

**STATE OF RHODE ISLAND
DEPARTMENT OF HEALTH**

**THE WESTERLY HOSPITAL
IN MASTERSHIP**

**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 – (JUSTICE BRIAN P. STERN)

**SUPPLEMENTAL 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**

Introduction

W. Mark Russo, Esq., in his capacity as the Special Master (“Special Master”) for The Westerly Hospital (“Westerly Hospital”), pursuant to Rhode Island General Law § 23-17.14-18 and Section 10 of the Rhode Island Department of Health’s Rules and Regulations Pertaining to Hospital Conversions (the “Rules and Regulations”), hereby requests approval from the Director of the Rhode Island Department of Health to eliminate obstetric labor and delivery services at Westerly Hospital as of June 1, 2013. The Special Master proposes such date for the elimination of obstetric labor and delivery services at Westerly Hospital because Westerly Hospital will lack coverage by physicians privileged and credentialed to provide obstetric labor and delivery services at Westerly Hospital after such date. In support thereof, the Special Master submits the following Plan pursuant to Section 10.1.2 of the Rules and Regulations.

Background

From the outset of appointment in December of 2011, the Mastership struggled with the issue of maintaining obstetric labor and delivery services at Westerly Hospital. The Mastership was able to trim overhead expenses and maintain that service during the Mastership Sale Process. The Mastership did so by releasing two (2) Westerly Hospital employed providers and contracting for call coverage with private obstetricians. However, the demographics in the Westerly Hospital service area are such that the historical labor and delivery service is simply not sustainable on a going forward basis. Moreover, due to expected change in work styles that would result from reduced number of obstetricians, it became impossible to recruit new providers to Westerly Hospital, where providers are expected to be on call more than one night a week.

Soon after the Court approved the Asset Purchase Agreement with LMW Healthcare, Inc. and LMW Physicians, Inc. (along with Lawrence + Memorial Hospital, collectively referred to as “L+M”), on September 10, 2012, the obstetric and pediatric health care providers in Westerly Hospital’s service area requested that the Mastership address the issue that the historical labor and delivery service was simply not sustainable. The first effort made by the Mastership was to recruit additional providers in the aftermath of the Court-approved Asset Purchase Agreement. Recruiting efforts were undertaken by the Westerly Hospital’s Chief Medical Officer (“CMO”). The CMO did not have success simply because of the demographics in Westerly Hospital’s primary service area and the call coverage requirements. At or about this time, an OB/GYN physician employed by Westerly Hospital resigned.

The CMO then convened a “Solutions Committee” which consisted of health care providers, nurse managers and representatives of the Court-approved buyer, L+M. The Solutions Committee quickly came to the conclusion that there were no easy answers. In fact, the Mastership’s review of the issue shows that Westerly Hospital’s administration had been wrestling with the issue for at least two (2) years prior to the inception of the Mastership. Therefore, the Mastership engaged a nationally recognized obstetric service administrator, Dr. Louis Weinstein. Dr. Weinstein’s *curriculum vitae* is attached hereto as **Tab A**. Dr. Weinstein reviewed historical data, made site visits to Westerly Hospital, and then conferred with the Mastership regarding options to transition labor and delivery service at Westerly Hospital while exploring some options to maintain labor and delivery in some manner. Dr. Weinstein referred to this as maintaining an “obstetric presence”.

As a result of Dr. Weinstein's work, the Mastership drafted an 18 page report, in conjunction with Dr. Weinstein, which is attached hereto as **Tab B¹**. The sum and substance of that report was to try and stabilize provider coverage for labor and delivery for one (1) year while Westerly Hospital and L+M could explore other options to maintain an obstetrics presence at Westerly Hospital. Unfortunately, and by no fault of theirs, the existing community providers were not able to maintain current coverage for one (1) year. Rather, they were able to commit to maintain coverage up to June 1, 2013.

The Mastership then explored other coverage options with private obstetricians who work in the primary and secondary service area of L+M. Those efforts were unsuccessful, as well. Therefore, without the prospect of recruiting additional providers, Westerly Hospital will not be able to provide obstetric labor and delivery services after June 1, 2013. Accordingly, the Mastership held special meetings with the Medical Executive Committee and informed them of the situation. The Mastership has had all employee meetings which we refer to as "Town Hall Meetings", to be available to answer questions in this regard. The Mastership has met with OB staff. Furthermore, the Mastership held a public forum on January 24, 2013, to answer questions from the community related to the cessation of obstetric labor and delivery services at Westerly Hospital. In turn, the Mastership reported to the Superior Court on an *ex parte* basis and is now furnishing the Court and parties in the Mastership proceeding with a report and seeks approval from the Director to terminate such services.

¹ To be clear, the Plan at Tab B never came into force and effect. Furthermore, it is no longer a plan under which the Special Mastership intends to proceed. The plan was merely attached to give historical reference in this matter. Although, it was the original hope of the Mastership to keep obstetric labor and delivery services in place until December 31, 2013, via the plan attached at Tab B, the Westerly Hospital does not have OB providers or pediatric coverage to keep the service in place past June 1, 2013. Therefore, to clarify, the Westerly Hospital will not be able to provide obstetric labor and delivery services after June 1, 2013, and the Special Master does not propose to move forward with the contents contained in Tab B.

I. A Description of the Services to be Eliminated – Rules and Regulations § 10.1.2(a)

The services that are proposed to be eliminated at Westerly Hospital are obstetric labor and delivery services. Westerly Hospital will maintain a robust prenatal and perinatal program along with significant additional women's health services that include lactation consulting, prenatal stress testing, child birth education, gynecological surgery, imaging, general gynecology, and women's gastroenterology services. Moreover, L+M intends to undertake a process to explore adding additional women's health services at Westerly Hospital such as gynecological oncology, breast health, urogynecology, women's heart health, and fertility services. The Mastership understands that this process is beginning with L+M undertaking interviews and focus groups that will include a focus on women's health service offerings. Said program is detailed as follows:

- in-depth interviews with key staff and stakeholders at both Westerly and L+M,
- patient focus groups to be held with existing and/or previous patients of Westerly Hospital,
- target patient focus groups that will be held with regional/local patients who have never visited Westerly Hospital to explore their barriers for seeking treatment at Westerly Hospital.

II. Proposed Changes in Hours of Operation – Rules and Regulations § 10.1.2(b)

Obstetric labor and delivery services are currently offered at Westerly Hospital 24 hours a day/7 days a week. The service is proposed to be eliminated.

III. Proposed Changes in Staffing – Rules and Regulations § 10.1.2(c)

A. Staffing Changes Prior to June 1, 2013

During the Mastership, two “employed” providers were released. They were an obstetric physician and a midwife. The obstetric physician, Karen McGoldrick, M.D. was released on March 9, 2012. The midwife, Susan Minnehan was released also on March 9, 2012. They were released because the Mastership could not continue to fund their presence at the Westerly Hospital. Quite simply, the Mastership had to reduce its overhead or the Mastership would not have been able to continue with obstetric labor and delivery as of March of 2012.

Once the Mastership released those staff members, the Mastership entered into a call coverage contract with Dr. Francis Mayeda of New London, Connecticut. Therefore, the Mastership was able to maintain the one-in-four coverage for the service area at the Westerly Hospital. The doctors providing coverage at that time were Dr. Andrew Neuhauser, Dr. Robert Greenlee, Dr. Francis Mayeda, and Dr. Minu Rowther.

On or about September 7, 2012, Dr. Rowther announced that she was leaving employment with the Atlantic Medical Group to take a job with Bristol Hospital in Connecticut. However, the Mastership was able to negotiate a call coverage contract with Dr. Rowther, which allows the Mastership to continue to maintain one-in-four coverage until the obstetric labor and delivery services will terminate on June 1, 2013.

B. Staffing Changes After June 1, 2013

As a result of the proposed elimination of obstetric labor and delivery services, there will be an adjustment in current staffing and staff roles. Currently on the day shift there are 7.5 full-time equivalent employees, or “FTE’s”, made up of 4.6 Registered Nurses (“RN’s”), including a lactation consultant, 1.8 Unit Coordinators, and 1.1 Nurse Managers. On the evening shift there are 5.4 FTE’s made up of 4.7 RNs, including a lactation consultant, and .7 Unit Coordinators.

The plan for the current staff has a number of different possibilities. A portion of the existing staff will staff continuing women's health services at Westerly Hospital. These services include lactation consulting, prenatal stress testing, child birth education, gynecological surgery, prenatal and perinatal care, imaging, general gynecology, and women's gastroenterology services. Further, there will be an expanded opportunity to offer women's health services, because the reduced number of infants in the unit will allow for a wider array of patients that can be accepted on the floor. These potential expanded treatment options include gynecological oncology, breast health, urogynecology, women's heart health, and fertility services.

Finally, L+M is exploring options to employ OB staff at L+M in New London, Connecticut.

In summary, there are no immediate plans for staffing changes for Westerly Women's Health Services. L+M has contracted with a consultant to undertake a market and focus study for expanded women's health services at the Westerly Hospital. Details on staffing plans will emerge after that study is completed. However, to make it absolutely clear, there will be no more staffing of obstetric labor and delivery services at Westerly Hospital after June 1, 2013, as there will not be any obstetric or pediatric physicians available to provide that service.

IV. Length of Time that Services have been Offered/Patient Utilization/ Payor Mix – Rules and Regulations § 10.1.2(d), (e), (f) and (g)

Labor and delivery services have been offered at Westerly Hospital since August 1925.

The number of patients who have utilized labor and delivery services from January 1, 2010, through December 31, 2012, is as follows:

- January 1, 2010 through December 31, 2010 – 324
- January 1, 2011 through December 31, 2011 – 339
- January 1, 2012 through December 31, 2012 – 334

The payor mix for labor and delivery patients at Westerly Hospital from January, 2010 through December, 2012 is contained at **Tab C**. The most common methods of payment for this time period were Rhode Island Blue Cross and Medicaid HMO and United Health Care Corporation, which combined accounted for approximately 55% of the patients' payment methods.

The payor mix for patients at Westerly Hospital across the entire array of hospital services from January, 2010 through December, 2012, is contained at **Tab D**. The most common methods of payments were Medicare, Rhode Island Blue Cross, and United Health Care Corporation, which combined, accounted for approximately 60% of the patients' payment methods.

V. Primary and Secondary Service Areas – Rules and Regulations § 10.1.2(h)

Westerly Hospital's primary service area is as follows: Westerly, Rhode Island; Hopkinton, Rhode Island; and Stonington, Connecticut. Westerly Hospital's secondary service area is as follows: Charlestown, Rhode Island; Groton, Connecticut; Ledyard, Connecticut; the village of West Kingstown, Rhode Island; the village of Wyoming, Rhode Island; the village of Carolina, Rhode Island; and the village of Wood River Junction, Rhode Island.

VI. Impact/Continuum of Care – Rules and Regulations § 10.1.2(i)

Westerly Hospital is only proposing to eliminate obstetric labor and delivery. Westerly Hospital will continue to maintain an array of 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. For obstetric labor and delivery services, the Special Master anticipates that most patients in the

community will choose either L+M in New London, Connecticut or South County Hospital in South Kingstown, Rhode Island².

Westerly Hospital anticipates being part of a hospital system with L+M. As such, L+M has begun the process of designing regional women's health services that will ensure continued access to affordable care with the service of obstetric labor and delivery being provided at L+M in New London, Connecticut. L+M offers many important obstetric services that are not available at Westerly Hospital including:

- A modern 24-bed maternity unit with state-of-the-art private labor/maternity rooms, cutting edge technology including central surveillance of all live fetal heart rate tracings, a triage area for assessment and antepartum evaluation, a fully staffed Normal Care Nursery, and 2 in-unit operating room suites for cesarean sections;
- 24/7 in-house availability of anesthesia services;
- The region's only neonatal intensive care unit ("NICU") which allows area women and their families to have high risk pregnancies delivered locally and for critically ill or at-risk newborns to receive the necessary specialized care close to home rather than have to travel to Providence or New Haven. Board-certified neonatologists staff the 14-bed Level IIIA unit, along with highly skilled nurse practitioners and physician assistants. L+M's NICU staff provides one-on-one intensive care around the clock for the most critically ill newborn babies;
- The neonatology practitioners attend all births – including routine deliveries -- relieving area pediatricians or family physicians from this burden;
- A full-time maternal and fetal medicine ("MFM") specialist; and
- Infertility services offered 5 days/week by one of the private practice obstetric-gynecology groups in New London, Connecticut.

² There are two remaining OB/GYN providers in the Westerly community. One is Dr. Robert Greenlee who is an employee of Atlantic Medical Group, an affiliate of the Westerly Hospital and who will become employed by L&M Physician Association, an affiliate of L&M Hospital, post-Mastership. The other provider, Dr. Andrew Neuhauser, has left Westerly Hospital and has affiliated with South County Hospital. Dr. Neuhauser has joined a practice that affiliates with South County Hospital. Accordingly, the Special Master anticipates that the majority of his patients will choose to have obstetric labor and delivery services at South County Hospital.

As above-stated, patients will continue to have access to affordable obstetric labor and delivery services. Both L+M and South County Hospital are readily accessible to Westerly Hospital's service areas. South County Hospital is twenty (20) miles from Westerly Hospital, and L+M is nineteen (19) miles from Westerly Hospital.

In 2012, there were 334 births at Westerly Hospital. Ninety eight percent (98%) of those patients resided less than twenty-five (25) miles from either South County Hospital or L+M. The six (6) patients that constitute the two percent (2%) not covered, resided more than twenty-five (25) miles from Westerly Hospital as well, and were clearly visiting the area at the time of delivery. **See Tab E.** Thus, it is reasonably expected that patients that would have utilized Westerly Hospital for obstetric labor and delivery services will now utilize L+M or South County Hospital.³

A. Impact on Minorities, Underserved Populations, and Charity Care

Please find the attached data at **Tab F**, identifying births at Westerly Hospital by race, ethnicity and payor source.

With regard to charity care, L+M's policies are consistent with, and in fact more liberal, than those of Westerly Hospital, and their application to existing patients of Westerly Hospital will not result in patient who no longer qualify for charity care under the policy. In addition, L+M has a best practice Financial Counseling division, dedicated to helping its patients and their families navigate complex State requirements for Medicaid enrollment, as well as guiding individuals through its internal charity care process.

³ Other hospitals that provide labor and delivery services in Rhode Island are as follows: Newport Hospital, Kent Hospital, Women and Infants Hospital, Landmark Medical Center, Memorial Hospital.

Attached at **Tab G** is the payor mix table submitted to the Department of Health on January 2, 2013 which was part of the Expedited Review Hospital Conversion Initial Application. It reports charity care based on costs and not charges.

B. Insurance

With regard to insurance, L+M currently participates in RI Medicaid. It is not a contracted provider currently for RItE Care patients but if eligible under RItE Care requirements to participate, it would be willing to participate in that program as well. L+M and Westerly Hospital have some overlap in their primary and secondary service areas. As a result both hospitals participate in largely the same payer community already. When L+M does receive patients with insurance for which it is not already a contracted provider, it has methods for negotiating single patient case rates with those payers. This process does not result in any loss of access to care for the patient. The amount of a patient's co-payment is determined by the employer's (for self-insured plans) or payer's (for fully-insured plans) plan design, which is information L+M and Westerly does not have access to. Although L+M cannot know the impact on all patient's co-payments for this reason, because of the significant overlap in payer participation between the entities, receipt of services from L+M as opposed to Westerly Hospital should not result in any increase in co-payments for patients.

C. Impact on Cities and Towns Whose Residents are Regularly Served by Westerly Hospital

The Special Master is extremely sympathetic to the fact that there will be an impact on certain person within the affected cities and towns of the elimination of obstetrics and labor and delivery services, as people who would previously delivered at Westerly Hospital will no longer be able to deliver at Westerly Hospital. That being said, the Special Master does not believe that the impact will create too heavy of a burden on the affected community. As detailed in the

charts and graphs at **Tab H**, from 2010 to 2012, 45% of births that took place in Westerly Hospital's primary service area took place at hospitals other than Westerly Hospital. The largest impact will likely be felt in Westerly itself, where over 60% of the births in 2012 in Westerly took place at Westerly Hospital. Thus, as evidenced by the large number of births from the Westerly Hospital primary service area that already take place at other hospitals (primarily South County Hospital and L+M), there is certainly not too heavy of a burden for patients to travel the approximately 20 miles or less to each of these hospitals for labor and delivery services. Moreover, a factor that reduces the potential burden on the community is that both perinatal and postnatal services will continue to be offered at Westerly Hospital so that patients need only travel to South County or L+M for the actual delivery and not for the perinatal and postnatal care.

