Public Community Forum Questions Regarding Transfer of ownership of Lawrence & Memorial Corporation to Yale New Haven Health Services Corporation CON Docket Number: 15-32033

Introduction

The Office of Health Strategy (OHS) conducted a Certificate of Need Community Education Engagement on October 24, 2019 at the Opportunities Industrialization Center. The purpose of this meeting was to discuss the agency's mission as the statewide health policy body, explain the Certificate of Need regulatory process and online information portal, and answer questions related to the acquisition. Below are questions that were received from New London community members.

Background: Lawrence & Memorial Corporation and Yale New Haven Health Services Corporation sought authorization to enter into an affiliation that would transfer ownership of Lawrence & Memorial Corporation and Yale New Haven Health Services Corporation through a Certificate of Need application on October 7, 2015. A public hearing was held on July 11, 2016 and an Agreed Settlement and Order was approved on September 8, 2016 with specific conditions.

The CON Application, Agreed Settlement and all documents and information can be found in the CON Portal Docket Number 32033

A. Comments and Questions:

1. **We, as intervenors, had no status after the conditions were ordered. We believe that intervenors should be given official status throughout the period encompassed by the conditions. The intervenors can serve as community "watchdogs" and play an important role in the recommendations.**

Response:

By definition, an intervenor is a person granted legal status by the presiding officer[1] of a Certificate of Need hearing to participate in the proceedings. In this context, a person can be an individual, partnership, corporation, limited liability company, association, governmental subdivision, agency or public or private organization.[2]

In order to be granted intervenor status, a person must identify facts to substantiate that their participation is in the interests of justice and that it will not impair the orderly conduct of the proceedings. The hearing officer, based upon the facts presented, decides whether the intervenor should be denied participation or granted either limited or full rights to participate in the hearing.[3] The hearing officer's decision to grant a person intervenor status does not impart rights to the intervenor to

[1] THE PRESIDING OFFICER IS THE HEARING OFFICER DESIGNATED BY THE HEAD OF THE AGENCY TO PRESIDE AT THE HEARING. CONN. GEN. STAT. § 4-166(13).
[2] DEFINITIONS. CONN. GEN. STAT. §§ 4-166(7) AND (11).
[3] CONTESTED CASES. CONN. GEN. STAT. § 4-177A.

serve in any capacity to enforce or monitor conditions contained in a subsequent Agreed Settlement between the parties.

2. **The applicants should not be the ones who decide who the community representative on the hospital board should be. In the case of the L+M/Yale acquisition, the hospital appointed someone who was already on their board. The community, not the hospital, should be the one selecting the community representative.**

   Response:
   With regard to selection of the community representative, the applicants reported reaching out to a multitude of community non-profits, social service organizations, healthcare providers and business interests, who all supported the community representative appointment to the Board. The applicants provided a summary of the responsibilities of the community representative which stated, in relevant part:

   The Condition requires that the community representative will be an "unbiased individual who will fairly represent the interests of the community served by Lawrence and Memorial Hospital." … The community representative should be accessible to any and all community groups to discuss the advancements YNHHS/L+M Hospital is making, receive input regarding issues and concerns that the community may have in order to provide information to the L+M Hospital Board … For the next three years, Yale New Haven Health System and L+M Hospital Boards will meet together twice per year and following these meetings a public meeting will be held to update the public on what is happening at the Hospital. The "community representative" should be actively engaged in all of these meetings." (Doc ID: 633, p. 3338)

   OHS' focus in drafting conditions strives to promote and preserve community engagement in all possible areas. In furtherance of that objective, OHS has recently revised its Orders to include a condition requiring each hospital/hospital system to submit to OHS: the name of the proposed community representative; a resume or curriculum vitae for that representative; and the rationale for the appointment of the community representative to its Board of Directors. This requirement ensures the appointment of an unbiased individuals who will fairly represent the interests of the communities served by each hospital.

3. **The applicants should not be the one to select the Independent Monitor (IM). We expressed concerns about financial entanglements between the applicants and Deloitte, which they selected as the IM. The community should be the ones selecting the IM.**

   Response:
   An IM's primary responsibility is to be able to independently and proactively monitor and assess an applicant's compliance with the conditions in an Agreed Settlement. In response to community concerns about the hospitals' ability to select neutral and unbiased IMs, OHS has reviewed and revised its conditions to require OHS to select the IM. OHS has also developed a review process that implements a rating system that measures each candidates' expertise, objectivity, and capacity to effectively fulfill their responsibilities. OHS is confident that this new process will alleviate actual and potential conflicts of interest, instill public confidence in the IM process and allow for the selection of highly qualified IMs. OHS continues to review and evaluate options to strengthen primary oversight and authority between OHS and the IM.

