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April 16, 2013

Via Electronic Mail

W. Mark Russo, Esq.
Ferrucci Russo, P.C.
55 Pine Street, 4th Floor
Providence, RI 02903

Bruce D. Cummings
President
Lawrence + Memorial Corporation
365 Montauk Avenue
New London, CT 06320

RE: Expedited Review of the Hospital Conversion Initial Application of Westerly Hospital Health Care, Inc., The Westerly Hospital and Lawrence + Memorial Corporation, LMW Healthcare, Inc. and LMW Physicians, Inc.

Dear Messrs. Russo and Cummings:

Please find attached Amended Decision with Conditions approving the Hospital Conversion Application of the following Transacting Parties: Westerly Hospital Health Care, Inc., The Westerly Hospital and Lawrence + Memorial Corporation, LMW Healthcare, Inc. and LMW Physicians, Inc.

Please be advised that any aggrieved Transacting Party may seek judicial review pursuant to section 23-17.14-34 of the Rhode Island General Laws, as amended.

Sincerely,

Michael Fine, MD
Director of Health

cc: Jodi Bourque, Esq.
Patricia Rocha, Esq.
Stephen Zubiago, Esq.

Rhode Island Department of Health

Amended Decision With Conditions***

Affiliation of Westerly Hospital Health Care, Inc., The Westerly Hospital and Lawrence + Memorial Corporation, LMW Healthcare, Inc. and LMW Physicians, Inc. Under the Hospital Conversions Act of Rhode Island

MICHAEL FINE, MD, DIRECTOR OF HEALTH

APRIL 16, 2013

***SEE ADDENDUM TO AMENDED DECISION.

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Purpose of this Report

The purpose of this document is to render the Director of Health's amended final decision[1] as it relates to the hospital conversion[2] application of The Westerly Hospital and the Lawrence + Memorial Corporation of New London, Connecticut.[3] It will discuss the eight criteria set forth in sections 23-17.14-11 and 23-17.14-28 of the Rhode Island General Laws, as amended, that the Department is directed to consider as part of its analysis and amended final decision.[4] Finally, this report will describe the Department's process for considering this conversion application as required by Section 23-17.14-7 of the Rhode Island General Laws, as amended, including the comments received by the public at meetings convened in Westerly and Providence, Rhode Island on March 27, 2013 and April 1, 2013.

Introduction & Statutory Authority

In Rhode Island, changes in hospital ownership and control are governed by the provisions of the "Hospital Conversions Act", Chapter 23-17.14 of the Rhode Island General Laws, as amended.[5] This law was enacted in 1997. The Rhode Island General Assembly was among 19

[1] The Director of Health's authority to issue this amended final report and order is in accordance with the provisions of Rhode Island General Laws (RIGL) section 23-17.14-5. Available online at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.14/23-17.14-5.HTM

[2] Hospital "*conversion*" is defined as "...any transfer by a person or persons of an ownership or membership interest or authority in a hospital, or the assets of a hospital, whether by purchase, merger, consolidation, lease, gift, joint venture, sale, or other disposition which results in a change of ownership or control or possession of twenty percent (20%) or greater of the members or voting rights or interests of the hospital or of the assets of the hospital or pursuant to which, by virtue of the transfer, a person, together with all persons affiliated with the person, holds or owns, in the aggregate, twenty percent (20%) or greater of the membership or voting rights or interests of the hospital or of the assets of the hospital, or the removal, addition or substitution of a partner which results in a new partner gaining or acquiring a controlling interest in the hospital, or any change in membership which results in a new person gaining or acquiring a controlling vote in the hospital." See RIGL section 23-17.14-4 (6) available online at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.14/23-17.14-4.HTM

[3] The transacting parties in this conversion application are formally named as: The Lawrence + Memorial Corporation, LMW Healthcare, Inc., LMW Physicians, Inc., The Westerly Hospital, and Westerly Hospital Healthcare, Inc.

[4] Note that all data contained in this report are those submitted by the transacting parties, unless the source is otherwise cited.

[5] RIGL 23-17.14, as amended, is available online at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.14/INDEX.HTM

states that enacted such hospital conversion laws in 1996-1997.[6] Such statutes were enacted nationwide in response to not-for-profit hospital acquisitions by for-profit corporations between 1980 and 1995, when 270 not-for-profits converted.[7]

The purpose of the Hospital Conversions law, in pertinent part, is to:

- Assure the viability of a safe, accessible and affordable healthcare system that is available to all of the citizens of the state; and
- Establish a process to review whether for-profit hospitals will maintain, enhance, or disrupt the delivery of healthcare in the state and to monitor hospital performance to assure that standards for community benefits continue to be met.[8]

The American Hospital Association estimated that in 2011, 156 hospitals announced mergers and acquisitions[9]. While many of these transactions involve the acquisition of not-for-profit hospitals by for-profit corporations, the Rhode Island statute also contemplates the conversion of not-for-profit corporations by other not-for-profit hospital systems.[10] In this matter, both the buyer/acquiror (Lawrence + Memorial Corporation) and the seller/acquiree (The Westerly Hospital) are not-for-profit corporations. Until 2012, hospital conversion reviews were conducted concurrently but separately by both the Rhode Island Departments of Health and Attorney General.

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[6] Collins, Sara R., Bradford H. Gray, and Jack Hadley. "The For-Profit Conversion of Nonprofit Hospitals in the U.S. Health Care System: Eight Case Studies", The Commonwealth Fund, May 2001. Available online at: www.cmwf.org (publication number 455).

[7] Needleman, Jack. "Nonprofit to For-profit Conversions by Hospitals, Health Insurers", *Public Health Reports*, March/April 1999; 114: 113.

[8] RIGL sections 23-17.14-3(1)(2) are available online: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.14/23-17.14-3.HTM

[9] American Hospital Association, *Trendwatch Chartbook 2012*, Chart 2.9 "Announced Hospital Mergers and Acquisitions, 1998 – 2011." Available online at: http://www.aha.org/research/reports/tw/chartbook/2012/chapter2.pdf Accessed February 8, 2013.

[10] See RIGL sections 23-17.14-9 through 23-17.14-10. Available online at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.14/23-17.14-9.HTM and http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.14/23-17.14-10.HTM

In June 2012, the General Assembly amended the Hospital Conversions Act to include a provision for the expedited review of unaffiliated community hospitals where the acquired hospital has been determined to be financially distressed by the Director of Health. [11] It shortened the review process to 90 days (120 days in a regular review) and limited the review to the Department of Health. The 2012 statutory amendments did not derogate the authority of the Department of Attorney General; the Attorney General still reviews the expedited conversion application as it relates, at a minimum, to the impact upon the charitable assets of the transacting parties.

The Westerly Hospital and Lawrence + Memorial Corporation conversion application is the first expedited review processed by the Department of Health. This hospital conversion will mark the first time an out-of-state owner will be the parent of an entity holding a Rhode Island hospital license.

Hospital Conversion Application Travel

On November 2, 2012, The Westerly Hospital and the Lawrence + Memorial expedited conversion application was filed with the Departments of Health ("Department") and Attorney General. This expedited application consists of responses to a series of 27 questions related to, among other issues, the hospitals' financial standing; board composition and governance structure; staffing plans; sale terms and agreement; actions of other state/federal licensing authorities; and provision of community benefits.[12]

On November 27, 2012, the Departments transmitted requests for additional information ("deficiencies") and deemed the application incomplete. On January 2, 2013, in accordance with the November 27, 2012 request, additional materials were received from the transacting parties. On January 10, 2013, the Department transmitted additional deficiencies to the transacting parties. On

[11] See Public Law 12-259 that includes a new section 23-17.14-12.1 on expedited reviews. Available online at: http://webserver.rilin.state.ri.us/PublicLaws/law12/law12259.htm

[12] Application is available online at: www.health.ri.gov

January 18, 2013, responses to these deficiencies were received. On January 22, 2013, the Department once again requested supplemental materials and the application remained incomplete. Responses to these deficiencies were received on January 28, 2013. After these three rounds of requests for additional information, the application was deemed complete and accepted for review on January 29, 2013.

On January 24, 2013 the Department received supplemental materials from the Special Master, W. Mark Russo, Esq., related to the elimination of labor and delivery services at The Westerly Hospital on or about June 1, 2013. These supplemental materials resulted in a "reverse Certificate of Need" application being filed with the Department on February 4, 2013 related to the elimination of labor and delivery services at The Westerly Hospital.

Use of Experts by the Department of Health

Pursuant to the provisions of section 23-17.14-13 of the Rhode Island General Laws, as amended, the Department may engage experts and/or consultants in the review of a conversion application. All costs and expenses accrued in connection with this consulting are the responsibility of the transacting parties, in an amount as determined by the Director of Health and as limited in the case of an expedited review, by the provisions of section 23-17.14-12.1(f).

For this conversion review, the Department contracted with Harborview Consulting, LLC[13] to work directly with Department staff to interpret and analyze financial information supplied by the transacting parties. Additionally, Harborview Consulting services included the review and analysis of financial documents, papers, and related financial records provided by the transacting parties, that included: audited and internal financial statements, including balance sheets, income statements, cash flow statements, capital budgets, internal operating statements, and any financial or utilization data provided to the Department by the transacting parties as part of the conversion

[13] The Principal of Harborview Consulting, LLC is John J. Schibler, CPA, Ph.D. {See Appendix "A" for full report}.

review. The purpose of the contract was to obtain consulting services of an expert in the hospital/health care accounting industry to develop a financial assessment of the proposed conversion.

The Department additionally contracted with TruMed, Inc. of Fall River, Massachusetts[14] for clinical consulting services. The Department sought the services of a physician consultant who possesses demonstrated expertise in medico-legal matters, including the interpretation of state and federal hospital licensure regulations. The goals for the Department's clinical consultant included: 1/work directly with Department staff to provide interpretation and analysis of clinical information as supplied by the transacting parties and as obtained by the Department; 2/ analyze all clinical documents, papers, and related records; and 3/ review federal Centers for Medicare and Medicaid Services findings of hospital survey and certification processes, including citations of deficiencies and written plans of correction, and related state surveyor information. Dr. Robert Crausman, of TruMed, Inc., was generally requested, based upon a review of available documentation, to ascertain if clinical practices of the transacting parties are in conformity with all applicable standards, statutes, and regulations.

Confidentiality of Documents

In accordance with section 23-17.14-32 of the Rhode Island General Laws, as amended, the Attorney General maintains jurisdiction over the determination of the confidentiality /propriety of documents submitted by the transacting parties as part of the hospital conversion review application. The statute reads, in part: "The decisions by the Attorney General shall be made prior to any public notice of an initial application or any public review of any information and shall be binding on the Attorney General, the Department of Health, and all experts or consultants engaged

[14] The Principal of TruMed, Inc. is Robert S. Crausman, MD, MMS. {See Appendix "B" for full report}.

by the Attorney General or the Department of Health."[15] Confidentiality is often requested by the parties for records that may contain "trade secrets and commercial or financial information which is of a privileged or confidential nature", "all tax returns", "preliminary drafts, notes, impressions, memoranda, working papers, and work products" and "any records which would not be available by law or rule of court to an opposing party in litigation."[16]

The transacting parties requested confidentiality for no less than 30 exhibits submitted to the Department along with the application. Of these 30, all or portions of nine exhibits were subsequently deemed confidential for purposes of this review by the Attorney General on March 19, 2013.

Change in Effective Control Review

Pursuant to Chapter 23-17 of the Rhode Island General Laws, as amended ("Licensing of Health Care Facilities"[17]), certain transfers in ownership, assets, membership interest, authority or control of a Rhode Island hospital require prior review by the Health Services Council[18] and approval by the Department. This review is done in conjunction with the hospital conversion review and is known as the "Change in Effective Control (CEC)" review. The Change in Effective Control review is a public process that can take up to 90 days. (See Figure #1 below). The Change in Effective Control review criteria are generally similar to, but distinct from, the criteria for a hospital conversion review.

[15] See section 23-17.14-32 RIGL. Available online at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.14/23-17.14-32.HTM

[16] See section 38-2-2 RIGL "Access to Public Records Definitions." Available online at: http://webserver.rilin.state.ri.us/Statutes/TITLE38/38-2/38-2-2.HTM

[17] See: RIGL Chapter 23-17 "Licensing of Health Care Facilities." Available online at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17/INDEX.HTM

[18] The Health Services Council is created under the authority contained in section 23-17-13 RIGL. This is a 24-member body that is advisory to the Department of Health. Statutory authority is available online at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-15/23-15-7.HTM

Figure #1: Comparison of Hospital Conversion Review Types

	Hospital Conversion Process		Change in Effective Control
	Regular	Expedited	
Type	Administrated with confidentiality	Administrated with confidentiality	Public
Review Conducted by	HEALTH & RIAG (concurrently but separately)	HEALTH & RIAG (concurrently but separately)	HEALTH with recommendation from the Health Services Council
Review trigger (transfer of ownership, control, etc)	20% or greater		Greater than 50%

Since 1997, only one hospital conversion application has been successfully completed, approved by the Rhode Island Departments of Attorney General and Health, and implemented. In July 2009, then Health Director David Gifford approved the affiliation of not-for-profits Roger Williams Medical Center and St. Joseph Health Services of Rhode Island. The Attorney General at the time, Patrick Lynch, approved the affiliation in October 2009. The two hospitals formed CharterCARE Health Partners, which control 579 licensed hospital beds, employ 3,200 staff, with an annual operating revenue of about $330 million dollars.[19] In 2012 the conversion applications of Landmark Medical Center and Steward Healthcare System were completed and approved by the Rhode Island Departments of Attorney General and Health; however, these approvals were ultimately not implemented by the transacting parties.

The Westerly Community

U.S. Census data reveal that Westerly is a relatively young, educated community. The median household income is $60,432, while 7.7 % of persons live below the federal poverty level. Of the

[19] See: Rhode Island Department of Health, " Rhode Island Department of Health Decision Proposed Affiliation of St. Joseph Health Services of Rhode Island, Roger Williams Hospital, Roger Williams Medical Center, and CharterCARE Health Partners Under the Hospital Conversions Act of Rhode Island." Available online at: http://www.health.ri.gov/applications/submitted/merger/stjoerogerwilliams/ConversionDecision.pdf
See also: "Merger Approved between Rhode Island Hospitals", *Becker's Hospital Review*, October 29, 2009. Available online at: http://www.beckershospitalreview.com/news-analysis/merger-approved-between-rhode-island-hospitals.html Accessed on February 8, 2013.

total population of 22,787 persons, 86.7% have completed a high school education (or higher). The median age for Westerly (Washington County) is 44.3 years.[20]

Westerly Hospital staff recently identified areas of unmet health needs within their community as follows:

- Fewer town residents have been tested for diabetes within the previous three years (51% as compared to 60% statewide);
- More town residents have "pre-diabetes" compared to the rest of Rhode Islanders (11% in Westerly compared to 8% statewide);
- More town residents smoke compared to other Rhode Islanders (37% in Westerly compared to 30% statewide);
- Fewer town residents have been exposed to a "no smoking" campaign (66% of Westerly residents compared to 75% statewide);
- Fewer Westerly children receive seasonal influenza vaccinations (59% in Westerly compared to 73% statewide);
- Town residents report a greater number of poor mental health days during the past 30 days (42% of Westerly residents compared to the Rhode Island average of 38%); and
- The number of town residents with a diagnosis of cancer is greater than the statewide average (11% in Westerly compared to 7% statewide).[21]

[20] U.S. Census Bureau, American Fact Finder, 2010 Demographic Profile Data. Available online at: www.factfinder2.census.gov Accessed on March 19, 2013.

[21] Information communicated to the DOH in written correspondence via email from Patricia K. Rocha, Esq., to Valentina Adamova, Acting Chief Program Evaluator, Rhode Island Department of Health, on February 21, 2013.

TRANSACTING PARTIES

The Westerly Hospital Healthcare, Inc.

Westerly Hospital Healthcare, Inc. is the parent entity of all of The Westerly Hospital affiliated entities. The Westerly Hospital is a 125-bed not-for-profit community hospital located in Westerly, Rhode Island.[22] The original articles of association for the Hospital, dated June 16, 1921, indicate that the corporation was created for "the purpose of establishing and maintaining a hospital in the Town of Westerly; of rendering medical and surgical aid to those in need thereof especially those unable to pay therefor; and of otherwise carrying out the charitable and humane intentions of the corporation; and of receiving and applying for the above purposes, gifts, devises and bequests of money or property and the income and principal of any trust fund or funds now or hereafter available for the establishment, maintenance or support of an (*sic*) hospital in said Westerly."[23]

The Westerly Hospital Snapshot
25 Well Street
Westerly, RI 02891

Facility Type: Short-term acute care

Control: Voluntary not-for-profit

Total Staffed Beds: 61 (average)

Total Patient Revenue: $81,453,751

Total Admissions: 3,708

Total Patient Days: 15,277

Accreditation Agency: DNV Healthcare, Inc.

Source: The Westerly Hospital, 2012

The primary service area of The Westerly Hospital includes Westerly, Rhode Island; Hopkington, Rhode Island; and Stonington, Connecticut. The Hospital's secondary service area includes the towns of: Charlestown, Rhode Island; Groton, Connecticut; Ledyard, Connecticut; West Kingstown, Rhode Island; Wyoming, Rhode Island; Carolina, Rhode Island; and Wood River Junction, Rhode Island.

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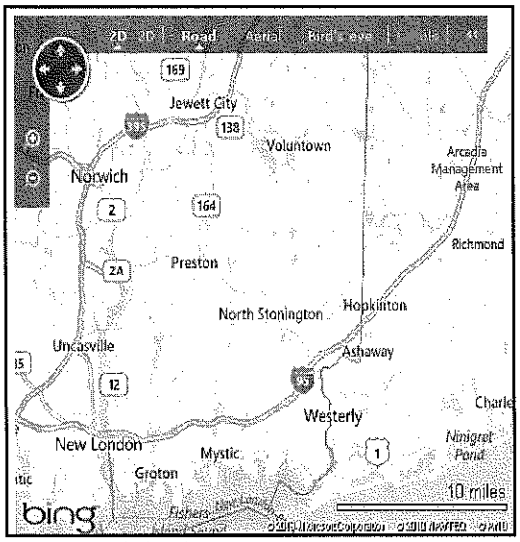
[22] See The Westerly Hospital's website at: http://www.westerlyhospital.org/

[23] See: State of Rhode Island and Providence Plantations, Original Articles of Association (Non-Business Corporation), Signed by Charles Perry, John O. Mills, Arthur M. Cottrell, Edgar P. Maxson and Harry B. Agard in the town of Westerly, June 16, 1921.

The distance between The Westerly Hospital and Lawrence + Memorial Hospital in New London, Connecticut is 19.6 miles.[24]

Figure #2: Map of The Westerly Hospital General Service Area



While licensed for 125 beds, The Westerly Hospital currently staffs between 52--70 beds, with an average daily in-patient census of 41 patients. The Westerly Hospital maintains active outpatient departments, offering diagnostic and imaging services, such as endoscopies and cardiac catheterizations. The Westerly Hospital Emergency Department logged over 24,000 visits in 2012.

According to data supplied by the transacting parties, the average length of stay at The Westerly Hospital is 4.0 days, compared to 4.6 at Rhode Island hospitals and 3.98 days nationally. (See Figure #3).

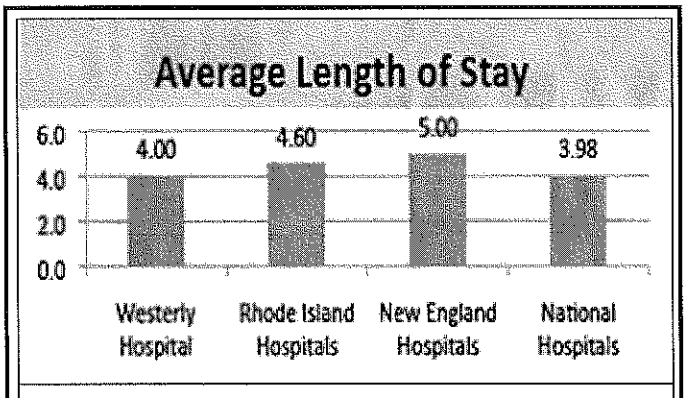


Figure #3

Source: Transacting Parties 2012 Data

[24] See Google maps: http://maps.google.com/maps?saddr=25+Wells+Street%2C+Westerly%2C+RI&daddr=365+Montauk+Ave%2C+New+London%2C+CT

North Stonington Health Center

The Westerly entities include the North Stonington Health Center in North Stonington, Connecticut. This Center was opened in early 2011 by Westerly Hospital Healthcare, Inc. and offered non-emergency urgent care walk-in services, laboratory, radiology and private physician office services. The Westerly Hospital expended $955,649 in opening this new venture, which was unveiled at the Hospital's annual meeting in December 2010.[25] The Special Master closed the North Stonington Health Center in March 2012[26], because the Center was operating at a loss of over $4 million dollars per year. As part of the Asset Purchase Agreement, Lawrence + Memorial is paying the lease obligations for the North Stonington Health Center (approximately $68,000/month) through the acquisition closing date. The Center is the subject of a bankruptcy proceeding in Connecticut courts.

Westerly Hospital Physicians: Atlantic Medical Group

The Westerly entities also include the Atlantic Medical Group[27], which is the corporate body for employing Westerly Hospital physicians. As part of this transaction, it was anticipated that physicians employed by Atlantic Medical Group would become employees of the LMW Physicians, Inc. However, as this transaction has progressed, Lawrence + Memorial has planned for Atlantic Medical Group physicians to become integrated into Lawrence + Memorial Physician Association, Inc., a multi-specialty medical foundation of approximately 100 providers. It has been publicly reported that 17 Atlantic Medical Group physicians have already signed agreements with Lawrence

[25] Faulkner, Dale P. "Hospital Takes Risks for Long-term Gain", Published online on December 9, 2010 in www.thewesterlysun.com/news. Accessed on February 16, 2013.

[26] Physicians with private offices at the North Stonington Health Center continue to see patients there as of this writing.

[27] Formerly legally incorporated as "CHOW NewCo, Inc."

+ Memorial Physician Association, Inc.[28] It appears likely that LMW Physicians, Inc. and the Atlantic Medical Group will be legally dissolved upon completion of this transaction.

Lawrence + Memorial Physician Association, Inc. has had significant losses over the last two (2) years and has required significant funding from the Lawrence + Memorial corporate parent (i.e., $9.2 million in 2011 and $12.1 million in 2012).

Role of the Special Master

On January 3, 2012 by order of the Rhode Island Superior Court for the County of Washington,[29] The Westerly Hospital and its related entities came under the jurisdiction of the Permanent Special Master, W. Mark Russo, Esq. (Special Mastership is similar to a receivership process). With this action, the Board of Trustees of The Westerly Hospital was dissolved and the Westerly entities were subsumed under the operating control of the Special Master. This action culminated a long period of financial distress for the Westerly entities.

On March 18, 2012 via a "Mastership Transaction Process Order", the Special Master began to seek proposals for the acquisition of the Westerly entities. The Mastership considered no less than 17 buyers, including some for-profit corporations. The goals related to the sale included:

- Maintain The Westerly Hospital as an acute-care community hospital;
- Encourage buyers to commit to maintain certain levels of employment;
- Encourage buyers to commit to a certain level of capital investment to insure sustainability;
- Encourage buyers to commit to expedite and fund the regulatory process.[30]

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[28] Benson, Judy. "L + M Purchase of Westerly Hospital Heads to Next Phase", Published online on February 8, 2013 on: www.TheDay.com. Accessed February 15, 2013.

[29] See: *Charles S. Kinney, Chief Executive Officer and Trustee v. Westerly Hospital Healthcare, Inc., The Westerly Hospital, Atlantic Medical Group, Inc., Ocean Myst, MSO, LLC, Women's Health of Westerly, LLC and North Stonington Health Center, Inc., C.A. No. 2011-0781.*

[30] See Presentation: "The Westerly Hospital Application for Change in Effective Control by Lawrence + Memorial Hospital", February 14, 2013, as presented to the Department of Health's Health Services Council. Available online at: www.health.ri.gov

On September 10, 2012 Judge Brian Stern of the Rhode Island Superior Court approved the sale of the Westerly entities to the Lawrence + Memorial Corporation, pending regulatory approvals.

Lawrence + Memorial Corporation

Lawrence + Memorial Corporation is the parent entity of the Lawrence + Memorial Hospital in New London, Connecticut and all of the Lawrence + Memorial entities. It is incorporated as a Connecticut non-stock corporation.

Lawrence + Memorial Hospital is a not-for-profit general medical surgical 280-bed private hospital that has been providing care to the residents of eastern Connecticut, southern Rhode Island, and Fisher's Island, New York for over 100 years.[31]

The Lawrence + Memorial Hospital Snapshot
365 Montauk Avenue
New London, CT 06320

Facility Type: Short-term acute care

Control: Voluntary not-for-profit

Total Staffed Beds: 256 (average)

Total Operating Revenue: $344,716,000

Total Discharges: 14,942

Total Patient Days: 70,822

Accreditation Agency: The Joint Commission

Source: L + M Corporation documents, 2012.

Lawrence + Memorial is fully accredited by the Joint Commission through the summer of 2013 and the Commission on Accreditation of Rehabilitation Facilities.

In addition to providing clinical care at its New London hospital, Lawrence + Memorial also provides clinical services at, among other locations, the Pequot Medical Center, a freestanding emergency care facility operating seven days per week in Groton, Connecticut. Additional off-site facilities include: Flanders Health Center (East Lyme, CT); Mystic Outpatient Services (Mystic, CT); Waterford Outpatient Rehabilitation Services (Waterford, CT); Lawrence + Memorial Sleep Center (Groton, CT); and its Wound and Hyperbaric Center (Waterford, CT).

[31] See Lawrence + Memorial Hospital website at: http://lmhospital.org/

In September 2013, Lawrence + Memorial plans to open a $34.5 million dollar cancer center in Waterford, CT in affiliation with Dana Farber Cancer Center. Lawrence + Memorial is currently conducting a major capital campaign to raise $30 million dollars for its new cancer center.

Clinical Care at Lawrence + Memorial

During this hospital conversion review, it was determined that Lawrence + Memorial Hospital was subject to an active consent order with the Connecticut Department of Public Health's Facility License and Investigations Section, effective March 16, 2011.[32] This consent order followed unannounced inspections by the Connecticut Department of Public Health on June 3, 2010 and October 6, 2010. Certain quality of care issues were raised as a result of an unfortunate pediatric clinical case in which there was a potentially preventable adverse outcome, triggering the subsequent Connecticut Department of Public Health inspections.

