HUSCH BLACKWELL

Rebecca Rodman
Senior Counsel

One Beacon Street, Suite 1320
Boston, MA 02108
Direct: 617.279.8990
Fax: 617.720.5092
Rebecca.Rodman@huschblackwell.com

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Via Email

Stephen Davis, Director
Division of Health Care Facility Licensure and Certification
Bureau of Health Care Safety and Quality
Department of Public Health
67 Forest Street
Marlborough, MA 01752

Re: UMass Memorial HealthAlliance-Clinton Hospital

Dear Mr. Davis:

We write on behalf of UMass Memorial HealthAlliance-Clinton Hospital's Leominster Campus (the Hospital) in response to the Department of Public Health's (the Department) questions about the Hospital's plan to preserve access to care following the closure of its inpatient maternity services (Services).

As emphasized in our previous correspondence, this difficult decision is a result of workforce shortages in essential clinical professions along with steadily declining delivery volume that severely impact the sustainability of the unit. Despite several years of good-faith efforts to enhance and invest in maternity services, including purchasing state of the art equipment, upgrading the facility, and multiple efforts to recruit staff, the Hospital unit's staffing in critical positions continued to decline.

This shortage of obstetricians, nurses, and other clinical professionals is projected to continue – to the point that after September 23, 2023, the maternity unit will be insufficiently staffed to provide appropriate care at all times, posing unnecessary risk to birthing patients and newborns. At the same time, patient volume has continued to decline. Based on this, clinical leaders at the Hospital and UMass Memorial Health (UMMH) made the hard, but clinically appropriate decision to close the unit.

We want to reiterate that following closure of the Services patients will continue to have the option to receive their prenatal and postpartum care from the same local obstetrics and gynecology and family medicine practices as they do now, and the Hospital and UMMH are providing additional supports to those practices. We believe that change in birthing location, to

an academic medical center 30 minutes away from Fitchburg and Leominster, is a far better and safer option for all birthing patients in our community.

As you will see below in our specific responses to the Department's recent questions, we have finalized detailed plans to provide 24/7/365 curb-to-curb transportation for patients needing non-emergency[1] maternity services at alternative birthing locations, including transportation for their families. We also address the Department's concerns about community engagement. Finally, we are announcing the investment of over $600,000 to help support prenatal and postpartum care needs for the most vulnerable in our community. Considering the above, we ask the Department to review the below, and our earlier submission, and agree with our conclusion that our plan for assuring access in the Hospitals service area is complete.

We appreciate the ongoing dialogue with the Department about our proposal as well as the sincere concerns raised by the Department, city leaders, other elected officials, and community members throughout this process. We also recognize how exceedingly difficult this decision is for our community. However, our duty must be to the health and safety of our patients. It is with that duty in mind that we made this decision, and note that our boards of trustees, after significant deliberation, have voted unanimously to support this decision.

Below are the Hospital's responses to your questions following the Hospital's submission of its access plan.

1. Assessment of Transportation Needs.

The Hospital has developed a plan, which will be operational at the time of the closure, that will meet the transportation needs of patients after discontinuance of the Service. In accordance with the applicable regulation and in response to the Department's request, the Hospital's transportation plan is focused on assisting pregnant patients who need access to the services at alternative locations and who experience transportation barriers.

Patient Transportation:

The transportation plan includes non-emergency[2], 24/7/365 curb-to-curb transportation for birthing patients who have barriers traveling to one of the other four area hospitals with birthing centers. The plan also includes transportation for family members traveling to the Medical

[1] The EMS system remains the appropriate option for any patient needing emergency transport.

[2] 911 remains the appropriate option for a patient experiencing an emergency.

Center during scheduled visiting hours. This 24/7/365 curb-to-curb service for patients will be provided pursuant to a contract the Hospital has executed with GoGo Technologies, Inc.[3] (GoGo), as described in more detail below.

Additionally, we are optimistic about the prospect that the 24/7/365 service provided by GoGo could be bolstered during daytime hours by similar on-demand, curb-to-curb service provided by the Montachusett Regional Transit Authority (MART). Culminating four months of discussion and negotiation between the Hospital and MART, both parties recently reached agreement on terms to provide on-demand, curb-to-curb, urgent patient transportation and visitor transportation during daytime hours, beginning upon closure of the maternity unit. As the largest provider for the Commonwealth's Executive Office of Health and Human Services (EOHHS) Human Service Transportation (HST) brokerage system and the local public transport agency for the North Central region, MART was identified by the Hospital as a preferred provider to transport vulnerable patients and families from its service area to one of the other four area hospitals with birthing centers.