Enclosed at **Tab I** is correspondence from L+M, indicating support for the elimination of obstetrics and labor and delivery services.

D. Impact of the Proposed Elimination of Obstetric and Labor and Delivery Services on other Licensed Hospitals or Healthcare Providers in the Community and in the State

With regard to the impact of the proposed elimination of obstetric and labor and delivery services on other licensed hospitals or healthcare providers in the community and in the State, the Special Master believes that local area providers are willing and able to absorb any increased activity due to the closing of the labor and delivery services at Westerly Hospital. Enclosed herein at **Tab I**, are letters of support from both L+M and South County Hospital in which they indicate that, though unlikely⁴, if necessary, they could absorb the 300+ yearly births that have historically taken place at Westerly Hospital. Moreover, because the impact of the proposed

⁴ It is likely that over time L+M and South County Hospital will split the births that would have taken place at Westerly Hospital, with patients living closer to South County Hospital using those services and with patients living closer to L+M utilizing those services.

elimination of obstetric and labor and delivery services can be easily absorbed by the community providers, there will be minimal, if any impact, on the providers throughout the State beyond the local community providers who can provide the additional services as necessary.

VII. The Transition Plan

L+M and the Special Master intend to pursue a transition plan designed to educate the Westerly Hospital community with regard to women's health services. In that regard, L+M will create a program where patients within Westerly Hospital's service area have access to a wide array of women's health services at Westerly Hospital, but undergo obstetric labor and delivery at L+M or any other facility of their choosing.

A. Plan for Notifying the First Responder Community

The plan for notifying the first responder community is detailed in **Tab J** (*EMS Communication Plan Discontinuation of Labor and Delivery Services at Westerly Hospital*). In short the plan is to send written notification to all area EMS providers and conduct an information session at L+M at which providers can ask any questions they may have. A copy of the notification letter can be found at **Tab K**. A list of EMS recipients for notification is contained at **Tab L**, and a letter of support for the plan from the Westerly Ambulance Corps, Inc. is attached at **Tab M**.

B. Protocol for the Stabilization and Transfer of Pregnant Women

The protocol for the stabilization and transfer of pregnant women in the WH emergency service can be found in **Tab N** *Protocol for Stabilization and Transfer of the Pregnant Patient*. The protocol is consistent with federal requirements for patient screening and transfer and special determination of emergency medical conditions for pregnant women as outlined in the

Guidelines for Perinatal Care published by the American Academy of Pediatrics and The American College of Obstetricians and Gynecologists.

C. Plan for the Expeditious Transfer of Obstetrical Patients

The plan for the expeditious transfer of obstetrical patients is outlined in **Tab N** (*Protocol for Stabilization and Transfer of the Pregnant Patient*) and takes effect on June 1, 2013. The plan will be tested in a mock drill on or about April 15, 2013 (see **Tab O** *Clinical Simulation*). Should the drill indicate any revisions to the transfer policy, they will be made no later than May 1, 2013 (see **Tab J** *EMS Communication Plan Discontinuation of Labor and Delivery Services at Westerly Hospital*). The transfer agreement between Lawrence + Memorial Hospital and Westerly Hospital is found at **Tab P**, *Obstetric Patient Transfer Agreement Westerly Hospital and Lawrence + Memorial Hospital*.

D. Policy for Maintaining Necessary Equipment

The policy for maintaining necessary equipment to perform emergency deliveries at WH can be found at **Tab Q** *Equipment, Supplies, and Medication for Emergency Department Deliveries*. This policy indicates the specific equipment and monitoring mechanism to be sure it is complete and maintained.

E. Assistance to Current Obstetric Patients

Upon closure of the obstetric labor and delivery service, patients will be offered the option to change their care to South County Hospital, L + M, or to any other hospital of their choice. At all times any hospital affiliated practice or hospital medical records will be available to the patient for her to take with her or they will be transferred in an expeditious manner to the institution of choice.

The letter attached at **Tab R** will be provided to all potential, obstetric labor and delivery patients informing them of the closure.

Effective March 1, 2013, Westerly Hospital established a toll free obstetric hotline (855-348-3906) for any patient to call in order to obtain information and guidance regarding her medical care. The hotline will assist the patient in obtaining the necessary medical care needed as well as the transfer of her medical records to the institution of her choice. This hotline shall be maintained for at least 30 days after the closure of the labor and delivery service at Westerly Hospital.

Emergency room medical staff at Westerly Hospital will be available to all female patients for their emergency obstetric needs after the labor and delivery service closes. As detailed above, the system for expeditious transfer of an obstetric will be in place by June 1, 2013. The emergency room will have the necessary equipment to perform an emergency vaginal delivery as well as to stabilize both the mother and her infant prior to transfer to the receiving hospital.

Programs will be undertaken at L+M to allow expecting parents to meet L+M staff and providers, and get comfortable with the facilities to increase access and reduce any perceived geographic barriers. Westerly/L+M will maintain and enhance locally available (i.e., in Westerly) birthing-related patient education services.

F. Continuum of Care, Post Closing

L+M Physicians Association (“L+M PA”) has recruited an obstetrician that will be based in Westerly and begin working in or about August of 2013. Additionally, L+M PA is recruiting for a certified nurse midwife to provide ante partum and post-partum care for those patients in the Westerly community who would like to have their delivery at L+M Hospital. The purpose of the additional obstetrician and midwife is for them to support and augment Westerly’s remaining

one physician and one physician assistant. While deliveries would still be performed at L+M, this arrangement will afford an appreciably greater level of integration, communication, and coordination of services for patients on the one hand, and a significantly higher likelihood of long-term retention of the providers on the other, owing to a more reasonable call burden.

Additionally, the L+M PA employed obstetricians have expressed their willingness to support the Westerly AMG/OB practice, although their availability for on-site presence in an hospital affiliated Westerly practice is predicated on obtaining Rhode Island medical licenses and privileges at Westerly Hospital. L+M will continue to work with providers' schedules for opportunities to lend some on-site presence in the near term in the Westerly AMG/OB space, but L+M will need time address the challenges identified above.

There are also two L+M PA midwives who are available for day-time support of the practice part-time. As noted with the physicians, they too will require Rhode Island professional licensure in order to assist. L+M PA is willing to work immediately on interim arrangements to bring the support of these L+M PA providers to the Westerly AMG/OB practice.

Assistance from the Rhode Island Department of Health to expedite the licensing process would substantially increase the likelihood that these L+M PA obstetricians and nurse-midwives would be available, when needed, and is hereby requested. If that cannot be assured or does not appear reasonable to State regulators, the L+M PA OB's and nurse midwives would be amenable to practicing part-time out of the North Stonington Health Center when the Court-supervised closing of that facility occurs later this month or early next.

For the longer term, both L+M PA and private practice obstetricians at L+M have indicated a willingness to participate in a call schedule to provide obstetrical services to Westerly patients coming to L+M for delivery. L+M physicians have an interest in exploring a model that would

have at least one obstetrician in-house at all times at L+M, under the so-called “laborist” concept. Finally, L+M’s private practice obstetricians are interested in exploring a rotating office presence in the Westerly community. This will require additional discussions and a needs assessment.

Conclusion

Wherefore, the Special Master requests that the Director of the Rhode Island Department of Health issue an approval of the within plan to eliminate obstetric labor and delivery services at Westerly Hospital effective June 1, 2013. The Special Master believes that this is a necessary step given the demographics of the service and the fact that the providers have withdrawn. The Special Master also believes that elimination of this service will lead to a strengthening of the financial position of Westerly Hospital, while also ensuring that other high quality women’s health services continue to be offered at Westerly Hospital.

TAB A

CURRICULUM VITAE

PERSONAL INFORMATION

Name: Louis Weinstein, M.D.
BP: Cambridge, MA
Home Address: PO Box 21829 843-817-0620
Charleston, SC 29413

EDUCATION AND TRAINING

B.S. Bates College 1968
Lewiston, Maine
M.D. Wake Forest University School of Medicine 1972
Winston-Salem, North Carolina

GRADUATE MEDICAL EDUCATION

FROM - TO

1972-1973 Internship: University of Colorado Medical Center
Denver, Colorado
1973-1976 Residency: University of Colorado Medical Center
Denver, Colorado
1979-1981 Fellowship: University of Arizona
Maternal-Fetal Medicine
Tucson, Arizona
1980 Fellowship: National Endowment for the Humanities
Fellow - "Autonomy, Authority and Role:
Ethical and Legal Perspectives on the
Interdependencies of Health Care Professionals"

EMPLOYMENT

FROM - TO

2010-2011 Thomas Jefferson University
Department of Obstetrics and Gynecology

Professor
 Philadelphia, PA
 Full time - Salaried

2004-2010 Thomas Jefferson University
 Department of Obstetrics and Gynecology
 Paul A. & Eloise B. Bowers Professor and Chairperson
 Philadelphia, PA
 Full time - Salaried

2000-2002 Associated Physicians of MCO, Inc.
 Toledo, Ohio
 Treasurer

1998-2000 Associated Physicians of MCO, Inc.
 Toledo, Ohio
 Treasurer

1998-1999 Medical College of Ohio
 Department of Obstetrics and Gynecology
 Director of Maternal-Fetal Medicine
 St. Vincent Mercy Medical Center
 Toledo, Ohio

1997-1999 Medical College of Ohio
 Department of Obstetrics and Gynecology
 Director, 3rd Year Student Clerkship
 Toledo, Ohio

1992-2004 Medical College of Ohio
 Department of Obstetrics and Gynecology
 Professor and Chairperson
 Toledo, Ohio
 Full-time - Salaried

1992-1993 Medical College of Ohio
 Department of Obstetrics and Gynecology
 Director of Maternal-Fetal Medicine
 The Toledo Hospital
 Toledo, Ohio
 Full-time - Salaried

1991-1992 University of Arizona
 Department of Obstetrics and Gynecology
 Director of Research
 Tucson, Arizona

Full-time - Salaried

1988-1992 University of Arizona
Department of Obstetrics and Gynecology
Professor
Tucson, Arizona

1984-1991 Full-time - Salaried
University of Arizona
Department of Obstetrics and Gynecology
Division of Maternal-Fetal Medicine
Director
Tucson, Arizona
Full-time - Salaried

1982-1988 University of Arizona
Department of Obstetrics and Gynecology
Associate Professor
Tucson, Arizona
Full-time - Salaried

1982-1984 University of Arizona
Department of Obstetrics and Gynecology
Division of Maternal-Fetal Medicine
Co-Director
Tucson, Arizona
Full-time - Salaried

1979-1991 University of Arizona
Prenatal Genetics Unit
Associate Director
Tucson, Arizona
Full-time - Salaried

1979-1984 University of Arizona
Department of Obstetrics and Gynecology
Division of Ultrasound
Director
Tucson, Arizona
Full-time - Salaried

1978-1982 University of Arizona
Department of Obstetrics and Gynecology
Assistant Professor
Tucson, Arizona
Full-time - Salaried

1976-1978	Naval Regional Medical Center Department of Obstetrics and Gynecology Staff - Lieutenant Commander Charleston, South Carolina Full-time - Salaried
1976-1978	Naval Regional Medical Center Department of Obstetrics and Gynecology Division of Ultrasound Director Charleston, South Carolina
1976-1978	Medical University of South Carolina Department of Obstetrics and Gynecology Clinical Instructor Charleston, South Carolina
1975	University of West Indies Department of Obstetrics and Gynecology Project Hope Instructor Kingston, Jamaica

CERTIFICATIONS/LICENSURES

Certifications:

1979	Obstetrics and Gynecology American Board of Obstetrics/Gynecology
1983	Maternal-Fetal Medicine Division American Board of Obstetrics/Gynecology

Recertifications:

1993, 2003, 2005, 2007, 2008, 2009	Obstetrics and Gynecology - Maternal-Fetal Medicine American Board of Obstetrics/Gynecology
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Licensures:

Pennsylvania State Medical Board
Ohio State Medical Board
South Carolina State Medical Board

MILITARY SERVICE

FROM - TO

1976-1978 U.S. Navy
Lieutenant Commander
Discharged: 1978
Type of Discharge: Honorable

NATIONAL ACTIVITIES

2007-2008 Association of Professors of Gynecology and Obstetrics Foundation Board

2007-2008 Task Force on Pain Management
American College of Obstetricians and Gynecologists

2002-2011 PROLOG Advisory Committee (5th, 6th & 7th Editions)
American College of Obstetricians and Gynecologists

2002-2004 Scientific Program Committee
Central Association of Obstetricians and Gynecologists

2001-2002 Co-Chair - PROLOG Unit 1 (5th Edition)
American College of Obstetricians and Gynecologists

2000-2001 Presidential Task Force on Neonatal Encephalopathy
American College of Obstetricians and Gynecologists

1999-2000 Chair – CD Rom on Obstetrics
American College of Obstetricians and Gynecologists

1999-2003 Committee on Quality Improvement and Patient Safety
American College of Obstetricians and Gynecologists

1999-2003 Chair - Subcommittee on Accreditation Activities
American College of Obstetricians and Gynecologists

1999 Course Director – Medical Diseases in Pregnancy, Virgin Islands
American College of Obstetricians and Gynecologists

1997-1998 Presidential Task Force on Office Evaluation
American College of Obstetricians and Gynecologists

1996-2001 Chair - PROLOG Advisory Committee (4th Edition)
American College of Obstetricians and Gynecologists

1995-1996 PROLOG Unit 5 Task Force (3rd Edition)

American College of Obstetricians and Gynecologists

1994 Course Director - High Risk Obstetrics, Barbados West Indies
American College of Obstetricians and Gynecologists

1994-2009 Board Examiner - American Board of Obstetricians and Gynecologists

1991-1993 Chair - Committee on Course Coordination
American College of Obstetricians and Gynecologists

1990-1991 PROLOG Unit 5 Task Force (2nd Edition)
American College of Obstetricians and Gynecologists

1990 Course Director - Update in Obstetrics, Norfolk, Virginia
American College of Obstetricians and Gynecologists

1989 Postgraduate Education Advisor, District VIII
American College of Obstetricians and Gynecologists

1988-1991 District VIII Representative - Committee on Course Coordination
American College of Obstetricians and Gynecologists

1988 Course Director - Update in Obstetrics, Juneau, Alaska
American College of Obstetricians and Gynecologists

1987-1988 PROLOG Unit 5 Task Force (1st edition)
American College of Obstetricians and Gynecologists

AWARDS AND COMMENDATIONS

- 2009 Association of Professors of Gynecology and Obstetrics – Excellence in Teaching Award
- 2006 Association of Professors of Gynecology and Obstetrics – Excellence in Teaching Award
- 2005 George Andros Excellence in Teaching Award – Thomas Jefferson University
- 2003 Residents Teaching Award - Medical College of Ohio, Department of Obstetrics and Gynecology
- 2003 Faculty Recognition Award - Medical College of Ohio, Department of Obstetrics and Gynecology,
- 2002 Alpha Omega Alpha Honor Society
- 1999 National Faculty Award for Excellence in Resident Education - Council of Resident Education in Obstetrics and Gynecology
- 1997-1998 Resident Teaching Award - Medical College of Ohio, Department of Obstetrics and Gynecology
- 1997 Central Prize Award of the Central Association of Obstetricians and Gynecologists. BONES - a new tool to determine who needs osteoporosis screening.
- 1995-1996 Resident Teaching Award - Medical College of Ohio, Department of Obstetrics and Gynecology
- 1994-1995 Resident Teaching Award - Medical College of Ohio, Department of Obstetrics and Gynecology
- 1977-1978 Best Overall Clinical Instructor - Naval Regional Medical Center, Charleston, SC
- 1977-1978 Best Instructor in Obstetrics and Gynecology - Naval Regional Medical Center, Charleston, SC
- 1972 Obstetrics and Gynecology Merit Award - Bowman Gray School of Medicine
- 1972 Frank Lock Travel Fellowship in Obstetrics and Gynecology - Bowman Gray School of Medicine