The consent order required that Lawrence + Memorial Hospital engage a Connecticut Department of Public Health-approved clinical consulting entity to review, address, and advise Lawrence + Memorial with resolution of the identified issues. Yale New Haven Children's Hospital was selected by Lawrence + Memorial, approved by the Connecticut Department of Public Health as the clinical consulting entity, and engaged on April 12, 2011. Yale New Haven worked with Lawrence + Memorial Hospital staff to develop a comprehensive corrective action plan that included 39 components. This plan was subsequently approved by the Connecticut Department of Public Health.

Connecticut Department of Public Health staff have related to the Department that Lawrence + Memorial Hospital has been in compliance with their consent order and has satisfied all of the requirements. The terms of this consent order were completed, on schedule, in March 2013.

[32] The Lawrence + Memorial Hospital Consent Order is available online at: http://www.ct.gov/dph/lib/dph/facility_licensing_and_investigations/regulatoryactiondocuments/lmhosp_3_16_2011conorder.pdf

January 2013 Licensure Survey

A routine licensure survey was conducted by the Connecticut Department of Public Health at the Lawrence + Memorial Hospital on January 10, 2013. This survey resulted in several deficiencies, one of which triggered a complete federal compliance survey that was conducted by the Connecticut Department of Public Health on March 14, 2013.

During the January 10, 2013 Connecticut Department of Public Health survey, a finding of "immediate jeopardy" was made related to the presence in the dialysis unit of a calibration device solely for use by the Hospital biomedical engineering staff. If this device had been used by clinical staff, it could have resulted in serious patient harm. (This finding triggered the full federal compliance survey on March 14, 2013). The device was immediately removed from the dialysis unit and the "immediate jeopardy" threat was resolved. The March 14, 2013 federal survey revealed the following deficiencies:

- Incomplete post-anesthesia medication orders;
- Failure to apply required clinical assessment tools for patient agitation/sedation, withdrawal, and pain;
- Physical plant issues related to bedside rails present on the psychiatric unit;
- Outdated hemacult cards at the Pequot emergency department;
- Operating room small refrigerator had a thermometer that was unlinked from the engineering department;
- An outdated informed consent form was present in one patient's colonoscopy record;
- Ventilator settings were not performed in accordance with hospital policy that requires specific physician orders.

The "immediate jeopardy" finding is concerning to the Department but the circumstances are unique and are unlikely to be repeated. The deficiencies identified in the March 2013 survey are of a type more commonly identified by health department inspectors and should be easily corrected.

The Department's clinical consultant noted that Lawrence + Memorial has demonstrated that it has the clinical, administrative, and board-level leadership, established infrastructure, and expertise requisite to fostering a culture of patient safety and quality as it acquires The Westerly Hospital.

Overview of this Transaction

The Lawrence + Memorial Corporation, LMW Healthcare, Inc.[33], and LMW Physicians, Inc.,[33] collectively represent the acquiror who proposes to purchase the Westerly entities[34] for a total consideration of $69,138,653. Provisions of this acquisition are stipulated in an Asset Purchase Agreement approved by an order of the Rhode Island Superior Court for the County of Washington on September 10, 2012. Key components of the Asset Purchase Agreement include the following terms:

- Lawrence + Memorial will assume $22 million dollars in liabilities of the Westerly entities;
- Lawrence + Memorial will pay the closing costs for the acquisition and costs related to the Special Mastership estimated at $1.5 million dollars;
- Lawrence + Memorial will provide $6.5 million dollars in working capital to The Westerly Hospital during the first two years after the acquisition;
- Lawrence + Memorial will spend $30 million dollars on capital purchases such as technology, equipment, and an expansion of services over a five year period;
- Lawrence + Memorial has committed to continuing The Westerly Hospital as a not-for-profit hospital, concomitant with its community mission;
- Lawrence + Memorial will establish a new board at The Westerly Hospital, drawing six members from the Westerly service area, including at least one physician. Three Westerly residents will be included on the Lawrence + Memorial corporate board;
- Lawrence + Memorial will maintain The Westerly Hospital as an acute care, community hospital for a period of at least five years after the acquisition;

[33] Both LMW Healthcare, Inc. and LMW Physicians, Inc. are Rhode Island not-for-profit corporations.

[34] The Westerly entities include: Westerly Hospital Healthcare, Inc.; The Westerly Hospital; Atlantic Medical Group, Inc.; Ocean Myst, MSO, LLC; Women's Health of Westerly, LLC; and North Stonington Health Center, Inc.

- Lawrence + Memorial has committed to maintaining clinical services offered at The Westerly Hospital for a two year period after the acquisition;
- Lawrence + Memorial indicates that it will "offer employment, commencing on the closing date to all union and non-union clinical, trade and services personnel of the Sellers (excluding certain management personnel and general and administrative support services personnel) and, after satisfactory review of Sellers Plan to Profitability and employment data, Buyer expects to offer employment to substantially all of the Hospital's other employees."[35]
- Lawrence + Memorial will assume physician contracts at The Westerly Hospital and initiate steps to strengthen its relationship with the Westerly physician community;
- Lawrence + Memorial will conduct a capital campaign for the benefit of Westerly Hospital. All funds raised in such campaign are committed to the Hospital's non-profit, community mission; and
- Lawrence + Memorial will not assume responsibility for outstanding Westerly bonds but will redeem these bonds prior to closing (with Lawrence + Memorial funds).

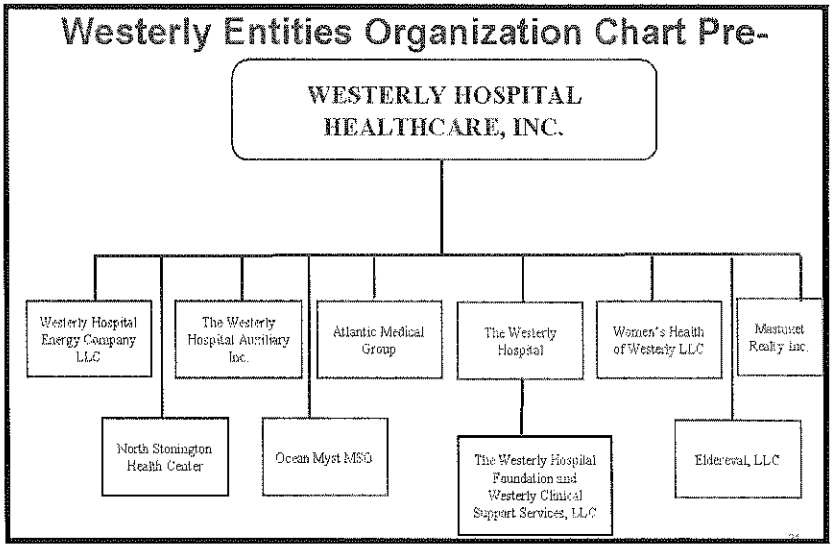
Lawrence + Memorial proposes to finance this acquisition with a short-term bridge loan of $20 million dollars. Lawrence + Memorial has made a commitment to inject $6.5 million in working capital into The Westerly Hospital during the first two years.

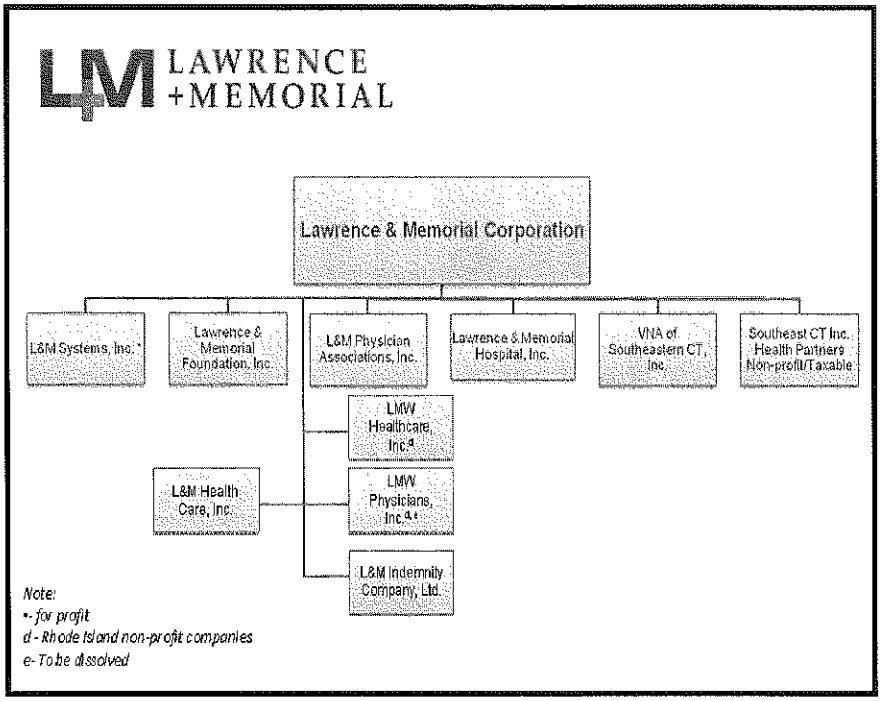
Lawrence + Memorial officials have stated publicly that they seek to acquire The Westerly Hospital in order to maintain the not-for-profit hospital with a community focus in a service area that is contiguous to Lawrence + Memorial's. They believe that by implementing the appropriate expense controls, the Hospital will be returned to profitability. Lawrence + Memorial forecasts

[35] See page 72 of the Asset Purchase Agreement.

that within three years, The Westerly Hospital will generate a three percent (3%) operating margin.[36]

Following the sale, The Westerly Hospital will become a wholly owned subsidiary of the Lawrence + Memorial Corporation. (Please see pre- and post-conversion organizational charts below).





[36] Remarks made by Bruce Cummings, CEO of L+ M Hospital, on February 14, 2013 to the Department of Health's Health Services Council.

Sections 23-17.14-11 and 23-17.14-28 of the Rhode Island General Laws, as amended, set forth the review criteria that reads as follows:

"In reviewing an application of a conversion involving a hospital in which the transacting parties are limited to not-for-profit corporations, the department shall consider the following criteria:

(1) Whether the character, commitment, competence, and standing in the community, or any other communities served by the proposed transacting parties are satisfactory;

(2) Whether sufficient safeguards are included to assure the affected community continued access to affordable care;

(3) Whether the transacting parties have provided satisfactory evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community;

(4) Whether procedures or safeguards are assured to insure that ownership interests will not be used as incentives for hospital employees or physicians to refer patients to the hospital;

(5) Whether the transacting parties have made a commitment to assure the continuation of collective bargaining rights, if applicable, and retention of the workforce;

(6) Whether the transacting parties have appropriately accounted for employment needs at the facility and addressed workforce retraining needed as a consequence of any proposed restructuring;

(7) Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state."[37]

(8) "For any conversion subject to this chapter, the Director…..shall consider issues of market share especially as they affect quality, access, and affordability of services."[38]

A discussion of these review criteria and the Director's findings appear below.

[37] See section 23-17.14-11 RIGL "Criteria for the Department of Health - Conversions limited to not-for-profit corporations." Available online at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.14/23-17.14-11.HTM

[38] See section 23-17.14-28 (a) RIGL. Available online at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.14/23-17.14-28.HTM

#1: Whether the character, commitment, competence, and standing in the community, or any other communities served by the proposed transacting parties are satisfactory

Discussion

The Department interprets this criterion to mean that patient care is delivered by the transacting parties in a manner that merits the public trust; that the transacting parties' methods of delivering patient care do not jeopardize the health, safety and well-being of the patients they serve; that there is no pattern of conduct, behavior, or inaction of the transacting parties that impedes the health, safety, and well-being of their patients; and that the mission and goals of the parties are focused upon patient care-giving and fostering the public trust.

"*Character*" of the transacting parties may be demonstrated by their corporate integrity, transparency of decision-making, and their emphasis on remaining inclusive in a dynamic healthcare marketplace. "*Commitment*" may be measured by the extent to which the transacting parties provide care that improves measurable health outcomes for the entire population in the geography served by the entities. "*Competence*" may be demonstrated by organizations that are committed to decisiveness, leadership, creativity, community and situational awareness, and are disciplined enough to achieve their stated goals in a financially prudent manner. "*Standing in the community*" may be demonstrated by the respect that local /state governments and community-based organizations have for the hospital.

The Department considered the following proxies for this criterion:

- Accreditation status of the transacting parties;
- Regulatory status, including any adverse licensure actions;
- Patient satisfaction survey results and other information compiled by the federal Centers for Medicare and Medicaid Services;

- Community health needs assessment contents; community benefit activities; and public health indicators for the population served;
- Quality improvement initiatives;
- Financial stability of the acquiror; and
- Standing in the community.

The Lawrence + Memorial Hospital is fully accredited in good standing by the Joint Commission, with both hospital and behavioral health care accreditations. The last full on-site survey was completed on May 6, 2010. Lawrence + Memorial's primary stroke center is certified under the Joint Commission's advanced certification program, having been last reviewed on March 25, 2011. The Hospital has completed all of the Joint Commission's 2010 safety goals, including (among others) improving the safety of medications, improving the accuracy of patient identification, and improving communication effectiveness among caregivers. Lawrence + Memorial Hospital's performance is similar to the target range/value among all hospitals nationwide for the 2010 national patient safety goals.[39]

As discussed above, Lawrence + Memorial Hospital operated under a consent order with the Connecticut Department of Public Health that was in full force and effect through March 16, 2013.

Multiple violations of relevant regulations and statutes were identified in five (5) broad areas in the findings of the unannounced inspection: 1/ life and safety/physical plant; 2/ food services; 3/ nursing care; 4/ medical staff; and 5/ medical records/documentation. Most significant of these violations were those relating to the care of pediatric patients with emergency or critical illness.

Although the physical plant and food services-related issues were significant, they were addressed through a corrective action plan and were not included as part of the consent order. The consent order focused primarily on issues related to the Lawrence + Memorial Hospital's care of

[39] See the Joint Commission's Summary on Lawrence + Memorial Hospital at: http://www.qualitycheck.org/qualityreport.aspx?hcoid=5681

pediatric patients with acute medical, surgical, and psychiatric illness. The order also dealt with the use of physical restraints in this population.

In May 2011, Yale New Haven conducted a three-day comprehensive review of the pediatric services provided at Lawrence + Memorial Hospital. In June 2011, pediatrics quality-of-care conferences were conducted with the medical staff. As part of the corrective action plan, a "Chief Quality and Patient Safety Officer" was designated by Lawrence + Memorial and approved by the Connecticut Department of Public Health.

Yale New Haven Children's Hospital, in conjunction with Lawrence + Memorial, developed a corrective action plan that included 39 recommendations, subsequently approved by the Connecticut Department of Public Health and implemented at the Lawrence + Memorial Hospital. The 39-point corrective plan included action items related to nursing care, supervision of physicians, pediatric anesthesia, and pediatric behavioral health services. These action items were comprehensive and fully addressed the issues required by the consent order and raised by the statement of deficiencies as they related to pediatric care.

As of December 7, 2012, Yale New Haven reported to the Connecticut Department of Public Health near completion of all topics on the consent order. Additionally, Lawrence + Memorial has implemented all of the recommendations made by Yale New Haven Children's Hospital, the clinical consulting entity.

Lawrence + Memorial also created a "pediatric emergency department" on-site at the New London hospital staffed by pediatric emergency department specialists with daily hours of operation between 4:00 PM and 11:00 PM.

Among other steps taken, Lawrence + Memorial revised relevant policies and procedures and conducted staff education. Periodic reporting on the progress achieved related to the clinical

consulting entity's recommendations was made to the medical staff and to Lawrence +Memorial's board of directors.

As an immediate consequence of the 2011 consent order, a Chief Quality and Patient Safety Officer was named at Lawrence + Memorial Hospital. This senior staff member is responsible for quality initiatives, monitoring, and assurance within the facility. This individual reports directly to the Vice-President/ Chief Medical and Operations Officer, who in turn reports directly to the Chief Executive Officer. This position is viewed as part of the Hospital's leadership team and is also a member of the organization's "Quality Council."

Over the past two years, Lawrence + Memorial has expanded its quality and patient safety program. Lawrence + Memorial has an experienced leadership team charged with leading its patient safety initiatives. This team has effectively engaged the board of trustees, administration, and clinical leadership staff. Its plan is to integrate The Westerly Hospital into this quality program upon approval of this conversion. Finally, Lawrence + Memorial's publicly-reported Centers for Medicare & Medicaid Services quality metrics are comparable to its peers in the region.

The Institute of Medicine's 2001 report entitled, "Crossing the Quality Chasm; A New Health System for the 21st Century"[40] emphasizes system redesign as a means to improved safety and quality. The appointment of a Lawrence + Memorial Chief Quality and Safety Officer with direct reporting to senior hospital leadership is viewed by the Department as an important institutional step towards eliminating a "silo mentality" that often exists in health care settings.

For the past two decades, there has been an increasing emphasis upon the development and implementation of quality performance measures in health care. "In the interest of promoting high-quality, patient-centered care and accountability," the Centers for Medicare & Medicaid Services and Hospital Quality Alliance began publicly reporting 30-day mortality measures for acute

[40] See: National Academy of Sciences, Washington, DC, 2001.

myocardial infarction and heart failure in June 2007 and for pneumonia in June 2008. Publicly reporting these measures increases the transparency of hospital care, provides useful information for consumers choosing care, and assists hospitals in their quality improvement efforts.[41]

The Medicare "Hospital Compare Quality of Care Compare Page" was queried on February 4, 2013 regarding the most recent available data concerning Lawrence + Memorial (See Appendix "C"). Data reported were collected generally between April 1, 2011 and March 31, 2012.

Data were reviewed first in the context of all other Connecticut hospitals and a national average; and then in comparison with The Westerly Hospital and Rhode Island average responses (See Appendix "C").

Patient Satisfaction Survey Results

Lawrence + Memorial Hospital achieved or exceeded the Connecticut state average for nurse communication and pain control. It fell below the state average for: 1/ physician communication and respect; 2/ how quickly call buttons were answered; 3/ how well staff explained medications; 4/ cleanliness of bathrooms; 5/ quiet rooms at night; 6/ post-discharge information; 7/ overall rating of the hospital; and 8/ would recommend the hospital. Connecticut as a state was below the national average on all but the last of these measures. Lawrence + Memorial Hospital achieved or exceeded the Rhode Island average for two of the eight measures and was generally comparable to The Westerly Hospital.

Clinical Care Measures

On the first measure related to timely and effective care ("heart attack"), Lawrence + Memorial Hospital achieved or exceeded the state average for percutaneous coronary intervention[42],

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[41] For background information on quality measures, see the CMS website. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/OutcomeMeasures.html.

[42] PCI is a procedure to open a narrowed or blocked coronary artery. It is also known as "angioplasty."

percutaneous coronary intervention within ninety (90) minutes of arrival, aspirin and statin[43] use. Lawrence + Memorial Hospital equaled or exceeded the performance of The Westerly Hospital in three of four measures scored with sufficient data.

On the second measure related to timely and effective care ("heart failure"), Lawrence + Memorial Hospital achieved or exceeded the state average for assessment of heart function and use of an ACE inhibitor.[44] It equaled or exceeded the performance of The Westerly Hospital in two of three measures.

On the third measure related to timely and effective care ("Pneumonia"), Lawrence + Memorial Hospital exceeded the state average for performance of blood cultures but was below the state average for antibiotic selection. Lawrence +Memorial equaled or exceeded the performance of The Westerly Hospital in two of two measures.

On the measure related to surgical care, Lawrence + Memorial Hospital achieved or exceeded the state average in five of 10 measures [with insufficient data for an eleventh measure relating to diabetes]. Lawrence + Memorial equaled or exceeded The Westerly Hospital in two of three measures of timeliness; and three of six measures of effectiveness.

On the measure related to Lawrence + Memorial's emergency department, it achieved or exceeded the state average in three of six measures [with insufficient data for a seventh measure relating to brain scans]. It exceeded Westerly Hospital's performance on influenza and pneumonia vaccination.

On the measure related to patient 30-day outcomes (readmissions and deaths), there was no difference for Lawrence + Memorial from national rates on all measures.

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[43] Statins are a class of drugs that are used to lower cholesterol.

[44] ACE inhibitors are medications used for, among other conditions, controlling blood pressure, preventing strokes and kidney damage in people with hypertension or diabetes.

The Department's clinical consultant's noted that Lawrence + Memorial's performance on Centers for Medicare & Medicaid Service's publicly-reported measures of quality was comparable to other acute care hospitals in the region. Like most hospitals in Rhode Island, surrounding Massachusetts, and Connecticut, there is clear opportunity for improvement in many areas.

According to the U.S. News + World Reports "Best Hospitals" survey,[45] sixty percent (60%) of Lawrence + Memorial's patients would rate the Hospital overall as "highest or very high." The Connecticut state average on this measure was sixty-six percent (66%). When patients were asked if they would recommend the hospital to family and friends, sixty-seven percent (67%) indicated they would "definitely" recommend the Hospital. The statewide hospital average score for this measure was seventy-two percent (72%).

Population Health Measures

In a recent study, the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute ranked United States counties by health status. For the fourth consecutive year, Robert Wood Johnson and the University of Wisconsin Population Health Institute examined the impact of health factors, such as socio-economic status,[46] clinical care[47],

[45]To view the Lawrence + Memorial Hospital patient satisfaction ratings, go to: http://health.usnews.com/best-hospitals/area/ct/lawrence-and-memorial-hospital-6160480

[46] In the RWJ – UW ranking, social and economic factors included measures related to: community safety, education, employment, family/social support, and income.

[47] In the RWJ – UW ranking, clinical care factors included measures related to: access to care and quality of care.

health behaviors,[48] and the physical environment[49] on health outcomes. Health outcomes are measured by morbidity and mortality rates.[50]

The primary service area of the Lawrence + Memorial Hospital includes the towns of: New London, East Lyme, Lyme, Groton, Ledyard, Montville, North Stonington, Stonington, Old Lyme, and Waterford, Connecticut. The secondary service area of the Lawrence + Memorial Hospital includes the towns of: Voluntown, Griswold, Lisbon, Sprague, Norwich, Franklin, Bozrah, Lebanon, Salem, and Colchester, Connecticut. These 20 municipalities comprise New London County, Connecticut.

In the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute health ranking, New London County's overall rank was fifth of eight Connecticut counties (1 being the highest ranking and 8 being the lowest). New London County ranked fifth on measures related to health factors, clinical care, and social /economic factors; and came in sixth of eight counties on measures related to the physical environment.[51]

Robert Wood Johnson and the University of Wisconsin Population Health Institute found that ten percent of New London County residents were uninsured, which is the same percentage for the state of Connecticut, but lower than the national benchmark of 11%. Twelve percent of New London County children live in poverty compared to 15% statewide and 14% nationally.

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[48] In the RWJ - UW ranking, health behaviors included measures related to: alcohol use, diet and exercise, sexual activity, and tobacco use.

[49] In the RWJ - UW ranking, physical environment factors included measures related to: the built environment and environmental quality.

[50] See: "County Health Rankings Show Healthiest and Least Healthy Counties in Every State", Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, March 20, 2013. Findings available online at: www.rwjf.org/en/about-rwjf/newsroom/newsroom-content
For explanation of methods, see: "Data Sources and Measures, County Health Rankings and Roadmaps" Available online at: www.countyhealthrankings.org/ranking-methods/data-sources-and-measures Accessed on March 20, 2013.

[51] See: "County Health Rankings Show Healthiest and Least Healthy Counties in Every State", Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, March 20, 2013. Findings available online at: http://www.countyhealthrankings.org/app/#/connecticut/2013/rankings/outcomes/overall/by-rank Accessed March 27, 2013.

Robert Wood Johnson and the University of Wisconsin Population Health Institute reported that the healthiest counties in the United States have at least one primary care physician for every 1,491 residents. According to these data, in New London County, Connecticut, there is one primary care physician for every 1,584 residents, compared to one primary care physician among 1,223 residents statewide. Sixty-two percent of New London County residents have attained some college education, compared to 66% statewide and 70% nationally. The teen birth rate in New London County is 24/1,000 (female population, ages 15 – 19) compared to 22/1,000 statewide and 21/1,000 nationally.

On physical environment measures, New London County scored less well. Four percent of New London County residents had limited access to healthy foods, compared to one percent nationally. On the drinking water safety measure, 7% percent of New London County residents received public drinking water from a public water system with at least one health-based violation, compared to one percent statewide.[52]

Washington County, Rhode Island fares well in the county rankings developed by the Robert Wood Johnson and the University of Wisconsin Population Health Institute. On the health behaviors measure, Washington County ranked third of five counties (1 being the highest ranking and 5 being the lowest) in Rhode Island. On the clinical care measure, Washington County ranked second of the five Rhode Island counties. Washington County also ranked second of five on measures related to socio-economic status. It was only on the physical environment measure that Washington County came in fifth (and last) of the five Rhode Island counties.[53]

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[52] See: "County Health Rankings Show Healthiest and Least Healthy Counties in Every State", Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, March 20, 2013. Findings available online at: http://www.countyhealthrankings.org/app/#/connecticut/2013/rankings/outcomes/overall/by-rank Accessed March 27, 2013.

[53] *Ibid.*, see: "Compare Counties in Rhode Island" at www.countyhealthrankings.org/app/ Accessed on March 20, 2013.

Robert Wood Johnson and the University of Wisconsin Population Health Institute found that ten percent of Washington County residents were uninsured compared to Providence County, where 16% of residents were uninsured. Twelve percent of Washington County children lived in poverty compared to 27% in Providence County.

According to these data, in Washington County, there is one primary care physician for every 1,041 residents, compared to one primary care physician among 1,116 residents statewide. Seventy-four percent of Washington County residents have attained some college education, compared to 59% in Providence County and 64% statewide.

On physical environment measures, Washington County scored less well. Nine percent of Washington County residents had limited access to healthy foods, compared to six percent statewide. On the drinking water safety measure, 31% percent of Washington County residents received public drinking water from a public water system with at least one health-based violation, compared to five percent statewide.

Community Health Needs Assessment

The Patient Protection and Affordable Care Act of 2010 requires that not-for-profit hospitals file Community Health Needs Assessments every three years with the Internal Revenue Service for the tax years beginning after March 23, 2012. The Affordable Care Act requires four components of the needs assessment as follows:

- Conduct a community health needs assessment;
- Adopt and implement written financial assistance and emergency medical care policies;
- Limit charges for emergency and other necessary medical care; and
- Comply with new billing and collection restrictions.[54]

[54] Bales, Rebecca, Kelly Tiberio, and Tara Tesch. "Nonprofit or For-profit? Hospital Conversion Considerations." The Camden Group, April 1, 2012. Available online at: http://www.thecamdengroup.com/wp-content/uploads/Camden-Nonprofit-or-For-profit-Hospital-Conversion-Considerations.pdf Accessed February 8, 2013.