Surprisingly, on Friday of last week, the day on which we expected to fully execute the contract, MART conveyed that it would not sign. Nonetheless, we will continue to pursue discussions with MART representatives to determine the rationale for this decision, address any concerns it may have with the negotiated contract, and hopefully reach an agreement that will become effective as soon as feasible. We also engaged with EOHHS regarding our transportation solution, including the role of MART, and would welcome EOHHS's assistance in finalizing a plan with MART to provide transportation services to MassHealth patients entitled to receive non-emergency transport pursuant to HST's PT-1 program.

Despite this development with MART, UMMH quickly and successfully renegotiated its contract with GoGo, which had originally covered non-daytime service outside of MART's expected service hours, to fill the gap resulting from MART's decision and thereby provide 24/7/365 on demand, curb-to-curb transportation for urgent transport of patients of the three participating OB/GYN practices to the Medical Center or one of the other three birthing centers in the region.

As noted above, we will continue to pursue negotiations with MART and if a final contract is executed with the terms previously negotiated by the parties, the plan with MART will provide on-demand, urgent transportation and visitor transportation utilizing their brokerage services

[3] MassMobility, a service of Massachusetts Department of Transportation, lists GoGo as a Transportation Network Company. GoGo currently provides transportation services in Massachusetts communities including Boston, Brookline and Martha's Vineyard.

during daytime hours while GoGo will continue to provide pregnant patients with transportation during evening and night hours.

UMMH and the Hospital

- UMMH has been working with the local Ob/Gyn and family medicine practices to develop workflows including assessing patients' needs and informing them of the transportation resources available to them.
- Any patient identifying barriers to transportation who needs on-demand, urgent transport will be eligible.
- As we know many of these patients are MassHealth eligible, we will continue to engage MART, the provider of PT-1 transportation services, to complement services when appropriate (as referenced above).
- Prior to the closure of the Services, workflows will be tested and implemented for requests for transportation during both practice office hours as well as "on call" evening/night coverage. Training will also be provided to all necessary staff to ensure they are able to connect patients to the appropriate resource.
- Informational materials will be provided to both providers and patients. As discussed in detail in the Hospital's August 22, 2023 letter to the Department, UMMH has a comprehensive Language Access program to meet the cultural and linguistic needs of its patients. While the transportation company provides English and Spanish language speakers at their call centers, the UMMH Language Access program will be fully accessible to patients who need translation services for other languages including but not limited to Haitian Creole, Portuguese.

GOGO:

- GoGo will operate and maintain a 24/7/365 call center to facilitate transportation service requests for timely transportation to and from the area birthing centers in the region.

- By collaborating with various 3rd-party contractors, including Uber and Lyft, **GoGo** maintains a highly reliable network for on-demand transit. Additionally, **GoGo** screens drivers to accommodate specific requests, such as assistance getting in and out of vehicles. **GoGo** has the capability to promptly dispatch and will immediately notify the patient via call or text in the event of a driver change. This ensures that patients have access to resources if a ride is cancelled.

- UMMH and **GoGo** will conduct ongoing assessment reviews and training sessions as necessary.

Immediate Family Transportation to the Medical Center

- Obstetric patients of Ob/Gyn and Family Medicine providers in the Hospital's service area will be able to request transportation resources for their immediate family members that have identified transportation barriers to Worcester. This resource will be available, at no cost to patients or their family members, during scheduled visiting hours of the birthing center utilizing local curb-to-curb transportation providers, including existing contracted taxicab companies and other services, such as Lyft or Uber.

Needs Assessment

In developing the transportation plan, the Hospital identified transportation barriers by utilizing multiple sources and reviewing:

1) Existing transportation assessments conducted within the Service Area over the last five years;
2) Secondary data from reputable sources at the local, state, and national level related to the intersection of prenatal and postpartum health and transportation; and
3) Findings from the initial listening sessions, the public hearings for the closure and preliminary information gathered by the Hospital and as provided by Health Resources in Action (HRiA).