1966-1968

Jessie Smith Noyes Scholar - Bates College

EDITORIAL BOARDS

2002-present	Associate Editor – UPDATE – A Clinical Continuum in Obstetrics and Gynecology - American College of Obstetricians and Gynecologists
1996-2002	Editorial Board – UPDATE – A Clinical Continuum in Obstetrics and Gynecology - American College of Obstetricians and Gynecologists
1990	Advisory Board - <i>Gestational and Perinatal Hypertension</i>
1988-1990	Advisory Board - <i>The Fetus</i>
1985	Advisory Board - <i>Journal of Perinatology</i>
1983	Advisory Board - Factline
1979-1981	OB-GYN Section - <i>Arizona Medicine</i>
1978-1980	- Advisory Board - <i>Current Prescribing</i>

JOURNAL REVIEWS

Obstetrics and Gynecology
American Journal of Obstetrics and Gynecology
Journal of Perinatology
Journal of American Medical Association
Archives of Internal Medicine
Life Sciences

ORGANIZATIONAL MEMBERSHIPS

Fellow	American College of Obstetricians and Gynecologists
	Central Association of Obstetricians/Gynecologists
	Association of Professors of Gynecology/Obstetrics
	Society of Maternal-Fetal Medicine
	American Gynecological and Obstetrical Society

COMMITTEES

Associated Physicians of Medical College of Ohio

2000-2002	Treasurer, Associated Physicians of Medical College of Ohio
2000-2002	Chair, Finance Committee, Associated Physicians of Medical College of Ohio
1998-2000	Treasurer, Associated Physicians of Medical College of Ohio
1998-2000	Chair, Finance Committee, Associated Physicians of Medical College of Ohio
1994-1996	Physician Recruitment Committee
1992-2004	Board of Directors
1992-2004	Executive Committee
1992-1998	Finance Committee
1992-2004	Pension Committee
1992-2004	Toledo Area Medical Foundation
1992-1993	Search Committee for Executive Director

Medical College of Ohio

2003	Chairperson, Task Force for Formation of a New 501c3 Practice Plan
2000	Chairperson, Evaluation Committee
1999	Member, Search Committee for Department of Medicine Chair
1998-1999	Curriculum Subcommittee - Years 3 and 4
1998-1999	Strategic Plan Implementation Committee
1998-1999	Clinical Enterprise Committee
1998	Center of Excellence Development Committee
1997	Student Promotions Committee

1994-1998	Chairman - Tenure Committee
1993-1994	Chairman - Search Committee Microbiology Chair
1993-1994	Tenure Committee
1992-2004	Credentials Committee
1992-2000	Disaster Preparedness Committee
1992-2004	Executive Committee of Medical Staff
1992-2004	Executive Committee of School of Medicine
1992-2000	Curriculum Committee
1992-1998	Chairman's Study Group
1992-2004	Clinical Service Chief Committee

University of Arizona

1989-1991	Quality Coordinating Council
1989-1991	Medical Director, Ob/Gyn Service
1989	Radiology Academic Review Committee
1989	Committee of Nine
1989	Chair - Residency Review Committee
1987-1991	University Medical Center Credentials Committee
1987-1991	Chair - Finance Committee
1986	Chair - Residency Evaluation Committee
1986	Faculty Evaluation Committee
1984-1989	Medical Staff Executive Committee
1984-1989	Elected Staff Executive Committee
1984-1989	Secretary Treasurer - Medical Staff University Medical Center
1984-1991	Pharmacy and Therapeutics Committee
1984	Chair - Psychiatry Academic Review Committee
1982-1984	Student Progress Committee

GRANTS

- "Neonatal Chlamydia Infection: Incidence and Treatment," National Institutes of Health
- "Induction of Brain Tumors by Papilloma Virus," Biomedical Research Support Grant, University of Arizona
- "Comparative Efficacy Studies of 100mg of Miconazole Nitrate Suppositories with Monistat 7 Vaginal Cream and Placebo for Seven and Fourteen Days," Ortho Pharmaceutical Company
- "Effectiveness of Depo-Provera in the Postmenopausal Patient," Upjohn Company
- "A Double-Blind Study of Tioconazole Cream vs Placebo in Patients with Vaginal Candidiasis," Pfizer Research, Inc.
- "An Evaluation of Anti-D Immunoglobulin for Prevention of Rh Hemolytic Disease," Armour Pharmaceutical Company
- "A Comparison of Single Dose Tioconazole Cream vs Clotrimazole Tablets in Patients with Vaginal Candidiasis," Pfizer Research, Inc.
- "Randomized Study to Compare the Efficacy and Safety of Ceftriaxone to Cefoxitin Sodium in the Treatment of Pelvic Inflammatory Disease and Post Operative Gynecological Infections," Hoffman La Roche, Inc.
- "Multiclinic Open Study of the Efficacy, Safety and Tolerance of Thienamycin Formamidine/Potentiator in the Parenteral Therapy of Infection Caused by Pathogenic Bacteria in Hospitalized Patients," Merck, Sharpe and Dohme, Inc.
- "Tioconazole Single Dose Ointment in the Treatment of Pregnant Patients with Vaginal Candidiasis," Pfizer Research, Inc.
- "An Open Labeled Multicenter Study of Oral UK-49,858 and Clotrimazole Intra-Vaginal Tablets in the Treatment of Patients With Vaginal Candidiasis," Pfizer Research, Inc.
- "Combined Premarin Plus C.T. Provera for the Treatment of the Menopause," Upjohn Company
- "Continuous Estrogen-Progestin Therapy for Postmenopausal Patients," Upjohn Company
- "Endothelial Disruption and Pre-eclamptic Coagulopathy--An In-Vivo and In-Vitro Study," Flinn Foundation

"Prospective Double-Blind Randomized Parallel Study of the Safety and Efficacy of Premarin and Medroxyprogesterone Acetate for Postmenopausal Hormone Replacement Therapy," Wyeth-Ayerst Research

"Vaginal Retention of 2% Butoconazole Nitrate Standard Vaginal Cream," Syntex Research

"A Randomized Multicenter Study of a Single Dose Oral Fluconazole Tablet Compared With Seven Days of Clotrimazole Vaginal Tablets in the Treatment of Acute Candidal Vaginitis in Women 18-65 Years of Age," Pfizer Research, Inc.

"The Effects of Post Menopausal Estrogen/Provera Hormone Replacement Therapy (HRT) on Endometrial Histology and Bone Mineral Density," Upjohn Research

"The Effects of Post Menopausal Ogen/Provera Hormone Replacement Therapy on Endometrial Histology," Upjohn Research

"Progestin Efficacy Study to Compare Three Doses of RPR Estradiol/Norethisterone Acetate (NETA) Patches Worn Continuously to an Estradiol 50 Patch," Rhone-Poulenc Rorer Research

"A Prospective, Double-Blind, Randomized Study of the Safety and Efficacy of Lower Doses of Premarin and Medroxyprogesterone Acetate in Postmenopausal Women," Wyeth-Ayerst Research

"A Double-Blind, Randomized, Placebo- and Historical-Controlled Study of the Safety and Efficacy of Premarin/Trimegestone for Postmenopausal Hormone Replacement Therapy," Wyeth-Ayerst Research

"A Double-Blind, Randomized, Placebo and Active Controlled Safety and Efficacy Study of Bazedoxifene/Conjugated Estrogen Combinations in Postmenopausal Women," Wyeth-Ayerst Research

"A Double-Blind, Placebo-Controlled, Parallel Group Design Dose-Ranging Study of Three Doses of Lasofoxifene vs. Placebo for the Treatment of Sexual Dysfunction (Hypoactive Desire) in Postmenopausal Women," Pfizer Inc.

"A Double-Blind, Placebo-Controlled, Parallel Group Design Dose-Ranging Study of Three Doses of Lasofoxifene vs. Placebo for the Treatment of Sexual Dysfunction (Arousal Disorder) in Postmenopausal Women," Pfizer Inc.

"A Study of the Safety and Efficacy of Lasofoxifene in the Treatment of Vaginal Atrophy in Postmenopausal Women," Pfizer Inc.

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2. Weinstein L, Farabow WS, Gusdon JP. Third stage of labor and transplacental hemorrhage. *Obstet Gynecol* 1971; 37:90-3
3. Weinstein L, Taylor ES. Hemolytic disease of the newborn secondary to anti-Fy. *Am J Obstet Gynecol* 1975; 121:643-5
4. Weinstein L. Irregular antibodies causing hemolytic disease of the newborn - a review. *Obstet Gynecol Surv* 1976; 31:581-91
5. Weinstein L, Droegemueller W, Greer B. The synergistic effect of calcium and prostaglandin F2 in second trimester abortion - a pilot study. *Obstet Gynecol* 1976; 48:469-71
6. Weinstein L. An open letter to all chairman. *Am J Obstet Gynecol* 1978; 131:915
7. Weinstein L. Lightning - a rare cause of intrauterine death with maternal survival. *Southern Med J* 1979; 72:632-3
8. Weinstein L. Cerebrospinal fluid rhinorrhea complicating pregnancy. *Southern Med J* 1979; 72:1026-7
9. Weinstein L, Droegemueller W, Cornette J, Greer B, Gutknecht G. (15s) - 15 Methyl prostaglandin F2 levels in amniotic fluid and blood in second trimester abortions. *Southern Med J* 1979; 71:1159-60
10. Weinstein L. A dying social grace. *Am J Obstet Gynecol* 1979; 135:548
11. Weinstein L. Breast milk - a natural resource. *Am J Obstet Gynecol* 1980; 136:973-5
12. Weinstein L, Allen R. Extra amniotic pregnancy - a rare event. *Southern Med J* 1980; 73:769-70
13. Weinstein L, Anderson C. The in-utero diagnosis by ultrasound of the Beckwith-Wiedemann syndrome. *Radiology* 1980; 134:474
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15. Chvapil M, Droegemueller W, Betts K, Heine W, Weinstein L. Postcoital tests with the collagen sponge. *Obstet Gynecol* 1980;56:503-6
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35. **Weinstein L.** Ectopic pregnancy - growing threat of the 80's. *Human Sexuality* 1985; 19: 86-7
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39. **Weinstein L.** Efficacy of a continuous estrogen-progestin regimen in the menopausal patient. *Obstet Gynecol* 1987; 69:929-32
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85. Baxter JK, Boyle K, Weinstein L. Fetal injury associated with cesarean delivery. *Obstet Gynecol* 2007;109:783
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102. **Weinstein L.** Society for Women’s Health Oversight: Establishing Equality in the Profession of Obstetrics and Gynecology – Reply *Obstet Gynecol* 2011;118:1417

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2. Droegemueller W, Weinstein L, Milzer G. Low dose prostaglandin for late second trimester abortion. *Contemporary Obstet Gynecol* 1980; 15:19-22
3. **Weinstein L.** Premature labor and method of delivery at 26 to 28 weeks gestational age. *Collected Letters of the International Correspondence Society of Obstetricians/Gynecologists* 1979; 20:52
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6. **Weinstein L.** Preventing Rh hemolytic disease. *Arizona Med* 1980; 37:28-9
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8. **Weinstein L.** A just reward - an academician's desire. *Resident and Staff Physician* 1985; 31:19
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16. **Weinstein L.** Let's take PORCC (PORK) out of the barrel. *J Perinatol* 1999;19:87
17. **Weinstein L, Peckinpaugh RA, Siegan RS.** Managing your malpractice defense. *ACOG Update* 1999;25:5
18. **Weinstein L Calvin SE, Trofatter KF.** Operative vaginal delivery: risks & benefits. *ACOG Update* 2001;27:5
19. **Weinstein L.** Sterile glove and gowning – that dreaded day. *Physician's Money Digest* 2003;March/April
20. **Weinstein L.** Learn expensive lessons with experience. *Physician's Money Digest* 2003; May/June
21. **Weinstein L.** The laws taketh, but occasionally giveth. *Physician's Money Digest* 2003;July/August
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23. **Weinstein L.** Look beyond market hype to find success. *Physician's Money Digest* 2003;Nov/Dec
24. **Weinstein L.** What I would really rather be doing. *Physician's Money Digest* 2004;Jan/Feb
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BOOK CHAPTERS

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9/12

TAB B

**THE WESTERLY HOSPITAL SPECIAL MASTERSHIP
OBSTETRIC SERVICE TRANSITION PLAN**

The Special Mastership of the Westerly Hospital and Related Entities, Charles S. Kinney v. Westerly Hospital Healthcare, Inc., et al, C.A. No. 2011-0781, has worked since appointment to address issues related to the Westerly Hospital obstetric service. The issues arise from the fact that the decrease in volume of births has required the Hospital to advance a considerable, annual subsidy to support the program. With the Court's final approval of sale of the assets of the Westerly Hospital and Related Entities to subsidiaries of Lawrence & Memorial Hospital Corporation (collectively, "L&M"), the obstetric service at the Westerly Hospital can now be addressed on a system-wide basis. The issue, or rather the opportunity, is transformed into how can the L&M/Westerly system best provide obstetric care, as opposed to how can the Westerly Hospital afford to continue to provide obstetric care.

Quite simply, this issue has been "ducked" for a number of years, because the solution for a stand-alone, community hospital meant that the particular hospital would no longer offer obstetric service to its community. If the Westerly Hospital – L&M transaction continues down its anticipated path to a closing, then the Westerly Hospital is no longer a stand-alone, community hospital, it becomes part of a progressive healthcare network. Assuming the L&M transaction concludes, the Special Master recommends a phased transition of how obstetric care is best provided in the Westerly Hospital's primary service area; and how it is best provided in a manner which encourages the community to maintain a sense of loyalty to the Westerly Hospital in regard to family healthcare decisions that often begin with obstetric care. It is also an opportunity to introduce and incorporate the southern Rhode Island community into a larger healthcare network that eliminates pre-conceived and outdated perceptions of "State borders" or the "bridge".

I. Background

The Westerly Hospital has experienced a declining volume of births from 2008 through the present. In logical response, the subsidy required by the obstetric service has grown in recent years. This reality is then magnified when coupled with all of the other challenges that stand-alone community hospitals face.

The Westerly Hospital currently has less than one birth per day. In fiscal year 2011, the Westerly Hospital performed 330 deliveries.

In September of 2011, the Westerly Hospital engaged a consultant to provide some insight as to appropriate staffing for the obstetric service. A report was provided by that consulting firm in early 2011. The consultant indicated that ideal staffing would be four obstetricians, two mid-wives, and a physician's assistant.

It is difficult to analyze the true subsidy to support that level of staffing, but the consultants then indicated that over 1000 births would be necessary to reach a financial break-even point. The Special Mastership realizes (and perhaps that consultant in 2011, did not take into account) that the obstetric service leads to considerable "downstream" revenue; nevertheless, the volume of births necessary to support such a structure does not seem to be attainable.

Based upon data provided to the Special Mastership, from 2007 to 2010, the State of Rhode Island has experienced a decline in births of 11.3%. Granted, the Westerly Hospital has lost some volume attributable to a loss in market share as opposed to a decrease in the overall demographic. However, there has been a decrease in the overall demographic. Moreover, the Special Mastership has engaged a consultant to be discussed in greater detail below. The Special Master's consultant has indicated that in today's world, obstetricians prefer coverage in a 1 to 6

ratio and therefore, the cost of the subsidy in a declining market would be even greater. The consultant also pointed to the age of the current obstetricians in the community and the difficulty of recruiting "Generation X or Y Physicians who would be mostly female" to this "small unit". Thus, the realities of properly staffing and subsidizing the current service are not financially feasible over any extended period of time.

After being appointed in December of 2011, the Special Mastership had to determine how to address the financial issues relative to the obstetric service pending a sale. The Special Mastership made the decision to reduce professional and support staffing to an absolute minimum while contracting outside of the Westerly Hospital for adequate call coverage. This strategy allowed the Hospital to maintain the service while being marketed for sale, so that community needs for obstetrics could hopefully be addressed when the Hospital became part of a larger network or system.