Not-for-profit hospitals not in compliance with this new mandate risk losing their non-profit status and are subject to monetary fines. According to one report, the community health needs assessment will "necessitate a well-defined approach and process from hospitals to ensure a successful completion of this IRS mandate."[55]

In its 2012 "Community Health Needs Assessment", Lawrence + Memorial Hospital prioritized its top three community health needs as follows: 1/ overweight and obesity; 2/ access to care; and 3/ cancer. After conducting a review and analyses of four sources of community health data, Lawrence + Memorial embarked upon a community health strategic planning process. The goal of the planning process is to guide the development of Lawrence + Memorial's "Community Health Implementation Plan."

As part of its planning process, Lawrence + Memorial found that the incidence of female breast cancer, colorectal cancer, and lung/bronchus cancers was higher in New London County than the state of Connecticut and the nation as a whole. Lawrence + Memorial also found that the percentage of patients who delayed care due to cost ranged from 5.9% to 14.2%, higher than the federal Centers for Disease Control's "Healthy People" goal of 4.2%.

Lawrence + Memorial has indicated that it will use the findings from the Westerly community health needs assessment to identify and serve the underserved in the Westerly service area.

Community Benefits

Lawrence + Memorial reports that it invested $15.6 million dollars in 2011 in community education and outreach activities. In addition to completing its community health needs assessment, Lawrence + Memorial seeks to accomplish three additional community benefits-related goals at The Westerly Hospital in the first three years after the acquisition. These community benefits goals

[55] *Ibid.*, at page 6.

include: 1/ implement an electronic software system for tracking, reporting, and evaluating community benefit activities; 2/ develop a "community health improvement plan" to match identified community needs with community benefit activities; and 3/ continue to offer and refine community health education programs that are in conformity with the community health needs assessment. Lawrence + Memorial pledges to invest in the Westerly community at a level that is comparable to its investment in the Lawrence + Memorial community.

On its 2010 Form 990-H submitted to the Internal Revenue Service, Lawrence + Memorial Hospital indicated that it is committed to providing "medically necessary health care services…to all individuals regardless of their ability to pay."[56] Further, Lawrence + Memorial provides charity care to all uninsured patients (earning less than 250% of the federal poverty guidelines) that exceeds Rhode Island's current standards. Lawrence + Memorial states its commitment to meeting or exceeding the Connecticut Hospital Association's "Statewide Discount Policy for Uninsured Patients."[57]

The last Westerly Hospital community benefits report was completed in 2009. (Draft reports were completed for 2010 and 2011). In its last federal Form 990-H filing, The Westerly Hospital indicated that resources have been allocated for an FY2013 community health needs assessment. The Hospital expressed an interest in identifying areas for improvements in population health. The Hospital offers community health education programs and participates in efforts to reduce teen pregnancy rates in Washington County. [58]

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[56] See: Guidestar's "Lawrence and Memorial Hospital, Inc." Available online at: http://www.guidestar.org/FinDocuments/2011/060/646/2011-060646704-0875335f-9.pdf Accessed on March 19, 2013.

[57] *Ibid.*, at Part VI, Schedule H (Form 990) 2010.

[58] See: Guidestar's "The Westerly Hospital." Available online at: http://www.guidestar.org/FinDocuments/2011/050/259/2011-050259100-0874559e-9.pdf Accessed on March 21, 2013.

Community Standing

Lawrence + Memorial demonstrates its standing in the community by the following measures: 1/ it is fully accredited in good standing by the Joint Commission; 2/ the Hospital's inclusion of Westerly residents on its Hospital and corporate boards; and 3/ the absence of comments at any of the public meetings that questioned the standing of Lawrence + Memorial in the community.

Summary of Public Comments

At the public meetings (March 27, 2013 in Westerly, Rhode Island and April 1, 2013 in Providence, Rhode Island) on this matter, a total of nine persons provided comments, including the Westerly Town Manager who is also the Chairman of the Westerly Area Residents' Committee.

No one suggested that the transaction should not go forward. Six persons spoke in support of the transaction. The other three persons in attendance raised concerns regarding the termination of the obstetric/labor and delivery services at The Westerly Hospital.

Financial Stability

The Department's financial consultant noted that Lawrence + Memorial maintains a strong financial position that includes an "A+" debt rating from Standard & Poor's in 2012. Lawrence + Memorial has a strong cash position with cash-on-hand in excess of 200 days for the period FY 2008 – FY 2012. Cash, and investments, on a consolidated basis, increased by about $23 million dollars between 2011 and 2012. Lawrence + Memorial maintains cash-on-hand well above the 60 days required by bond agreements. Over $200 million dollars remains in unrestricted investments by Lawrence + Memorial.

Over the last three years, Lawrence + Memorial has invested significant resources into the L + M Physician Association, Inc. Approximately $22 million dollars have been transferred from

the obligated group[59] to the L + M Physician Association, Inc. The L + M Physician Association, Inc. is projected to lose $16 million in FY 2013.

Generally, the Lawrence + Memorial obligated group has consistently demonstrated strong operational performance with operating margins at, or in excess of, benchmarks.

Under the terms and conditions of the Asset Purchase Agreement, Lawrence + Memorial has agreed to fund $30 million dollars of improvements at The Westerly Hospital over the next five years. An additional $6.5 million dollars is pledged to The Westerly Hospital as part of a "profitability improvement plan."

When the Special Master took control of the Westerly entities, they were losing over $1 million dollars per month. In September 2012, Standard & Poor's downgraded The Westerly Hospital's credit rating from a "C" to a "D."[60] The Westerly Hospital is expected to experience a $1.6 million dollar loss as part of its 2013 budget.

Summary

In summary, Lawrence + Memorial has presented evidence of its commitment, competence, and character by presenting evidence of its strong current financial position to support the acquisition of Westerly Hospital; of its rigorous community health assessment and community benefit plan, that establishes Lawrence + Memorial as a hospital deeply committed to the community it serves; and has presented evidence of adequate clinical performance on most quality measures, when compared to its Connecticut and national peers. Lawrence + Memorial is well-respected and firmly supported by the community it serves.

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[59] The "obligated group" consists of: the Lawrence + Memorial Hospital, Associated Specialists of Connecticut, and L + M Healthcare.

[60] Herman, Bob. "7 Hospitals Receive Credit Downgrades in Past Month." Becker's Hospital Review, September 17, 2012. Available online at: www.beckershospitalreview.com Accessed on February 20, 2013.

Finding

Based upon the discussion above, the transacting parties are deemed to have satisfactorily met the requirements described in criterion #1.

#2: Whether sufficient safeguards are included to assure the affected community continued access to affordable care

Discussion

The Department interprets this criterion in light of the health care delivery system that is currently in place in the affected community and the commitments that the acquiror has made to the community in facilitating continued access to affordable care in southern Rhode Island.

Researchers point out that health insurance alone does not ensure access to care. Within a community, there has to be a sufficient number of primary care and specialty services and providers within proximity to patients. The health insurance plan also has to be accepted by the provider.[61]

In non-metropolitan areas, geography limits access to health care. The limited number of practitioners and scarcity of public transportation can become impediments to accessing needed health care services.

In The Westerly Hospital service area, primary care is principally provided: 1/ at The Westerly Hospital; 2/ by the Wood River Health Services, Inc.; and 3/ by the Narragansett Indian Health Center in Charlestown, Rhode Island;[62]

In Westerly, there are 96 physicians, 33 of whom are primary care practitioners.[63] Approximately fourteen percent (14%) of this total number of physicians are employed by the Atlantic Medical Group at Westerly Hospital, which, upon consummation of the transaction, will

[61] See: "County Health Rankings Show Healthiest and Least Healthy Counties in Every State", Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, March 20, 2013. Findings available online at: www.rwjf.org/en/about-rwjf/newsroom/newsroom-content

[62] See information on the Narragansett Indian Health Center online at: http://www.211ri.org/find/Details.aspx?OrgId=29524

[63] See: "Coordinated Health Planning Project: Final Report of Findings", The Robert Graham Center, Washington, DC, February 2013, Table #14, page 30. Available from the DOH upon request.

become folded into the Lawrence + Memorial Physicians Association, Inc. While the primary care supply of physicians in Westerly numbers 33, the specialty care supply is 63 physicians.

Related to specialty care at The Westerly Hospital in 2012, there were 4,964 endoscopies and 2,294 outpatient surgeries performed and 2,250 IV outpatient therapy visits. Also in 2012, there were 203 outpatient visits at the cardiac catheterization laboratory. For intensive care unit services, there were 1,586 patient days (ICU days) for this service in 2012. In 2012, there were 68,737 ancillary health service outpatient visits to physical therapists, occupational therapists, and speech pathologists at The Westerly Hospital. There were 43,012 outpatient visits for medical imaging services at The Westerly Hospital in 2012.

Westerly Women's Health: Obstetrics Labor and Delivery Services

The Westerly Hospital operates a women's health program, including a perinatal program and labor/delivery services. Labor and delivery services have been offered at the Hospital continuously since August 1925. As part of its women's health program, the Hospital provides prenatal stress testing, child birth education, gynecological surgery, imaging, general gynecology, and women's gastroenterology services. In calendar year 2012, 334 patients utilized the Hospital's labor and delivery services.

The payer mix for the Hospital's labor and delivery patients for the period January 2010 through December 2012 appears below as Figure #4. As seen in Figure #4, the largest payers are the Rhode Island Medicaid HMO Program (22.5%) and Blue Cross/Blue Shield of Rhode Island (18.5%).

Payer	*Percentage*
Champus	7.0576%
HMO	11.2992%
Medicare	0.8453%
RI Blue Cross	18.4868%
CT Blue Cross	9.7303%
RI Medicaid	0.5494%
CT Medicaid	2.6765%
Self Pay	1.8450%
Commercial	4.2310%
Medicaid HMO	22.4830%
Out of State Blue Cross	5.2628%
United Health Care Corporation	15.5329%
Total	100.0000%

Figure #4: Payer Mix TWH L & D Patients: Jan 2010 – Dec 2012

Since 2008, Westerly Hospital has seen a declining trend in its labor/delivery volume, to its current volume of less than one birth/day. Of the 334 births at Westerly Hospital in 2012, 98% of these babies were born to parents who resided within 25 miles of South County Hospital in Wakefield, Rhode Island or Lawrence + Memorial Hospital in New London, Connecticut.

As a result of the decline in volume of births at the Hospital, the fact that only two (2) OB/GYN providers remain in Westerly, and pediatric coverage for newborns ended on December 30, 2012 (but was extended for an additional six months to allow for a planned termination of the program), the Hospital filed a plan on February 4, 2013 with the Rhode Island Department of Health to eliminate obstetric labor and delivery services at the Hospital on or about June 1, 2013.[64] The Director of Health has 90 days from the date this plan is accepted by the Department as complete to make a decision on the matter; otherwise, it is automatically approved. This plan was deemed complete and accepted for review by the Department of Health on March 6, 2013.

Opportunity to provide comments was offered to the public in the form of two public meetings[65] and submission of written comments by March 20, 2013. At the public meeting on March, 19, 2013, a total of three persons spoke in opposition to the application. At the public meeting on March, 20, 2013, there were no public comments offered. The written comment period was subsequently extended to March 27, 2013. One-hundred and twelve (112) written comments were submitted to the Department. The vast majority of the comments were opposed to The Westerly Hospital eliminating its labor and delivery services. Most people opposed pointed out the critical role that maternity services at The Westerly Hospital plays in the pride the community places in taking care of mothers and newborns. Many people spoke about being the second or third generation born at

[64] The plan is also known as a "reverse certificate of need {CON}" and is required by law when there will be a reduction in emergency department and/or primary care services by a hospital. See enabling authority at section 23-17.14-18 RIGL (available online at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.14/23-17.14-18.HTM) and section 10.0 of the *Rules and Regulations Pertaining to Hospital Conversions* promulgated by the Department of Health and last amended January 2007 (also available online at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/4378.pdf).

[65] Meetings were convened on March 19, 2013 at The Westerly Hospital and on March 20, 2013 at the Rhode Island Department of Health in Providence.

Westerly Hospital. There was no public evidence presented, however, suggesting that the elimination of labor and delivery services at Westerly Hospital was likely to put the health or safety of Westerly residents (or other Rhode Islanders) at risk.

Continuing Access to Obstetric Care

The two neighboring hospitals, South County Hospital (19 miles away) and Lawrence + Memorial Hospital (20 miles away) have overlapping services areas with those of The Westerly Hospital. Both hospitals provided letters of support and assurances that the additional volume from The Westerly Hospital could be accommodated at their facilities. Specifically, South County Hospital indicated that it would have a sufficient number of providers to deliver proper care to the approximately 300 -- 325 newborns (projected for 2013 /2014) if The Westerly Hospital were to eliminate its obstetrics service. Lawrence + Memorial Hospital represented that up to 85% (or 256 newborns) could be accommodated at its hospital. Lawrence + Memorial further estimated that it is more likely that only 25% -- 50% (88 – 175 newborns) would be served there should the Westerly obstetrics service be closed.

Labor and delivery services are also provided at six other hospitals in Rhode Island as follows: Kent Hospital (Warwick); Landmark Medical Center (Woonsocket); Memorial Hospital (Pawtucket); Newport Hospital (Newport); South County Hospital (Wakefield); and Women & Infants Hospital (Providence). Based upon the support and assurances of South County Hospital and Lawrence + Memorial Hospital, it is unlikely that other Rhode Island hospitals should experience an influx of patients that could not be accommodated.

Provisions for Emergency Transfer

The Westerly Hospital has developed draft protocols and transfer agreements, acceptable to the Department, for the stabilization and expeditious transfer of obstetric patients to both nearby hospitals (i.e., South County and Lawrence + Memorial hospitals). This transfer plan will be tested

by The Westerly Hospital in a mock drill on or about April 15, 2013. For those women who arrive at The Westerly Hospital and must deliver emergently and are not high-risk, equipment and supplies will be maintained at The Westerly Hospital for emergency department staff to deliver such newborns.

Additionally, The Westerly Hospital has developed an "EMS Communication Plan for Discontinuation of Labor and Delivery Services at Westerly Hospital." This plan for notifying the first responder community has been deemed satisfactory by the Department.

The Department reviewed The Westerly Hospital's plan and, after due consideration of the record and the public interest in light of attendant circumstances, on April 15, 2013 the Director of Health approved the request of The Westerly Hospital to eliminate obstetric labor and delivery services at The Westerly Hospital on or about June 1, 2013, subject to the conditions noted in the "Amended Decision of the Director of Health Regarding The Westerly Hospital's Plan to Eliminate Obstetric Labor and Delivery Services at The Westerly Hospital" (attached as Appendix "D" herein and as amended on April 16, 2013).

Finding

Based upon the discussion above, the transacting parties are deemed to have satisfactorily met the requirements described in criterion #2 but access to obstetrics (labor and delivery services) in Westerly remains a concern for some members of the community.

#3: Whether the transacting parties have provided satisfactory evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community

Discussion

The Department interprets this criterion in light of the historical role that Rhode Island non-profit hospitals have played in their communities. Non-profit hospitals remain the "safety net" providers for many who are sick, vulnerable, and lack access to health care.

Traditionally "underserved communities" are often defined in terms of income level, educational achievement, employment status, insurance status, race, culture, disabilities, and numbers of families with children living below the federal poverty level. For the Westerly community, U.S. Census data reveal the following:

- Total population of Westerly town, Washington County, Rhode Island is 22,787;
- Median household income is $60,432;
- Percent of residents with a high school degree (or higher) is 86.7%;
- Percent of population in the labor force is 68.1%;
- Percent of persons unemployed is 8.6%;
- Percent of female households with no husband present is 11.8%;
- Women comprise 52.1% of the total population; and
- Racial composition of the community is as follows: 92.9% White; 2.5% Asian; 1.0% Black or African American; and 0.7% American Indian and Alaska Native.[66]

While these data depict a Westerly population that is relatively educated, insured, and comfortable, pockets of unmet health needs exist.

[66] [66] U.S. Census Bureau, American Fact Finder, 2010 Demographic Profile Data. Available online at: www.factfinder2.census.gov Accessed on March 19, 2013.

The "safety net" provider in the Westerly service area for supporting the "medically underserved"[67] is the federally qualified health center, Wood River Health Services, Inc., located in Hope Valley, Rhode Island.[68] In 2011, Wood River treated 7,553 area residents with medical, dental, and mental health services. Its mission is to provide, "primary health care and dental services for the rural population in southwest Rhode Island and eastern Connecticut, regardless of ability to pay."[69]

Of the total number of patients seen at Wood River in 2011, 64% were adults, aged 18—64 years and 24% were children under 18 years. Almost all (99%) of Wood River patients were at or below 200% of the federal poverty level and seven percent (7%) of all patients self-identified as being members of a racial/ethnic minority. Of all patients treated at Wood River, 25% were treated for hypertension and 11% were treated for diabetes. [70] Wood River is part of a system of nine federally-funded community health centers throughout Rhode Island that are committed to providing a well-trained, culturally-competent, diverse clinical work force for treating Rhode Island's medically underserved population.

The Department considered the following proxy related to this criterion:

- Charity care trends of the transacting parties.

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[67] For information on medically underserved areas of the U.S., see the U.S. Department of Health & Human Services, Health Resources and Services Administration, Data Warehouse, "Medically Underserved Areas." Available online at: http://datawarehouse.hrsa.gov/default.aspx Accessed on March 19, 2013.

[68] See: Wood River Health Services' website at: http://www.woodriverhealthservices.org/

[69] See: Guidestar's "Non-profit Report for Wood River Health Services, Inc." Available online at: http://www.guidestar.org/organizations/05-0378071/wood-river-health-services.aspx Accessed on March 19, 2013.

[70] See: U.S. Department of Health & Human Services, Health Resources and Services Administration, Data Warehouse, Primary Care: The Health Center Program , 2011 Individual Health Center Data. Available online at: http://bphc.hrsa.gov/uds/view.aspx?q=rlg&year=2011

Charity Care

Section 11.0 of the *Rules and Regulations Pertaining to Hospital Conversions* promulgated by the Department of Health requires Rhode Island-licensed hospitals to provide charity care[71], uncompensated care[72], and community benefits[73] to eligible patients.[74] Hospitals are required to provide "full charity care" (defined as 100% discounted service for patients whose annual family income is up to and including 200% of the federal poverty level). "Partial charity care" (defined as discounted service covered at less than 100% for patients whose annual family income is between 200% and 300% of the federal poverty level) must also be provided by Rhode Island-licensed hospitals.[75]

Hospitals may not discourage patients who cannot afford to pay from seeking essential medical services or direct them to seek such services from other providers. Hospitals must prominently display notices in emergency departments, admissions areas, outpatient care areas,

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[71] "*Charity care*", as defined in section 1.8 of the *Rules and Regulations Pertaining to Hospital Conversions*, "means health care services provided by a hospital without charge to a patient and for which the hospital does not and has not expected payment. Said health care services shall be rendered to patients determined to be uninsured, underinsured or otherwise deemed to be eligible at the time of delivery of services. Charity care services are those health care services that are not recognized as either a receivable or as revenue in the hospital's financial statements. Charity care shall not include health care services provided to individuals for the purpose of professional courtesy without charge or for reduced charge. Under no circumstances shall bad debt be deemed to be charity care. Charity care shall be cost-adjusted by applying a ratio of cost to charges from the hospital's Medicare Cost Reports to charity care charges-foregone."

[72] "*Uncompensated care*", as defined in section 1.33 of the *Rules and Regulations Pertaining to Hospital Conversions* "means a combination of free care, which the hospital provides at no cost to the patient, bad debt, which the hospital bills for but does not collect, and less than full Medicaid reimbursement amounts."

[73] "*Community benefits*" as defined in section 1.9 of the *Rules and Regulations Pertaining to Hospital Conversions* "means the provision of hospital services that meet the ongoing needs of the community for primary and emergency care in a manner that enables families and members of the community to maintain relationships with persons who are hospitalized or are receiving hospital services, and shall also include, but not be limited to, charity care and uncompensated care. Community benefit activities may also include the following: a) programs, procedures, and protocols that meet the needs of the medically indigent; b) linkages with community partners that focus on improving the health and well-being of community residents; c) contribution of non-revenue producing services made available to the community, such as fitness programs, health screenings, or transportation services; d) public advocacy on behalf of community health needs; e) scientific, medical research, or educational activities."

[74] See: *Rules and Regulations Pertaining to Hospital Conversions* promulgated by the Department of Health. Last amended January 2007. Available online at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/4378.pdf

[75] See: "Charity Care: A Health Care Provider's Guide to Rhode Island Regulations", Published by the Rhode Island Department of Health. Available online at: http://www.health.ri.gov/publications/guides/CharityCareForProviders.pdf

hospital websites, and on patients' bills that inform patients that they may be eligible for free or discounted care.

Between October 1, 2009 and September 30, 2012, The Westerly Hospital reports that it distributed $2,285,049 in free care, which represents 0.91% of its net patient revenue ($251,302,714) for the same time period. Between 2007 -- 2009, Rhode Island's statewide charity care burden was 1.8% of patient revenue. This amount ranged from a low of 0.2% at The Westerly Hospital to a high of 3.2% at Rhode Island Hospital.[76] As the 2009 Department report states, "The geographic area in which a hospital operates may influence the patient mix and variations in charity care burdens. To expect each hospital to incur the same charity burden ignores these factors that hospitals may have little ability to influence."[77]

Lawrence + Memorial indicates, that as a not-for-profit corporation, it is committed to providing access to traditionally underserved populations. Lawrence + Memorial does not discriminate based upon a patient's ability to pay. Lawrence + Memorial plans to implement its corporate charity care policy at The Westerly Hospital and provide free care to eligible Westerly area patients. Lawrence + Memorial demonstrated its commitment to charity care between FY2009 and FY2012 by providing $5,551,837 in charity care, which represents an average of 0.45% of its net revenue during that time period.

In summary, health care and appropriate access with respect to traditionally underserved populations in Westerly, with the exception of inpatient maternity services, will continue to be provided in Westerly by The Westerly Hospital after the affiliation with Lawrence + Memorial.

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[76] "Rhode Island Uncompensated Hospital Care (2009)", Prepared by Bruce Cryan, MBA, MS, Rhode Island Department of Health. Available online at: http://www.health.ri.gov/publications/financialreports/hospitals/2009UncompensatedCare.pdf

[77] *Ibid.*, at Page 11.

There was no evidence presented that loss of inpatient maternity services will adversely impact the health status of traditionally underserved populations in The Westerly Hospital service area.

Finding

Based upon the discussion above, the transacting parties are deemed to have satisfactorily met the requirements described in criterion #3.

#4: Whether procedures or safeguards are assured to insure that ownership interests will not be used as incentives for hospital employees or physicians to refer patients to the hospital

Discussion

The Department interprets this criterion as it relates to the Medicare Anti-Kickback statute, Section 1128B of the Social Security Act,[78] and the 1989 federal "Stark Act", Section 1877 of the Social Security Act.[79] Stark applies to both not-for-profit and for-profit hospitals, and their employed or affiliated physicians. Stark may be broadly interpreted to mean that "...a physician may not refer a patient for certain services[80] to be reimbursed by federal healthcare programs to an entity with which the physician has an ownership interest or compensation arrangement."[81]

The Medicare Anti-Kickback statute applies to both not-for-profit and for-profit hospitals. This statute governs the hospital – physician financial relationship. Broadly, "it is a felony for a person to knowingly and willfully offer, pay, solicit, or receive anything of value (i.e., "remuneration") in return for a referral or to induce generation of business reimbursable under a federal health care program."[82] Violations of the Anti-Kickback statute can result in fines, imprisonment, and exclusion from participation in government-funded health care programs.

The Department considered the following proxies related to this criterion:

- Codes of conduct and corporate compliance documents; and

[78] The Anti-Kickback Statute was created as section 1128B of the Social Security Act and codified at 42 U.S.C. § 1320a – 7(b). Available online at: http://www.ssa.gov/OP_Home/ssact/title11/1128B.htm

[79] The Stark Act was created as section 1877 of the Social Security Act and codified at 42 U.S.C. § 1395nn. Available online at: http://www.ssa.gov/OP_Home/ssact/title18/1877.htm

[80] Stark originally related to the self-referral of clinical laboratory services, but was later expanded to include these services: physical therapy; occupational therapy; outpatient speech-language pathology; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

[81] Bales, Rebecca *et.al. op.cit.* at page 4.

[82] Staman, Jennifer. "Health Care Fraud and Abuse Laws Affecting Medicare and Medicaid: An Overview", Congressional Research Service, August 10, 2010. Available online at: www.crs.gov Accessed on February 24, 2013.

- Compliance with the federal Stark and Anti-Kickback statutes.

The Lawrence + Memorial Corporation will be the sole member of the not-for-profit entity that will include The Westerly Hospital. As such, ownership interests will not be available to any third parties, including physicians or hospital employees.

The Lawrence + Memorial Corporation submitted its corporate code of conduct to the Department as part of this review. This code applies to all employees, volunteers, students, and contractors associated with Lawrence + Memorial Hospital. The Lawrence + Memorial code is based on four principles: legal and regulatory compliance; confidentiality; business ethics and professional conduct; and reporting noncompliance and discipline. Lawrence + Memorial maintains a "hotline" that is staffed 24 hours/day for reports of noncompliance. Violations of the Hospital's code may result in disciplinary action and/or termination.

In November 2010, the federal Office of Inspector General of the U.S. Department of Health & Human Services, issued subpoenas to The Westerly Hospital and CHOW NewCo, Inc. (later known as the Atlantic Medical Group). In response, the Hospital produced documents for the Office of Inspector General. The Office of Inspector General requested information and analyses related to agreements with physicians and physician practice groups.

In March 2013, a settlement was reached by the Mastership with the Office of Inspector General related to this matter. The settlement contains a provision for the payment of a fine by the Mastership to the federal government.

The Office of Inspector General's claim against the Mastership constitutes a "pass through liability." As part of the Asset Purchase Agreement, Lawrence + Memorial reserved the option to not acquire the Westerly entities unless it could do so free and clear of any pass through liabilities for defined claims. Final settlement of this Office of Inspector General claim is critical for the acquisition to be consummated.

This federal investigation has not resulted in any legal charges being filed against any of the parties involved.

In summary, there is no evidence to suggest that ownership interests can or will be used as an incentive for hospital employees or physicians to refer patients to The Westerly Hospital.

Finding

Based upon the discussion above, the transacting parties are deemed to have satisfactorily met the requirements described in criterion #4. The Department takes administrative notice, however, of the risks to professional practice and integrity inherent in employment relationships between hospitals and physicians, and will continue to provide oversight and monitor these relationships through its professional and facilities regulatory processes.