Major findings include:

- Some patients, particularly those living with low-incomes and/or of diverse racial and ethnic backgrounds, do not have reliable personal transportation to get to and from medical appointments[1,3,5,6,7], which includes transportation for non-emergency maternity services, nor can they afford the cost of private or public[2] transportation services.
- The curb-to-curb transport of patients from North Worcester County to regional labor and delivery centers spans two Regional Transit Authorities and the MBTA[4], requiring cooperation between entities and coordination of available services. Such a system is not easily accessed by a pregnant person who needs maternity services.
- Ambulance services charge at a per mile rate, making the cost of transportation via emergency medical services prohibitive[8], particularly for people who are un-/under-insured, and for most maternity service transportation, ambulance transportation is not appropriate.

- PT-1 via MassHealth is a helpful resource[1] and provided by a single entity within the region.[9] However, PT-1 is not accessible to those with a personal vehicle, even if that vehicle is not reliable[1]; additionally, paratransit services are not always punctual[1,6] and may not wait if the patient is not at the curb upon arrival.[1]

The transportation strategy outlined here is responsive to anticipated needs. The GoGo service will provide transportation for patients who do not have reliable transportation and who cannot afford the cost of transportation services to get to maternity services at alternative locations when the Services close, including those who cannot rely on MassHealth's PT-1 service. This plan will also ensure that patients needing such transportation are not required to rely on the various Regional Transit Authorities or MBTA for transportation to maternity services at alternative locations. In addition, this transportation plan is anticipated to ease the burden on the EMS service by reducing the number of patients who seek ambulance transport because they do not have access to private transportation.

In addition to the Hospital's assessment and transportation plan to address access to the Service after closure, the Hospital is also more broadly engaged with the community regarding a review of barriers and needs of birthing people and ways to reduce these barriers. This initiative, which involves the Hospital's engagement with HRiA, includes an assessment to inform the Hospital's leadership and Community Benefits Advisory Committee on the future investments from the Hospital to community-based organizations. This targeted initiative is outside the scope of this access plan relating to closure of the Services and therefore, completion of the initiative, while important, is not necessary in order to assure access to the Service or to meet the requirements for the closure of the Services.

Timeframe

The Hospital commits to providing transportation-related resources to support transportation needs of birthing people and their family members within the Hospital's service area for at least three years. The Hospital will continue to utilize the various resources outlined in the community engagement strategy and will seek user feedback to improve user experience, as necessary. In addition, the Hospital will meet regularly with the participating practices and any transportation vendors being used to analyze usage data and workflows to ensure adequate transportation resources are provided going forward. Lastly, the Hospital will utilize the results of the community needs assessment, patient feedback and other data sets to inform the Hospital's community benefits investment strategy to address barriers to accessing care. As this will be an

active assessment process, investing resources into the most appropriate and utilized transportation options will be prioritized.

References:

1. Health Resources in Action (HRiA). 2023. Preliminary findings from community listening sessions. Full report to be released in October 2023.
2. American Hospital Association. 2017. "Transportation and the Role of Hospitals." Accessed September 2023 at: https://www.aha.org/system/files/hpoe/Reports-HPOE/2017/sdoh-transportation-role-of-hospitals.pdf
3. National Partnership for Women & Families. 2018. "Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities." Accessed September 2023 at: https://nationalpartnership.org/report/black-womens-maternal-health/
4. Mass.gov. Public Transportation in Massachusetts. Accessed September 2023 at: https://www.mass.gov/info-details/public-transportation-in-massachusetts#mbta-services-
5. UMass Memorial Health HealthAlliance-Clinton Hospital. 2021. "Community Health Needs Assessment." Accessed September 2023 at: https://www.ummhealth.org/sites/umass-memorial-hospital/files/Documents/About/Community_benefits/211222Final%20HA%20CHNA_v2_dec2021.pdf
6. UMass Memorial Health. 2023. "2024 Greater Worcester Community Health Assessment." Preliminary findings from community listening sessions. Full report to be released in October 2023.
7. Making Opportunity Count, Inc. 2023. "2024-2026 Community Needs Assessment."
8. Massachusetts Health Policy Commission. 2023. "Emergency Ground Ambulance Utilization and Payment Rates in Massachusetts." Accessed September 2023 at: https://www.mass.gov/doc/emergency-ground-ambulance-utilization-and-payment-rates-in-massachusetts-chartpack/download
9. Montachusett Regional Planning Commission. 2018. "Coordinated Public Transit – Human Services Transportation Plan Update – 2018." Accessed September 2023 at: https://www.mrpc.org/sites/g/files/vyhlif3491/f/uploads/mpo_endorsed_cpthst_plan_update_9_19_2018_0.pdf