At or about the time of the Court-approved sale, two other developments took place which further magnified the issues regarding the obstetric service. First, one of the obstetricians opted not to renew her contract to work at another hospital in Connecticut. Secondly, in October of 2012, the pediatricians providing call coverage for obstetrics provided notice of their intention to cease call coverage for obstetrical cases on or after December 31, 2012. This should not and cannot put the pediatricians in a negative light; they had been providing this call coverage for quite some time and were asking to see a plan for how the obstetric service would be addressed. No plan was ever presented. Since that point in time, the pediatric providers have agreed to continue this service beyond December 31, 2012, **provided that there is a plan in place to address their concerns going forward.** The instant transition plan is designed to address at least some of their concerns.

The result of this factual background is the conclusion that the current obstetric service at the Westerly Hospital is not sustainable. There must be a plan put in place that benefits the community of patients, providers, and employees of the new L&M/Westerly healthcare network. As stated above, the Special Mastership sees an incredible opportunity to address these issues on a system-wide basis taking into account the Westerly Hospital's inclusion in the L&M structure.

With that said, the Special Mastership engaged Dr. Louis Weinstein as a consultant. Dr. Weinstein's curriculum vitae is attached hereto for reference. Dr. Weinstein was engaged to provide options to address the issues on a system-wide basis, to assist the Mastership in selecting an option and to review a plan authored by the Special Mastership to transition the obstetric service at the Westerly Hospital into a system-wide service anticipating the sale of the Westerly Hospital and Related Entities to L&M.

At this time, the Special Mastership sets forth a draft transition plan which the Special Master intends on reviewing with the following constituencies:

1. Dr. Louis Weinstein;
2. The obstetricians and pediatricians who provide services to the patients of the Westerly Hospital;
3. The Westerly Medical Staff Liaison Committee;
4. The Westerly Hospital management and employees (more specifically, the employees of the obstetric service and Women's Health of Westerly);
5. The Westerly Hospital Area Residents Committee ("WHARC");
6. Lawrence & Memorial Hospital Corporation; and
7. Wood River Health Services, Inc.

II. The Proposed Transition Plan

The proposed transition plan is one that maintains all gynecological services of the Westerly Hospital, maintains all pre and post-natal care in the Westerly county, directs all "high-risk" births to L&M, and undertake an effort to maintain an "obstetric presence" at the Westerly Hospital in one of the following ways: a mid-wife run unit or "Birthing Center", in partnership with L&M, the University of Rhode Island, and/or a regional partner to establish a "hospital within a hospital" plan; a partnership between L&M and the Wood River Health Center, a federally qualified health center; a collaborative of the type being undertaken at Memorial Hospital and the Brown University Family Medicine Department; or a program to be developed by the current network of providers in Westerly and a potential "Laborist" program at L&M, which is being considered.

The proposed transition plan is a phased plan which takes place over eighteen (18) months in order to allow adequate time to ensure that: (1) our current obstetricians, mid-wife and physician's assistant remain in the community; (2) the potential to secure employment opportunities for existing staff in the system-wide model is maximized; (3) additional obstetrician/mid-wife resources are recruited into the future L&M/Westerly system; (4) the "Laborist" program at L&M to be considered; (5) a midwifery program is implemented; (6) an intensive community education/marketing program is implemented; and (7) the necessary market study/financial analysis is undertaken regarding the development of the "Birthing Center" as a regional draw, or the exploration of one of the other suggested partnership/collaborations is undertaken.

Dr. Weinstein advises that if marketed properly, this plan allows an "obstetrics presence" to be maintained at the Westerly Hospital while having a service that has the potential

to be “revenue neutral” before the incorporation of downstream revenue. In turn, Dr. Weinstein opines that a Birthing Center as a regional draw has the potential of increasing current obstetric volume by 20%-30% over a two year time interval.

A. Phase I [January 1, 2013 – June 30, 2013]

1. Keep the Existing Providers in the Community. Negotiate and secure employment contracts with L&M for the existing community obstetricians and mid-wife.

2. Divert High-Risk and C-Sections to L&M. Maintain the Westerly Hospital’s current obstetric service during Phase I. Notwithstanding, there would be a definitive protocol established to identify high-risk births and births that require cesarean sections (“C-sections”), both of which would be performed at L&M. The protocol and program needs to be designed by L&M in cooperative measure with Westerly obstetricians and the Westerly Hospital maternity staff. This first step in the community education and marketing process is absolutely crucial. It will require the support and cooperation of the community obstetricians and an active and aggressive liaison function by existing Hospital employees in maternity. If the obstetricians and maternity staff work with patients and L&M to educate high risk and C-section patients on the strengths of the L&M program, where to park, where to walk-in, who is there to help, how the pediatricians in the community will care for the infants after discharge, then it could be an invaluable segway into the balance of the plan.

3. Allow for Consideration of an L&M’s “Laborist Program”. A laborist program employs obstetricians who work a defined number of hours. This enables a hospital to offer obstetric care by a physician 24 hours per day, 7 days per week in a safe, controlled environment. This is not unlike the successful “Hospitalist” program at the Westerly Hospital. A Laborist Program at L&M, which becomes part of the system in the Westerly community, will take a

tremendous burden off of our existing obstetricians and will markedly improve the success for the Westerly community to recruit "Generation X and Generation Y" obstetricians into the system-wide program.

4. Educate and Market. Design an intensive community education and marketing campaign for the transition plan that reaches the entire network community service area. Marketing should be presented to the entire Westerly community as well as to the existing L&M service area community. The Westerly Area Residents Committee would be an excellent foundation for delivering the information and message to the community. Marketing should explain that the Westerly Hospital will continue to serve all of its residents in and around the surrounding area for all necessary, family pre and post-natal needs including family counseling, counseling for teenage parents, single mothers, as well as traditional families. It should be expressed that this L&M/Westerly collaborative is a top-notch, modern day physician and para-professional organization. Marketing should deliver the message that the integration of the Westerly Hospital into L&M creates new and improved methods of prenatal care with immediate access to maternal fetal medicine specialists which can only be accomplished through the synergy of the combined hospitals. The metamorphosis of the Westerly Hospital obstetric program and the L&M laborist program is the "**Birth of New Innovation; the first of many to come**". This could also be part of a platform to market Swing Beds, access to the Joslin Diabetes Center, and a new partnership with Dana Farber.

Marketing communication should advance the concept that by obtaining excellent pre-natal and post-natal care, Westerly Hospital is the home base to Southern Rhode Island communities, providing the entire service area community the opportunity to have a safe, successful and rewarding delivery experience at the magnificent obstetric facility of Lawrence &

Memorial, which is equipped with a "NICU". For low risk pregnancies, the alternative midwifery/Birthing Center model should be promoted as warm, friendly, enjoyable, safe and preferable. While this message is the concept, a marketing expert would be engaged to refine and advance the message.

In addition, the employees at the Westerly Hospital should be incorporated in developing and implementing this marketing process. First, so that they understand that they are part of the new L&M /Westerly community. Second, so that they can use their years of experience in the community in the delivery and treatment of pre and post-natal cases for the benefit of the program. Third, so that they understand that they are an integral part of the success of this unit and transition, so that the message to the community is positive.

Marketing material in web-based content as well as a hard-copy, should ultimately be made available to all current and prospective patients. Classes and educational information, designed at different levels should be designed for presentation to medical staff, hospital personnel and patients. Classes and lectures should be started at the Westerly Hospital whereby the "audience" can go through an orientation and education program during this six month period to learn about the "new" Westerly / L&M obstetric care and midwifery program.

5. Develop a midwifery program. The new midwifery model to be implemented at the Westerly Hospital should be announced as a positive, progressive new program, as the L&M obstetric delivery and laborist model is introduced to the community. This program can possibly be implemented in a partnership between L&M, URI and/or a regional healthcare provider as a "hospital within a hospital" model, and be a launching point to study the Birthing Center model.

Marketing and community education should:

- a. Inform families that the program will monitor all physical, psychological, and social concerns of the mother, father and baby through the entire pregnancy;
- b. Provide within AMA and Mid Wife Task Force guidelines, education and counseling and pre-natal and post natal/post-partum care. Provide, at L&M's New London location, a first class safe state of the art assistance and guidance program during all aspects of labor and delivery from routine to complex;
- c. Educate patients and staff on the benefits of reducing technological intervention, especially when it is unnecessary, while simultaneously identifying those who require more hands on obstetrical intervention and attention; and
- d. Integrate the WHOW and Westerly Hospital maternity ward personnel into this model, using them as part of the promotional marketing to inform the community that this is not a termination of obstetrics but a growth and implementation of new and advanced services.

At the conclusion of the Phase I, the midwifery model would be ready for actual implementation in the obstetric and gynecological community, the medical staff community and the patient community.

6. The Birthing Center Model. Undertake a marketing and financial feasibility study for expanding the midwifery program by locating and developing a Birthing Center. A birthing center allows for a home-like birth in a non-hospital alternative. This could be a new market for the L&M/Westerly Hospital system. This would be only the second hospital network, supported birthing center in Rhode Island. A birthing center model should be considered leading up to and during the midwifery phase of the obstetric reorganization. A marketing study should be

commissioned to determine the need and market for non-traditional birthing situations. There are approximately 215 existing birthing centers in the United States according to the American Association of Birthing Centers. There are several models in the New England area. One is located in Danbury, Connecticut. Another is affiliated with Gifford Hospital in Vermont. Gifford Hospital boasts a birthing center which has evolved over a twenty-year period. They claim that 35% of their births are performed at this center. It appears that many birthing centers are not for profit and obtain funds in many cases from grants. A full study would have to be performed on the economic feasibility as well as the population that would use this model. The Westerly Hospital Foundation should be approached and invited to be a part of the formation of this program. Done properly significant grant dollars and donations for the initial capitalization and start up could be obtained. The Mastership emphasizes that the close knit, comfortable and geographically desirable location of the Westerly Hospital creates a marketing tool in and of itself. The ability to draw from south and northeast of New London with the L&M reputation and the Westerly atmosphere creates a very strong marketing tool that cannot be otherwise created. The model for the Westerly/L&M Birthing Center would have 4 primary operational/clinical and philosophical components:

- a. A collaborative practice within L&MPA of midwives, obstetricians and maternity nurses from the Westerly Hospital;
- b. Comprehensive prenatal services including case management, health education, nutrition counseling, social services;
- c. The option of having birth in the Birthing Center or at the L&M Hospital in New London; and

- d. Women choosing the Birthing Center would be pre-determined/ approved based upon history and medical work up during the early stages of the pregnancy to determine their obstetric risk profile.

The objective marketing study would be accompanied by development of a financial model to be incorporated and balanced into the Westerly Hospital turnaround plan.

Based upon research and discussions, some preliminary findings include:

- a. Birthing Center proponents that can draw from a diverse demographic and socio-economic population, boast that discharge of the patient and baby occurs 4-24 hours after delivery; and
- b. When given an option, low income women and families with low risk pregnancies choose a birthing center because of
 - i. Recommendations of friends and family;
 - ii. Friendly staff;
 - iii. Previous positive experience and care during the pre-natal treatment at the birthing center location;
 - iv. Location of the birthing center;
 - v. Bi-lingual staffing; and
 - vi. Financial considerations.

The financial model should be developed to meet the four (4) primary components taking into account 100% of current pre-acquisition WHOW and Westerly Hospital professional, technical and plant components of expense and revenue and then perform a comparative analysis between pre-acquisition and projected Birthing Center deliveries coupled with traditional obstetrical intervention deliveries at L&M.

According to Dr. Weinstein, the Birthing Center will need one full-time nurse on duty 24 hours/day. There will need to be a second nurse on call when the Birthing Center has several patients in labor. These positions should be offered to the current nurses before anyone else is recruited. For better utilization and economics for the Birthing Center, Dr. Weinstein recommended that the current OB/GYN physicians perform their gynecology practice at the Birthing Center and move out of their offices which would be a substantial cost saving measure and allow better utilization of nursing personnel.

Dr. Weinstein believes that one or both of the current obstetricians would find advantage to stay on to practice gynecology and be the physician consultant for the Birthing Center. This change in workload would add 5 to 10 years to their work life. In turn, the Birthing Center would allow Westerly to continue to offer the type of user friendly obstetric care that has become its strength.

7. Recruiting. Begin to recruit a third obstetrician who would maintain an office in the Westerly service area and work within the L&M laborist program. Also, recruit additional mid-wife support for the Westerly community in conjunction with the transition plan. The Phase I Plan anticipates that recruitment for the physician would be underway and that additional midwives would be in the hiring process.

8. Potential Partnership with Wood River. Explore the potential for continuing a "low risk" non-interventional obstetric service at the Westerly Hospital by and through a partnership with the Wood River Health Center which is a federally qualified health center. A federally qualified health center does not have to carry the cost burdens of malpractice insurance.

9. Potential Family Medicine, Low-Risk Program. Explore the potential for a program such as that being undertaken by Memorial Hospital in conjunction with Brown University School of Medicine, Family Medicine.

B. Phase II – [July 1, 2013 – December 31, 2013]

1. Marketing and Education. Implement an intensive community education and marketing program aimed at transitioning the community to being comfortable with having pre-natal and post-natal care administered in Westerly while having the actual birth administered by the L&M laborist program or a midwifery/Birthing Center program as an option.

2. Phase Out Existing Service. In conjunction with the education and marketing program begin to phase out the existing obstetric service at the Westerly Hospital over the six months of Phase II. It is anticipated that at the successful conclusion of Phase II, that there would be no more obstetric births in the current maternity unit at the Westerly Hospital on and after January 1, 2014. All Westerly service area patients and their referring medical providers would be enrolled in a comprehensive program that would involve birthing at L&M, or in the midwifery program as an alternative.

3. Public Input on Birthing Center/Wood River Partnership/or other Options to Maintain an “Obstetric Presence” at the Westerly Hospital. Announce the findings from the studies undertaken in Phase I and set up public workshops to discuss expansion of a Birthing Center concept, a Wood River partnership or a family-medicine/low risk model.

C. Phase III [January 1, 2014 – June 30, 2014]

1. Implement a New Program. Fully, implement the program of having obstetrics offered on a system-wide basis. This would involve the majority of pre-natal and post-natal care being delivered in the Westerly community. Births would be administered by the L&M laborist program or in conjunction with midwifery program as an option. Birthing (outside the Birthing Center/midwifery model or a partnership with Wood River) would no longer take place at the Westerly Hospital.

2. Transition Employment. Transition obstetric services and staff to support the system-wide model.

3. Education/Marketing. Continue with the education and marketing program.

4. The Birthing Center. Assuming that the market study and financial feasibility study support Dr. Weinstein's option for a Birthing Center, the full development of the Birthing Center would begin. In turn, the other options for maintaining the "Obstetric presence" may be pursued independently or in tandem with the Birthing Center concept.

III. The Rationale for Implementing the Obstetric Service Transition Plan pre-Closing.

The Asset Purchase and Sale Agreement between the Special Master for the sale of the assets of the Westerly Hospital and Related Entities to the subsidiaries of the Lawrence & Memorial Hospital Corporation anticipates that L&M "shall commit not to discontinue any clinical service (including maternity)" for a period of two (2) years from the date of the Closing.

So long as there are no safety or equality issues associated with provision of such clinical services and so long as such clinical services is still being provided by the Hospital immediately prior to the Closing Date and so long as there are no safety or quality issues associated with provisions of such clinical service based, among other things, upon the volume of services provided in such a clinical setting as reviewed by the Hospital Board.

See APA at §10.1. The Special Mastership strongly believes that it is improper to have this issue dealt with post-Closing. The Special Master is concerned that there will be arguments about the application of the language of Section 10.1 of the APA, that could be destructive to a relationship between L&M and the community. It is absolutely critical that the relationship start on the strongest possible foundation. The Special Mastership is firmly committed to addressing this issue, pre-Closing, in a responsible fashion that takes advantage of the opportunity to implement a plan on a system-wide basis with positive support from the community as opposed to the negative reaction that could possibly result from an ongoing argument over post-closing conditions.