#5: Whether the transacting parties have made a commitment to assure the continuation of collective bargaining rights, if applicable, and retention of the workforce

Discussion

The Department considered the following proxy for this criterion:

- Presence of collective bargaining agreements at the new hospital.

Lawrence + Memorial reports that they have a collective bargaining agreement ("union agreement") in place, effective January 1, 2013, with the Westerly United Nurses and Allied Professionals Local 5075 and the Westerly United Nurses and Allied Professionals Local 5104. The President of Local 5075 (at The Westerly Hospital) publicly supported the Westerly acquisition by Lawrence +Memorial on February 14, 2013 at a Department of Health's Health Services Council meeting regarding this conversion.[83]

Finding

Based upon the discussion above, the transacting parties are deemed to have satisfactorily met the requirements described in criterion #5.

[83] Audio recording of the Department's February 14, 2013 Health Services Council meeting is available to the public upon request.

#6: Whether the transacting parties have appropriately accounted for employment needs at the facility and addressed workforce retraining needed as a consequence of any proposed restructuring

Discussion

The Department interprets this criterion in light of the transacting parties' commitments to provide sufficient and appropriate staffing at the new hospital and to address workforce retraining, as needed.

Section 10.6 of the APA describes Lawrence + Memorial's commitment to employees as follows: to "...offer employment, commencing on the closing date to all union and non-union clinical, trade and services personnel of the Sellers (excluding certain management personnel and general and administrative support services personnel) and, after satisfactory review of Sellers Plan to Profitability and employment data, Buyer expects to offer employment to substantially all of the Hospital's other employees."[84]

Lawrence + Memorial has committed to maintaining the current employment level at The Westerly Hospital. Lawrence + Memorial believes that its acquisition of The Westerly Hospital will "advance the turnaround efforts and preserve the Westerly Entities as a community asset and economic engine."[85]

In FY 2013, The Westerly Hospital employed 550.4 full-time equivalents (FTEs) for a total payroll expense (with fringe benefits) of $45,029,682. For FY 2015, payroll expense (with fringe benefits) is expected to be $42,549,679, with a total of 535.4 FTEs. Of this total projected staff complement, 92.5 FTEs are Registered Nurses; 22.7 FTEs are nursing assistants; 11 FTEs are physical therapists, occupational therapists, and speech therapists; and 2.5 FTEs are physicians.

[84] See page 72 of the Asset Purchase Agreement.

[85] See Presentation: "The Westerly Hospital Application for Change in Effective Control by Lawrence + Memorial Hospital, Slide #26", February 14, 2013, as presented to the Department of Health's Health Services Council. Available online at: www.health.ri.gov

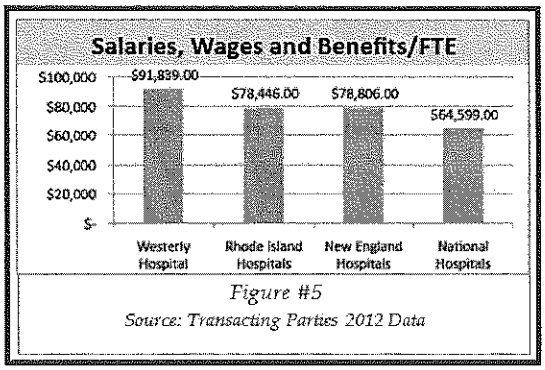


Figure #5

Source: Transacting Parties 2012 Data

Figure #5 shows average salaries, wages and benefits per FTE for Westerly Hospital, the hospitals in Rhode Island, in New England, and in the US. The Westerly Hospital's average salary of $91,839 is approximately seventeen percent (17%) higher than the other hospitals in Rhode Island and New England, and 42% higher than the hospitals in the United States.

The Department considered the following proxy related to this criterion:

- Workforce retraining policies, as well as any demonstrated initiatives related to employee retraining.

Lawrence + Memorial has indicated that it will offer workforce retraining to those employees at The Westerly Hospital who are not retained after the conversion is completed. If restructuring of The Westerly Hospital workforce becomes apparent, Lawrence + Memorial has stated that it will first seek to move displaced workers into alternate existing positions. Lawrence + Memorial has indicated a willingness to re-train displaced workers who, with re-training, would be suitable for alternate positions. No additional details and no formal re-training plan were provided.

Finding

Based upon the discussion above, the transacting parties are deemed to have partially met the requirements described in criterion #6.

#7: Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state

Discussion

The Department views this criterion as a representative summary of the statutory criteria, and related issues, in determining if the public interest will be served by approving the acquisition of The Westerly Hospital by the Lawrence + Memorial Corporation.

The Department interprets this criterion in light of its definition of "essential" medical services as, "hospital services that are reasonably required to diagnosis (*sic*), correct, cure, alleviate, or prevent the worsening of conditions that endanger life or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the person requesting the service."[86] Typically, essential medical services have included those services for which the state Medicaid Program provides reimbursement.

A "balanced" health care delivery system could be characterized as one that provides an optimal mix of primary and secondary services within a defined geographical area. Such a system would enable patients to receive care in their own communities and would include key ingredients, such as home health care services. Although there is no evidence in the record that this will occur, there is a potential that children admitted to The Westerly Hospital who require a higher level of specialty care will be transferred to the Lawrence + Memorial Hospital. In the event this involves a

[86] See: Section 1.15 "Essential" of the *Rules and Regulations Pertaining to Hospital Conversions* promulgated by the Department of Health. Last amended January 2007. Available online at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/4378.pdf

substantial number of children, there may be a destabilizing effect on the Hasbro Children's Unit at the Rhode Island Hospital.

Lawrence + Memorial has committed to maintaining essential medical services in place at Westerly as of the date of the acquisition. Because this acquisition affects a relatively small portion of the health care services rendered statewide, it is not anticipated to affect access and is not likely to result in an imbalanced health care delivery system.

Finding

Based upon the discussion above, this transaction is deemed to have a minimal impact on a balanced health care delivery system; therefore the requirements described in criterion #7 are deemed to be met. This hospital conversion is in the public interest.

#8: "For any conversion subject to this chapter, the Director....shall consider issues of market share especially as they affect quality, access, and affordability of services." [See section 23-17.14-28 (a) RIGL]

Discussion

The Department views this final criterion in light of the Federal Trade Commission's merger review process as it relates to this transaction.

In consideration of this criterion, it is also instructive to examine patient behavior as it relates to local hospitals' market shares. According to a Rhode Island state health planning report, the number of out-of-state residents who were discharged from Rhode Island hospitals has fallen at five percent per year since 2008.[87] These changes in patient behavior reflect that the number of Rhode Island patients seeking care in Connecticut and Massachusetts is rising, while out-of-state patients seeking care in Rhode Island is falling.

A recent review of Rhode Island hospital patient migration patterns revealed that more than 50% of patients received hospital services at their local hospitals.[88] In Westerly, 67% of patients received care in Westerly, while 21% traveled to Providence, 8% traveled to Wakefield, and 3% traveled to Warwick for hospital care.[89] During the same time period, six percent of hospitalized Wakefield residents were discharged from The Westerly Hospital. No residents of other sections of the state were discharged from The Westerly Hospital during this time period.[90] Additionally, 4.3% of admissions to The Westerly Hospital were transferred to another acute care hospital.[91]

[87] See: "Health Care Planning & Accountability Advisory Council Report to the General Assembly", March 2013, at page 14. *In press*. Copies available upon request to DOH.

[88] *Ibid.*, at page 23.

[89] *Ibid.*, at page 23.

[90] *Ibid.*, at page 23.

[91] See: Rhode Island Department of Health, Rhode Island Hospital Discharge Data, 2009 – 2011.

Bales *et.al* point out in their publication on hospital conversions that "....the party who is most at-risk in a conversion (or any corporate restructuring transaction) is the patient. A hospital's ability to continue delivering quality care to its patient population is its first priority. Conversions can change patient and community perception of a hospital (and subsequent market share). Careful branding and community messaging can allay fears and even strengthen perception, but marketing maneuvers must be supported by patient-oriented solutions."[92]

The Department considered the following proxy for this criterion:

- Federal Trade Commission ruling as it relates to market share.

On July 2, 2012, the Lawrence + Memorial Corporation and the Special Master filed "Notification and Report Forms for Certain Mergers and Acquisitions" pursuant to the Hart-Scott-Rodino Antitrust Improvement Act of 1976.[93] The federal government reviewed this petition, requested additional information from the transacting parties, and established a waiting period. The final transaction may not be completed until the waiting period expires or is terminated early by the federal authorities.

On August 1, 2012, the Federal Trade Commission permitted the waiting period to expire and the Federal Trade Commission review of this transaction was completed.

Finding

Based upon the discussion above, the impact upon market share is expected to be minimal.

[92] Bales, Rebecca *et.al. op.cit.*, at page 21.

[93] See: "FTC Guide to the Antitrust Laws", Available online at: http://www.ftc.gov/bc/antitrust/antitrust_laws.shtm Accessed on March 23, 2013.

This hospital conversion proposed by the transacting parties, Westerly Hospital Health Care, Inc., The Westerly Hospital and Lawrence + Memorial Corporation, LMW Healthcare, Inc. and LMW Physicians, Inc., is hereby approved by the Rhode Island Department of Health, subject to the conditions outlined below:

1. The transacting parties shall implement the conversion, as detailed in the initial application, and as approved by the Director of Health.
2. The new hospital shall comply with section 23-17.14-12.1 (g) of the Rhode Island General Laws, as amended, that requires: "Following a conversion, the new hospital shall provide on or before March 1 of each calendar year a report in a form acceptable to the Director containing all updated financial information required to be disclosed pursuant to subdivision 23-17.14-12.1(b)(7)."
3. LMW Healthcare, Inc. shall comply with the Buyer Commitments as defined in the September 10, 2012 Order Approving the Sale of the Assets of The Westerly Hospital and the Related Entities Free and Clear of Liens and Liabilities ("Sale Order") and identified in Section 10 of the Asset Purchase Agreement by and among LMW Healthcare, Inc., LMW Physicians, Inc. and W. Mark Russo, Esq., solely in his capacity as the court-appointed Special Master for Westerly Hospital Healthcare, Inc., The Westerly Hospital, Atlantic Medical Group, Inc., Ocean Myst MSO, LLC, Women's Health of Westerly, LLC, and North Stonington Health Center, Inc. dated as of June 20, 2012, and for the time periods set forth therein.
4. LMW Healthcare, Inc. shall comply with the enforcement provisions relative to the Buyer Commitments as established at Section 3 of the Sale Order.
5. The new hospital shall be maintained as an acute care, community hospital for a period of at least five years after the acquisition date.
6. LMW Healthcare, Inc. shall provide services to all patients without discrimination, including payment source or ability to pay.
7. The new hospital shall continue to participate in Rhode Island's Emergency Medical Services for Children's Inter-hospital Transport Agreement.

8. The new hospital shall provide data to the Department on November 1st for each of the first five years after the date of this amended decision related to the number of pediatric patients who are referred from the new hospital's emergency department to an alternate facility for care and treatment as well as the name /location of the facility to which the pediatric patient has been referred.
9. The new hospital shall participate in all applicable hospital quality and transitions of care collaboratives in Rhode Island endorsed by the Department.
10. The new hospital shall participate in the community health needs assessment process being sponsored by the Hospital Association of Rhode Island (HARI) and provide the Director of Health with a summary report showing how the new hospital's community benefits 990-H federal IRS filing is aligned with the Department's community health goals and objectives.
11. The new hospital shall maintain a corporate compliance plan to address, among other regulatory compliance-related requirements, compliance with Stark and Anti-Kick Back statutes and regulations.
12. Within one year of the date of this amended decision, the new hospital shall submit a plan to the Department that includes the following components:
    - Provisions for delivering primary care at the new hospital that support a balanced health care delivery system in The Westerly Hospital service area that promotes best health outcomes at the lowest cost. Such plan shall discuss the supply of primary and specialty health care services in The Westerly Hospital's service area over time. It shall also discuss leading population health indicators in the Hospital's service area. It shall also discuss per person per year cost of health care, discharges/1,000 population and average length of stay in the Hospital's service area.
    - A quality improvement plan for the new hospital;
    - A formal staff re-training plan that shall include, but not be limited to, the re-training needs of labor/delivery staff and any emergency department staff who may be caring for labor/delivery patients in the new hospital's emergency department;
    - A description of activities undertaken at the new hospital to ensure continued care and access for the underserved in order to reduce disparities.
13. The new hospital shall continue to enroll patients in the *currentcare* Program and continue to comply with all *currentcare* data submission requirements.

14. The new hospital shall provide data, including but not limited to, finances, utilization, and demographic patient information be furnished to the Department upon request.
15. Services at the new hospital shall be provided in conformance with the requirements of the *Rules and Regulations for Licensing of Hospitals (R23-17-HOSP)* and *Rules and Regulations Pertaining to Hospital Conversions (R23-17.14-HCA).*

The conditions set forth above shall be enforceable and have the same force and effect as if imposed as a condition of licensure, in accordance with Chapters 23-17 and 23-17.14 of the Rhode Island General Laws, as amended. The Director of the Rhode Island Department of Health may take appropriate action to enforce compliance with these conditions and each of them, as circumstances may require, provided that such action is directly related to this conversion.

If any of the aforesaid conditions or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect any other condition or application of any other condition which can be given effect without the invalid provision, condition, or application, and to this end the conditions and each of them severally are declared to be severable.

RHODE ISLAND DEPARTMENT OF HEALTH

Michael Fine, MD, Director of Health
Rhode Island Department of Health

4 | 16 | 2013

Date

ADDENDUM TO THE DIRECTOR'S DECISION WITH CONDITIONS OF APRIL 15, 2013

The Director of Health's Decision with Conditions of April 15, 2013 approving the Hospital Conversion Application of the following Transacting Parties: Westerly Hospital Health Care, Inc., The Westerly Hospital and Lawrence + Memorial Corporation, LMW Healthcare, Inc. and LMW Physicians, Inc. has been amended by removing condition #6 and replaces the initial "Decision of the Director of Health Regarding The Westerly Hospital's Plan to Eliminate Obstetric Labor and Delivery Services at The Westerly Hospital" with an amended Decision now contained in Appendix "D" herein. Other changes that are non-substantive are included in this amended Decision with Conditions.

APPENDIX "A"

Report of Harborview Consulting, LLC

harborview consulting llc

Westerly/Lawrence & Memorial Merger Analysis

Final Report

harborview consulting llc

Executive Summary

- Operating losses at Westerly, exclusive of restructuring costs, increased through 2012 to $13.6 million; however, restructuring efforts have significantly reduced these losses based on year-to-date results.
- Lawrence & Memorial (L+M) has a strong balance sheet and therefore the financial resources to successfully assume the operations of Westerly Hospital:
  - L+M has generated positive operating margins for the five year period 2008 through 2012.
  - Debt service coverage for the five years has been well above the 1.2X required by existing bond covenants and has ranged from 3.7X to 7.9X
  - Cash on hand is in excess of 200 days over this five-year period as compared to the existing bond covenant of 60 days cash on hand. Cash on hand at the end of 2012 was 236 days.
  - The bond rating of the L+M Obligated Group is rated A+ by both Standard & Poors and Fitch. S&P recently issued a "Negative Outlook" but maintained the A+ rating.
- As a result of my review, nothing has come to my attention that would indicate that the transaction should not be approved.

harborview consulting llc

Overview of the Transaction

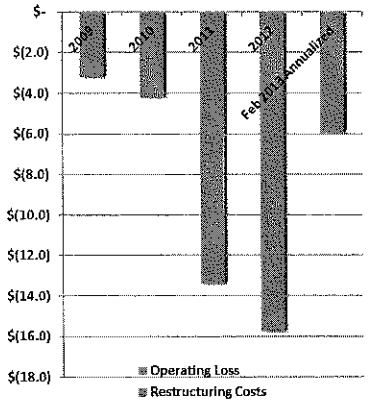
- Total purchase price and consideration is $64 million which includes the assumption of certain liabilities.
- L+M is required under the Asset Purchase Agreement to fund $30 million of improvements at Westerly over five years, $7.2 million for a profitability improvement plan, as well as other payments at closing.
- L+M has received a proposal from Bank of America for a $20 million bridge loan to redeem the outstanding Westerly Bonds upon closing. The proposal is subject to certain conditions including financial covenants. L+M intends to refinance this loan through the issuance of tax-exempt bonds.

Scope of Work

- ✓ Performed an analysis of transacting parties' financial statements to assess the reasonableness of the proposed combination.
- ✓ Participated in interviews of key management personnel of Westerly and Lawrence & Memorial
- ✓ Provided expertise in hospital/healthcare accounting on as as needed basis
- ✓ Provided a final written report that is clear and concise, single suitable for comprehension by those professionals not engaged in the auditing/accounting profession.
- ✓ Performed other related activities that were requested by the Department.
- ✓ Be alert for any conditions observed during the review that would give rise to concerns about internal controls.
- ✓ Financial forecasts for the transaction were not provided; however, given L+M's strong balance sheet, as indicated by significant cash reserves and low debt, an A+ bond rating, and consistently strong operating margins this is not considered a significant limitation to the scope of this review.

Westerly Hospital & Affiliates: Operating Losses

Westerly's operating losses increased over the past four years; however, restructuring efforts in Mastership have reduced these losses by approximately $10.0 million.



Estimated Improvements	(000's omitted)
Defined Benefit Plan	$ 3,800
Interest on Bonds	565
North Stonington	3,000
Women's Health	800
AMG (Physician's Group)	1,000

Source: Westerly & Affiliates Internal Financial Statements and analysis. Loss for 2013 is based on annualized results through February, 2013.

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Lawrence & Memorial Corporation

- Lawrence & Memorial (L+M) Corporation consists of the following entities
  - Obligated Group:
    - L+M Healthcare
    - L+M Hospital
    - Associated Specialists of Connecticut (a physician group)
  - L&M Systems
  - L+M Physician Association
  - L&M Indemnity (a captive insurance company)
  - VNA of Southeastern Connecticut
- The Obligated Group is responsible for the current outstanding bond obligations.
- Based on 2012 financial information, the Obligated Group includes substantially all of the Organization's revenues (93%), cash and investments (91%), assets (96%), and net assets (94%).

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Lawrence & Memorial (cont'd)

- Generally L+M has consistently demonstrated strong operational performance with key ratios at or in excess of industry benchmarks:
  - Operating Margins and Excess Margins generally above benchmarks, except for a decline in 2012.
  - The Debt Service Coverage Ratio of L&M's Obligated Group has consistently exceeded industry benchmarks (3.8X in 2011) and L+M's covenant requirements (1.1X).
  - L+M's Obligated Group has consistently demonstrated a strong cash position with cash on hand in excess of 200 days for the entire period examined (FY 2008-2012). In addition L+M maintains cash on hand well above the 60 days required by the bond agreements.
  - The debt-to-capitalization ratio of 27.3% is well below the benchmark (41%).
  - Carries a bond rating of A+ by both Standard & Poor's (S&P) and Fitch.

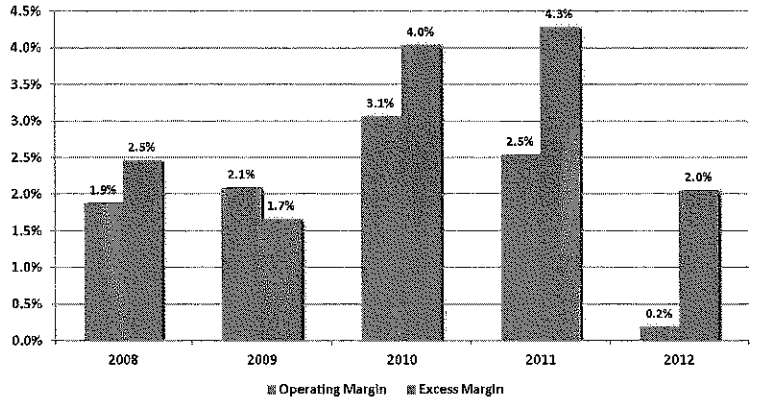
L&M Obligated Group Key Indicators

	2008	2009	2010	2011	2012	Benchmark/L+M Covenant
L+M Covenant Analysis:						
Debt Service Coverage Ratio	4.9	5.1	3.7	8.3	7.9	**3.8X/1.20 X**
Days Cash on Hand	223.2	222.7	234.6	228.6	236.5	**228 days/60 days**
Other Ratios:						
Operating Margin	3.1%	2.8%	4.2%	5.0%	3.7%	**2.7%**
Excess Margin	3.5%	2.7%	0.1%	6.7%	5.4%	**4.1%**
Current Ratio (X)	4.8	5.0	4.9	4.7	5.0	**2.3X**
Days in Accounts Receivable	47.3	36.7	35.9	34.2	32.1	**45.1 days**
Payment Period (Days)	59.8	55.5	59.5	59.2	60.4	**63.5 days**
Average Age of Fixed Assets (Years)	11.7	11.3	11.6	12.2	11.9	**10.4 years**
Debt to Capitalization (%)	25.4%	25.4%	24.2%	28.7%	27.3%	**40.8%**

Sources:
Ratios are derived from L+M Obligated Group's audited financial statements
Benchmarks are Fitch Median Ratios for Nonprofit Hospitals and Hospital Systems for 2011

Lawrence & Memorial: Margins (Consolidated)

L+M has had positive margins for the last five years; however, margins have declined in 2012. The decline is primarily due to the operations of LMPA (physician group).



Sources:
Ratios are derived from L+M Obligated Group's audited financial statements

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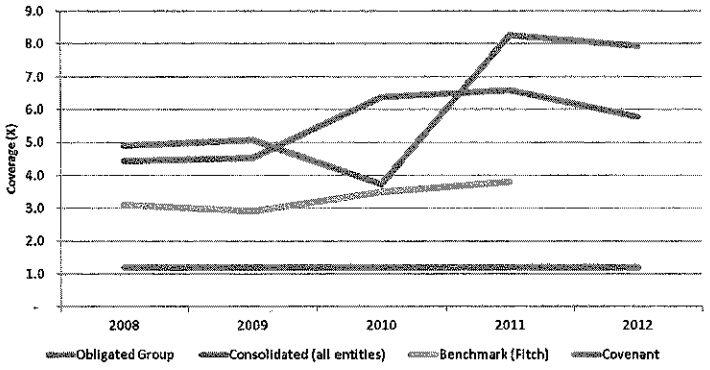
Lawrence & Memorial: Debt Service Coverage Ratio

The Debt Service Coverage Ratio represents a measure of the cash available to pay debt obligations. L&M's Obligated Group has consistently exceeded industry benchmarks and L+M's covenant requirement of 1.2X.



Sources:
Ratios are derived from L+M Obligated Group's audited financial statements
Benchmarks are Fitch Median Ratios for Nonprofit Hospitals and Hospital Systems for 2011

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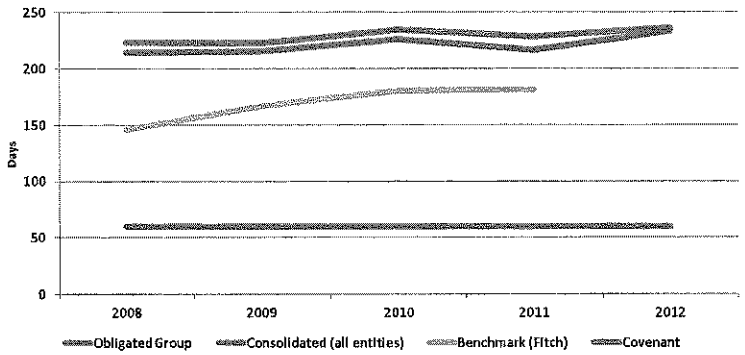
Lawrence & Memorial: Days Cash on Hand

L+M maintains cash on hand well above the 60 days required of the Obligated Group by existing bond agreements. In addition, days cash on hand consistently exceeds Fitch's benchmark.



Sources:
Ratios are derived from L+M Obligated Group's audited financial statements
Benchmarks are Fitch Median Ratios for Nonprofit Hospitals and Hospital Systems for 2011

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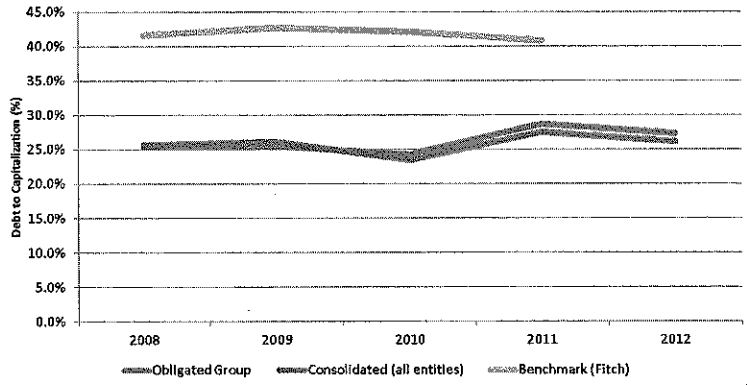
Lawrence & Memorial: Debt to Capitalization

L+M has historically used low levels of leverage as demonstrated by the low Debt to Capitalization Ratio which is below national benchmarks. This suggests that there is additional borrowing capacity available to L+M.



Sources:
Ratios are derived from L+M Obligated Group's audited financial statements
Benchmarks are Fitch Median Ratios for Nonprofit Hospitals and Hospital Systems for 2011

harborview consulting llc

Lawrence & Memorial

- In December, 2012 Standard & Poor's Rating Services (S&P) affirmed its bond rating of A+; however, S&P revised its outlook for L+M from "stable" to "negative". The negative outlook reflects:
  - The decrease in operating profitability
  - L+M's plans to acquire Westerly Hospital from receivership
  - Plans to issue additional indebtedness
- S&P indicated that they could consider a lower rating during the next one to two years if operating margins fail to increase.
  - S&P, in reaffirming the A+ bond rating, cited L+M's dominate business position (65% market share in primary service area), strong balance sheet, and historically strong debt service.
- Over the last three years, L+M has invested significant resources into the L+M Physician Association (LMPA). Approximately $22 million has been transferred from the Obligated Group to LMPA.

Forward Looking Risks

- While L+M has demonstrated strong performance historically, changes in the healthcare market pose certain risks. These risks are not specific to Westerly/L+M; however, they will result in additional challenges in maintaining strong operating performance.
  - Health care reform poses a level of uncertainty as new regulations, delivery models, and reimbursement methodologies evolve.
  - Federal sequestration will result in payments from Medicare to providers being reduced by 2%
  - States are reevaluating Medicaid payments to providers as a result of fiscal pressures and expanding Medicaid coverage in the context of healthcare reform.
  - The protracted economic recession has resulted in significant increases in uninsured patients.
- L+M has significant cash reserves which generate strong levels of investment income. These investments are subject to market fluctuations influenced by changes in the environment.