2. Location and Service Capacity of Alternative Delivery Sites.

Multiple discussions and communications have occurred with leadership at UMass Memorial Medical Center, Emerson Hospital, Heywood Hospital and St. Vincent hospital regarding potential increases in obstetric inpatient care post closure. Contact was made again in September 2023 and the leaders of each facility confirmed that they have the facility and staffing capacity to absorb any additional patient volume that may occur after the closure. Facility data supporting these discussions is included below from the CHIA inpatient case mix data. As noted by occupancy rates, each of the facilities can accommodate additional volume as per daily census and licensed beds.

Hospital Maternity Inpatient Occupancy Rate FY19-FY21[4]

	Discharges			Patient Days			Avg Daily Census			Licensed Beds			Occupancy Rate		
	2019	2020	2021	2019	2020	2021	2019	2020	2021	2019	2020	2021	2019	2020	2021
UMMH															
UMass Memorial Medical Center	4,305	4,151	4,148	14,768	13,995	13,620	40.5	38.3	37.3	65	65	65	62.2%	59.0%	57.4%
HA-Clinton	568	547	561	1,579	1,373	1,326	4.3	3.8	3.6	19	19	19	22.8%	19.8%	19.1%
UMMH Total	**4,873**	**4,698**	**4,709**	**16,347**	**15,368**	**14,946**	**44.8**	**42.1**	**40.9**	**84**	**84**	**84**	**53.3%**	**50.1%**	**48.7%**
Saint Vincent Hospital	1,920	1,789	1,840	5,776	5,025	4,900	15.8	13.8	13.4	28	28	28	56.5%	49.2%	47.9%
Heywood Healthcare	380	375	324	967	929	773	2.6	2.5	2.1	11	11	11	24.1%	23.1%	19.3%
Emerson Hospital	1,235	1,273	1,292	3,558	3,466	3,448	9.7	9.5	9.4	24	24	24	40.6%	39.6%	39.4%
Grand Total	**8,408**	**8,135**	**8,165**	**26,648**	**24,788**	**24,067**	**73.0**	**67.9**	**65.9**	**147**	**147**	**147**	**49.7%**	**46.2%**	**44.9%**