The Special Mastership has met with and spoken with numerous people on this topic and although this is an emotional issue, everyone agrees that the obstetric service as it currently exists is not sustainable and that some change must be implemented. Moreover, the Special Master truly believes that the transition plan can be successful, if it is undertaken in a cooperative effort by all of the constituencies including the community, the obstetricians, the pediatricians, existing staff working within the Westerly Hospital obstetric service and L&M. The most opportune time to advance such a plan is now.

IV. Plan Review

As stated above, the Special Mastership will undertake a review of this draft plan with a number of constituencies. In addition, the Special Mastership is researching certain issues, including whether there is the necessity of filing a reverse Certificate of Need for this transition plan which, if required, would be filed in Phase II or III of the transition. Furthermore, the Special Mastership has inquired of Dr. Weinstein with regard to the question of emergency room treatment for unforeseen, obstetric emergencies. In the proposed model of the Birthing

Center, the OB/GYN physician(s) doing the gynecology at the Westerly Hospital would be the consultant(s) for the ER as well as the Birthing Center. Also, the ER physicians at the Westerly Hospital can call L&M for consultation, especially if L&M has a Laborist Program where a physician would be immediately available on the labor floor. This would require one OB/GYN physician who could easily do both. As there are currently two OB/GYN physicians at the Westerly Hospital, Dr. Weinstein suggests they split this duty each doing alternate months.

In a continuing effort to advance ideas, the Special Mastership has and continues to speak with several hospitals in the nationally who have transitioned their obstetric service. The message has been that with adequate time to transition and educate, a program of this nature can work. Each administrator (CEO or COO) interviewed indicated that had they to do it all over again, they would ensure the following:

1. A debriefing with local political boards, fire, police, EMT would be initiated early as part of the Plan development and not after the fact;
2. Communication and explanation to local Town or City councils would be done in advance of a formal announcement. The communication would identify the fiscal and healthcare reasons for the change as well as the plan for relocation or modification of the services. They would be kept informed with presentations at regular meetings.
3. Prepared public relations to adjust to and respond to the community and staff responses would be done professionally and proactively and not reactively.
4. For those Union hospitals, they would have provided more information, reasons for the closure and sought cooperation earlier.
 - a. In one instance the Union staff initiated a campaign by past and expecting mothers negatively picketing the hospital.
 - b. Union officials and staff when taken by surprise were very difficult in the decommissioning process and then future offers of employment were seen as too little too late.
5. The ability to "phase out" complicated cases over a reasonable period of time with notification to the community, and further "transition" of the service was seen as a luxury they did not have because when they made their decision they moved without forethought or because they waited too long and could no longer afford the unit. When we explained the timing of our plan they stated that in

hindsight the Special Master's plan was something they all believed would have made their process smoother.

6. Consideration of ancillary services such as anesthesiology was of considerable importance. In one case it had not been considered and the back lash among other physician groups nearly became unmanageable. This occurred in the case of a hospital that determined closing the unit was in the best interest of patient service, given their sister hospital 30 minutes away could provide "better" service. Failing to hold informational meetings with the medical staff and not addressing the concern to the anesthesiologists led to a three week long "fire drill" to explain that the hospital was not failing financially, which eventually leaked to the press.
7. Two hospital administrators expressed that a plan that could still allow for a midwifery program would have made it easier for their staff and their obstetricians to transition. These hospitals did not have this option because they did not have a network healthcare system within which to work. They essentially sent all their patients to a "friendly" competing hospital, however in many cases because of a lack of ability to treat pre-natal patients the births went to other hospitals other than the hospital with which they were trying to work.

In discussing the plan the Mastership has outlined, the administrators we spoke to believed that delivery of babies is an emotional event which they will not underestimate in the future. They indicated that it is their belief that no matter how much education and how much planning is provided to staff and community there will still be some negative feedback, but it can be substantially reduced the earlier you begin the process with a slow, but steady plan to transition versus a short term plan with abrupt changes.

While not at all scientific, the results of the interviews demonstrate unanimously that a longer term, well thought out, educational and positively communicated transition of obstetric service is preferable to a short term plan. The administrators with whom we spoke also believed that employee retention, staff communication and cooperation were things they would have done earlier and differently to foster a positive experience, if it had to be done again. Finally they all indicated, while it would require further thought and investigation, an alternative replacement program/service, such as a perinatal service without delivery and a birthing center would be luxuries they would promote, if possible and feasible.

In conclusion, with positive community input and enthusiasm for the "system", the potential for a perceived negative event can be promoted as a dynamic opportunity to advance the delivery of care by the Westerly Hospital as part of a healthcare network. As stated above, the Special Mastership hopes this issue is not the end of such creative partnering, but a beginning of beneficial healthcare programs which will include not just growth and positive change for obstetrics, but also the Swing Bed Program, access to the Joslin Diabetes Center, and access to the Dana Farber Cancer Treatment Center.

k:\w\westerly hospital\obstetrics - gyn\westerly hospital special mastership obstetrics service transition plan 12-13-12.docx

TAB C

Payor Mix for The Westerly Hospital's Obstetric Labor and Delivery Patients from January, 2010 through December, 2012

Payor	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%

TAB D

The Westerly Hospital Payor Mix from January, 2010 through December, 2012

Payor	Percentage
Champus	1.5258%
HMO	6.0594%
Medicare	36.3550%
RI Blue Cross	13.7413%
CT Blue Cross	5.9323%
RI Medicaid	0.5446%
CT Medicaid	1.0419%
RI Workers Comp	0.4825%
CT Workers Comp	0.4230%
Self Pay	4.0924%
Bal After Medicare	0.0484%
Commercial	3.0279%
RI-General Public Assistance	0.0806%
HMO Medicare	8.5212%
Industry	0.0144%
Medicaid HMO	3.9148%
Self Pay After Insurance	0.0516%
Institutional Self-Pay	0.2457%
Employee/Clergy/Physician	0.0432%
Out of State Blue Cross	3.1598%
United Health Care Corporation	10.6941%
Total	100.0000%

TAB E

Total Number of Births in 2012 at Westerly Hospital	334
Percent of Births within 20 miles of South County Hospital	59%
Percent of Births within 25 miles of South County Hospital	77%
Percent of Births within 20 miles of L+M	27%
Percent of Births within 25 miles of L+M	83%
Percent of Births within 25 miles of South County or L+M	98%*

*The remaining 6 births were from areas further than 25 miles from Westerly Hospital and clearly visiting the area at the time

2012 Births by Zip Code at Westerly Hospital and Patients' distance from surrounding Hospitals

Distance to Lawrence & Memorial Hospital

Zip Code	Number of Births in 2012	Distance to Hospital (miles)
6320	3	0
6375	1	3.4
6385	1	3.7
6340	14	6
6382	1	7.3
6353	1	7.4
6335	3	7.9
6355	8	8.9
6339	7	10.1
6378	11	13.7
6360	2	15.7
6379	36	17.4
6365	2	17.6
6359	12	20.4
2804	22	22
2891	135	22
6351	3	22.5
2833	1	22.6
2808	15	23.7
2832	11	25.6
2898	8	27
6384	1	28
6331	1	28.2
2873	2	30
2813	14	31.2
2892	1	32
2822	4	33.2
2817	1	35
2879	5	40.1
2816	1	41.1
2893	1	44.3
2852	1	45.7
2818	1	46.4
2809	1	70.8
11738	1	72.2
6770	1	73.2
12550	1	134

2012 Births by Zip Code at Westerly Hospital and Patients' distance from surrounding Hospitals

Distance to South County Hospital

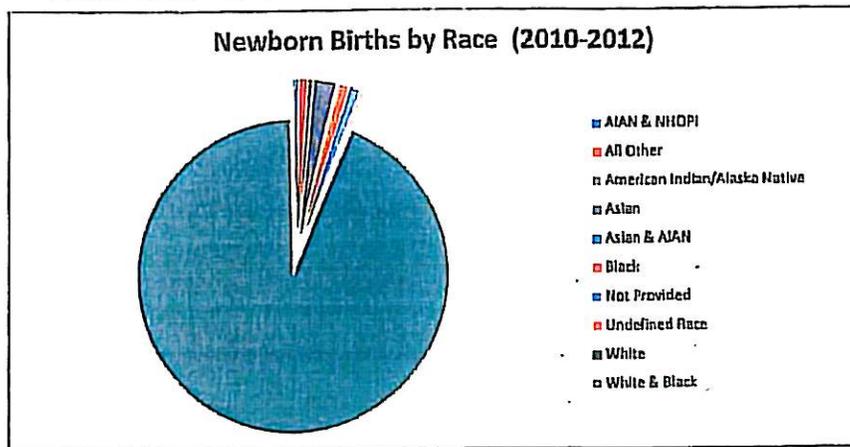
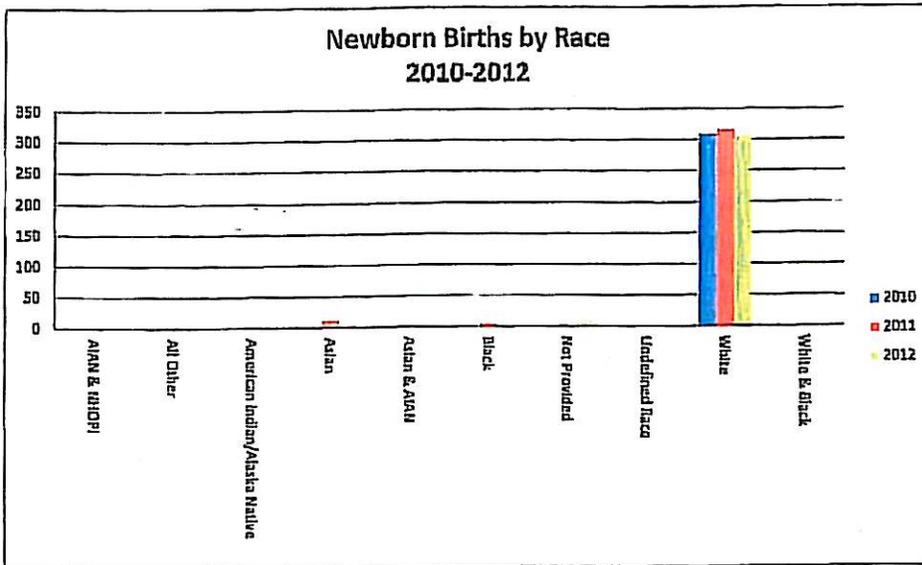
Zip Codes	Number of Births in 2012	Distance to Hospital (miles)
2879	5	0.00
2892	1	9.60
2852	1	12.20
2813	14	12.70
2898	8	14.20
2832	11	15.20
2818	1	16.30
2808	15	18.40
2822	4	18.60
2891	135	18.80
2873	2	19.70
2804	22	21.60
2817	1	23.10
2833	1	23.30
2893	1	23.30
6379	36	23.50
6384	1	25.00
6378	11	26.80
2816	1	27.70
6359	12	30.30
2809	1	31.30
6351	3	32.30
6355	8	33.60
6340	14	37.50
6365	2	39.00
6360	2	39.10
6339	7	39.30
6331	1	40.20
6320	3	40.30
6335	3	42.90
6375	1	43.30
6385	1	45.00
6382	1	46.60
6353	1	46.80
11738	1	111.00
6770	1	112.00
12550	1	174.00

TAB F

Newborn Births By Race

January 1, 2010 thru December 31, 2012

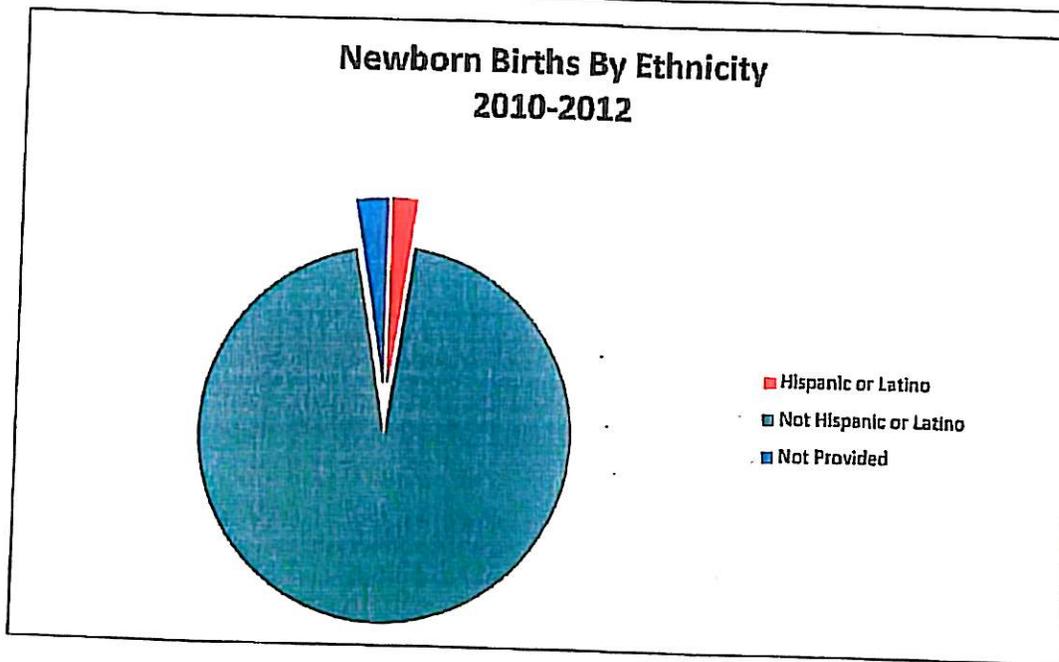
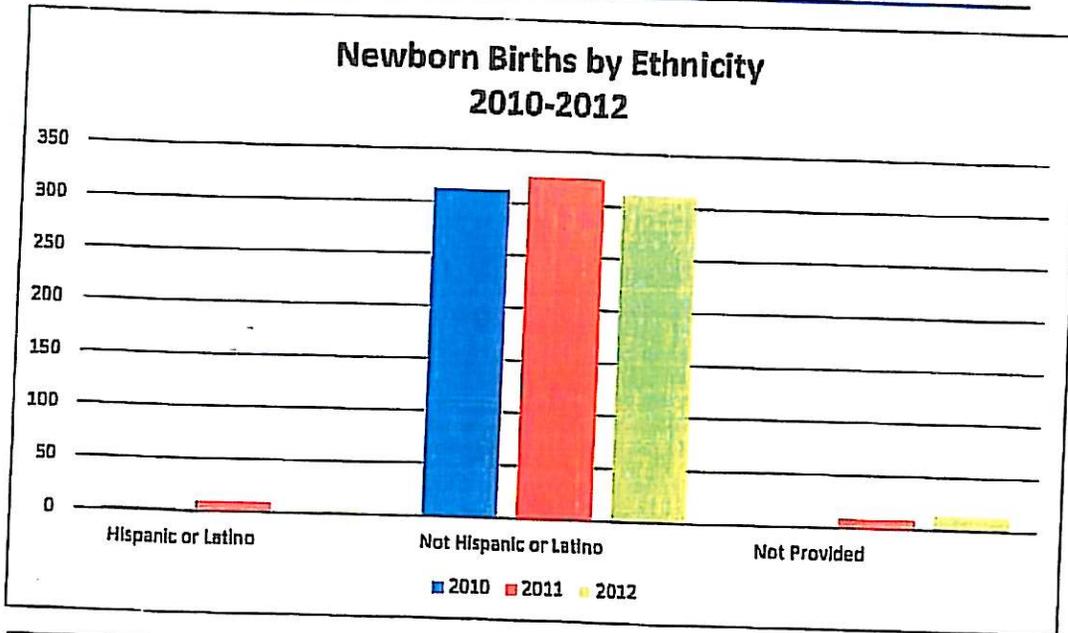
Count Race	AdmitYear			Grand Total	%Total
	2010	2011	2012		
AIAN & NHOPI		2		2	0.20
All Other	2	4	2	8	0.80
American Indian/Alaska Native		2	4	6	0.60
Asian	3	13	6	22	2.19
Asian & AIAN	1			1	0.10
Black		6	4	10	1.00
Not Provided		2	10	12	1.20
Undefined Race		1	1	2	0.20
White	312	318	308	938	93.43
White & Black	2		1	3	0.30
Grand Total	320	348	336	1004	100