Other Considerations

- There is still an outstanding $2.0 million state license fee due from Westerly which, at this time is still an open issue and unresolved at this time.
- There is a preliminary settlement related to an OIG investigation, settlement has not yet been approved by the US Department of Justice.
- Westerly has applied to the Pension Benefit Guaranty Association (PBGC) for a "distress termination". An agreement has been negotiated by by the Mastership. It has been represented that these claims will not impact the closing.
- Westerly is intending to close the maternity unit at the hospital. It is represented that the closure will not have a significant negative impact on operating performance.
- While conducting the Westerly/L+M Merger Analysis, nothing has come to my attention that would indicate any significant weaknesses in internal control.

Overall Assessment of Westerly/L+M Merger

- Nothing has come to my attention that would suggest that the proposed merger should not be approved. This is based on the following:
  - Through Mastership, Westerly's operations have been restructured decreasing operating losses. While losses are still significant, there are opportunities for further improvement that will be available to Westerly through the merger.
  - L+M has demonstrated strong operational performance over the last five years. The decline in margins that occurred in 2012 can be partially attributed to the start-up of LMPA, a physician practice and costs associated with the merger.
  - L+M's debt service coverage ratio is well above the covenants required by the current outstanding bonds and significantly exceeds industry benchmark.
  - L+M has a strong balance sheet demonstrated by low leverage and a significant cash position. The system has in excess of 200 days cash on hand which exceeds the 60 days required by existing bond covenants and is well above industry benchmarks.
  - L+M has an A+ bond rating from both S&P and Fitch. While S&P has revised their outlook from "stable" to "negative" management has to date demonstrated the ability to manage operations.

APPENDIX "B"

Report of TruMed, Inc.

Lawrence and Memorial Hospital (L&M) proposed acquisition of The Westerly Hospital (WH)

Robert S. Crausman MD MMS

March 28, 2013

Lawrence and Memorial Hospital (L&M)

- TJC accredited
- general medical and surgical hospital
- New London, CT
- 252 beds
- 80,000 ED visits
- 14,000 admissions
- 13,000 inpatient and outpatient surgeries

Consent Order

- L&M was subject to an active consent order with the FLIS March 16th 2011
- Unannounced inspection
- Multiple violations

5 broad areas

- (1) life and safety/physical plant
- (2) food services
- (3) nursing
- (4) medical staff
- (5) medical records/documentation

Most significant

- violations/concerns relating to the care of pediatric patients with emergency or critical illness.
- Engage CCE
- Yale New Haven Children's Hospital
- Comprehensive assessment
- Corrective action plan
- Regular progress reports to FLIS

Also

- physical plant
- food services
- corrective action plan
- not included as part of the consent order

CO's issued by CT FLIS

2013

3-7-13 Greystone Rest Home, Inc. - Portland
3-5-13 Fernwood Rest Home, Inc. - Litchfield
1-18-13 Garden View Manor, Inc. - Hamden

2012

11-19-12 Youth Challenge Mission for Women - Hartford
9-12-12 Center for Ambulatory Surgery, LLC - Westport
8-28-12 Maxim Healthcare Services, Inc. - East Hartford
8-21-12 Walnut Hill Care Center - New Britain
3-29-12 Charter Oak - Hartford
1-11-12 Waterbury Hospital - Waterbury

2011

12-20-11 Glenlunan - Waterbury
11-29-11 Constitution Eye Surgery Center East - Waterford
11-22-11 Robbins Eye Center, PC - Bridgeport
9-30-11 Fernwood Manor Inc, of Hartford - Hartford
5-26-11 Center for Ambulatory Surgery, LLC - Westport (revised interim)
5-24-11 Center for Ambulatory Surgery, LLC - Westport
5-4-11 Center for Amulatory Surgery, LLC - Westport (interim)
3-16-11 L&M Hospital - New London
1-19-11 Lab Xpress - West Hartford, Wethersfield, New Britain, Manchester

2010

11-17-10 William Backus Hospital - Norwich

Organizational structure

Quality Council's operations were reviewed

Pediatrics Quality Council was created

A Chief Quality and Patient Safety Officer, Sherry Strammiello BSN, MPA, CPHQ [Certified Professional in Healthcare Quality], and is responsible for quality initiatives, monitoring and assurance within the facility.

Daniel Rissi MD, the Vice-President/ Chief Medical and Operations Officer who in turn reports directly to the CEO Bruce Cummings and is viewed as part of the hospital's leadership team. Sherry Strammiello is also a member of the institution's Quality Council.

The Institutional Quality Council includes broad representation of the hospital's administrative, clinical and Board leadership. The Chair of the Council is a Board member. The new Pediatrics Quality Council reports to the institutional council via the Chief of Pediatrics.

Premier Quest

Westerly Hospital

- Incorporation into L&M quality and safety structure
- Dr Christopher Lehrach

Quality of Care

- CMS Hospital Compare/HCAPS
- L&M achieved or exceeded the Ct State average for nurse communication and pain control. It fell below for physician communication and respect, how quickly call buttons were answered, how well staff explained medications, cleanliness of bathrooms, quiet rooms at night, post-discharge information, overall rating of the hospital and recommend the hospital.
- L&M achieved or exceeded the RI average for 2/8 indicators and was comparable to the WH

Timely and Effective care

- Heart attack – L&M achieved or exceeded the CT state average for PCI within 90 minutes of arrival, aspirin and statin use. It equaled or exceeded the performance of WH in 3 of 4 measures with sufficient data.
- Heart failure – L&M achieved or exceeded the CT state average for assessment of heart function and use of an ACE inhibitor; Below for discharge instructions. It equaled or exceeded the performance of WH in 2 of 3 measures.
- Pneumonia – L&M exceeded the CT state average for performance of blood cultures but below for antibiotic selection. It equaled or exceeded the performance of WH in 2/2 measures.
- Surgical care details – L&M achieved or exceeded the CT state average in 5 of 10 measures [insufficient data for an 11th measure relating to diabetes]. It equaled or exceeded WH in 2/3 measures of timeliness; and 3/6 measures of effectiveness.
- Emergency department – L&M achieved or exceeded the CT state average in 3 of 6 measures [insufficient data for a 7th measure relating to brain scans]. It exceeded WH's performance on influenza and pneumonia vaccination.
- Mortality – No difference from national rate

CO Accomplishments

Nursing

- Core group of pediatric nurses with the requirement that one pediatric nurse be present on every shift.
- Core group of pediatric nurses to report to a nurse manager with pediatric expertise.
- Specific pediatric competency training for all nurses who may care for pediatric patients.

Supervision of physicians

- Development and implementation of a pediatric hospitalist/LIP program.
- Pediatric training for emergency medicine physicians satisfied by assurance that all ED physicians are board certified in emergency medicine.
- A requirement for the development of the pediatric rapid response team was satisfied by the utilization of the hospital's code team to include PALS certified emergency medicine physicians.
- Respiratory therapists are required to have age-specific competencies for the patient populations that they care for.
- Planning for the development of a pediatric specific emergency medicine service.
- Implementation of daily multidisciplinary rounds for pediatric patients.
- Construction and implementation of a quality council for pediatric care.
- Reporting of the quality council's activities to pediatrics providers.
- Development and implementation of transfer guidelines for pediatric patients requiring higher levels of care.
- Practice guidelines for common impatient pediatric illnesses expected to be treated at Lawrence and Memorial.
- An ongoing medical records audit to assure compliance with transfer and practice guidelines.
- Collaborative regular policy review.
- Implementation of an education plan for new policies, audit findings, etc.
- A pediatric emergency equipment checklist to assure that pediatric appropriate equipment is present in the emergency department and in the pediatrics unit.
- Coordinated regular didactics with Yale Children's Hospital for emergency medicine providers regarding pediatric emergency case reviews.
- All pediatric emergency medicine patients seen by triage nurse upon presentation.
- All pediatric patients to have their vital signs taken upon presentation by an ED nurse who is PALS certified (all ED nurses are now PALS certified).
- All pediatric patients to have weights taken and recorded in kilograms upon admission to the emergency department.

CO Accomplishments

Pediatric Anesthesia

- Addition of a second anesthesia care provider when necessary.
- A data driven pediatric CQI process.
- Training of the core group of anesthesiologists in pediatric competencies.
- Intern limitation to ASA class I and II patients pending satisfaction of these pediatric competencies.
- Anesthesia oversight over all sedation activities of pediatric patients.
- Five hours of CME in pediatrics required for all anesthesia providers per each re-credentialing cycle.

Pediatric Behavioral Health Services

- Change in policy to address restraint and seclusion to include patients aged nine (9) and under.
- Improved documentation requirements of neurovascular and medical assessments of restrained pediatric patients.
- Ongoing audit to assure compliance with pediatric restraint procedures and policies.
- Designated individual (crisis manager) to be notified of any/all restraint use with pediatric patients.
- Space planning towards assuring separation of pediatric behavioral health patients from adult patients in the emergency department.
- Standard protocols for administration of psychoactive medications in pediatric patients.
- A new hire to add expertise in pediatric psychiatry. The Medical Director of Consultation and Crisis services was hired on 7/11/2011.
- Pediatric behavioral health orientation module for any locum tenens physicians.
- Individualized treatment plans for extended lengths of stay of pediatric behavioral health patients in the emergency department.
- Staff education and resources to be made available.
- Consultation resources and manuals to be included.
- Internet availability of these resources as well.

Conclusions

- As a result of the CO L&M made certain immediate corrective actions and subsequently entered into in a Consent Order with the Ct Department of Public Health to improve its care of pediatric patients.
- At this point all items delineated in the plan have been completed and the CO ended in March 2013.
- Over the past two years L&M has expanded its Quality and Patient Safety program. L&M has an experienced leadership team charged with leading its Patient Safety initiatives; And has accomplished effective engagement of its Board, administration and clinical leadership. It has a very sensible plan to integrate Westerly Hospital into this structure should this acquisition be approved
- L&M's publicly reported CMS quality metrics are comparable to its peers in the region.
- L&M has demonstrated that it has the clinical, administrative and board level leadership, established infrastructure and expertise requisite to fostering a culture of patient safety and quality as it acquires WH.

APPENDIX "C"

- Patient Survey Results Details (Medicare.gov)
- Hospital Compare: Westerly and Lawrence + Memorial Hospitals (Medicare.gov)
- Hospital Compare: South County Hospital, Newport Hospital, Kent County Memorial Hospital (Medicare.gov)

Medicare.gov
The Official U.S. Government Site for Medicare

Patient Survey Results Details

Table 1 of 10 How often did nurses communicate well with patients? Hide Details

Patients reported how often their nurses communicated well with them during their hospital stay. "Communicated well" means **nurses explained things clearly, listened carefully** to the patient, and treated the patient with **courtesy and respect.**

	Patients who reported that their nurses "Always" communicated well.	Percent of patients who reported that their nurses "Usually" communicated well.	Percent of patients who reported that their nurses "Sometimes" or "Never" communicated well.	Data Collected From	Data Collected To
LAWRENCE & MEMORIAL HOSPITAL	**78%**	**17%**	**5%**	**4/1/2011**	**3/31/2012**
Connecticut Average	**77%**	**18%**	**5%**	**4/1/2011**	**3/31/2012**
National Average	**78%**	**17%**	**5%**	**4/1/2011**	**3/31/2012**

	Number of completed Surveys	Survey Response Rate
LAWRENCE & MEMORIAL HOSPITAL	**300 or more**	**34%**

Table 2 of 10 How often did doctors communicate well with patients? Hide Details

Patients reported how often their doctors communicated well with them during their hospital stay. "Communicated well" means **doctors explained things**

clearly, listened carefully to the patient, and treated the patient with **courtesy and respect.**

	Patients who reported that their doctors "Always" communicated well.	Percent of patients who reported that their doctors "Usually" communicated well.	Percent of patients who reported that their doctors "Sometimes" or "Never" communicated well.	Data Collected From	Data Collected To
LAWRENCE & MEMORIAL HOSPITAL	**76%**	**18%**	**6%**	**4/1/2011**	**3/31/2012**
Connecticut Average	**79%**	**16%**	**5%**	**4/1/2011**	**3/31/2012**
National Average	**81%**	**15%**	**4%**	**4/1/2011**	**3/31/2012**

	Number of completed Surveys	Survey Response Rate
LAWRENCE & MEMORIAL HOSPITAL	**300 or more**	**34%**

Table 3 of 10 How often did patients receive help quickly from hospital staff?

Hide Details

Patients reported how often they were helped quickly when they used the **call button** or needed help in **getting to the bathroom** or **using a bedpan.**

	Patients who reported that they "Always" received help as soon as they wanted.	Percent of patients who reported that they "Usually" received help as soon as they wanted.	Percent of patients who reported that they "Sometimes" or "Never" received help as soon as they wanted.	Data Collected From	Data Collected To
LAWRENCE & MEMORIAL HOSPITAL	**58%**	**29%**	**13%**	**4/1/2011**	**3/31/2012**
Connecticut Average	**62%**	**27%**	**11%**	**4/1/2011**	**3/31/2012**
National Average	**66%**	**24%**	**10%**	**4/1/2011**	**3/31/2012**

	Number of completed Surveys	Survey Response Rate
LAWRENCE & MEMORIAL HOSPITAL	**300 or more**	**34%**

Table 4 of 10 How often was patients' pain well controlled? Hide Details

If patients needed medicine for pain during their hospital stay, the survey asked how often their pain was well controlled. "Well controlled" means their **pain was well controlled** and that the **hospital staff did everything they could to help** patients with their pain.

	Patients who reported that their pain was "Always" well controlled.	Percent of patients who reported that their pain was "Usually" well controlled.	Percent of patients who reported that their pain was "Sometimes" or "Never" well controlled.	Data Collected From	Data Collected To
LAWRENCE & MEMORIAL HOSPITAL	**73%**	**22%**	**5%**	**4/1/2011**	**3/31/2012**
Connecticut Average	**69%**	**24%**	**7%**	**4/1/2011**	**3/31/2012**
National Average	**70%**	**23%**	**7%**	**4/1/2011**	**3/31/2012**

	Number of completed Surveys	Survey Response Rate
LAWRENCE & MEMORIAL HOSPITAL	**300 or more**	**34%**

Table 5 of 10 How often did staff explain about medicines before giving them to patients? Hide Details

If patients were given medicine that they had not taken before, the survey asked how often staff explained about the medicine. "Explained" means that hospital staff told **what the medicine was for** and what **side effects it might have** before they gave it to the patient.

	Patients who reported that staff "Always" explained about medicines before giving it to them.	Percent of patients who reported that staff "Usually" explained about medicines before giving it to them.	Percent of patients who reported that staff "Sometimes" or "Never" explained about medicines before giving it to them.	Data Collected From	Data Collected To
LAWRENCE & MEMORIAL HOSPITAL	**57%**	**22%**	**21%**	**4/1/2011**	**3/31/2012**
Connecticut Average	**59%**	**21%**	**20%**	**4/1/2011**	**3/31/2012**
National Average	**63%**	**18%**	**19%**	**4/1/2011**	**3/31/2012**

	Number of completed Surveys	Survey Response Rate
LAWRENCE & MEMORIAL HOSPITAL	**300 or more**	**34%**

Table 6 of 10 How often were the patients' rooms and bathrooms kept clean? Hide Details

Patients reported how often their **hospital room and bathroom were kept clean.**

	Patients who reported that their room and bathroom were "Always" clean.	Percent of patients who reported that their room and bathroom were "Usually" clean.	Percent of patients who reported that their room and bathroom were "Sometimes" or "Never" clean.	Data Collected From	Data Collected To
LAWRENCE & MEMORIAL HOSPITAL	**68%**	**22%**	**10%**	**4/1/2011**	**3/31/2012**
Connecticut Average	**72%**	**20%**	**8%**	**4/1/2011**	**3/31/2012**
National Average	**73%**	**18%**	**9%**	**4/1/2011**	**3/31/2012**

	Number of completed Surveys	Survey Response Rate
LAWRENCE & MEMORIAL HOSPITAL	**300 or more**	**34%**

Table 7 of 10 How often was the area around patients' rooms kept quiet at night?

Hide Details

Patients reported how often **the area around their room was quiet at night.**

	Patients who reported that the area around their room was "Always" quiet at night.	Percent of patients who reported that the area around their room was "Usually" quiet at night.	Percent of patients who reported that the area around their room was "Sometimes" or "Never" quiet at night.	Data Collected From	Data Collected To
LAWRENCE & MEMORIAL HOSPITAL	**46%**	**36%**	**18%**	**4/1/2011**	**3/31/2012**
Connecticut Average	**51%**	**33%**	**16%**	**4/1/2011**	**3/31/2012**
National Average	**60%**	**29%**	**11%**	**4/1/2011**	**3/31/2012**

	Number of completed Surveys	Survey Response Rate
LAWRENCE & MEMORIAL HOSPITAL	**300 or more**	**34%**

Table 8 of 10 Were patients given information about what to do during their recovery at home?

Hide Details

The survey asked patients about information they were given when they were ready to leave the hospital. Patients reported whether hospital staff had **discussed the help they would need at home.** Patients also reported whether they were given **written information about symptoms or health problems to watch for during their recovery.**

	Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	Percent of patients who reported that they were not given information about what to do during their recovery at home.	Data Collected From	Data Collected To
LAWRENCE & MEMORIAL HOSPITAL	**80%**	**20%**	**4/1/2011**	**3/31/2012**
Connecticut Average	**82%**	**18%**	**4/1/2011**	**3/31/2012**
National Average	**84%**	**16%**	**4/1/2011**	**3/31/2012**

	Number of completed Surveys	Survey Response Rate
LAWRENCE & MEMORIAL HOSPITAL	**300 or more**	**34%**

Table 9 of 10 How do patients rate the hospital overall?

Hide Details

After answering all other questions on the survey, **patients answered a separate question that asked for an overall rating of the hospital.** Ratings were on a scale from 0 to 10, where "0" means "worst hospital possible" and "10" means "best hospital possible."

	Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	Percent of patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest).	Percent of patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest).	Data Collected From	Data Collected To
LAWRENCE & MEMORIAL HOSPITAL	**64%**	**27%**	**9%**	**4/1/2011**	**3/31/2012**
Connecticut Average	**67%**	**24%**	**9%**	**4/1/2011**	**3/31/2012**
National Average	**69%**	**23%**	**8%**	**4/1/2011**	**3/31/2012**

	Number of completed Surveys	Survey Response Rate
LAWRENCE & MEMORIAL HOSPITAL	**300 or more**	**34%**

Table 10 of 10 Would patients recommend the hospital to friends and family? **Hide Details**

The survey asked patients whether they would **recommend the hospital** to their friends and family.

	Patients who reported YES, they would definitely recommend the hospital.	Percent of patients who reported YES, they would probably recommend the hospital.	Percent of patients who reported NO, they would not recommend the hospital.	Data Collected From	Data Collected To
LAWRENCE & MEMORIAL HOSPITAL	**69%**	**25%**	**6%**	**4/1/2011**	**3/31/2012**
Connecticut Average	**71%**	**24%**	**5%**	**4/1/2011**	**3/31/2012**
National Average	**70%**	**25%**	**5%**	**4/1/2011**	**3/31/2012**

	Number of completed Surveys	Survey Response Rate
LAWRENCE & MEMORIAL HOSPITAL	**300 or more**	**34%**

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Timely & Effective Care:Heart Attack Care Details

Timely Heart Attack Care Hide Details

Measures	LAWRENCE & MEMORIAL HOSPITAL	Connecticut Average	National Average	Data Collected From	Data Collected To
Average number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital *A **lower** number of minutes is better*	**Too few cases**	**66 Minutes**	**59 Minutes**	**4/1/2011**	**3/31/2012**
Average number of minutes before outpatients with chest pain or possible heart attack got an ECG *A **lower** number of minutes is better*	**13 Minutes**	**9 Minutes**	**7 Minutes**	**4/1/2011**	**3/31/2012**
Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival ***Higher** percentages are better*	**Not Available**	**26%**	**60%**	**4/1/2011**	**3/31/2012**
Outpatients with chest pain or possible heart attack who got aspirin within 24 hours of arrival ***Higher** percentages are better*	**92% of 26 Patients**	**98%**	**97%**	**4/1/2011**	**3/31/2012**
Heart attack patients given fibrinolytic medication within 30 minutes of arrival ***Higher** percentages are better*	**Not Available**	**100%**	**60%**	**4/1/2011**	**3/31/2012**
Heart attack patients given PCI within 90 minutes of arrival ***Higher** percentages are better*	**94% of 48 Patients**	**94%**	**94%**	**4/1/2011**	**3/31/2012**

Effective Heart Attack Care

Hide Details

Measures	LAWRENCE & MEMORIAL HOSPITAL	Connecticut Average	National Average	Data Collected	
				From	To
Heart attack patients given aspirin at discharge ***Higher** percentages are better*	**100% of 120 Patients**	**99%**	**99%**	**4/1/2011**	**3/31/2012**
Heart attack patients given a prescription for a statin at discharge ***Higher** percentages are better*	**97% of 117 Patients**	**97%**	**98%**	**4/1/2011**	**3/31/2012**

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Timely & Effective Care:Heart Failure Care Details

Effective Heart Failure Care

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Measures	LAWRENCE & MEMORIAL HOSPITAL	Connecticut Average	National Average	Data Collected From	Data Collected To
Heart failure patients given discharge instructions ***Higher** percentages are better*	**85% of 194 Patients** [2]	**89%**	**93%**	**4/1/2011**	**3/31/2012**
Heart failure patients given an evaluation of Left Ventricular Systolic (LVS) function ***Higher** percentages are better*	**100% of 274 Patients** [2]	**100%**	**99%**	**4/1/2011**	**3/31/2012**
Heart failure patients given ACE inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD) ***Higher** percentages are better*	**95% of 42 Patients** [2]	**94%**	**96%**	**4/1/2011**	**3/31/2012**

[2] The hospital indicated that the data submitted for this measure were based on a sample of cases.

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Timely & Effective Care:Pneumonia Care Details

Effective Pneumonia Care

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Measures	LAWRENCE & MEMORIAL HOSPITAL	Connecticut Average	National Average	Data Collected From	Data Collected To
Pneumonia patients whose initial emergency room blood culture was performed prior to the administration of the first hospital dose of antibiotics ***Higher** percentages are better*	**98% of 136 Patients** [2]	**96%**	**97%**	**4/1/2011**	**3/31/2012**
Pneumonia patients given the most appropriate initial antibiotic(s) ***Higher** percentages are better*	**94% of 62 Patients** [2]	**96%**	**95%**	**4/1/2011**	**3/31/2012**

[2] The hospital indicated that the data submitted for this measure were based on a sample of cases.

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Timely & Effective Care:Surgical Care Details

Timely Surgical Care

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Measures	LAWRENCE & MEMORIAL HOSPITAL	Connecticut Average	National Average	Data Collected From	Data Collected To
Outpatients having surgery who got an antibiotic at the right time (within one hour before surgery) ***Higher** percentages are better*	90% of 190 Patients	95%	96%	4/1/2011	3/31/2012
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection ***Higher** percentages are better*	96% of 277 Patients [2]	98%	98%	4/1/2011	3/31/2012
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery) ***Higher** percentages are better*	97% of 267 Patients [2]	97%	97%	4/1/2011	3/31/2012
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery ***Higher** percentages are better*	96% of 344 Patients [2]	98%	97%	4/1/2011	3/31/2012

[2] The hospital indicated that the data submitted for this measure were based on a sample of cases.

Effective Surgical Care

Hide Details

Measures	LAWRENCE &	Connecticut	National	Data Collected

	MEMORIAL HOSPITAL	Average	Average	From	To
Outpatients having surgery who got the right kind of antibiotic ***Higher** percentages are better*	**96% of 181 Patients**	**95%**	**97%**	**4/1/2011**	**3/31/2012**
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery ***Higher** percentages are better*	**98% of 107 Patients** [2]	**95%**	**96%**	**4/1/2011**	**3/31/2012**
Surgery patients who were given the right kind of antibiotic to help prevent infection ***Higher** percentages are better*	**98% of 278 Patients** [2]	**98%**	**98%**	**4/1/2011**	**3/31/2012**
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery ***Higher** percentages are better*	**Not Available** [2]	**96%**	**96%**	**4/1/2011**	**3/31/2012**
Surgery patients whose urinary catheters were removed on the first or second day after surgery ***Higher** percentages are better*	**90% of 188 Patients** [2]	**94%**	**95%**	**4/1/2011**	**3/31/2012**
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery ***Higher** percentages are better*	**100% of 419 Patients** [2]	**99%**	**100%**	**4/1/2011**	**3/31/2012**
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries ***Higher** percentages are better*	**96% of 344 Patients** [2]	**98%**	**98%**	**4/1/2011**	**3/31/2012**

[2] The hospital indicated that the data submitted for this measure were based on a sample of cases.

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Timely & Effective Care:Emergency Department Care Details

Timely Emergency Department Care

Hide Details

Measures	LAWRENCE & MEMORIAL HOSPITAL	Connecticut Average	National Average	Data Collected From	Data Collected To
NEW Average (median) time patients spent in the emergency department, before they were admitted to the hospital as an inpatient *A **lower** number of minutes is better*	438 Minutes [2]	351 Minutes	277 Minutes	1/1/2012	3/31/2012
NEW Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room *A **lower** number of minutes is better*	104 Minutes [2]	145 Minutes	98 Minutes	1/1/2012	3/31/2012
NEW Average time patients spent in the emergency department before being sent home *A **lower** number of minutes is better*	116 Minutes	135 Minutes	140 Minutes	1/1/2012	3/31/2012
NEW Average time patients spent in the emergency department before they were seen by a healthcare professional *A **lower** number of minutes is better*	45 Minutes	31 Minutes	30 Minutes	1/1/2012	3/31/2012
NEW Average time patients who came to the emergency department with broken bones had to wait before receiving pain medication *A **lower** number of minutes is better*	58 Minutes	61 Minutes	62 Minutes	1/1/2012	3/31/2012
NEW Percentage of patients who left the emergency department before being seen *__Lower__ percentages are better*	0% of 43278 Patients	Not Available	Not Available	1/1/2011	12/31/2011

Measures	LAWRENCE & MEMORIAL HOSPITAL	Connecticut Average	National Average	Data Collected From	Data Collected To
NEW Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival ***Higher** percentages are better*	**Too few cases**	**51%**	**43%**	**1/1/2012**	**3/31/2012**

[2] The hospital indicated that the data submitted for this measure were based on a sample of cases.