4. **Board meetings should not be kept secret. Are these public meetings and if so, Minutes of Meetings should be made available to the public?**

Response:

Organizational bylaws usually indicate whether board meetings are open or closed to the public, and whether they can share board meeting minutes. While OHS cannot require that all Board meetings be open to the public, Condition 33d of the Agreed Settlement in 15-32033-CON requires the hospital to convene a yearly public forum in New London, CT to review the IM's annual report and to provide updates to the hospital community.

5. **The Public Forums that were held shortly after the board meetings did not inform the public about evolving plans on how the $300 million dollars was to be used. Only after decisions had been finalized was the public informed. One role that the community representative should play is to keep the community informed of plans as they evolve when input can still affect the outcome.**

Response:

L+M and YNHHS pledged to make total commitments of $300 million in Eastern Connecticut and Western Rhode Island over 5 years. Anticipated resource commitments included investments in primary care clinical services, specialty clinical services, ambulatory services, post-acute services, infrastructure within L+M facilities, information technology, population health, branding, operational improvements, and community need/community building. Investments in excess of $116 million have been reported between FY 2017 though the first half of FY 2019.

Capital Investments			
	FY2017	**FY2018**	**1st ½ of FY2019**
Primary Care Clinical Services	$242,726	$1,492,186	$1,122,716
Specialty Clinical Services	$3,369,455	$8,281,956	$5,571,003
Ambulatory Services	$0	$873,502	$76,676
Post-Acute Services	$0	$235,508	$83,844
Infrastructure	$6,523,652	$9,090,697	$4,331,082
Information Technology	$17,442,848	$3,523,475	$1,718,619
Population Health	$2,000,001	$2,000,000	$1,000,000
Branding	$2,163,306	$1,564,301	$712,501
Operational Improvements	$15,540,512	$19,019,378	$8,494,465
Community Need/Community Building	$122,335	$152,900	$0
Total:	**$47,404,835**	**$46,233,903**	**$23,110,906**

6. **OHS should demand a much larger commitment of financial resources to community building when a large corporation takes over the local community hospital. The mandated increase of $588.74 in community building was pitiful. The efforts of the community to achieve the health goals enumerated in the Community Health Needs Assessment are hobbled by the dearth of financial resources dedicated to the health improvement plan. We felt that an additional $2 million a year over the five years of the mandated condition would have been a more appropriate amount.**

Response:

Condition 11 of the Order in Agreed Settlement 15-32033-CON states: *"The Applicant shall maintain community benefit programs and community building activities for 3 years after the Closing Date consistent with L+MH's most recent Schedule H of IRS Form 990 OR L+MH shall provide other community benefit and community building activities that are at least as generous and benevolent to the community as L+MH's current programs, AND the Applicants shall apply no less than a 1% increase per year for the next 3 years toward the L+MH's community building activities in terms of dollars spent."*

While OHS decisions are guided by our statutory mandates and the criteria therein, a key focus remains how each affected community will be impacted, and benefited, from each transaction we approve. CHNAs are crucial tools for assessing and planning future investments in those communities' health and well-being. We mandate that each hospital directly address the health needs identified by the applicable CHNA in determining its participation and investment in both community benefits and community building activities. Additionally, in more recent transactions OHS has worked to more clearly tie a hospital's community benefit activities to the needs and opportunities identified in the CHNA. In furtherance of ensuring as much funding as possible for that objective, OHS now directs applicants to apply no less than a 1% increase per year toward the hospitals' net community benefit expenses (Other Benefits, not financial assistance) and net community building expense in terms of dollars spent.

7. **Community benefits and community building, what does this figure represent?**

Response:

Nonprofit hospital organizations are required by federal tax law to spend some of their surplus on community benefits, which are goods and services that address a community need. They must report this spending to the Internal Revenue Service annually in order to remain exempt from paying federal income taxes. The allowable purposes of community benefits are to improve access to services, enhance the health of the community, advance medical knowledge, and reduce government burden. To meet the IRS requirement, many hospitals have traditionally provided free or low-cost clinical care and paid for other hospital-centered activities.

Community building is defined as money spend on activities that protect or improve the community's health or safety. Understanding the difference between community benefit and community building can be challenging because some community building activities may also meet the definition of community benefit. However, community building activities help build the capacity of the community to address health needs and often address the "upstream" factors and social determinants that impact health, such as education, air quality, and access to nutritious food. Some examples of community building are housing rehabilitation for vulnerable populations, creating employment opportunities in areas with high joblessness rates and community supports such as childcare, mentoring programs, and neighborhood support groups.

