining negotiations. The first mediation session was held on Feb. 11 and a second session is scheduled for March 9.

"After several bargaining sessions, the parties were unable to reach agreement on certain contract proposals," Pattison said. "As a result, both parties agreed that mediation would be an appropriate next step in the negotiation process."

Some positive developments

A hospital cannot fix a negative operating margin only by making cuts, Sanville said. It also needs to increase revenues.

"It would mean making sure patients have the appropriate access to clinics, whether it be primary care or surgical specialties or what have you," he said. "You've got to improve access, and that's already been accomplished in a number of clinics. Our professional revenue year to date is up around 14%, so that means that we're seeing more patients."

A number of systems revisions are also happening.

"Our billing processes here are less than ideal," Sanville said. "We have great deal of timeliness issues, denials from

payers, making sure that we're getting credit for the good work we are doing. All of those things are being looked at aggressively and formally."

The hospital is also examining the services it provides.

"Are we providing services in the most effective and efficient way?" Sanville said. "There may be some services that we decide cannot be improved, but we need to carry them as part of our commitment to the local community. And there may be some that we realize, you know, we shouldn't be in that business."

Consequently, "as we clean up the internal financial reporting systems, we're now being able to create data that will help us make good business and clinical decisions relative to the services we offer," he said.

Birthing, oncology services on the line

What kinds of service losses would reduce the hospital budget?

"Prior to David's arrival, leadership had already begun a number of cost savings [and] revenue generating projects and initiatives," Pattison said. "Since his arrival, many other projects and initiatives have been added. There are currently more than two dozen formal projects in process and many smaller works geared towards reducing the operating losses."

The hospital will be looking at every service line in detail.

"As of this writing, there have been no decisions to eliminate any service line," Pattison said. "Relative to service line review, we will be looking at each service in light of our mission and commitment to our patients/communities, the service's contribution to the bottom line, the availability of the service elsewhere for our patients if it was unavailable at BMH, and what might be done to improve its financial performance."

This may include cuts, additional investments, and efficiency development.

However, with all services on the table, the hospital is also looking into the possibility of eliminating whole departments. Right now, staff is focusing hard on the Birthing Center and the oncology department.

"As the birthing rates across the country are diminishing — and our county and our state are no exception to that — we're losing reps," Sanville said.

"At some point it becomes a quality issue. It's not today, but as we get tighter and tighter on having an appropriate level of staffing for clinicians, that could be a concern," he added.

Also, he said, "Medicaid is in the payer mix, and Medicaid is the worst payer, next to no insurance."

Sanville said birthing has been a financial issue everywhere he worked.

"Birthing at every place I've ever worked that had a birthing center has been a negative margin," he said.

At Gifford Medical Center, "they did 300 births a year at the time I was there, and we did have high Medicaid. So we were able to mitigate the loss because of the volume," Sanville said, noting that "the fixed expense were being spread over more procedures."

"Here, we're going the opposite way," he continued. "So it's a growing concern, but we think it's an important service for our community to have, and we will make every effort to find a way to figure it out. But that's where we are right now."

The inability of the hospital to attract OB/GYN doctors and oncologists may be a big source of the problem.

"We have limited OB/GYN practitioners available to us," Sanville said. "We just had somebody announce retirement, and we have another resignation as well."

Pattison said the hospital has searched high and low for an oncologist.

"While an oncologist does not attend every infusion session, they provide oversight to the protocols, adjust treatments and medications, and meet with the patients and oncology staff to ensure proper care and treatment for all patients," she said.

"With no oncologist, there can be no program," Pattison continued. "Unfortunately, to this point we have been unable to hire, contract, or obtain an oncologist from any source, for any amount of money."

The hospital has explored other avenues.

"We have considered telemedicine solutions, had discussions with many other entities, and have asked the state of Vermont for assistance," Pattison said. "Dartmouth Health, the University of Vermont (UVM), etc., are all reporting inadequate provider staffing in this clinical area."

She conceded that "sending our sickest patients on the road for treatment is a horrible outcome" but said that BMH will "continue to work with UVM to find a pathway forward to support local oncology care."

These financial issues do not mitigate the need for the birthing and oncology centers.

"Being good people and providing excellent care no longer translates to being a sustainable resource for our communities in this environment," Pattison said.

Hospital cooperation

Recently, Gifford Hospital has managed to coordinate some services with Dartmouth and UVM Healthcare, both hospitals outside of its own network. Could BMH similarly coordinate services with, for example, nearby Grace Cottage Hospital in Townshend or Cheshire Medical Center in Keene, New Hampshire?

Sanville said it's a complicated issue.

"Historically, a lot of hospitals don't want to play in that sandbox," he said. "I have personally been a proponent of that for literally decades. And in fact, I'm looking at some opportunities

to partner with payers [or] other providers, [and do] whatever I can do to ensure that the services are provided here at high quality and helping us overcome our margin deficiency."

BMH is actively working to develop partnerships, Pattison agreed.

"We are looking to share providers and staff to deliver clinical care in conjunction with other clinical entities like hospitals, hospital systems, private firms, etc.," she said.

BMH is "actively engaged" with HealthTrust, a national buying group and with the New England Collaborative Health Network and other groups to leverage cost savings and to benefit from support service resources.

"We have spoken with Grace Cottage and Cheshire on a number of matters, as well as Dartmouth Health, Rutland, North Star Health [in Springfield], and many others," Pattison said.

"We are also communicating and brainstorming with various state agencies about our situation," she said. "It should be noted that many other health care entities are also under pressure in this environment and dealing with similar issues as BMH, so hopefully, there is a greater incentive to work with others."

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