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Use of Medical Imaging Details

Use of Medical Imaging **Hide Details**

Measures	LAWRENCE & MEMORIAL HOSPITAL	Connecticut Average	National Average	Data Collected From	Data Collected To
Outpatients with low back pain who had an MRI without trying recommended treatments first, such as physical therapy. (If a number is high, it may mean the facility is doing too many unnecessary MRIs for low back pain.) *__Lower__ percentages are better*	33.5%	32%	36.8%	1/1/2010	12/31/2010
Outpatients who had a follow-up mammogram or ultrasound within 45 days after a screening mammogram. (A number that is much lower than 8% may mean there's not enough follow-up. A number much higher than 14% may mean there's too much unnecessary follow-up.) *Percentages __between 8 percent and 14 percent__ are better*	6.6%	12.6%	8.5%	1/1/2010	12/31/2010
Outpatient CT scans of the chest that were "combination" (double) scans. (The range for this measure is 0 to 1. A number very close to 1 may mean that too many patients are being given a double scan when a single scan is all they need.) *Numbers __closer to zero__ are better*	0	0.021	0.044	1/1/2010	12/31/2010
Outpatient CT scans of the abdomen that were "combination" (double) scans. (The range for this measure is 0 to 1. A number very close to 1 may mean that too many patients are being given a double scan when a single scan is all they need.) *Numbers __closer to zero__ are better*	0.056	0.092	0.149	1/1/2010	12/31/2010
Outpatients who got cardiac imaging stress tests before low-risk outpatient surgery. *__Lower__ percentages are better*	5.5%	5.1%	5.6%	1/1/2010	12/31/2010

Measures	LAWRENCE & MEMORIAL HOSPITAL	Connecticut Average	National Average	Data Collected From	Data Collected To
Outpatients with brain CT scans who got a sinus CT scan at the same time. *Lower percentages are better*	1.7%	2%	2.7%	1/1/2010	12/31/2010

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30-Day Outcomes Readmission and Deaths Details

Table 1 of 6 Rate of readmission for heart attack patients **Hide Details**

The rates displayed in this table were calculated from Medicare and VA data on patients discharged between July 1, 2008 and June 30, 2011. They do not include people in Medicare Advantage (like an HMO or PPO) plans or people who do not have Medicare.

Rate of readmission for heart attack patients tells you how the 30-day readmission rates from Rate of readmission for at the hospitals you selected compare to the U.S. National Rate of readmission for heart attack patients . These comparisons take into account how sick patients were before they were admitted to the hospital and differences in readmission rates that might be due to chance. For more information, see **How are the hospital readmission measures calculated?**

Rate of readmission for heart attack patients Compared to the U.S. National Rate.

The U.S. National Rate of readmission for heart attack patients = 19.7%

Hospital Name	Better Than U.S. National Rate (Adjusted readmission is lower than U.S. National Rate)	No Different Than U.S. National Rate (Adjusted readmission is about the same as U.S. National Rate or difference is uncertain)	Worse Than U.S. National Rate (Adjusted readmission is higher than U.S. National Rate)
LAWRENCE & MEMORIAL HOSPITAL		X	

The 'total number' of hospitals in the table below is the total number of hospitals that had eligible admissions for this measure. See **30-Day Death and Readmission Measures** for additional information about the data collection for the readmission measures.

Out of 4519 in the United States →	**30** hospitals in the United States were Better than U.S. National Rate	**2338** hospitals in the United States were No different than U.S. National Rate	**41** hospitals in the United States were Worse than U.S. National Rate
	2110 hospitals in the United States did not have enough cases to reliably tell how well they are performing		
Out of 31 in Connecticut →	**0** hospitals were Better than U.S. National Rate	**29** hospitals were No different than U.S. National Rate	**0** hospitals were Worse than U.S. National Rate

2 hospitals in Connecticut did not have enough cases to reliably tell how well they are performing

Note: Medicare derived the 30-Day Risk-Adjusted Readmission measures from VA data as well as its own data about patients on Original Medicare and the hospitals that treat them. The information in this table reflects care given only to patients who are on Original Medicare. All data are **risk-adjusted** .

Table 2 of 6 Death rate for heart attack patients **Hide Details**

The rates displayed in this table were calculated from Medicare and VA data on patients discharged between July 1, 2008 and June 30, 2011. They do not include people in Medicare Advantage (like an HMO or PPO) plans or people who do not have Medicare.

Death rate for heart attack patients tells you how the 30-day readmission rates from Death rate for at the hospitals you selected compare to the U.S. National Death rate for heart attack patients . These comparisons take into account how sick patients were before they were admitted to the hospital and differences in readmission rates that might be due to chance. For more information, see **How are the hospital readmission measures calculated?**

Death rate for heart attack patients Compared to the U.S. National Rate.

The U.S. National Death rate for heart attack patients = 15.5%

Hospital Name	Better Than U.S. National Rate (Adjusted mortality is lower than U.S. National Rate)	No Different Than U.S. National Rate (Adjusted mortality is about the same as U.S. National Rate or difference is uncertain)	Worse Than U.S. National Rate (Adjusted mortality is higher than U.S. National Rate)
LAWRENCE & MEMORIAL HOSPITAL		X	

The 'total number' of hospitals in the table below is the total number of hospitals that had eligible admissions for this measure. See **30-Day Death and Readmission Measures** for additional information about the data collection for the mortality measures.

Out of 4605 in the United States →	**72** hospitals in the United States were Better than U.S. National Rate	**2668** hospitals in the United States were No different than U.S. National Rate	**23** hospitals in the United States were Worse than U.S. National Rate
	1842 hospitals in the United States did not have enough cases to reliably tell how well they are performing		
Out of 31 in Connecticut →	**3** hospitals were Better than U.S. National Rate	**27** hospitals were No different than U.S. National Rate	**0** hospitals were Worse than U.S. National Rate
	1 hospitals in Connecticut did not have enough cases to reliably tell how well they are performing		

Note: Medicare derived the 30-Day Risk-Adjusted Death (Mortality) measures from VA data as well as its own data about patients on Original Medicare and the hospitals that treat them. The information in this table reflects care given only to patients who are on Original Medicare. All data are **risk-adjusted** .

Table 3 of 6 Rate of readmission for heart failure patients **Hide Details**

The rates displayed in this table were calculated from Medicare and VA data on patients discharged between July 1, 2008 and June 30, 2011. They do not include people in Medicare Advantage (like an HMO or PPO) plans or people who do not have Medicare.

Rate of readmission for heart failure patients tells you how the 30-day readmission rates from Rate of readmission for at the hospitals you selected compare to the U.S. National Rate of readmission for heart failure patients . These comparisons take into account how sick patients were before they were admitted to the hospital and differences in readmission rates that might be due to chance. For more information, see **How are the hospital readmission measures calculated?**

Rate of readmission for heart failure patients Compared to the U.S. National Rate.

The U.S. National Rate of readmission for heart failure patients = 24.7%

Hospital Name	Better Than U.S. National Rate (Adjusted readmission is lower than U.S. National Rate)	No Different Than U.S. National Rate (Adjusted readmission is about the same as U.S. National Rate or difference is uncertain)	Worse Than U.S. National Rate (Adjusted readmission is higher than U.S. National Rate)
LAWRENCE & MEMORIAL HOSPITAL		X	

The 'total number' of hospitals in the table below is the total number of hospitals that had eligible admissions for this measure. See **30-Day Death and Readmission Measures** for additional information about the data collection for the readmission measures.

Out of 4829 in the United States →	**95** hospitals in the United States were Better than U.S. National Rate	**3959** hospitals in the United States were No different than U.S. National Rate	**162** hospitals in the United States were Worse than U.S. National Rate
	613 hospitals in the United States did not have enough cases to reliably tell how well they are performing		
Out of 32 in Connecticut →	**0** hospitals were Better than U.S. National Rate	**32** hospitals were No different than U.S. National Rate	**0** hospitals were Worse than U.S. National Rate
	0 hospitals in Connecticut did not have enough cases to reliably tell how well they are performing		

Note: Medicare derived the 30-Day Risk-Adjusted Readmission measures from VA data as well as its own data about patients on Original Medicare and the hospitals that treat them. The information in this table reflects care given only to patients who are on Original Medicare. All data are **risk-adjusted** .

Table 4 of 6 Death rate for heart failure patients

Hide Details

The rates displayed in this table were calculated from Medicare and VA data on patients discharged between July 1, 2008 and June 30, 2011. They do not include people in Medicare Advantage (like an HMO or PPO) plans or people who do not have Medicare.

Death rate for heart failure patients tells you how the 30-day readmission rates from Death rate for at the hospitals you selected compare to the U.S. National Death rate for heart failure patients . These comparisons take into account how sick patients were before they were admitted to the hospital and differences in readmission rates that might be due to chance. For more information, see **How are the hospital readmission measures calculated?**

Death rate for heart failure patients Compared to the U.S. National Rate.

The U.S. National Death rate for heart failure patients = 11.6%

Hospital Name	Better Than U.S. National Rate (Adjusted mortality is lower than U.S. National Rate)	No Different Than U.S. National Rate (Adjusted mortality is about the same as U.S. National Rate or difference is uncertain)	Worse Than U.S. National Rate (Adjusted mortality is higher than U.S. National Rate)
LAWRENCE & MEMORIAL HOSPITAL		X	

The 'total number' of hospitals in the table below is the total number of hospitals that had eligible admissions for this measure. See **30-Day Death and Readmission Measures** for additional information about the data collection for the mortality measures.

Out of 4821 in the United States →	**196** hospitals in the United States were Better than U.S. National Rate	**3801** hospitals in the United States were No different than U.S. National Rate	**119** hospitals in the United States were Worse than U.S. National Rate
	705 hospitals in the United States did not have enough cases to reliably tell how well they are performing		
Out of 32 in Connecticut →	**5** hospitals were Better than U.S. National Rate	**25** hospitals were No different than U.S. National Rate	**2** hospitals were Worse than U.S. National Rate
	0 hospitals in Connecticut did not have enough cases to reliably tell how well they are performing		

Note: Medicare derived the 30-Day Risk-Adjusted Death (Mortality) measures from VA data as well as its own data about patients on Original Medicare and the hospitals that treat them. The information in this table reflects care given only to patients who are on Original Medicare. All data are **risk-adjusted** .

Table 5 of 6 Rate of readmission for pneumonia patients **Hide Details**

The rates displayed in this table were calculated from Medicare and VA data on patients discharged between July 1, 2008 and June 30, 2011. They do not include people in Medicare Advantage (like an HMO or PPO) plans or people who do not have Medicare.

Rate of readmission for pneumonia patients tells you how the 30-day readmission rates from Rate of readmission for at the hospitals you selected compare to the U.S. National Rate of readmission for pneumonia patients . These comparisons take into account how sick patients were before they were admitted to the hospital and differences in readmission rates that might be due to chance. For more information, see **How are the hospital readmission measures calculated?**

Rate of readmission for pneumonia patients Compared to the U.S. National Rate.

The U.S. National Rate of readmission for pneumonia patients = 18.5%

Hospital Name	Better Than U.S. National Rate (Adjusted readmission is lower than U.S. National Rate)	No Different Than U.S. National Rate (Adjusted readmission is about the same as U.S. National Rate or difference is uncertain)	Worse Than U.S. National Rate (Adjusted readmission is higher than U.S. National Rate)
LAWRENCE & MEMORIAL HOSPITAL		X	

The 'total number' of hospitals in the table below is the total number of hospitals that had eligible admissions for this measure. See **30-Day Death and Readmission Measures** for additional information about the data collection for the readmission measures.

Out of 4859 in the United States →	**33** hospitals in the United States were Better than U.S. National Rate	**4325** hospitals in the United States were No different than U.S. National Rate	**125** hospitals in the United States were Worse than U.S. National Rate
	376 hospitals in the United States did not have enough cases to reliably tell how well they are performing		
Out of 32 in Connecticut →	**1** hospitals were Better than U.S. National Rate	**30** hospitals were No different than U.S. National Rate	**1** hospitals were Worse than U.S. National Rate
	0 hospitals in Connecticut did not have enough cases to reliably tell how well they are performing		

Note: Medicare derived the 30-Day Risk-Adjusted Readmission measures from VA data as well as its own data about patients on Original Medicare and the hospitals that treat them. The information in this table reflects care given only to patients who are on Original Medicare. All data are **risk-adjusted** .

Table 6 of 6 Death rate for pneumonia patients **Hide Details**

The rates displayed in this table were calculated from Medicare and VA data on patients discharged between July 1, 2008 and June 30, 2011. They do not include people in Medicare Advantage (like an HMO or PPO) plans or people who do not have Medicare.

Death rate for pneumonia patients tells you how the 30-day readmission rates from Death rate for at the hospitals you selected compare to the U.S. National Death rate for pneumonia patients . These comparisons take into account how sick patients were before they were admitted to the hospital and differences in readmission rates that might be due to chance. For more information, see **How are the hospital readmission measures calculated?**

Death rate for pneumonia patients Compared to the U.S. National Rate.

The U.S. National Death rate for pneumonia patients = 12.0%

Hospital Name	Better Than U.S. National Rate (Adjusted mortality is lower than U.S. National Rate)	No Different Than U.S. National Rate (Adjusted mortality is about the same as U.S. National Rate or difference is uncertain)	Worse Than U.S. National Rate (Adjusted mortality is higher than U.S. National Rate)

Hospital Name	Better Than U.S. National Rate (Adjusted mortality is lower than U.S. National Rate)	No Different Than U.S. National Rate (Adjusted mortality is about the same as U.S. National Rate or difference is uncertain)	Worse Than U.S. National Rate (Adjusted mortality is higher than U.S. National Rate)
LAWRENCE & MEMORIAL HOSPITAL		X	

The 'total number' of hospitals in the table below is the total number of hospitals that had eligible admissions for this measure. See **30-Day Death and Readmission Measures** for additional information about the data collection for the mortality measures.

Out of 4844 in the United States →	**189** hospitals in the United States were Better than U.S. National Rate	**4056** hospitals in the United States were No different than U.S. National Rate	**219** hospitals in the United States were Worse than U.S. National Rate
	380 hospitals in the United States did not have enough cases to reliably tell how well they are performing		
Out of 32 in Connecticut →	**7** hospitals were Better than U.S. National Rate	**24** hospitals were No different than U.S. National Rate	**1** hospitals were Worse than U.S. National Rate
	0 hospitals in Connecticut did not have enough cases to reliably tell how well they are performing		

Note: Medicare derived the 30-Day Risk-Adjusted Death (Mortality) measures from VA data as well as its own data about patients on Original Medicare and the hospitals that treat them. The information in this table reflects care given only to patients who are on Original Medicare. All data are **risk-adjusted** .

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Hospital Compare

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General Information

	WESTERLY HOSPITAL 25 WELLS STREET WESTERLY, RI 02891 (401) 596-6000 Add to my Favorites Map and Directions	LAWRENCE & MEMORIAL HOSPITAL 365 MONTAUK AVE NEW LONDON, CT 06320 (860) 442-0711 Add to my Favorites Map and Directions
Hospital Type [?]	Acute Care Hospitals	Acute Care Hospitals
Provides Emergency Services [?]	Yes	Yes
Registry Type [?]		Stroke Care Registry Nursing Care Registry
NEW Able to receive lab results electronically [?]	Yes	Yes
NEW Able to track patients' lab results, tests, and referrals electronically between visits [?]	Yes	No

Patient Survey Results

Patient Survey Results

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is a national survey that asks patients about their experiences during a recent hospital stay. Use the results shown here to compare hospitals based on ten important hospital quality topics.

- More information about patient survey results.
- Current data collection period.

	WESTERLY HOSPITAL 25 WELLS STREET WESTERLY, RI 02891 (401) 596-6000 Add to my Favorites Map and Directions	**LAWRENCE & MEMORIAL HOSPITAL** 365 MONTAUK AVE NEW LONDON, CT 06320 (860) 442-0711 Add to my Favorites Map and Directions
Patients who reported that their nurses "Always" communicated well.	75%	78%
Patients who reported that their doctors "Always" communicated well.	80%	76%
Patients who reported that they "Always" received help as soon as they wanted.	61%	58%
Patients who reported that their pain was "Always" well controlled.	68%	73%
Patients who reported that staff "Always" explained about medicines before giving it to them.	59%	57%
Patients who reported that their room and bathroom were "Always" clean.	78%	68%
Patients who reported that the area around their room was "Always" quiet at night.	51%	46%

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Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	81%	80%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	67%	64%
Patients who reported YES, they would definitely recommend the hospital.	68%	69%

Timely & Effective Care

Timely & Effective Care

These measures show how often hospitals provide care that research shows gets the best results for patients with certain conditions. This information can help you compare which hospitals give recommended care most often as part of the overall care they provide to patients.

- Heart Attack Care
- Heart Failure Care
- Pneumonia Care
- Surgical Care
- Emergency Department
- Children's Asthma Care
- Preventive Care

Heart Attack Care

An acute myocardial infarction (AMI), also called a heart attack, happens when one of the heart's arteries becomes blocked and the supply of blood and oxygen to part of the heart muscle is slowed or stopped. When the heart muscle doesn't get the oxygen and nutrients it needs, the affected heart tissue may die. These measures show some of the standards of care provided, if appropriate, for most adults who have had a heart attack.

- More information about timely and effective care measures.
- Why heart attack care measures are important.
- Current data collection period.

Timely Heart Attack Care

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Average number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital *A **lower** number of minutes is better*	Too few cases	Too few cases
Average number of minutes before outpatients with chest pain or possible heart attack got an ECG *A **lower** number of minutes is better*	13 Minutes	13 Minutes
Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival ***Higher** percentages are better*	Too few cases	Not Available
Outpatients with chest pain or possible heart attack who got aspirin within 24 hours of arrival ***Higher** percentages are better*	100%	92%
Heart attack patients given fibrinolytic medication within 30 minutes of arrival ***Higher** percentages are better*	Not Available	Not Available
Heart attack patients given PCI within 90 minutes of arrival ***Higher** percentages are better*	Not Available	94%

Effective Heart Attack Care

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	Map and Directions	Map and Directions
Heart attack patients given aspirin at discharge ***Higher*** *percentages are better*	100% [1]	100%
Heart attack patients given a prescription for a statin at discharge ***Higher*** *percentages are better*	95% [1]	97%

Heart Failure Care

Heart Failure is a weakening of the heart's pumping power. With heart failure, your body doesn't get enough oxygen and nutrients to meet its needs. These measures show some of the process of care provided for most adults with heart failure.

- More information about timely and effective care measures.
- Why heart failure care measures are important.
- Current data collection period.

Effective Heart Failure Care

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Heart failure patients given discharge instructions ***Higher*** *percentages are better*	75%	85% [2]
Heart failure patients given an evaluation of Left Ventricular Systolic (LVS) function ***Higher*** *percentages are better*	99%	100% [2]
Heart failure patients given ACE inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD) ***Higher*** *percentages are better*	91%	95% [2]

Pneumonia Care

Pneumonia is a serious lung infection that causes difficulty breathing, fever, cough and fatigue. These measures show some of the recommended

treatments for pneumonia.

- More information about timely and effective care measures.
- Why pneumonia care measures are important.
- Current data collection period.

Effective Pneumonia Care

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Pneumonia patients whose initial emergency room blood culture was performed prior to the administration of the first hospital dose of antibiotics ***Higher** percentages are better*	94%	98%[2]
Pneumonia patients given the most appropriate initial antibiotic(s) ***Higher** percentages are better*	88%	94%[2]

Surgical Care

Hospitals can reduce the risk of infection after surgery by making sure they provide care that's known to get the best results for most patients. Here are some examples:

- Giving the recommended antibiotics at the right time before surgery
- Stopping the antibiotics within the right timeframe after surgery
- Maintaining the patient's temperature and blood glucose (sugar) at normal levels
- Removing catheters that are used to drain the bladder in a timely manner after surgery.

Hospitals can also reduce the risk of cardiac problems associated with surgery by:

- Making sure that certain prescription drugs are continued in the time before, during, and just after the surgery. This includes drugs used to control heart rhythms and blood pressure.
- Giving drugs that prevent blood clots and using other methods such as special stockings that increase circulation in the legs.

- More information about timely and effective care measures.
- Why surgical care measures are important.
- Current data collection period.

Timely Surgical Care

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Outpatients having surgery who got an antibiotic at the right time (within one hour before surgery) ***Higher** percentages are better*	97%	90%
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection ***Higher** percentages are better*	100%	96%[2]
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery) ***Higher** percentages are better*	96%	97%[2]
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of	94%	96%[2]

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surgery ***Higher*** *percentages are better*		

Effective Surgical Care

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Outpatients having surgery who got the right kind of antibiotic ***Higher*** *percentages are better*	98%	96%
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery ***Higher*** *percentages are better*	94%	98% [2]
Surgery patients who were given the right kind of antibiotic to help prevent infection ***Higher*** *percentages are better*	99%	98% [2]
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery ***Higher*** *percentages are better*	Not Available	Not Available [2]
Surgery patients whose urinary catheters were removed on the first or second day after surgery ***Higher*** *percentages are better*	96%	90% [2]

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Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery ***Higher** percentages are better*	99%	100% [2]
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries ***Higher** percentages are better*	97%	96% [2]

Emergency Department Care

Timely and effective care in hospital emergency departments is essential for good patient outcomes. Delays before receiving care in the emergency department can reduce the quality of care and increase risks and discomfort for patients with serious illnesses or injuries. Waiting times at different hospitals can vary widely, depending on the number of patients seen, staffing levels, efficiency, admitting procedures, or the availability of inpatient beds.

The information below shows how quickly the hospitals you selected treat patients who come to the hospital emergency department, compared to the average for all hospitals in the U. S.

- More information about timely and effective care measures.
- Why emergency department care measures are important.
- Current data collection period.

Timely Emergency Department Care

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NEW Average (median) time patients spent in the emergency department, before they were admitted to the hospital as an inpatient *A **lower** number of minutes is better*	280 Minutes[2]	438 Minutes[2]
NEW Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room *A **lower** number of minutes is better*	80 Minutes[2]	104 Minutes[2]
NEW Average time patients spent in the emergency department before being sent home *A **lower** number of minutes is better*	108 Minutes	116 Minutes
NEW Average time patients spent in the emergency department before they were seen by a healthcare professional *A **lower** number of minutes is better*	29 Minutes	45 Minutes
NEW Average time patients who came to the emergency department with broken bones had to wait before receiving pain medication *A **lower** number of minutes is better*	Too few cases	58 Minutes
NEW Percentage of patients who left the emergency department before being seen ***Lower** percentages are better*	1%	Not Available[+]
NEW Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival ***Higher** percentages are better*	Not Available	Too few cases

Preventive Care

Hospitals and other healthcare providers play a crucial role in promoting, providing and educating patients about preventive services and screenings and maintaining the health of their communities. Many diseases are preventable through immunizations, screenings, treatment, and lifestyle changes. The information below shows how well the hospitals you selected are providing preventive services.

- More information about timely and effective care measures.
- Why preventive care measures are important.
- Current data collection period.

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NEW Patients assessed and given influenza vaccination ***Higher** percentages are better*	90%[2]	92%[2]
NEW Patients assessed and given pneumonia vaccination ***Higher** percentages are better*	82%[2]	92%[2]

Children's Asthma Care

Asthma is a chronic lung condition that causes problems getting air in and out of the lungs. Children with asthma may experience wheezing, coughing, chest tightness and trouble breathing.

- More information about timely and effective care measures.
- Why children's asthma care measures are important.
- Current data collection period.

Effective Children's Asthma Care

	WESTERLY HOSPITAL 25 WELLS STREET	LAWRENCE & MEMORIAL HOSPITAL 365 MONTAUK AVE

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Children who received reliever medication while hospitalized for asthma ***Higher** percentages are better*	Not Available	Not Available
Children who received systemic corticosteroid medication (oral and IV medication that reduces inflammation and controls symptoms) while hospitalized for asthma ***Higher** percentages are better*	Not Available	Not Available
Children and their caregivers who received a home management plan of care document while hospitalized for asthma ***Higher** percentages are better*	Not Available	Not Available

† No patients met the criteria for inclusion in the measure calculation.
[1] The number of cases is too small to reliably tell how well a hospital is performing.
[2] The hospital indicated that the data submitted for this measure were based on a sample of cases.

Readmissions , Complications & Deaths

Readmissions, Complications and Deaths

Patients who are admitted to the hospital for treatment of medical problems sometimes get other serious injuries, complications, or conditions, and may even die. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients.

30-Day Outcomes Readmission and Deaths

30-Day Readmission is when patients who have had a recent hospital stay need to go back into a hospital again within 30 days of their discharge. Below, the rates of readmission for each hospital are compared to the U.S. National Rate. The rates take into account how sick patients were before they were admitted to the hospital.

30-Day Mortality is when patients die within 30 days of their admission to a hospital. Below, the death rates for each hospital are compared to the U.S. National Rate. The rates take into account how sick patients were before they were admitted to the hospital.

- More information about Hospital Readmission and Mortality Measures.
- Current data collection period.

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Rate of readmission for heart attack patients	No Different than U.S. National Rate	No Different than U.S. National Rate
Death rate for heart attack patients	No Different than U.S. National Rate	No Different than U.S. National Rate
Rate of readmission for heart failure patients	No Different than U.S. National Rate	No Different than U.S. National Rate
Death rate for heart failure patients	No Different than U.S. National Rate	No Different than U.S. National Rate
Rate of readmission for pneumonia patients	No Different than U.S. National Rate	No Different than U.S. National Rate
Death rate for pneumonia patients	No Different than U.S. National Rate	No Different than U.S. National Rate

Serious Complications and Deaths

This section shows serious complications that patients with Original Medicare experienced during a hospital stay, and how often patients who were admitted with certain conditions died while they were in the hospital. These complications and deaths can often be prevented if hospitals follow procedures based on best practices and scientific evidence.

- Why Serious Complications and Death Measures are Important.
- Current data collection period.

Results for the following 4 measures are suppressed due to a software issue:
- Death after surgery to repair weakness in the abdominal aorta
- Deaths after admission for a broken hip
- Deaths for certain conditions
- Breathing failure after surgery (except performance categories)

	WESTERLY HOSPITAL	LAWRENCE & MEMORIAL HOSPITAL

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Serious complications This is a 'composite' or summary measure.	No Different than U.S. National Rate Get Results for this Hospital	No Different than U.S. National Rate Get Results for this Hospital
Deaths for certain conditions This is a 'composite' or summary measure.	Not Available [4]	Not Available [4]
Other complications and deaths	Get Results for this Hospital	Get Results for this Hospital

Hospital-Acquired Conditions

This section shows certain injuries, infections, or other serious conditions that patients with Original Medicare got while they were in the hospital. These conditions, also known as "Hospital Acquired Conditions," are usually very rare. If they ever occur, hospital staff should identify and correct the problems that caused them.