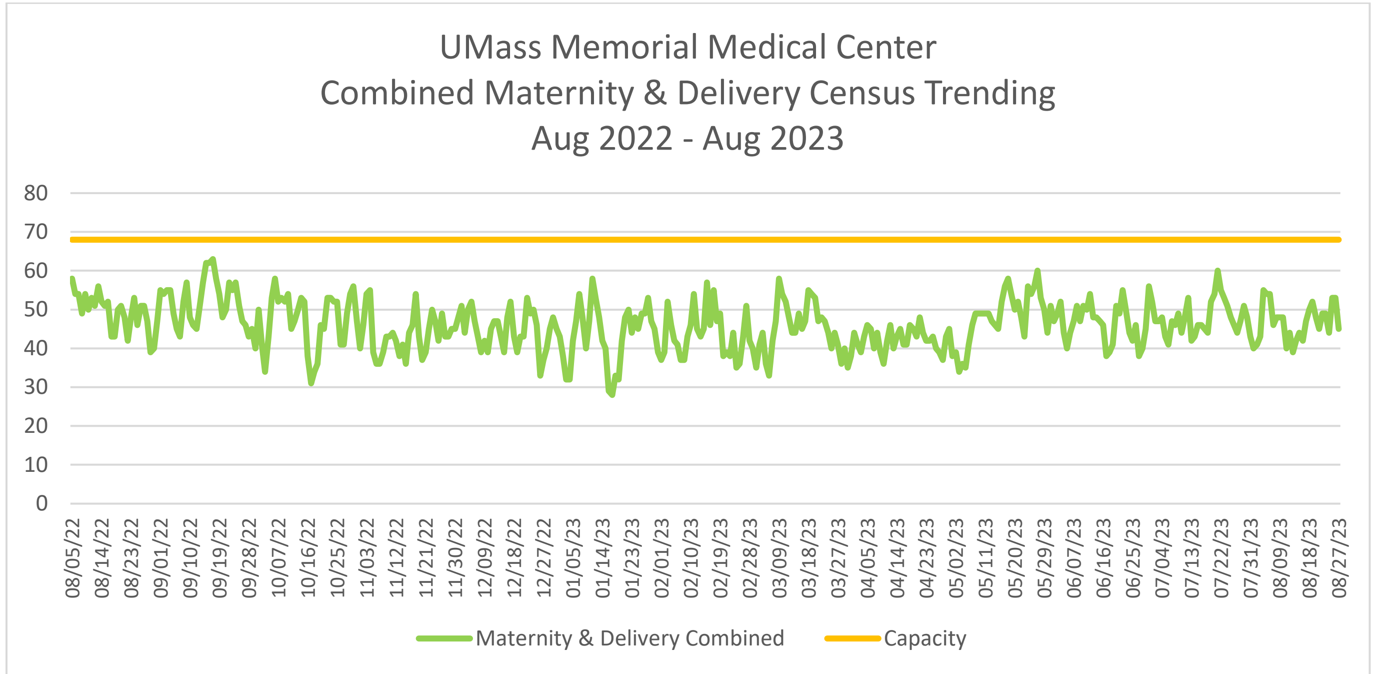
Given that the Medical Center, like the Hospital, is a UMMH entity, there is a significant amount of information known to the Hospital about the Medical Center's ability to absorb patients who would have otherwise delivered at the Hospital. A review of this information confirms that the Medical Center can accommodate all the delivery volume currently occurring at the Hospital.

Jensen Partners recently completed a masters facility evaluation of UMMH physical plant assets. As noted in the table below, with 39 labor-delivery-recovery-postpartum beds and with 25 postpartum beds the unit at the Medical Center accommodates 4,500-5,300 deliveries with an ideal utilization of 65-75%.[5] In FY22, the Medical Center performed 4,528 deliveries and the Hospital performed 513 deliveries; combined this equals, 5,041 deliveries which is well within the 4,500-5,300 range at ideal utilization at the Medical Center. In FY23 based on 11 months of actual data and 1month projected data, the Medical Center is on track to perform 4,652 deliveries and the Hospital will perform 472 deliveries; combined, this equals 5,124 deliveries which is well within the 4,500-5,300 range. The physical plant additionally includes 3 operating rooms, a post-anesthesia care unit, a neonatal resuscitation unit, and 8 bay triage area, amongst other features.

[4] Source: CHIA Inpatient Case Mix and CHIA 403 Cost Report Data.
[5] The Medical Center has the ability to add additional beds: up to 40 labor-delivery-recovery-postpartum beds and 28 postpartum beds. This means there is additional capacity to meet the needs of its patients.

OB Bed Utilization	Associated Volume			Comments
	LDRP (39 beds)	Post-Partum (25 beds)	Total Deliveries	
<65%	<25 ADC	<16 ADC	<4,500	Operationally inefficient and underutilized space
65-75%	25-29 ADC	16-18 ADC	4,500-5,300	Ideal utilization that can accommodate fluctuations in census and staffing requirements
75-85%	30-33 ADC	19-21 ADC	5,300-6,000	Acceptable utilization but at risk of capacity constraints during peak periods
85-95%	34-37 ADC	22-24 ADC	6,000-6,800	Inefficient and likely continually enacting contingency planning for peak periods
95%+	38+ ADC	24+ ADC	6,800+	Highly inefficient and potentially unsafe for patients

The experience of this capacity and the reality of antepartum, intrapartum/delivery, and postpartum volume is indicated in the line graph below which demonstrates the daily census trend over the past year. On average, the anticipated additional 1-2 deliveries/day can be accommodated. Similarly, the capacity report indicates that the vast majority of the time, the maternity center is at a level 1 (90%) and has never been at a level 4 or 5.