Newborn Births By Ethnicity

January 1, 2010 thru December 31, 2012

Ethnicity	AdmitYear			Grand Total	%Total
	2010	2011	2012		
Hispanic or Latino	4	11	6	21	2.09
Not Hispanic or Latino	314	327	314	955	95.12
Not Provided	2	10	16	28	2.79
Grand Total	320	348	336	1004	100



Newborn Births

January 1, 2010 thru December 31, 2012

Count Primlms	ZipCode	AdmitYear			Grand Total
		2010	2011	2012	
AETNA INSURANCE					
	02804			2	2
	02813	1			1
	02832	1			1
	02891	7	1	4	12
	06355			1	1
	06359			1	1
	06378			1	1
	06379	1	1		2
	06384	1			1
AETNA INSURANCE Total		11	2	9	22
BLUECHIP					
	02808		1		1
	02891		2		2
	02898			1	1
BLUECHIP Total			3	1	4
CIGNA INSURANCE					
	02832			1	1
	02879		1		1
	02891	5	4	1	10
	06335		1		1
	06340			1	1
	06355		1	1	2
	06359			1	1
	06360	1		1	2
	06365			1	1
	06379	1		2	3
CIGNA INSURANCE Total		7	7	9	23
COMMUNITY HEALTH NETWORK					
	06241		1		1
	06340		1		1
	06355		1		1
	06359		5		5
	06378	1			1
	06379	1	6		7
COMMUNITY HEALTH NETWORK Total		2	14		16
COMPASS ROSE HEALTH PLAN					
	02813		1		1
COMPASS ROSE HEALTH PLAN Total			1		1
CONN BX ANTHEM					
	02804	2			2
	02808		1		1
	02813	1		1	2
	02832			2	2
	02833		1		1
	02891	4	13	10	27
	02893	1			1
	02894			1	1
	02921		1		1
	06320	1		1	2

CONN BX ANTHEM		06335		1		1
		06339	1	1	5	7
		06340	1		1	2
		06351	1	1	1	3
		06355	2	5	2	9
		06359	2	2		4
		06370		1		1
		06375		1		1
		06378	1		3	4
		06379	9	6	4	19
		06384	1			1
		06469	1			1
CONN BX ANTHEM Total			28	34	31	93
CONN BX STATE		02808	1			1
		02833		1		1
		02891		1		1
		06359	1	1		2
		06379	1	1	1	3
CONN BX STATE Total			3	4	1	8
CONNECTICARE		02808		1		1
		02832		1		1
		02891		1	1	2
		02892	1			1
		06340			1	1
		06351			1	1
		06355	1	1		2
		06359	1	1		2
		06378			1	1
CONNECTICARE Total			3	5	4	12
CONNECTICUT MEDICAID		02891			2	2
		06320	1			1
		06339			1	1
		06340			1	1
		06351			1	1
		06355			1	1
		06359		2	5	7
		06360			1	1
		06378		2	3	5
		06379	1	3	9	13
		06384		1		1
		06770			1	1
CONNECTICUT MEDICAID Total			2	8	25	35
EB UNITEDHEALTHCARE		02804	1		1	2
		02812		1		1
		02832	1	1		2
		02891	2	6	4	12
		06320		1		1
		06335		1		1
		06340		1		1

EB UNITEDHEALTHCARE	06353			1	1
	06355	1			1
	06359	1			1
	06378		1	1	2
	06379	1		2	3
	06384		1		1
EB UNITEDHEALTHCARE Total		7	13	9	29
FEDERAL BLUE CROSS	02804		2		2
	02808			1	1
	02813		1		1
	02816	1			1
	02836		1		1
	02852	1			1
	02891	2	1	2	5
	06320	1			1
	06335		1		1
	06340		1		1
	06379	2			2
	06385			1	1
FEDERAL BLUE CROSS Total		7	7	4	18
GOLDEN RULE INSURANCE	06359		1		1
GOLDEN RULE INSURANCE Total			1		1
HARVARD PILGRIM HEALTH CARE	06340	1			1
HARVARD PILGRIM HEALTH CARE Total		1			1
HEALTH FIRST	11738			1	1
HEALTH FIRST Total				1	1
HEALTHMATE	02804	4	4	2	10
	02808	7	4	4	15
	02812	2			2
	02813	1	2	4	7
	02816			1	1
	02832	3	3	1	7
	02874	1			1
	02879			1	1
	02891	20	19	22	61
	02898		1	2	3
	06320	1			1
	06351		1		1
	06355	1		1	2
	06359	1	1		2
	06378	1	1		2
	06379	7	8	5	20
	06382	1		1	2
HEALTHMATE Total		50	44	44	138
HEALTHNET	06355	1			1
HEALTHNET Total		1			1
NEIGHBORHOOD HLTH PLAN	02804		2	4	6
	02808		2	6	8
	02813		2	2	4

NEIGHBORHOOD HLTH PLAN		02816		1		1
		02822			2	2
		02832		5	1	6
		02852		1		1
		02873			2	2
		02891	8	37	30	75
		02892	1		1	2
		02893	1		1	2
		02894		1		1
		02898			2	2
		06379			2	2
		06380		1		1
NEIGHBORHOOD HLTH PLAN Total			10	52	53	115
OUT OF STATE BLUE CROSS		01201	1			1
		02804	1		1	2
		02808	1			1
		02832	1			1
		02833	1			1
		02874	1			1
		02879	1		1	2
		02888		1		1
		02891	6	3	4	13
		02893	1			1
		06320		1		1
		06339		1		1
		06340	1		1	2
		06351	1			1
		06355	2	1		3
		06359		1	2	3
		06379	1	2	4	7
		06382		1		1
		06384	1			1
		12550			1	1
		33477		1		1
OUT OF STATE BLUE CROSS Total			20	12	14	46
OXFORD HEALTH		02891		1	4	5
		06331		1	1	2
		06335			1	1
		06340		1	1	2
		06355		1		1
		06359			2	2
		06379			2	2
OXFORD HEALTH Total				4	11	15
PRINCIPAL LIFE INSURANCE CO		06355	1			1
PRINCIPAL LIFE INSURANCE CO Total			1			1
RHODE ISLAND BLUE CROSS		02804			1	1
		02808		1	1	2
		02813			3	3
		02832		1		1

RHODE ISLAND BLUE CROSS	02873			1	1
	02888	1			1
	02891	2	1	7	10
	06335			1	1
	06359		1		1
	06378			1	1
	06379			1	1
RHODE ISLAND BLUE CROSS Total		3	4	16	23
RHODE ISLAND MEDICAID	02808	1			1
	02817			1	1
	02832	2			2
	02891	2	2	2	6
	02898			1	1
	02911		1		1
RHODE ISLAND MEDICAID Total		5	3	4	12
SELF PAY	02804			3	3
	02809			1	1
	02891	4	3	1	8
	02892		1		1
	06254	1			1
	06355			1	1
	06359	1			1
	06378		1		1
	06379	1		1	2
	(blank)		1		1
SELF PAY Total		7	6	7	20
SELF PAY AFTER INSURANCE	06379		1		1
SELF PAY AFTER INSURANCE Total			1		1
Self Pay Private - DO NOT USE	02804	1			1
Self Pay Private - DO NOT USE Total		1			1
TRICARE HEALTHNET FED SERV INC	02804		1	1	2
	02817	1			1
	02832		1		1
	02879		1		1
	02891		3	6	9
	02893		1		1
	06320			2	2
	06335		1		1
	06339	3	3		6
	06340	13	12	6	31
	06355	7	5		12
	06359		1	1	2
	06378		1	1	2
	06379	1	3	3	7
TRICARE HEALTHNET FED SERV INC Total		25	33	20	78
TUFTS HEALTH PLAN	02898			1	1
	06335			1	1
TUFTS HEALTH PLAN Total				2	2
UMR	02813			1	1

UMR	02891			2	2
UMR Total				3	3
UNITED HEALTH CARE				3	5
02804	1	1			2
02808	1	1			4
02813	1	3			1
02822		1			3
02832	1			2	1
02833		1			1
02852				1	1
02879		1		2	3
02882	1				1
02891	12	13		8	33
02893				1	1
02898	1				1
06339				1	1
06340		1		2	3
06355	1				1
06359	3				3
06375				1	1
06378	1	4		1	6
06379	1	3			4
06384				1	1
UNITED HEALTH CARE Total	24	29		23	76
UNITED HEALTH CARE RITE CARE					
02804	1	5		2	8
02808	1	2		3	6
02813		2		2	4
02817		1			1
02818				1	1
02822	1			2	3
02832	3	3		2	8
02833		1		1	2
02874		1			1
02879				1	1
02891	4	28		20	52
02893				1	1
06372		1			1
06379	1				1
UNITED HEALTH CARE RITE CARE Total	11	44		35	90
UNITED HLTH MASHANTUCKET					
02804	1	1			2
02808	1				1
02813		2			2
02822		1			1
02832	1			1	2
02873	1				1
02891	4	5		6	15
06082	1				1
06339		1		1	2
06355	1	4		1	6
06360	2				2

UNITED HLTH MASHANTUCKET	06365		1		1
	06378		1		1
	06379		1	1	2
	06382	1			1
UNITED HLTH MASHANTUCKET Total		13	17	10	40
ZBLUECHIP	02879	1			1
	02891	3			3
	02892	1			1
ZBLUECHIP Total		5			5
ZBLUECHIP RITECARE	02879	1			1
	02891	3			3
	06355	1			1
ZBLUECHIP RITECARE Total		5			5
ZCOMMUNITY HEALTH NETWORK	06359	1			1
	06378	1			1
	06379	5			5
ZCOMMUNITY HEALTH NETWORK Total		7			7
ZNEIGHBORHOOD HLTH PLAN	02804	4			4
	02808	4			4
	02812	1			1
	02813	2			2
	02832	2			2
	02852	1			1
	02882	1			1
	02891	15			15
	02892	1			1
	06340	1			1
	(blank)	1			1
ZNEIGHBORHOOD HLTH PLAN Total		33			33
ZOXFORD HEALTH	02891	3			3
	06378	1			1
ZOXFORD HEALTH Total		4			4
ZUNITED HEALTH CARE RITE CARE	02808	3			3
	02813	1			1
	02832	1			1
	02840	1			1
	02879	1			1
	02891	16			16
	02892	1			1
ZUNITED HEALTH CARE RITE CARE Total		24			24
Grand Total		320	348	336	1004

TAB G

APPENDIX A (CONT.)

3. Please complete the table below for the existing and new hospital for each year indicated.

PAYOR SOURCE:	Past Three Fiscal Years (Actual)				Budgeted Current Year		Projected First Three Operating Years (if approved)							
	FY: 2009 \$	%	FY: 2010 \$	%	FY: 2011 \$	%	FY: 2012 \$	%	FY: 2013 \$	%	FY: 2014 \$	%	FY: 2015 \$	%
Medicare	31,757,072.09	37.74	31,917,829.93	36.88	30,275,198.95	36.34	29,843,757.85	36.64	30,299,117	36.64	30,982,087	36.64	30,982,087	36.64
Medical	4,883,714.53	5.8	5,535,013.86	6.4	4,955,468.81	5.95	5,466,625.57	6.71	5,548,773.90	6.71	5,673,848.3	6.71	5,673,848.3	6.71
Blue Cross	16,374,245.96	19.46	16,131,924.00	18.64	16,380,918.88	19.66	16,480,983.34	20.23	16,729,016.90	20.23	17,106,103	20.23	17,106,103	20.23
Commercial	19,465,703.44	23.13	21,758,516.79	25.14	19,817,865.00	23.79	19,817,865.00	20.11	16,629,783	20.11	17,004,633	20.11	17,004,633	20.11
HMO's	4,279,793.81	5.09	3,906,671.64	4.51	2,838,821.95	3.41	5,064,738.29	6.22	5,143,572.80	6.22	5,259,516.6	6.22	5,259,516.6	6.22
Self Pay	6,326,004.00	7.52	5,989,535.00	6.92	8,443,668.00	10.14	7,132,255.03	8.76	7,244,002.90	8.76	7,407,289.3	8.76	7,407,289.3	8.76
Other:	1,057,002.17	1.26	1,305,861.79	1.51	591,668.41	0.71	1,083,278.29	1.33	1,059,831.50	1.33	1,124,622.7	1.33	1,124,622.7	1.33
TOTAL	\$84,143,536	100	\$86,545,353	100	\$83,303,610	100	\$81,453,751	100	\$82,694,090	100	\$84,558,098	100	\$84,558,098	100
Charity Care*	434,836	0.50%	901,641	1.04%	719,764	0.86%	663,644	0.81%	663,644	0.80%	663,644	0.78%	663,644	0.78%

*Charity Care does not include bad debt, and is based on costs (not charges).

TAB H

Percentage of Births not performed at Westerly Hospital for patients residing
in the Westerly Hospital primary service area
January 1, 2010-December 31, 2012

City & Town	Year											
	2010					2011					2012	
	Total amount of Births	Births at Westerly Hospital	Percentage of Births performed in the service area by Hospitals other than Westerly Hospital	Total amount of Births	Births at Westerly Hospital	Percentage of Births performed in Westerly Hospital's primary service area by Hospitals other than Westerly Hospital	Total amount of Births for Westerly Hospital's primary service area	Births at Westerly Hospital	Percentage of Births performed in Westerly Hospital's primary service area by Hospitals other than Westerly Hospital	Total amount of Births	Percentage of Births performed in Westerly Hospital's primary service area by Hospitals other than Westerly Hospital	
Hopkinton, RI including: -Ashaway, and -Hope Valley.	89	33	62.92%	71	35	50.70%	67	31	53.73%			
Westerly, RI	211	122	42.18%	196	144	26.53%	207	136	34.30%			
Stonington, CT*	108	59	45.37%	126	65	48.41%	118	57	51.69%			
North Stonington, CT*	43	11	74.42%	40	16	60.00%	42	12	71.43%			
Total for RI 2010-2012	300	155	48.33%	267	179	32.96%	274	167	39.05%			
Total for CT 2010-2012*	151	70	53.64%	166	81	51.20%	160	69	56.87%			
Total 2010-2012	451	225	50.11%	433	260	39.95%	434	236	45.62%			

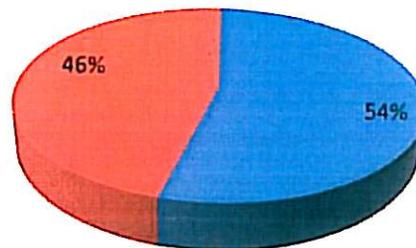
*The number of births for CT consists only of births performed at CT hospitals and births performed at Westerly Hospital

	Total amount of Births performed in Westerly Hospital's primary service area	Total amount of Births performed at Westerly Hospital for patients residing in Westerly Hospital's primary service area	Percentage of Births performed in Westerly Hospital's primary service area by Hospitals other than Westerly Hospital
Total for RI 2010-2012	841	501	40.43%
Total for CT 2010-2012*	477	220	53.88%
Total 2010-2012	1318	721	45.30%

*The number of births for CT consists only of births performed at CT hospitals and births performed at Westerly Hospital

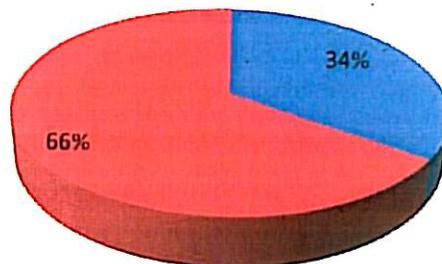
**Percentage of births not performed at
Westerly Hospital for patients residing in
Hopkinton, Ashaway and Hope Valley, RI
2012**

- Births performed at Hospitals other than Westerly Hospital
- Births performed at Westerly Hospital



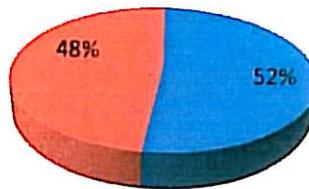
**Percentage of births not performed at Westerly
Westerly Hospital for patients residing in
Westerly, RI
2012**

- Births performed at Hospitals other than Westerly Hospital
- Births performed at Westerly Hospital



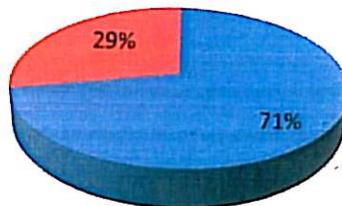
**Percentage of births not performed at Westerly Hospital for patients residing in Stonington, CT*
2012**

- Births performed at Hospitals other than Westerly Hospital
- Births performed at Westerly Hospital



**Percentage of births not performed at Westerly Hospital for patients residing in North Stonington, CT*
2012**

- Births performed at Hospitals other than Westerly Hospital
- Births performed at Westerly Hospital



*The number of births for CT consists only of births performed at CT hospitals and births performed at Westerly Hospital

TAB I

LAWRENCE
& MEMORIAL
HOSPITAL



Bruce D. Cummings
President &
Chief Executive Officer

February 22, 2012

Ms. Valentina D. Adamova
Acting Chief Health Program Evaluator
Rhode Island Department of Health
Office of Health Systems Development
3 Capitol Hill, Room 410
Providence, RI 02908

Mr. Michael Dexter, Chief
Health Systems Development
Rhode Island Department of Health
3 Capitol Hill, Room 410
Providence, RI 02908

RE: Discontinuation of Obstetrical Deliveries at The Westerly Hospital

Dear Ms. Adamova, Mr. Dexter, and members of the Health Services Council,

I am pleased to confirm that Lawrence + Memorial Hospital has sufficient available capacity in its maternity unit (a/k/a "LDRP) with which to accommodate Westerly area women. As the accompanying data show, even if one were to assume that as many as 85% (256 of ~ 350 deliveries/year) of pregnant women who previously delivered at The Westerly Hospital were to now come to L+M, our existing 24 bed unit would be able to handle the volume. We are not expecting that to be the case -- indeed, with Dr. Andrew Neuhauser's announcement that he will remain in Westerly but bring his births to South County Hospital as of June 1 -- a more likely scenario is that somewhere between 25% (88) and no more than 50% (175) of the deliveries would gravitate to L+M.