8. **Public Forums are not advertised properly.**

Response:
The language in the order provides, in relevant part, that:

> *"For three (3) years following the Closing Date, the Applicants shall hold a meeting of the YNHHSC Board and L+M Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of L+MH's activities and afforded an opportunity to ask questions and make comments."*

It is difficult for OHS to specifically respond to this comment without knowing which community meeting is being referenced and without having detailed information about the sufficiency of the efforts made by the hospital to provide notice to the public. Notwithstanding, OHS has received similar complaints from members of other hospital communities unrelated to L&M and we are modifying our Agreed Settlements to require advance notice over multiple mediums to ensure active participation from each affected hospital community. In the interim, we encourage members of the community to contact OHS to express concerns about insufficient notice in advance of community meetings and forums at ohs@ct.gov

9. **What are the outcomes from the CHNA and what was the process with Ledge Light Health District? Did they look back and measure outcomes?**

Response:

On May 26, 2015, L+M and Ledge Light Health District organized the first meeting of what would become the Southeastern CT Health Improvement Collaborative- a coalition of health care providers, local public health officials, federally qualified health centers, tribal representatives, higher education officials, and numerous non-profit organizations serving the region. Representatives from a number of community agencies were invited to serve as a steering/advisory committee for L+M and Ledge Light's assessment. The Collaborative met bi-monthly and provided insight and guidance in the design of data collection efforts.

In November 2015, Collaborative members joined other community agencies for a facilitated conversation considering the assets and challenges to health in the region. Following the completion of the 2016 CHNA, the Collaborative engaged in a process to prioritize issues and develop strategies to improve health and well-being in the region.

In May 2016, 35 community partners participated in a data review and prioritization process using an objective scoring tool to focus on the most important indicators. In addition to these group exercises by the Collaborative, input was solicited from the residents who had participated in the CHNA focus groups, the community at large via the Ledge Light Health District website, and the ACHIEVE New London Collaborative. Over 65 individuals participated in the prioritization work to develop the following goals and objectives.

CHNA Implementation Plan Goals and Objectives		
Goals		**Objectives/Outcome Measures**
1	Ensure systems are in place to support mental and emotional well-being in the community	By January 2018, better understand the characteristics of people living with opioid addiction in order to inform prevention activities.
		By January 2018, identify and understand local disparities related to anxiety and depressions and take concrete action to improve local mental health systems of care.
2	Increase healthy food consumption and physical activity – both contributing factors to diabetes, to reduce incidence, particularly among minority populations	By January 2018, identify policy/systems change opportunities and take concrete action in support of healthy food consumption and increased physical activity.
		By January 2018, develop a plan and implement a campaign to raise awareness of healthy lifestyles.
		By January 2018, identify gaps in the system of care for people with pre-diabetes and create strategies to address those gaps.
3	Increase access to equitable and quality health care for low income residents.	By January 2018, increase understanding of community needs and misalignments between local systems of care, transportation systems and other factors impacting access, and take concrete action to increase access to equitable and quality healthcare.
4	Ensure systems are in place to support healthy pregnancies and positive birth outcomes for all SECT residents.	By January 2018, identify and understand local disparities with regard to prenatal care, low birthweight, neonatal abstinence syndrome, and infant mortality, and take concrete action to improve local systems that improve these birth outcomes.

Two projects arose from the Implementation Plan: L+M funded a certification program for local substance abuse recovery providers so that they could meet national standards for quality and safety (Goal 1). The second initiative addressed social determinants of health in the City of New London. (Goal 3).

The initiatives in this CHNA are ongoing efforts, so specific outcome measures have not yet been identified. The full CHNA report can be viewed through this link: https://www.lmhospital.org/about/community-involvement/community-partnerships/community-health-needs-assessment.aspx

10. Health Care Improvement Collaborative and Action Team were not included in the community benefits and had to write grants to carry out the work in the Community Health Needs Assessment. Why did the hospital not fund this?

Response:

Hospitals have discretion to align community benefit expenditures with their operational and strategic plans. It is outside of OHS' direct statutory authority to mandate who, aside from the Applicants, should perform the objectives identified in the CHNA. Additionally, an Applicant's failure to fund a desired activity, organization, etc., does not render an Applicant non-compliant with the terms of an Agreed Settlement.

11. The hospital usually states that they have no money to carry out the action plan from the community health needs assessment.

Response:

The CHNA and subsequent Implementation Plan proposed four broad goals and seven objectives aimed at meeting those goals (see question #9). These goals were considered when YNHHS and L+M developed their strategic plan, and as a result a percentage of funds from the $300 million capital investment commitment was dedicated for community need/community building. However, there is no law that requires hospitals to remediate every issue identified in a CHNA.