UMass Memorial Medical Center
Combined Maternity & Delivery Census Trending
Aug 2022 - Aug 2023
80
70
60
50
40
30
20
10
0
08/05/22
08/14/22
08/23/22
09/01/22
09/10/22
09/19/22
09/28/22
10/07/22
10/16/22
10/25/22
11/03/22
11/12/22
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06/07/23
06/16/23
06/25/23
07/04/23
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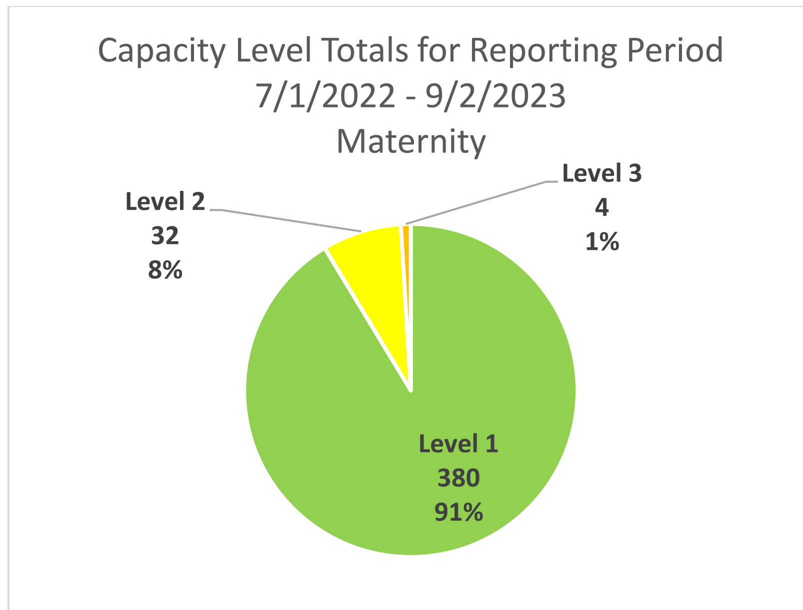
07/31/23
08/09/23
08/18/23
08/27/23
Maternity & Delivery Combined
Capacity


Capacity Level Totals for Reporting Period
7/1/2022 - 9/2/2023
Maternity
Level 2
32
8%
Level 3
4
1%
Level 1
380
91%

Beyond physical space, staffing is an essential contributor to capacity. The Medical Center currently has full nurse staffing with approximately 250 nurses, inclusive of labor and delivery nurses, mother-baby nurses, and float nurses that can do either, in addition to approximately 49 non-nurse staff caregivers, and 8 leaders at the manager or higher level. Pediatric care of the newborn is available 24/7/365 through in-house NICU services. Additionally, non-NICU pediatricians provide day-time rounding and care of newborns. Anesthesia went to a dedicated OB anesthesia service model in January 2023 and even before that provided 24/7 in-house coverage. In general, there are reliably three Ob/Gyn coverage groups (faculty and resident practice, private practice, and combined community practice with two solo practitioners) and one Family Medicine coverage group. Given this, there are a minimum of three attending physicians in-house at all times, and most commonly four, covering predominantly the maternity center at any given time. There is additionally an advanced practice provider or attending physician covering postpartum rounding and triage. Starting October 1, 2023 there will be a high-risk maternal-fetal medicine (MFM) specialist in-house 7 days/week to round on the high-risk antepartum service, and then on-call and available for consults and other high-risk care as primary back-up to the on-service faculty member, as needed. The unit additionally benefits from the care provided by our Ob/Gyn residents, Maternal Fetal Medicine fellows, emergency medicine residents, and family medicine residents. Additionally, with the closure of the Services one attending Ob/Gyn, one Certified Nurse Midwife (CNMW), and three family medicine physicians (two with OB fellowship training), in addition to the Fitchburg Medicine residents, all of whom currently deliver at the Hospital, will join the care team at the Medical Center. It is precisely this level of staffing that is available at the Medical Center to ensure consistent 24/7/365 access to care that the Hospital will be unable to provide and that it is unrealistic to provide given the increasingly low volume of deliveries at the Hospital.