L+M has the requisite capacity, expertise, and resources as evidenced by in its 24-bed maternity unit, full-time level II NICU, 24/7 in-house anesthesia coverage, lactation consultation and other patient education and support services with which to provide a safe, high quality, and comfortable birthing experience for Westerly area women who choose to come to L+M. Therefore, we support the recommendation of the Special Master to file a reverse CON for the purpose of terminating obstetrical services at The Westerly Hospital as of June 1, 2013.

If you have further questions or need additional information, please feel free to contact me.

Sincerely,


Bruce D. Cummings, FACHE
President and CEO

C: W. Mark Russo, Special Master
Lauren Williams, RN, Chief Nursing Officer
Maureen Anderson, General Counsel
Dan Rissi, MD, Chief Medical Officer

Bed Need at L+M with Volume Shift from WH

	FY 2012 L+M Discharges	FY 2011 WH Discharges	Volume Shift from WH to L+M (1)	Projected L+M Discharges	ALOS (2)	Patient Days	Average Daily Census	Bed Need (3)	Current Beds	Surplus/ Deficit
OB Delivery	1,489	347								
OB Non-Delivery	130	16	256	1,875	2.8	5,250	14.4	24	24	(0)
Total	1,619	363								

Note: L+M = Lawrence + Memorial Hospital, WH = Wesley Hospital

- (1) Assumes WH OB Delivery discharges originating from towns in L+M's primary or secondary service areas will can shift to L+M
- (2) Assumes L+M's current average length of stay (ALOS) in days
- (3) Assumes 60% utilization target

Source data provided by: CHA and RI DOH.



SOUTH COUNTY HOSPITAL
HEALTHCARE SYSTEM

South County Hospital ■ VNS Home Health Services ■ South County Quality Care ■ South County Surgical Supply

February 26, 2013

Ms. Valentina D. Adamova
Acting Chief Health Program Evaluator
Rhode Island Department of Health
Office of Health Systems Development
3 Capitol Hill, Room 410
Providence, RI 02908

Mr. Michael Dexter, Chief
Health Systems Development
Rhode Island Department of Health
3 Capitol Hill, Room 410
Providence, RI 02908

Re: Westerly Hospital Obstetric Labor and Delivery Reverse CON

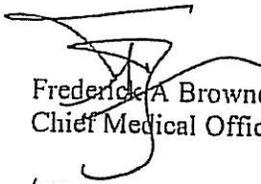
To Whom It May Concern:

South County Hospital received notice that The Westerly Hospital intends to cease labor and delivery services as of June 1, 2013. South County Hospital and its affiliates are in support of this request.

Further, we have been in contact with the Special Master for The Westerly Hospital with regard to our ability to absorb the obstetric labor and delivery patients who previously would have sought care at The Westerly Hospital should the hospital close its obstetric labor and delivery service. We have been advised that the projected annual birth at The Westerly Hospital for the next two calendar years (2013 and 2014) is approximately 300 to 325 birth and deliveries for each year. South County Hospital and its affiliates have sufficient providers and call coverage, such that if all of these projected births were to come to South County Hospital, we would be able to provide the requisite and proper care to these patients.

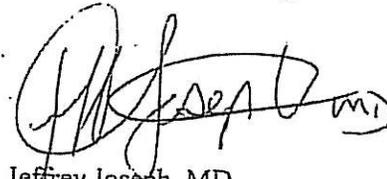
Should you have any questions, please do not hesitate to contact the undersigned.

Sincerely,



Frederick A. Browne MD
Chief Medical Officer, VP Medical Affairs

/sm



Jeffrey Joseph, MD
Chief, Obstetrics & Gynecology

TAB J

EMS Communication Plan

Discontinuation of Labor and Delivery Services at Westerly Hospital

Below is the communication plan for notifying Rhode Island EMS providers regarding the discontinuation of labor and delivery services at Westerly Hospital. Notification will be sent to all Rhode Island and Southeastern Connecticut EMS Providers. In addition to a written notice, Lawrence + Memorial Hospital will host a question and answer session for EMS providers at Westerly Hospital prior to June 1st to clarify any points and answer questions about this matter.

The list of providers who will receive notification is attached. The Administrator of Westerly Ambulance reviewed the list for its completeness to be sure no entity was missed.

Timeline for communication

Execute transfer agreement between Westerly Hospital and L+M Hospital	March 1, 2013
Notice email and mailing to EMS providers	March 1, 2013
Informational (question & answer) session	April 1, 2013
Complete education of transfer procedure and drill process	April 15, 2013
Complete revision to process (if required)	May 1, 2013
Process implementation	June 1, 2013

Attachments

EMS Provider contact list
Transfer Agreement
Service Discontinuation Notice to EMS
Westerly Ambulance Support Letter (Draft)
Hospital Staff Transfer Guideline
Clinical Simulation Document

TAB K

Date

Dear EMS Chief,

I am writing to provide you with important information as it relates to the care and transport of Westerly area obstetrics patients requiring labor and delivery services.

As you may be aware, deliveries will no longer take place at The Westerly Hospital after June 1, 2013.

Therefore, also on that date, any patient presenting with a need for labor and delivery including obstetrical emergencies should not be transported to The Westerly Hospital. Instead, the patient should be brought to a proximal facility providing labor and delivery, obstetric services likely Lawrence + Memorial Hospital or South County Hospital.

In an effort to share more information and answer concerns you may have, we will be hosting a Question and Answer session at The Westerly Hospital on {insert date}.

In the meantime, if you have specific questions, you can call me directly at 860.442.0711, ext. 2683.

Sincerely,

Ron Kersey
EMS Coordinator

TAB L

Fire and Police Rescue Servicing Westerly Hospital Primary Service Area

Town	Fire Department	Police Department
Westerly, RI 02891	<p>Chief: John Mackay Chief's phone: (401) 596-6661 e-mail: chief@westerlyfire.com Dept. phone: (401) 596-0402 Dept. fax: (401) 596-3350 Address: 7 Union Street, Westerly, RI 02891-2131</p>	<p>Chief: Edward St. Clair Phone: (401) 348-6101 (401) 596-2022 e-mail: estclair@westerlypolice.org Address: 60 Airport Road, Westerly, RI 02891</p>
Hope Valley, RI 02832	<p>Chief: Frederick Stanley Phone: (401) 539-2229 Address: Main Street, Hope Valley, RI 02832 Mailing Address: P.O. Box 25, Hope Valley, RI 02832</p>	<p>Hope Valley does not have its own Police Department. It is serviced by Hopkinton.</p>
Hopkinton, RI 02833	<p>Hopkinton does not have its own Fire Department. Hopkinton is serviced by Ashaway and Hope Valley Fire Departments</p>	<p>Chief: David Palmer e-mail: chief@hopkintonpolice.org Phone: (401) 377-7750 Fax: (401) 377-7755 Address: 406 Woodville Road, Hopkinton, RI 02833</p>
Ashaway, RI 02804	<p>Chief: Michael Williams Phone: (401) 377-4549 Location: Main Street, Ashaway, RI 02804 Mailing Address: P.O. Box 44, Ashaway, RI 02804</p>	<p>Ashaway does not have its own Police Department. It is serviced by Hopkinton.</p>
Stonington, CT	<p>Stonington is serviced by six volunteer fire departments:</p>	<p>Chief: J. Darren Stewart Phone: Routine Police Calls: (860) 599-4411</p>

Mystic Fire Department

Chief: Fritz Hilbert

Phone: (860) 572-7567 (Non-Emergency)

Fax: (860) 536-691034

Address: 34 Broadway, Mystic, CT. 06355

Old Mystic Fire Department

Chief: Kenneth Richards Jr.

Telephone: (860) 536-2220

Fax: (860) 536-7811

Address: 295 Cow Hill RD,
Mystic, CT 6355

Pawcatuck Fire Department

Chief: Tom Long

Telephone: (860) 599-4251

Fax: (860) 599-8116

Address: 33 Liberty St, Pawcatuck, CT

Quiambug Fire Department

Chief: James McPherson

Address: 50 Old Stonington Road,
Stonington, CT 6378

Telephone: (860) 536-1743

Fax: (860) 572-9243

Stonington Borough Fire Department

Chief: Jeffrey T. Hoadley

Address: 100 Main St, Stonington, CT
06378

Phone:(860) 535-0329

Wequetequock Fire Department

Chief: Edward Dennett

Telephone: (860) 599-8343

Fax: (860) 599-2979

Fax: (860) 599-7576

Voice Attended Phone: (860) 599-7500

Address: 173 South Broad Street
Pawcatuck, CT 06379

	<p>Address: 6 Farmholme Rd., Pawcatuck, CT 06379</p>	
<p>North Stonington, CT 06359</p>	<p>Chief: Charles Steinhart V Phone: (860) 535-0937 Address: 267 Norwich-Westerly Road, P.O. Box 279, North Stonington, CT 06359</p>	<p>Address: Old Town Hall, 40 Main Street North Stonington, CT 06359 Phone: (860) 535-1451</p>
<p>Ambulance Services for Westerly Hospital Primary Service Area</p>		
<p>Ambulance Service</p>	<p>Town</p>	<p>Telephone Number</p>
<p>Med Tech</p>	<p>South Kingston/Narragansett, RI</p>	<p>(401) 783-4800</p>
<p>Westerly</p>	<p>Westerly, RI</p>	<p>(401) 596-2213</p>
<p>Ashaway</p>	<p>Ashaway, RI</p>	<p>(401) 596-2213</p>
<p>Charlestown</p>	<p>Charlestown, RI</p>	<p>(401) 364-3742</p>

Eastern Connecticut EMS Agency List

American Ambulance Service

One American Way

Norwich CT 06320

(860) 886-1463 GAllard@americanamb.com

Ledyard Ambulance

P.O.Box 10

Ledyard, Ct 06339

(860) 464-8222 lves.director@ledyardct.org

North Stonington Ambulance

10 Mains Crossing

North Stonington, CT 06459

(860) 535-1135 president@nsambulance.org

Stonington Ambulance Association

P.O. Box 424

Stonington, Ct 06378

(860) 535-3721 theresa.hersh@facebook.com

Mystic River Ambulance

P.O. Box 64

West Mystic, Ct 06388

(860) 572-0581 mwilson@mysticriverambulance.org

Voluntown Fire Department Ambulance

P.O. Box 10

Voluntown Ct 06384

(860)

TAB M



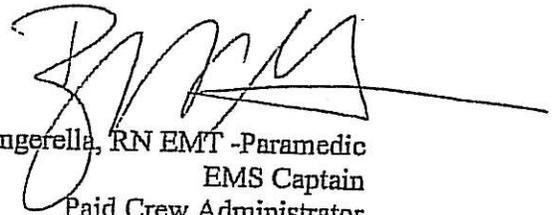
February 20, 2013

Lawrence and Memorial Hospital
365 Montauk Avenue
New, London CT 06320

Dear Paramedic Ron Kersey,

Please let this letter show as documentation that The Westerly Ambulance Corps, Inc is willing and able to participate in transports out of Westerly Hospital both emergent and non-emergent. We have spoken with our mutual aid companies who are willing at this point to assist in the emergent transports as needed. I am confident when we get to planning in regards to the non-emergent transports they will be willing to assist there as well. If there is anything I or Westerly Ambulance can do to assist in the planning and implementation of the transport and/or emergency services policies out of Westerly Hospital in the future please let me know. I look forward to forming a solid working relationship.

Respectfully Submitted,



Bethany Gingerella, RN EMT -Paramedic
EMS Captain
Paid Crew Administrator

TAB N



THE WESTERLY HOSPITAL

Name of Document: Protocol for Stabilization and Transfer of the Pregnant Patient		
Search Words: maternal transfer, stabilization		
Revision/Effective Date:	Supersedes: NEW	Origination Date: 2-19-2013
Owner of Document and responsible reviewers: Nurse Manager, ED	Department: ED	Manual: ED
Approval: Margaret Austin, VP, Clinical Operations, Chief Nursing Officer	Approval Date:	Page : 1 of 3

Policy Statement:

1. A pregnant woman presenting to the Emergency Department complaining of suspected labor (contractions) will have a medical screening examination performed. Fetal heart tones are monitored via Doppler.
2. If delivery is not imminent and there is adequate time for a safe transfer, a collaborative plan will be made between an obstetrical provider at or on-call at L+M Hospital and the WH ED physician. Transfer arrangements will be made.
3. If an emergency delivery occurs, the mother and infant(s) will be stabilized and transported post birth.

Responsibility and Authority:

Emergency Department providers and clinicians.

Definitions: An emergency medical condition exists if a pregnant woman is having contractions and there is inadequate time to effect a safe transfer to another hospital before delivery; or that the transfer may pose a threat to the health or safety of the woman or the unborn child. The unstable patient may be transferred if based on the information available at the time of the transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the woman in labor, to the woman or the unborn child, from being transferred.

Procedure:

1. TRANSFERRING WH PROVIDER -

- a) Evaluates risk status of mother and fetus to determine required level of care and appropriate receiving facility.
- b) Transports to L+M, or other appropriate receiving facility, should be initiated while maternal/fetus status is stable; and not delayed until condition has progressed.

- c) Transferring WH physician or mid-level communicates pertinent history, physical exam and laboratory findings to receiving physician. In the majority of cases the receiving physician will be the L+M on call OB provider.

2. Photocopy Patient Record to include lab reports, x-rays, ultrasound reports, and history/physical, nurses' notes and any and all ED records.