Please note that the numbers shown here do not take into account the different kinds of patients treated at different hospitals. For this reason, they should not be used to compare one hospital to another.

- Why Hospital Acquired Conditions measures are important.
- Current data collection period.

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Hospital-acquired conditions	Get Results for this Hospital	Get Results for this Hospital

Healthcare-Associated Infections

Healthcare Associated Infections are reported using a Standardized Infection Ratio (SIR). This calculation compares the number of Central Line Associated Bloodstream Infections (CLABSI) in a hospital intensive care unit or Surgical Site Infections (SSI) from operative procedures performed in a hospital to a national benchmark based on data reported to NHSN from 2006 – 2008. Scores for Catheter Associated Urinary Tract Infections (CAUTI) are compared to a national benchmark based on data reported to NHSN in 2009. The results are adjusted based on certain factors such as the type and size of a hospital or ICU for CLABSI and CAUTI, and based on certain factors related to the patient and surgery that was conducted for SSI. Each hospital's SIR is shown in the graph view.

- A score's confidence interval that is less than 1 means that the hospital had fewer infections than hospitals of similar type and size.
- A score's confidence interval that includes 1 means that the hospital's infections score was no different than hospitals of similar type and size.
- A score's confidence interval that is more than 1 means that the hospital had more infections than hospitals of similar type and size.

- Why Healthcare Associated Infections (HAIs) measures are important.
- Current data collection period.

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Central Line Associated Bloodstream Infections (CLABSI) ***Lower** numbers are better. A score of zero (0) - meaning no CLABSIs - is best.*	Not Available	No different than the U.S. National Benchmark
NEW Catheter Associated Urinary Tract Infections (CAUTI) ***Lower** numbers are better. A score of zero (0) - meaning no CAUTIs - is best.*	Not Available	No different than the U.S. National Benchmark
NEW Surgical Site Infections from colon surgery (SSI: Colon) ***Lower** numbers are better. A score of zero (0) - meaning no SSIs - is best.*	Not Available	Not Available
NEW Surgical Site Infections from abdominal hysterectomy (SSI: Hysterectomy) ***Lower** numbers are better. A score of zero (0) - meaning no SSIs - is best.*	Not Available	Not Available

[4] Suppressed for one or more quarters by CMS.

Use of Medical Imaging

Use of Medical Imaging

Use of Medical Imaging (tests like Mammograms, MRIs, and CT scans)
These measures give you information about hospitals' use of medical imaging tests for outpatients based on the following:

- Protecting patients' safety, such as keeping patients' exposure to radiation and other risks as low as possible.
- Following up properly when screening tests such as mammograms show a possible problem.
- Avoiding the risk, stress, and cost of doing imaging tests that patients may not need.

The information shown here is limited to medical imaging facilities that are part of a hospital or associated with a hospital. These facilities can be inside or near the hospital, or in a different location. This information only includes medical imaging done on outpatients. Medical imaging tests done for patients who have been admitted to the hospital as inpatients aren't included.
These measures are based on Medicare claims data.

- Why the Use of Medical Imaging measures are important.
- Current data collection period.

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Outpatients with low back pain who had an MRI without trying recommended treatments first, such as physical therapy. (If a number is high, it may mean the facility is doing too many unnecessary MRIs for low back pain.) ***Lower** percentages are better*	22.6%	33.5%
Outpatients who had a follow-up mammogram or ultrasound within 45 days after a screening mammogram. (A number that is much lower than 8% may mean there's not enough follow-up. A number much higher than 14% may mean there's too much unnecessary follow-up.) *Percentages **between 8 percent and 14 percent** are better*	14.6%	6.6%

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Outpatient CT scans of the chest that were "combination" (double) scans. (The range for this measure is 0 to 1. A number very close to 1 may mean that too many patients are being given a double scan when a single scan is all they need.) *Numbers **closer to zero** are better*	0.004	0
Outpatient CT scans of the abdomen that were "combination" (double) scans. (The range for this measure is 0 to 1. A number very close to 1 may mean that too many patients are being given a double scan when a single scan is all they need.) *Numbers **closer to zero** are better*	0.091	0.056
Outpatients who got cardiac imaging stress tests before low-risk outpatient surgery. ***Lower** percentages are better*	9.1%	5.5%
Outpatients with brain CT scans who got a sinus CT scan at the same time. ***Lower** percentages are better*	2.2%	1.7%

Medicare Payment

Spending per hospital patient with Medicare

The "Spending per Hospital Patient with Medicare" measure shows whether Medicare spends more, less or about the same per Medicare patient treated in a specific hospital, compared to how much Medicare spends per patient nationally. This measure includes any Medicare Part A and Part B payments made for services provided to a patient during the 3 days prior to the hospital stay, during the stay, and during the 30 days after discharge from the hospital.

This result is a ratio calculated by dividing the amount Medicare spends per patient for an episode of care initiated at this hospital by the median (or middle) amount Medicare spent per patient nationally.

A result of 1 means that Medicare spends ABOUT THE SAME amount per patient for an episode of care initiated at this hospital as it does per hospital patient nationally.

A result that is more than 1 means that Medicare spends MORE per patient for an episode of care initiated at this hospital than it does per hospital patient nationally.

A result that is less than 1 means that Medicare spends LESS per patient for an episode of care initiated at this hospital than it does per hospital patient nationally.

Lower numbers are better.

- More about Spending per Hospital Patient with Medicare.
- Current data collection period.

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Spending per hospital patient with Medicare	Get Results for this Hospital	Get Results for this Hospital

Number of Medicare Patients

Medical Patients Search

Select a Medical Condition or Surgical Procedure and update your results.

Medical Conditions

Surgical Procedures

Number of Medicare patients treated

This shows the number of Medicare patients with a certain condition (MS-DRG) that a hospital treated during the current data collection period. These data are based on the number of Medicare patients that were discharged with a certain condition. They do not include patients in Medicare Health Plans.

'CC' refers to complications or comorbidities. 'MCC' refers to major complications or comorbidities.

- More information about Number of Medicare Patients Treated.
- Current data collection period.

Update Results

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To view Medicare Payment and Volume data, you must select a Medical Condition or Surgical Procedure in the Medical Patients Search and update your results.

Back to Top

Data Last Updated: February 1, 2013

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The Official U.S. Government Site for Medicare

Hospital Compare

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General Information

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Hospital Type [?]	Acute Care Hospitals	Acute Care Hospitals	Acute Care Hospitals
Provides Emergency Services [?]	Yes	Yes	Yes
Registry Type [?]	Stroke Care Registry Nursing Care Registry	Stroke Care Registry Nursing Care Registry	Stroke Care Registry Nursing Care Registry
NEW Able to receive lab results electronically [?]	Yes	Yes	Yes
NEW Able to track patients' lab results, tests, and referrals electronically between visits [?]	Yes	Yes	Yes

Patient Survey Results

Patient Survey Results

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is a national survey that asks patients about their experiences during a recent hospital stay. Use the results shown here to compare hospitals based on ten important hospital quality topics.

- More information about patient survey results.
- Current data collection period.

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Patients who reported that their nurses "Always" communicated well.	84%	81%	77%
Patients who reported that their doctors "Always" communicated well.	85%	80%	78%
Patients who reported that they "Always" received help as soon as they wanted.	76%	68%	65%
Patients who reported that their pain was "Always" well controlled.	76%	73%	74%
Patients who reported that staff "Always" explained about medicines before giving it to them.	69%	61%	55%
Patients who reported that their room and bathroom were "Always" clean.	80%	81%	73%

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Patients who reported that the area around their room was "Always" quiet at night.	65%	55%	50%
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	89%	84%	82%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	83%	73%	65%
Patients who reported YES, they would definitely recommend the hospital.	86%	78%	69%

Timely & Effective Care

Timely & Effective Care

These measures show how often hospitals provide care that research shows gets the best results for patients with certain conditions. This information can help you compare which hospitals give recommended care most often as part of the overall care they provide to patients.

- Heart Attack Care
- Heart Failure Care
- Pneumonia Care
- Surgical Care
- Emergency Department Care
- Children's Asthma Care
- Preventive Care

Heart Attack Care

An acute myocardial infarction (AMI), also called a heart attack, happens when one of the heart's arteries becomes blocked and the supply of blood and oxygen to part of the heart muscle is slowed or stopped. When the heart muscle doesn't get the oxygen and nutrients it needs, the affected heart

tissue may die. These measures show some of the standards of care provided, if appropriate, for most adults who have had a heart attack.

- More information about timely and effective care measures.
- Why heart attack care measures are important.
- Current data collection period.

Timely Heart Attack Care

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Average number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital *A **lower** number of minutes is better*	Too few cases	49 Minutes	53 Minutes [1]
Average number of minutes before outpatients with chest pain or possible heart attack got an ECG *A **lower** number of minutes is better*	10 Minutes	7 Minutes	9 Minutes
Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival ***Higher** percentages are better*	Not Available	Not Available	Not Available
Outpatients with chest pain or possible heart attack who got aspirin within 24 hours of arrival ***Higher** percentages are better*	98%	100%	98%
Heart attack patients given fibrinolytic medication within 30 minutes of arrival ***Higher** percentages are better*	Not Available	Not Available	Not Available

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Heart attack patients given PCI within 90 minutes of arrival ***Higher** percentages are better*	Not Available	Not Available	Not Available

Effective Heart Attack Care

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Heart attack patients given aspirin at discharge ***Higher** percentages are better*	100% [1]	Too few cases	99%
Heart attack patients given a prescription for a statin at discharge ***Higher** percentages are better*	100% [1]	Too few cases	82%

Heart Failure Care

Heart Failure is a weakening of the heart's pumping power. With heart failure, your body doesn't get enough oxygen and nutrients to meet its needs. These measures show some of the process of care provided for most adults with heart failure.

- More information about timely and effective care measures.
- Why heart failure care measures are important.
- Current data collection period.

Effective Heart Failure Care

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Heart failure patients given discharge instructions ***Higher** percentages are better*	99%	90%	77%
Heart failure patients given an evaluation of Left Ventricular Systolic (LVS) function ***Higher** percentages are better*	99%	99%	99%
Heart failure patients given ACE inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD) ***Higher** percentages are better*	96% [1]	100%	88%

Pneumonia Care

Pneumonia is a serious lung infection that causes difficulty breathing, fever, cough and fatigue. These measures show some of the recommended treatments for pneumonia.

- More information about timely and effective care measures.
- Why pneumonia care measures are important.
- Current data collection period.

Effective Pneumonia Care

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	Add to my Favorites Map and Directions	Map and Directions	Add to my Favorites Map and Directions
Pneumonia patients whose initial emergency room blood culture was performed prior to the administration of the first hospital dose of antibiotics ***Higher** percentages are better*	99%[2]	97%[2]	95%[2]
Pneumonia patients given the most appropriate initial antibiotic(s) ***Higher** percentages are better*	95%[2]	95%[2]	91%[2]

Surgical Care

Hospitals can reduce the risk of infection after surgery by making sure they provide care that's known to get the best results for most patients. Here are some examples:

- Giving the recommended antibiotics at the right time before surgery
- Stopping the antibiotics within the right timeframe after surgery
- Maintaining the patient's temperature and blood glucose (sugar) at normal levels
- Removing catheters that are used to drain the bladder in a timely manner after surgery.

Hospitals can also reduce the risk of cardiac problems associated with surgery by:

- Making sure that certain prescription drugs are continued in the time before, during, and just after the surgery. This includes drugs used to control heart rhythms and blood pressure.
- Giving drugs that prevent blood clots and using other methods such as special stockings that increase circulation in the legs.

- More information about timely and effective care measures.
- Why surgical care measures are important.
- Current data collection period.

Timely Surgical Care

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Outpatients having surgery who got an antibiotic at the right time (within one hour before surgery) ***Higher** percentages are better*	96%	97%	91%
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection ***Higher** percentages are better*	98% [2]	98%	95%
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery) ***Higher** percentages are better*	99% [2]	96%	95%
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery ***Higher** percentages are better*	96% [2]	94%	97%

Effective Surgical Care

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Outpatients having surgery who got the right kind of antibiotic	95%	97%	96%

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***Higher** percentages are better*			
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery ***Higher** percentages are better*	100% [2]	93%	94%
Surgery patients who were given the right kind of antibiotic to help prevent infection ***Higher** percentages are better*	100% [2]	98%	98%
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery ***Higher** percentages are better*	Not Available [2]	Not Available	Not Available
Surgery patients whose urinary catheters were removed on the first or second day after surgery ***Higher** percentages are better*	98% [2]	99%	89%
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery ***Higher** percentages are better*	100% [2]	100%	100%
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries ***Higher** percentages are better*	96% [2]	95%	98%

Emergency Department Care

Timely and effective care in hospital emergency departments is essential for good patient outcomes. Delays before receiving care in the emergency department can reduce the quality of care and increase risks and discomfort for patients with serious illnesses or injuries. Waiting times at different hospitals can vary widely, depending on the number of patients seen, staffing levels, efficiency, admitting procedures, or the availability of inpatient beds.

The information below shows how quickly the hospitals you selected treat patients who come to the hospital emergency department, compared to the average for all hospitals in the U. S.

- More information about timely and effective care measures.
- Why emergency department care measures are important.
- Current data collection period.

Timely Emergency Department Care

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NEW Average (median) time patients spent in the emergency department, before they were admitted to the hospital as an inpatient *A **lower** number of minutes is better*	293 Minutes[2]	282 Minutes	429 Minutes
NEW Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room *A **lower** number of minutes is better*	113 Minutes[2]	96 Minutes	262 Minutes
NEW Average time patients spent	138 Minutes	147 Minutes	153 Minutes

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in the emergency department before being sent home *A **lower** number of minutes is better*			
NEW Average time patients spent in the emergency department before they were seen by a healthcare professional *A **lower** number of minutes is better*	20 Minutes	54 Minutes	14 Minutes
NEW Average time patients who came to the emergency department with broken bones had to wait before receiving pain medication *A **lower** number of minutes is better*	56 Minutes [1]	48 Minutes [1]	66 Minutes
NEW Percentage of patients who left the emergency department before being seen ***Lower** percentages are better*	1%	3%	1%
NEW Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival ***Higher** percentages are better*	Too few cases	Too few cases	Too few cases

Preventive Care

Hospitals and other healthcare providers play a crucial role in promoting, providing and educating patients about preventive services and screenings and maintaining the health of their communities. Many diseases are preventable through immunizations, screenings, treatment, and lifestyle changes. The information below shows how well the hospitals you selected are providing preventive services.

- More information about timely and effective care measures.
- Why preventive care measures are important.
- Current data collection period.

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NEW Patients assessed and given influenza vaccination ***Higher** percentages are better*	92%[2]	95%	86%
NEW Patients assessed and given pneumonia vaccination ***Higher** percentages are better*	94%[2]	94%	91%

Children's Asthma Care

Asthma is a chronic lung condition that causes problems getting air in and out of the lungs. Children with asthma may experience wheezing, coughing, chest tightness and trouble breathing.

- More information about timely and effective care measures.
- Why children's asthma care measures are important.
- Current data collection period.

Effective Children's Asthma Care

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	Map and Directions		Map and Directions
Children who received reliever medication while hospitalized for asthma ***Higher** percentages are better*	Not Available	Not Available	Not Available
Children who received systemic corticosteroid medication (oral and IV medication that reduces inflammation and controls symptoms) while hospitalized for asthma ***Higher** percentages are better*	Not Available	Not Available	Not Available
Children and their caregivers who received a home management plan of care document while hospitalized for asthma ***Higher** percentages are better*	Not Available	Not Available	Not Available

[1] The number of cases is too small to reliably tell how well a hospital is performing.
[2] The hospital indicated that the data submitted for this measure were based on a sample of cases.

Readmissions , Complications & Deaths

Readmissions, Complications and Deaths

Patients who are admitted to the hospital for treatment of medical problems sometimes get other serious injuries, complications, or conditions, and may even die. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients.

30-Day Outcomes Readmission and Deaths

30-Day Readmission is when patients who have had a recent hospital stay need to go back into a hospital again within 30 days of their discharge. Below, the rates of readmission for each hospital are compared to the U.S. National Rate. The rates take into account how sick patients were before they were admitted to the hospital.

30-Day Mortality is when patients die within 30 days of their admission to a hospital. Below, the death rates for each hospital are compared to the U.S. National Rate. The rates take into account how sick patients were before they were admitted to the hospital.

- More information about Hospital Readmission and Mortality Measures.
- Current data collection period.

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Rate of readmission for heart attack patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Death rate for heart attack patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Rate of readmission for heart failure patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Death rate for heart failure patients	Worse than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Rate of readmission for pneumonia patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Death rate for pneumonia patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate

Serious Complications and Deaths

This section shows serious complications that patients with Original Medicare experienced during a hospital stay, and how often patients who were admitted with certain conditions died while they were in the hospital. These complications and deaths can often be prevented if hospitals follow procedures based on best practices and scientific evidence.

- Why Serious Complications and Death Measures are Important.
- Current data collection period.

Results for the following 4 measures are suppressed due to a software issue:
- Death after surgery to repair weakness in the abdominal aorta
- Deaths after admission for a broken hip
- Deaths for certain conditions
- Breathing failure after surgery (except performance categories)

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Serious complications This is a 'composite' or summary measure.	No Different than U.S. National Rate Get Results for this Hospital	No Different than U.S. National Rate Get Results for this Hospital	No Different than U.S. National Rate Get Results for this Hospital
Deaths for certain conditions This is a 'composite' or summary measure.	Not Available [4]	Not Available [4]	Not Available [4]
Other complications and deaths	Get Results for this Hospital	Get Results for this Hospital	Get Results for this Hospital

Hospital-Acquired Conditions

This section shows certain injuries, infections, or other serious conditions that patients with Original Medicare got while they were in the hospital. These conditions, also known as "Hospital Acquired Conditions," are usually very rare. If they ever occur, hospital staff should identify and correct the problems that caused them.

Please note that the numbers shown here do not take into account the different kinds of patients treated at different hospitals. For this reason, they should not be used to compare one hospital to another.

- Why Hospital Acquired Conditions measures are important.
- Current data collection period.

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Hospital-acquired conditions	Get Results for this Hospital	Get Results for this Hospital	Get Results for this Hospital

Healthcare-Associated Infections

Healthcare Associated Infections are reported using a Standardized Infection Ratio (SIR). This calculation compares the number of Central Line Associated Bloodstream Infections (CLABSI) in a hospital intensive care unit or Surgical Site Infections (SSI) from operative procedures performed in a hospital to a national benchmark based on data reported to NHSN from 2006 – 2008. Scores for Catheter Associated Urinary Tract Infections (CAUTI) are compared to a national benchmark based on data reported to NHSN in 2009. The results are adjusted based on certain factors such as the type and size of a hospital or ICU for CLABSI and CAUTI, and based on certain factors related to the patient and surgery that was conducted for SSI. Each hospital's SIR is shown in the graph view.

- A score's confidence interval that is less than 1 means that the hospital had fewer infections than hospitals of similar type and size.
- A score's confidence interval that includes 1 means that the hospital's infections score was no different than hospitals of similar type and size.
- A score's confidence interval that is more than 1 means that the hospital had more infections than hospitals of similar type and size.

- Why Healthcare Associated Infections (HAIs) measures are important.
- Current data collection period.

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Central Line Associated Bloodstream Infections (CLABSI) ***Lower** numbers are better. A score of zero (0) - meaning no CLABSIs - is best.*	Not Available	No different than the U.S. National Benchmark	No different than the U.S. National Benchmark

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NEW Catheter Associated Urinary Tract Infections (CAUTI) ***Lower** numbers are better. A score of zero (0) - meaning no CAUTIs - is best.*	Not Available	Not Available	No different than the U.S. National Benchmark
NEW Surgical Site Infections from colon surgery (SSI: Colon) ***Lower** numbers are better. A score of zero (0) - meaning no SSIs - is best.*	Not Available	Not Available	Not Available
NEW Surgical Site Infections from abdominal hysterectomy (SSI: Hysterectomy) ***Lower** numbers are better. A score of zero (0) - meaning no SSIs - is best.*	Not Available	Not Available	Not Available

[4] Suppressed for one or more quarters by CMS.

Use of Medical Imaging

Use of Medical Imaging

Use of Medical Imaging (tests like Mammograms, MRIs, and CT scans)
These measures give you information about hospitals' use of medical imaging tests for outpatients based on the following:

- Protecting patients' safety, such as keeping patients' exposure to radiation and other risks as low as possible.
- Following up properly when screening tests such as mammograms show a possible problem.
- Avoiding the risk, stress, and cost of doing imaging tests that patients may not need.

The information shown here is limited to medical imaging facilities that are part of a hospital or associated with a hospital. These facilities can be inside or near the hospital, or in a different location. This information only includes medical imaging done on outpatients. Medical imaging tests done for

patients who have been admitted to the hospital as inpatients aren't included. These measures are based on Medicare claims data.

- Why the Use of Medical Imaging measures are important.
- Current data collection period.

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Outpatients with low back pain who had an MRI without trying recommended treatments first, such as physical therapy. (If a number is high, it may mean the facility is doing too many unnecessary MRIs for low back pain.) ***Lower** percentages are better*	41.3%	42.2%	40%
Outpatients who had a follow-up mammogram or ultrasound within 45 days after a screening mammogram. (A number that is much lower than 8% may mean there's not enough follow-up. A number much higher than 14% may mean there's too much unnecessary follow-up.) *Percentages **between 8 percent and 14 percent** are better*	9.9%	5.3%	9.6%
Outpatient CT scans of the chest that were "combination" (double) scans. (The range for this measure is 0 to 1. A number very close to 1 may mean that too many patients are being given a double scan when a single scan is all they need.) *Numbers **closer to zero** are better*	0.05	0.066	0.034
Outpatient CT scans of the abdomen that were "combination" (double) scans. (The range for this	0.119	0.06	0.08

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measure is 0 to 1. A number very close to 1 may mean that too many patients are being given a double scan when a single scan is all they need.) *Numbers **closer to zero** are better*			
Outpatients who got cardiac imaging stress tests before low-risk outpatient surgery. ***Lower** percentages are better*	Not Available [1]	3.1%	5.7%
Outpatients with brain CT scans who got a sinus CT scan at the same time. ***Lower** percentages are better*	2.4%	3.2%	4.9%

[1] The number of cases is too small to reliably tell how well a hospital is performing.

Medicare Payment

Spending per hospital patient with Medicare

The "Spending per Hospital Patient with Medicare" measure shows whether Medicare spends more, less or about the same per Medicare patient treated in a specific hospital, compared to how much Medicare spends per patient nationally. This measure includes any Medicare Part A and Part B payments made for services provided to a patient during the 3 days prior to the hospital stay, during the stay, and during the 30 days after discharge from the hospital.

This result is a ratio calculated by dividing the amount Medicare spends per patient for an episode of care initiated at this hospital by the median (or middle) amount Medicare spent per patient nationally.

A result of 1 means that Medicare spends ABOUT THE SAME amount per patient for an episode of care initiated at this hospital as it does per hospital patient nationally.

A result that is more than 1 means that Medicare spends MORE per patient for an episode of care initiated at this hospital than it does per hospital patient nationally.

A result that is less than 1 means that Medicare spends LESS per patient for an episode of care initiated at this hospital than it does per hospital patient nationally.

Lower numbers are better.

- More about Spending per Hospital Patient with Medicare.
- Current data collection period.

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Spending per hospital patient with Medicare	Get Results for this Hospital	Get Results for this Hospital	Get Results for this Hospital

Number of Medicare Patients

Medical Patients Search

Select a Medical Condition or Surgical Procedure and update your results.

Medical Conditions

Surgical Procedures

Update Results

Number of Medicare patients treated

This shows the number of Medicare patients with a certain condition (MS-DRG) that a hospital treated during the current data collection period. These data are based on the number of Medicare patients that were discharged with a certain condition. They do not include patients in Medicare Health Plans.

'CC' refers to complications or comorbidities. 'MCC' refers to major complications or comorbidities.

- More information about Number of Medicare Patients Treated.
- Current data collection period.

	SOUTH COUNTY HOSPITAL INC	NEWPORT HOSPITAL	KENT COUNTY MEMORIAL

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To view Medicare Payment and Volume data, you must select a Medical Condition or Surgical Procedure in the Medical Patients Search and update your results.

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Data Last Updated: February 1, 2013

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APPENDIX "D"

Amended Decision of the Director of Health Regarding The Westerly Hospital's Plan to Eliminate Obstetric Labor and Delivery Services at The Westerly Hospital

Michael Fine, MD, Director

Department of Health
Three Capitol Hill
Providence, RI 02908-5097

TTY: 711
www.health.ri.gov

VIA ELECTRONIC MAIL

16 April 2013

W. Mark Russo, Esq.
Ferrucci Russo, P.C.
55 Pine Street, 4th Floor
Providence, RI 02903

Dear Mr. Russo:

This is in response to The Westerly Hospital's plan to eliminate obstetric labor and delivery services at The Westerly Hospital (hereinafter also known as "the Plan") submitted by The Westerly Hospital.

Pursuant to Section 10.0 of the *Rules and Regulations Pertaining to Hospital Conversions* (R23-17.14-HCA), the Department has reviewed the Plan and hereby approves the Plan with conditions. Please find attached the amended decision[1].

Please contact Valentina Adamova at (401) 222-2788, if you have any questions.

Sincerely,

Michael Fine, MD
Director of Health

cc: Patricia K. Rocha, Esq.

[1] This amended decision replaces in total the initial decision dated April 15, 2013, which herein is amended by removing from said decision one of the conditions of approval and making several ministerial changes. No other substantive changes are included in this amended decision.

AMENDED DECISION OF THE DIRECTOR OF HEALTH REGARDING THE WESTERLY HOSPITAL'S PLAN TO ELIMINATE OBSTETRIC LABOR AND DELIVERY SERVICES AT THE WESTERLY HOSPITAL

BACKGROUND

The Westerly Hospital, Inc., whose parent entity is Westerly Hospital Healthcare, Inc., is a not-for-profit hospital located at 25 Wells Street in Westerly, Rhode Island. The Westerly Hospital has a licensed capacity of 125 beds. In 2011 The Westerly Hospital sought protection and the Court appointed a Special Master to manage The Westerly Hospital. The Westerly Hospital is currently undergoing regulatory reviews[2] in order to be acquired by Lawrence + Memorial Corporation of New London, Connecticut.

The instant proposal is for The Westerly Hospital to eliminate obstetric labor and delivery services on and after June 1, 2013. Only labor and deliveries are proposed to be eliminated; all prenatal/perinatal programs at The Westerly Hospital will remain in place. The Westerly Hospital has offered labor and delivery services since 1925. The Westerly Hospital's primary service area includes Westerly, Rhode Island; Hopkinton, Rhode Island; and Stonington, Connecticut.

The Westerly Hospital represented that it is unable to continue to offer obstetric labor and delivery services past June 1, 2013 because it will lack coverage by physicians privileged and credentialed to provide obstetric labor and delivery services after this date. The Special Master represented that he explored different options with regard to maintaining this service at The Westerly Hospital but the existing providers were not able or willing to maintain call coverage beyond June 1, 2013. The Westerly Hospital also represented that it would not have sufficient pediatric physician coverage necessary to serve these newborns. In October 2012, the pediatricians providing call coverage for The Westerly Hospital obstetricians notified the Special Master that a plan had to be in place by December 31, 2012 to address their issues; otherwise, these pediatricians would discontinue call coverage on December 31, 2012. Because such a plan was developed, pediatric coverage is in place until June 1, 2013.

REVIEW PROCESS

Pursuant to Section 10.1 [Elimination or Reduction in Emergency Department and Primary Care Services] of the *Rules and Regulations Pertaining to Hospital Conversions* (R23-17.14-HCA)[3] ("Hospital Conversions Regulations"), "*No hospital emergency department or primary care services which existed for at least one (1) year and which significantly serve uninsured or underinsured individuals shall be eliminated or significantly reduced without the prior approval of the Director in accordance with section 23-17.14-18 of the Rhode Island General Laws, as amended.*"

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[2] Hospital Conversion (R23-17.14-HCA) and Change in Effective Control (R23-17-HOSP) reviews

[3] See: *Rules and Regulations Pertaining to Hospital Conversions* promulgated by the Department of Health. Last amended January 2007. Available online at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/4378.pdf

In accordance with Section 10.1.2 of the Hospital Conversions Regulations, the following information must be submitted:

a) a description of the services to be reduced or eliminated;

b) the proposed change in hours of operation, if any;

c) the proposed changes in staffing, if any;

d) the documented length of time the services to be reduced or eliminated have been available at the facility;

e) the number of patients utilizing those services that are to be reduced or eliminated annually during the most recent three (3) years;

f) aggregate data delineating the insurance status of the individuals served by the facility during the most recent three (3) years;

g) data describing the insurance status of those individuals utilizing those services that are to be reduced or eliminated annually during the most recent three (3) years;

h) the geographical area for which the facility provides services;

i) identification and description, including supporting data and statistical analyses, of the impact of the proposed elimination or reduction on:

1) access to health care services for traditionally underserved populations, including but not limited to, Medicaid, uninsured and underinsured patients, and racial and ethnic minority populations;

2) the delivery of such services on the affected community: emergency and/or primary care in the cities and towns whose residents are regularly served by the hospital (the "affected" cities and towns);

3) other licensed hospitals or health care providers in the affected community or cities and towns; and,

4) other licensed hospitals or health care providers in the state; and,

j) such other information as the Director deems necessary.

Based upon the information contained in the Plan, in accordance with Section 10.1.3 of the Hospital Conversions Regulations, the Director shall determine based upon the public interest in light of attend circumstances whether the services affected by the proposed elimination significantly serve uninsured and/or underinsured individuals.

On January 24, 2013, the Plan was submitted to the Department of Health. The Plan was reviewed and, after corrections of deficiencies, found it to be acceptable in form. On March 6, 2013, in accordance with Section 10.1.4 of the Hospital Conversions Regulations, the Department of Health ("Department") notified The Westerly Hospital and the public that the

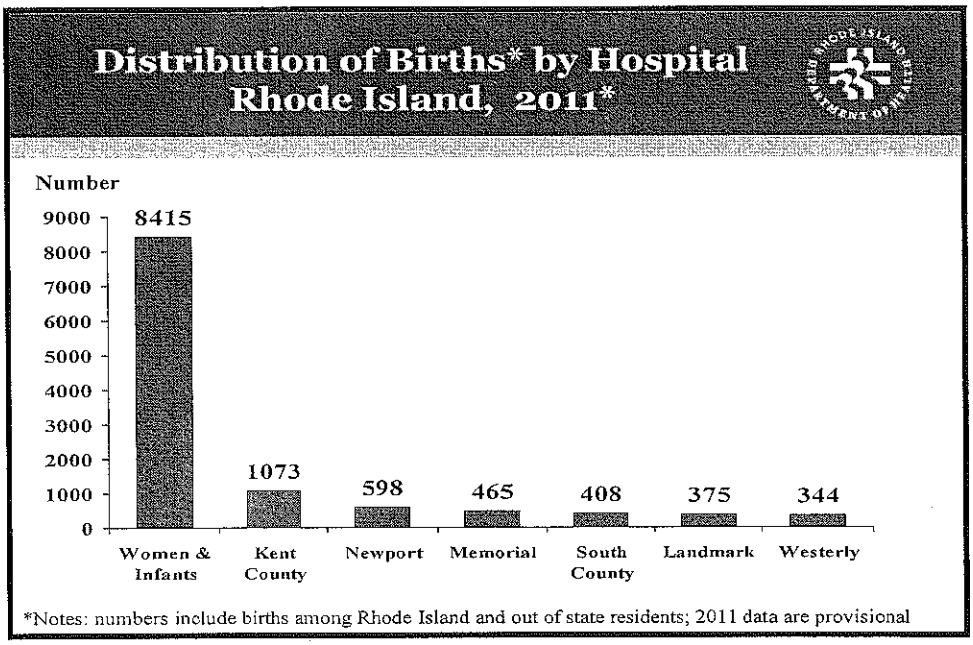
Plan was accepted for review. Section 10.1.4 of the Hospital Conversions Regulations further provides that "*.....the Director shall have the sole authority to review all plans submitted under this section...*" The decision of the Director of Health shall be issued within 90 days of the receipt of a completed Plan and a comment period may be provided.

Opportunity to provide comments was offered in the form of two public meetings[4] and submission of written comments by March 20, 2013. At the public meeting on March 19, 2013, a total of three persons spoke in opposition to the Plan. At the public meeting on March, 20, 2013, there were no public comments offered. The written comment period was subsequently extended to March 27, 2013. One-hundred and twelve (112) written comments were submitted to the Department. The written comments were in opposition to the Plan.

CONSIDERATION

Volume and Outcomes

According to information provided in the Plan, the number of patients who have utilized the labor and delivery services at The Westerly Hospital has been consistent over the past three years: 2010 - 324 patients, 2011 – 339 patients, and 2012 – 334 patients. Other Rhode Island community hospitals, such as Landmark Medical Center, and South County Hospital, as shown below based on 2011 data, offer labor and deliver services at comparable birthing levels to that of The Westerly Hospital [source: Center for Health Data and Analysis, Rhode Island Department of Health].



As shown below based on 2011 data, 79% of Westerly residents who gave birth did so at The Westerly Hospital [source: Center for Health Data and Analysis, Rhode Island Department of

[4] March 19, 2013 at The Westerly Hospital and March 20, 2013 at Rhode Island Department of Health

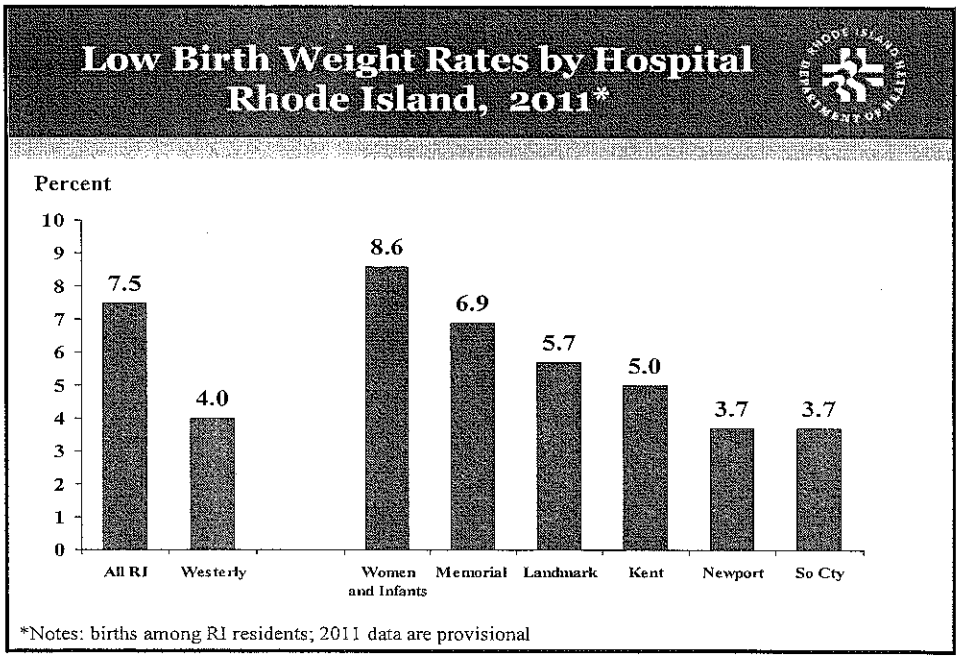
Health]. The low volume at The Westerly Hospital may be more of a reflection of the declining birth rates in general rather than birthing location preferences of the surrounding communities.

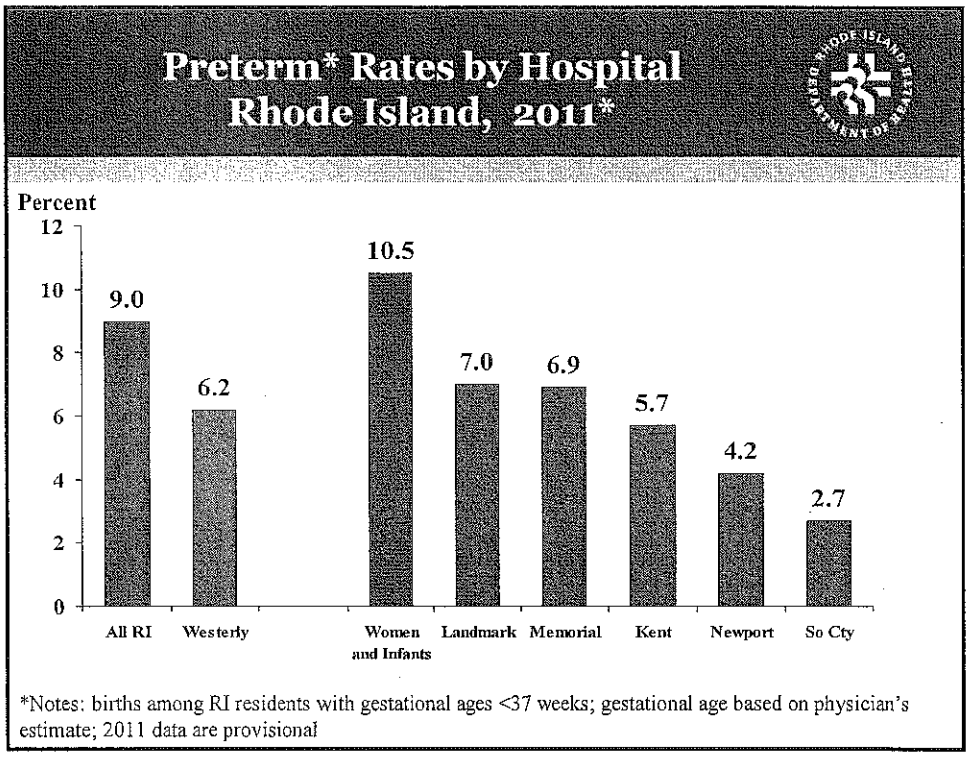
Distribution of Births Among Westerly Residents Rhode Island, 2011*

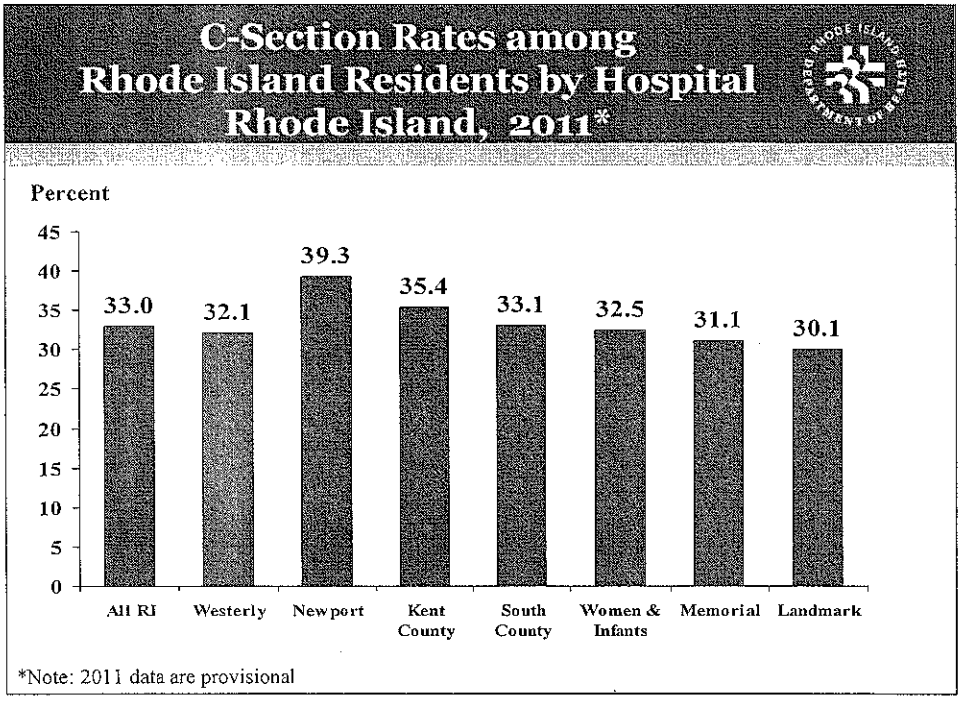
Hospital	Number	Percent
Westerly	156	78.8
WIH	17	8.6
South County	16	8.1
Kent	1	0.5
Memorial	1	0.5
Out of State	7	3.5
Total	198	100.0

*Note: 2011 data are provisional

In fact, The Westerly Hospital compares favorably to other hospitals in Rhode Island with regards to birth outcomes for low birth weight and preterm. As shown below for 2011, it was below the state average for both of those metrics. Data also reveals that the labor and delivery unit at the Westerly Hospital has the third lowest Caesarian section rate of the seven birthing hospitals in Rhode Island [source: Center for Health Data and Analysis, Rhode Island Department of Health]. There has been no information submitted in the Plan to indicate that the lower volume of births at The Westerly Hospital has any impact on the quality of its services.







Traditionally Underserved

As it relates to access to health care for the traditionally underserved patients, the Department reviewed both insurance status and racial/ethnic population data provided by The Westerly Hospital.

In calendar years 2010-2012, of a total of 1,004 births at The Westerly Hospital, 93% were among Caucasian women, while 2% of deliveries were to Asian women and only 1% of births were among African-American women. In the same time period, 95% of births were identified as being "not Hispanic or Latino" and only 2% were of Hispanic or Latino origin. The births by Rhode Island residents at The Westerly Hospital are not reflective of a diverse racial/ethnic population.

The Department also reviewed patient insurance status for the calendar years 2010, 2011, and 2012. In the aggregate, approximately 26 percent of The Westerly Hospital's obstetric labor and delivery patients were either enrolled in RI Medicaid, CT Medicaid or Medicaid HMO (including RIte Care). Accordingly, these services at The Westerly Hospital are significantly utilized by the traditionally underserved population based on insurance status.

Access

The two neighboring hospitals, South County Hospital (19 miles away) and Lawrence + Memorial Hospital (20 miles away) have overlapping services areas with those of The Westerly Hospital. Additionally, 98% of The Westerly Hospital's patients reside within 25 miles of each of these hospitals (remaining 2% were visitors to the area). Further, South County Hospital and Lawrence + Memorial Hospital provided letters of support and assurances that additional volume from The Westerly Hospital could be accommodated at their facilities (attached).

Specifically, South County Hospital stated that with approximately 300 to 325 births and deliveries projected for 2013 and 2014 for The Westerly Hospital it would have sufficient providers and call coverage to deliver proper care. Further, Lawrence + Memorial Hospital represented that up to 85% (256) of The Westerly Hospital patients could be accommodated at its hospital and further estimated that it is more likely that only 25%-50% (88-175) of The Westerly Hospital patients would be served there.

Labor and delivery services are also provided at six other hospitals in Rhode Island. They are Kent Hospital, Landmark Medical Center, Memorial Hospital, Newport Hospital, South County Hospital and Women & Infants Hospital. Based upon the support and assurances as shown in the letters submitted by South County Hospital and Lawrence + Memorial Hospital, it is unlikely that other Rhode Island hospitals should experience an influx of patients that could not be accommodated.

Provision for Emergency Transfer

As part of the Plan, The Westerly Hospital has developed draft protocols and transfer agreements, for the stabilization and expeditious transfer of obstetric patients to both hospitals (i.e., South County Hospital and Lawrence + Memorial Hospitals). This transfer plan will be tested by The Westerly Hospital in a mock drill on or about April 15, 2013. For those women who arrive at The Westerly Hospital and must deliver emergently and are not high-risk, equipment and supplies will be in place for The Westerly Hospital emergency department staff to deliver such newborns.

Additionally, The Westerly Hospital has developed an "EMS Communication Plan for Discontinuation of Labor and Delivery Services at Westerly Hospital" for notifying the first responder community.

The Women's Health Center

It should further be noted that The Westerly Hospital will continue to provide an array of many other women's health services, including: lactation consulting, prenatal stress testing, child birth education, gynecological surgery, prenatal and perinatal care, imaging, general gynecology, and women's gastroenterology services.

The Westerly Hospital reports that there are no immediate changes planned in the staffing patterns at its Women Health Services after June 1, 2013, which are shown below:

	Day Shift	Evening Shift
Registered Nurse	4.6	4.7
Unit Coordinator	1.8	0.7
Nurse Manager	1.1	
Total	7.5	5.4

POLICY AND POWERS

In order to fully inform the Department's decision-making under the authority granted under R.I.G.L. 23-17.14-18 and 23-1-1 and as delineated in Section 10.1.2 of the Hospital Conversions Regulations, the Director relies on the authority provided in section 23-1-1, including:

> *"take cognizance of the interests of life and health among the peoples of the state....[to] make investigations into the causes of disease,....the sources of mortality, the effect of localities, employments and all other conditions and circumstances on the public health, and do all in its power to ascertain the causes and the best means for the prevention and control of diseases or conditions detrimental to the public health, and adopt proper and expedient measures to prevent and control diseases and conditions detrimental to the public health in the state."*[5]

The Department received over 100 comments in opposition to the Plan to terminate labor and delivery services at The Westerly Hospital on or about June 1, 2013. For the Department, these statements triggered two broad policy questions:

- What childbirth settings produce the best labor and delivery outcomes?; and
- What labor and delivery services are optimally provided in the town of Westerly?

The medical literature does not effectively answer the question about the most optimal location for maternity care[6]. While some medical interventions have been shown to have the best

[5] See RIGL section 23-1-1. Available online: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-1/23-1-1.HTM
[6] Snowden, J. M, PhD; Cheng, Y. W., MD, PhD; Kontgis, C. P., MS; Caughey, A. B., MS, PhD. (2012) The association between hospital obstetric volume and perinatal outcomes in California. American Journal of Obstetrics & Gynecology, December 2012;207:478.e1-7

outcomes in high volume settings, maternity care has not been clearly shown to demonstrate such a relationship. There is consensus that high risk pregnancies, those in which the mother has underlying medical illness or a history of premature labor, for example, should be delivered in high volume institutions, with quick access to on-site anesthesiology, pediatric support, and a neonatal intensive care unit[7].

There is not consensus, however, about the best way to manage low-risk or normal deliveries. Some providers would argue that all deliveries are best managed at high volume institutions, since no pregnancy is truly low risk. Other providers believe that normal deliveries are best managed in community hospitals, with the laboring mother surrounded by family and community in a setting that supports her, without or at least with less intrusive technology[8].

A single recent study compared the risk of asphyxia between high volume and lower volume and rural maternity hospitals in California, in a population that is greater than 40 percent Hispanic, and thus possibly different from the population of Westerly. While this study found the risk of asxphyxia to be greater in low volume than higher volume hospitals, it found the risk of neonatal death to be the same, and it did not evaluate caesarian section rate, premature delivery rate, maternal morbidity or maternal mortality, and the study authors did not recommend closing low volume maternity units those than those in urban high obstetric density areas; instead the authors recommended that lower volume rural units "*focus on equipping these hospitals with the staff, training, and other resources needed to provide high-quality obstetric care in the absence of high patient volume*[9]."

Data reveal that the labor and delivery unit at The Westerly Hospital has the third lowest Caesarian section rate of the seven birthing hospitals in Rhode Island at 32.1% of all deliveries, behind Landmark Medical Center (30.1%) and Memorial Hospital of Rhode Island (31.1%). Using metrics that are typically applied to maternity care labor and delivery services at The Westerly Hospital are not so much better than similar units elsewhere in the state that the unit needs to be preserved because of the unusually positive character of its outcomes, unavailable to women from Westerly elsewhere in Rhode Island. On the other hand, there has been no medical or public health evidence presented to suggest there is additional risk to the women and children of Westerly, should the labor and delivery unit be closed.

The issue of what services should be available at The Westerly Hospital (or at any Rhode Island community hospital) is thus difficult to decide based on public health science. With few exceptions, decisions about hospital services are usually economic decisions made by communities, and not public health decisions. As noted above, there is no medical or public health evidence showing either risk to the public's health should the labor and delivery unit at The Westerly Hospital be closed, or risk to the public's health should the unit remain open. But the absence of evidence showing risk can never be taken to mean that risk is absent, and the Department acknowledges that while there may be an unmeasurable risk to closing the unit, that risk is likely smaller than the risk to the community of closing The Westerly Hospital altogether.

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[7] Illuzzi J. L., Lundsberg, L. S., Bracken M. B. (2012) Hospital volume, provider volume, and complications after childbirth in U.S. hospitals. American Journal of Obstetrics & Gynecology, February 2012;119(2 Pt 1):379

[8] Deutchman, Mark, MD (2001) Cesarean Delivery and Hospitals: Size Matters. The Journal of Family Practice, Vol. 50, No. 3

[9] LeFevre, M., Sanner, L., Anderson, S., Tsutakawa, R. (1992) The Relationship Between Neonatal Mortality and Hospital Level. The Journal of Family Practice

On one hand, Rhode Island communities have chosen their hospital services for decades, even centuries. The Westerly Hospital, and a number of other Rhode Island hospitals, were started by public subscription so that the Westerly community could take care of its own citizens. The public testimony in this matter makes it clear that the labor and delivery unit at The Westerly Hospital is a source of great community pride. An emerging body of knowledge suggests that there is an association between social capital, or the extent to which people in communities are interconnected and trust each another, and classic public health outcomes, such as longevity and infant mortality[10].

One the other hand, the comment from the Westerly Hospital Area Residents Committee contains much wisdom. The Westerly Hospital Area Residents Committee reflected their disappointment regarding the Plan but nevertheless supported the acquisition by Lawrence + Memorial Corporation of The Westerly Hospital without these services. Such comment is informed, as maternity care is expensive, and difficult to maintain in a small hospital, with a small medical staff. The better staffing, better training and more resources than may well be necessary to further improve birth outcomes will be more expensive yet. Over the years, more resources have been dedicated and will have to be dedicated to routine maternity care, in response to the rising expectations of all Rhode Islanders, and because of the cost of new technologies. Some communities deeply committed to being places in which people take care of one another, will choose to bear that cost. Other communities may make a different, but also reasonable choice.

The health care system in Rhode Island is transitioning from one in which there are excess hospital beds, to a system with more robust community health services and facilities. Some change is inevitable, and is the healthy evolution of a health care system that is putting science, technology, prevention, and primary care to best use. Westerly is wise to understand these changes, to anticipate them, and make best use of these new opportunities.

The evidence in this matter suggests that labor and delivery services are now provided safely at The Westerly Hospital, but also can be provided safely elsewhere in the region to women in The Westerly Hospital service area. It may not be the same for Westerly woman to deliver elsewhere. The Westerly Hospital will not be the same without its treasured obstetric unit. But, with the support of a competent and committed purchaser, The Westerly Hospital will continue to exist, and will continue to serve, and ennoble, its community.

AMENDED DECISION WITH CONDITIONS

The Department has examined the Plan and provided due consideration of the record and the public interest in light of attendant circumstances. Accordingly, the Director of Health hereby approves the plan of The Westerly Hospital to eliminate obstetric labor and delivery services at The Westerly Hospital on or about June 1, 2013, subject to the conditions noted below.

[10] Yang, T., Teng, H., Haran, M. (2009) The Impact of Social Capital on Infant Mortality in the U.S.: A Spatial Investigation.. Springer Science + Business Media, 24 June 2009

1. The Westerly Hospital shall implement the provisions of its "Application for Approval from the Director of the Rhode Island Department of Health for the Elimination of Obstetric Labor and Delivery Services at The Westerly Hospital" as detailed in such application and as approved by the Director of Health.

2. Any material amendments (as determined by the Director of Health) to the "Application for Approval from the Director of the Rhode Island Department of Health for the Elimination of Obstetric Labor and Delivery Services at The Westerly Hospital" shall be submitted to and approved by the Director of Health prior to implementation.

3. The Westerly Hospital shall maintain a robust prenatal / perinatal program with all of the women's health services that were in place on June 1, 2013, including but not limited to: lactation consulting, prenatal stress testing, child birth education, gynecological surgery, imaging, general gynecology, and women's gastroenterology services for a period of at least two (2) years from the date of this amended decision.

4. Prior to June 1, 2013, The Westerly Hospital shall execute written protocols and transfer agreements for the stabilization and expeditious transfer of obstetric patients to South County Hospital and Lawrence + Memorial Hospitals and these protocols and agreements shall be submitted to the Department.

The conditions set forth above shall be enforceable and have the same force and effect as if imposed as a condition of licensure, in accordance with RIGL 23-17 RIGL. Additionally, in accordance with RIGL 23-17.14-30, the Director of the Department of Health may take appropriate action to enforce compliance with these conditions.

This amended Decision with conditions shall be applicable to all successor(s) of The Westerly Hospital.

RHODE ISLAND DEPARTMENT OF HEALTH

Michael Fine, MD
Director of Health

4/16/2013
Date