3. Nursing Role:

- a) Assure written order in patient record for and reason for transfer
- b) Arrange transportation as dictated by ED provider, i.e., auto, ambulance.
- c) Document all patient findings in patient record to point of discharge:
 - 1) Progress to discharge
 - 2) Condition of patient and fetus upon transfer (vital signs, FHR, contractions, etc.)
 - 3) Mode of transportation, accompanied by _____
 - 4) Release of clinical information form signed
 - 5) Initiate an ambulance transfer form, if indicated

4. Procedure for Maternal Transport (Ambulance):

- a) The decision as to the necessity of a nurse or physician accompanying the patient in transfer is made in each individual case. When condition warrants and when ordered by ED provider, a physician, mid-Level provider, and/or RN will accompany patient (s) when indicated.
- b) Ground Transport - contact the Westerly Ambulance Association (911) and request an Advanced Life Support Transport Unit.
- c) Helicopter Transport - contact LIFE Star center at 1-800-437-4378 and Westerly Ambulance association.

5. Nurse Accompanied Transport:

- a) The patient's condition is continuously observed and documented.
- b) Vital signs are monitored and charted.
- c) Uterine activity and fetal heart rate are assessed according to diagnosis and medical status.
- d) Report of the patient's history and clinical status is given to the receiving hospital.

6. Patient Refuses to Consent to Transport:

The Emergency Provider should take steps to:

- a) Restate offer to transport the patient to another medical facility.

- b) Inform the patient of the risks and benefits of the transport.
- c) Obtain written informed refusal including informed risks, benefits and the reason for refusal.
- d) Document in the medical record a description of the proposed transport and the refusal.

References:

Guidelines for Perinatal Care, American Academy of Pediatrics and The American College of Obstetricians and Gynecologists 7th edition, Appendix G.

AWHONN. *Templates for Protocols and Procedures for Maternity Services*, 2007.

Essentials of Maternity, Newborn, and Women's Health Nursing. Lippincott, 2007.

TAB O

**Lawrence + Memorial Hospital
Clinical Simulation Center**

Clinical Simulation:

Transfer of Obstetric Patient Simulation

Target date - April 3, 2013 (on or about April 15)

Participants:

Westerly Hospital Emergency Department

Westerly Emergency Communications Center

Westerly Ambulance Association

Lawrence + Memorial Hospital (L+M) Clinical Simulation Center

Lawrence + Memorial Hospital Emergency Department

Lawrence + Memorial Hospital LDRP (4.4)

Equipment/Resources Required:

SimMom Manikin with Simulation Center Staff Operator

Transport Ambulance

Scenario:

An obstetric patient presents by car to the Westerly Emergency Department and is evaluated by ED staff. It is concluded that delivery is imminent and the need for urgent transfer to L+M is indicated. The patient is stable and experiencing contractions ___minute apart. Her water has broken and the fluid is clear. It is her first pregnancy and she has been receiving prenatal care appropriately. There are no known complication to her pregnancy to date.

Vital/Patient Presentation:

Heart rate	92
Blood Pressure	110/68
Respiratory rate	16
Neuro status	alert/anxious
Skin	warm & dry
Fetal Status	stable

Desired staff response:

Westerly ED Staff implement transfer guideline process

Westerly Communication Center is aware of process and identifies and dispatches the appropriate transport agency.

Westerly Ambulance responds to hospital in acceptable timeframe.

ED staff and transport crew communicate effectively

Transfer of patient to ambulance in a safe manner

Patient is transported to L+M LDRP

During transport Westerly Ambulance communicates effectively with L+M ED.

Upon arrival Westerly Ambulance staff are familiar with LDRP location and the patient is delivered to LDRP safely.

Westerly Ambulance Staff and L+M staff communicate patient condition during transport effectively.

Debriefing:

A debriefing of all key players will be conducted immediately following the simulation. Process issues identified in the debriefing will be revised and a second simulation will be conducted if necessary.

TAB P

**OBSTETRIC PATIENT TRANSFER AGREEMENT
WESTERLY HOSPITAL
and
LAWRENCE + MEMORIAL HOSPITAL**

THIS TRANSFER AGREEMENT ("Agreement") is made as of this first day of March, 2013 by and between Westerly Hospital ("the Referring Facility") and Lawrence + Memorial Hospital ("the Receiving Facility"), each individually referred to herein as "facility" and collectively as "facilities."

WITNESSETH:

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of obstetric patients between the two facilities located in Rhode Island and Connecticut; and

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of obstetric patients between the facilities;

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties hereto agree as follows:

1. TRANSFER OF PATIENTS. In the event any patient of either facility is deemed by that facility ("referring facility") as requiring the services of the other facility ("receiving facility"), the Referring Facility or the patient's attending physician will contact the receiving facility to arrange for appropriate treatment as contemplated herein. The referring facility will contact the Westerly Ambulance Service by calling "911" to initiate the response of the transport ambulance. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of the Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO") and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious, or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. RESPONSIBILITIES OF THE REFERRING FACILITY. The Referring Facility shall be responsible for performing or ensuring performance of the following:

- a. Provide, within its capabilities, for the medical screening and stabilizing treatment of the patient prior to transport.
- b. Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations.
- c. Designate a person who has authority to represent the Referring Facility and coordinate the transfer of the patient from the facility.
- d. Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient.
- e. Prior to patient transfer, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care.
- f. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient.
- g. Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician.
- h. Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs of patient's condition, preliminary diagnosis, treatment provided, results of any tests, and with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risks of transfer. If all necessary and relevant medical records are not available, then the records will be forwarded by the Transferring Facility as soon as possible.

- i. Transfer of patient's personal effects, including, but not limited to, money and valuables, and information related to those items.
- j. Provide the Receiving Facility any information that is available concerning the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a health care assistance program established by a county, public hospital, or hospital district.
- k. Notify the Receiving Facility of the estimated time of arrival of the patient.
- l. Provide for the completion of a certification statement, summarizing the risk and benefits of the transfer of a patient with an emergency condition that has not been stabilized, by the transferring physician if not physically present at the facility at the time of transfer.
- m. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider.
- n. Recognize the right of a patient to refuse consent to treatment or transfer.
- o. Complete, execute, and forward a memorandum of transfer form to the Receiving Facility for every patient who is transferred.
- p. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) for the inventory and safekeeping of any patient valuables sent with patient to the Receiving Facility.

3. RESPONSIBILITIES OF THE RECEIVING FACILITY. The Receiving Facility shall be responsible for performing or ensuring performance of the following:

- a. Provide, as promptly as possible, confirmation to the Referring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond within 10 minutes after receipt of the request to transfer a patient with an emergency medical condition.
- b. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient at the Receiving Facility and provide, on request, the names of on-call physicians to the Referring Facility.
- c. Reserve beds, facilities, and services as appropriate for patients being transferred from the Referring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by the Receiving Facility for an emergency.
- d. Designate a person who has authority to represent and coordinate the transfer and receipt of patients into a facility.
- e. When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician.
- f. Provide the Referring Facility with a copy of the medical records of the patient that were generated at the Receiving Facility, if the patient is returned to the Referring Facility by the Receiving Facility.
- g. Maintain the confidentiality of the patient's medical records in accordance with applicable state and federal law.
- h. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into the facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient.
- i. Acknowledge any contractual obligations and comply with statutory or regulatory obligations that might exist between a patient and a designated provider.
- j. Complete, execute, and return the memorandum of transfer form to the Referring Facility.
- k. Ensure a procedure is in place to provide medical information to the referring physician on a regular and periodic basis.

4. BILLING. All charges incurred with respect to any services performed by facility or patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party coverage, Medicare or Medicaid, or other sources normally billed by the facility. In addition, it is understood that professional fees will be billed by the physicians or other professional providers that may participate in the care and treatment of the patient. Subject to applicable law, each facility shall provide such

information in its possession to the other facility and such physicians/providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payers.

5. RETRANSFER; DISCHARGE. At such time as the patient is ready for transfer back to the Referring Facility or another health care facility or discharge from the Receiving Facility, in accordance with the direction from the Referring Facility and with the proper notification of the patient's family or guardian, the patient will be transferred to the agreed upon location. If the patient is to be transferred back to the Referring Facility, the Receiving Facility will be responsible for the care of the patient up until the time the patient is re-admitted to the Referring Facility.

6. COMPLIANCE WITH LAW. Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of medical records and confidentiality of patient information as well as with all standards promulgated by a relevant accrediting agency.

7. RESPONSIBILITY; INSURANCE. The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents. In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party, and shall provide evidence of such coverage upon request.

8. TERM; TERMINATION.

a. The initial term of this Agreement ("Initial Term") shall be for a period of one year unless sooner terminated as provided herein. At the end of the Initial Term, this Agreement shall automatically renew for subsequent terms of one year each (each a "Renewal Term"), unless either party provides the other with notice of its intent not to renew this Agreement at least thirty (30) days prior to expiration of the then current term.

b. Either party may terminate this Agreement at any time without cause upon thirty (30) days prior written notice to the other party. Either party may terminate this Agreement upon breach by the other party of any material provision of this Agreement, provided such breach continues for five (5) days after receipt by the breaching party of written notice of such breach from the non-breaching party. This Agreement may be terminated immediately upon the occurrence of any of the following events:

(1) Either facility closes or discontinues operations to such an extent that patient care cannot be carried out adequately.

(2) Either facility loses its license, or Medicare certification.

9. ENTIRE AGREEMENT; MODIFICATION. This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

10. GOVERNING LAW. This Agreement shall be construed in accordance with the laws of the State of Connecticut.

11. PARTIAL INVALIDITY. If any provision of this Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this Agreement.

12. NOTICES. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

Westerly Hospital (Contact Information): 25 Wells Street, Westerly, RI 02891, Attn: _____

Lawrence + Memorial Hospital (Contact): 365 Montauk Avenue, New London, CT 06320 Attn: _____

or to such other persons or places as either party may from time to time designate by written notice to the other.

13. **WAIVER.** A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. **ASSIGNMENT; BINDING EFFECT.** Facilities shall not assign or transfer, in whole or part, this Agreement or any of Facilities' rights, duties or obligations under this Agreement without the prior written consent of the other Facility, and any assignment or transfer by either facility without such consent be null and void. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs representatives, successors and permitted assigns.

15. **EXECUTION OF AGREEMENT.** This Agreement shall not become effective or in force until all of the required signatories below have executed this Agreement.

THE PARTIES HERETO have executed this Agreement as of the day and year first above written.

WESTERLY HOSPITAL
(Referring Hospital)

LAWRENCE + MEMORIAL HOSPITAL
(Receiving Hospital)

By: _____
Print Name:
Its:

By: _____
Print Name:
Its:

Date

Date

Address:

Address:

City/Town, State, Zip Code

City/Town, State, Zip Code

TAB Q



THE WESTERLY HOSPITAL

Name of Document: Equipment, Supplies, and Medication for Emergency Department Deliveries

Search Words: emergency, imminent, delivery

Revision/Effective Date: 6/1/13

Supersedes: NEW

Origination Date:

Owner of Document and responsible reviewers: Nurse Manager, ED

Department: WHC

Manual: Emergency Department

Approval: Margaret Austin, VP Clinical Operations, Chief Nursing Officer

Approval Date:

Page 1 of 2

Policy Statement: The following equipment and supplies will be readily available at all times in the Emergency Department for an emergency delivery.

Responsibility and Authority: All physicians, RNPs, PAs and RN of the Emergency Department. The Emergency Room Technician will be responsible for monitoring outdates on sterile supplies and par levels. The Pharmacy Department will continually monitor expiration dates and replace medications as needed.

Equipment:

1. Doppler
2. Delivery Table
3. Stool
4. Light
5. Warmed Stabilette with resuscitation equipment

-Delivery Kit

1. placenta basin
2. 2 small basins
3. 1 straight mayo scissor
4. 2 sponge sticks
5. 1 smooth forcep
6. 1 mouse tooth forcep
7. 1 cord scissor (curved)
8. 1 needle holder
9. 3 Kellys
10. 2 Allis
11. med glass
12. 2 cord blood tubes
13. 5 ½ sheets
14. 4 towels



THE WESTERLY HOSPITAL

Name of Document: Equipment and Supplies for Emergency Department Deliveries		
Search Words: emergency, imminent, delivery		
Revision/Effective Date: 2/19/2013	Supersedes: NEW	Origination Date:
Owner of Document and responsible reviewers: Nurse Manager, ED	Department: WHC	Manual: ED
Approval: Margaret Austin, VP Clinical Operations, Chief Nursing Officer	Approval Date:	Page 2 of 2

ADD TO KIT

1. bulb syringe
2. syringe and needle for local
3. sutures
4. gloves
5. gown
6. drape for under buttocks
7. package sterile 4x4s

Medications include:

Maternal:

1. Local Anesthesia
2. Oxytocin (10ml vial for IM use or 20units mixed in 1000ml NS)
3. Uterine Hemorrhage Kit
 - a) Methergine 0.2mg/ml injection
 - b) Hemabate 250mcg/ml injection
 - c) Cytotec 100mcg tablets

Infant:

1. Delivery Kit
2. Vitamin K 1mg/0.5ml IM
3. Erythromycin Ophthalmic Ointment 0.5%
4. Emergency Delivery Kit
 - a) Epinephrine 1:10,000 injectable
 - b) Naloxone HCl 0.4mg/ml
 - c) 4.2% Sodium BiCarbonate 0.5mEq/mLs

TAB R

Sample letter to be sent to all current WH obstetric patients.

To the Obstetric Patients of Westerly Hospital:

This is to inform you that all obstetric labor and delivery services at The Westerly Hospital ("Westerly Hospital") will cease effective June 1, 2013.

Despite attempts by many parties to maintain these services, a lack of health care providers has made it impossible to maintain obstetric labor and delivery services at the high quality for which Westerly Hospital has become known. Please be assured that until June 1, 2013, all services will be maintained at Westerly Hospital in the manner that will offer you a safe, quality environment for your delivery and newborn care.

For those of you whose delivery date is after June 1, 2013, it will be necessary for you to transfer your care to another institution. Please contact your OB/GYN provider immediately to discuss your options.

Close alternatives include South County Hospital in Wakefield, Rhode Island and Lawrence + Memorial Hospital ("L+M") in New London, Connecticut. Both hospitals are excellent choices although there may be others you may choose.

Additionally, Westerly Hospital has established an 800 hotline for you to call (1-800-_____) that will be staffed by an obstetric nurse 24 hours/day effective March 1, 2013 until June 30, 2013. The nurse will be able to answer any questions you have regarding your obstetric care and will facilitate your obtaining an appointment and the transfer of your medical records to the provider of your choice.

The emergency room staff at WH will be available for all emergent obstetric labor and delivery needs after June 1, 2013 and will establish the necessary mechanism for an immediate transfer to another institution if medically necessary.

Westerly Hospital will maintain a safe, high quality environment for your obstetric care until the closure date of June 1, 2013. For any questions or concerns, please call 1-800-_____ to talk with one of our obstetric staff who shall assist with any of your needs.

Though, Westerly Hospital will cease to offer obstetric labor and delivery services, Westerly Hospital will maintain a robust prenatal and perinatal program along with significant additional women's health services that include lactation consulting, prenatal stress testing, child birth education, gynecology surgery, prenatal and perinatal care, imaging, general gynecology, and GI services.

Additionally, we would recommend that you consider L+M's obstetric program as it offers many important services that have not been available at Westerly Hospital including:

- A modern 24-bed maternity unit with state-of-the-art private labor/maternity rooms, cutting edge technology including central surveillance of all live fetal heart rate tracings, a triage area for assessment and antepartum evaluation, a fully staffed Normal Care Nursery, and 2 in-unit operating room suites for cesarean sections;
- 24/7 in-house availability of anesthesia services;
- The region's only neonatal intensive care unit ("NICU") which allows area women and their families to have high risk pregnancies delivered locally and for critically ill or at-risk newborns to receive the necessary specialized care close to home rather than have to travel to Providence or New Haven. Board-certified neonatologists staff the 14-bed Level IIIA unit, along with highly skilled nurse practitioners and physician assistants. L+M's NICU staff provides one-on-one intensive care around the clock for the most critically ill newborn babies;
- The neonatology practitioners attend all births – including routine deliveries -- relieving area pediatricians or family physicians from this burden;
- A full-time maternal and fetal medicine ("MFM") specialist; and
- Infertility services offered 5 days/week by one of the private practice obstetric-gynecology groups in New London, Connecticut.

We at the Westerly Hospital appreciate your support and understanding during this transition time and assure you we are there to meet all your needs regarding your obstetric care.