3. <u>Protocol that describes how patients will access the services at alternative delivery sites.</u>

The Hospital and the Medical Center will continue to collaborate to ensure the continued availability of the Medical Center to provide care to patients who would have otherwise delivered at the Hospital. In addition, the Medical Center will continue to work with all area facilities, as it does now, to ensure continued access. The UMMH system has a daily briefing at which capacity issues in the system are reviewed and addressed, and if there is ever a capacity issue at the Medical Center labor and delivery unit, it will be raised and the system will develop a plan, based on the specific circumstances. In addition, there is always the ability to work through census problems at hospitals in the region through the regular Region 2 capacity calls.

4. Ambulance Service Availability

The Hospital met several times, both in-person and virtually, with members of the private and community EMS services. The initial meetings included the Mayors of Fitchburg and Leominster along with their Fire Chiefs. Subsequent virtual meetings included the private EMS providers currently providing services in the area (Medstar Ambulance and Coastal Medical Transportation Systems) as well as with Cataldo Ambulance Services, which anticipates providing ambulance services in the area by the end of this year; local cities and towns and CMED. The Chair of Emergency Medicine at the Hospital was also involved. Hospital staff discussed background information leading to the decision to close the Service, including efforts that had been made to keep the unit open and staffing challenges involving physicians and nurses. The Hospital also reiterated that prenatal and postpartum medical care would continue to be provided in the community. Participants provided feedback about the challenges some municipalities might face if they needed to provide long distance transports, which might leave an area with limited EMS coverage. Finally, as recently as 9/7/23, the Board of Central Mass EMS Corporation (CMEMSC) discussed the closure and the Regional EMS Medical Director solicited feedback from the group. No specific EMS operational concerns were raised at that time. Future CMEMSC Board meetings are another forum in which the topic can be discussed as need, going forward.

In reviewing the feedback, and in light of what is already known about patient volume and the mode of transportation usually needed for pregnant patients, it has been discussed that the impact to the EMS system will likely be minimal. After closure of the Service, most patients will have already chosen an alternative delivery site and will most frequently plan a mode of transportation in advance, sometimes with input from their provider. If patients are in need of non-emergent transportation, they can make arrangements utilizing the transportation plan (as described above) that will be in effect at the time of closure. When patients have unanticipated medical concerns, they will consult with their provider, and will either be referred to the closest Emergency Department (ED) or the facility at which they plan to deliver. If EMS is contacted and the pregnant patient has an emergent need, OEMS protocols will dictate where the patient should be transported for assessment. Available data, which was provided in the Hospital's August 22 response, indicates that most pregnant individuals do not require EMS transport and intervention. The Hospital's non-emergency transportation plan is anticipated to ease the burden on the EMS service by reducing the number of patients who seek ambulance transport because they do not have private transportation.

On those occasions in which EMS transport to a hospital at a distance is required, and EMS is then needed for another patient in the same area, mutual aid will occur, and a neighboring town or city will assist. This is no different than the current practice during EMS responses to multisystem trauma, cardiac arrests or critically ill patients or for other regional facilities that do not have birthing centers.

5. Transfer During Labor.

If a patient in labor arrives at the ED, the ED Attending Physician will determine whether the patient is likely to deliver precipitously. If so, the patient will be delivered in the ED as occurs in other area EDs without co-located maternity centers. If the Attending Physician determines that it is likely that the time to delivery is adequate to transfer, the Hospital will call MedStar, the primary provider of EMS transportation services for the Hospital, and the UMass Memorial Transfer and Access Center (TrAC) will be contacted along with the Medical Center Labor and Delivery Unit. The patient will be transferred with licensed EMS personnel. If the ED Attending Physician feels there is a possibility of delivery during transport, however remote, a physician or appropriately trained Advanced Practice Provider will accompany the patient in the ambulance during transfer. Should this occur, the ED Administrator on Call, who is also an ED Physician, will be contacted and will facilitate additional support if needed. This process is in keeping with EMTALA regulations and guidance.

6. Emergency Department Volume.

Emergency Deliveries are part of the core training and privileges for Emergency Medicine Physicians. Residency training includes time on the Obstetrics service assessing unexpected obstetrical emergencies, monitoring pregnancies, performing deliveries, and providing postpartum care as well as time rotating in the Neonatal Intensive Care Unit. Management of obstetrical, gynecologic, and neonatal emergencies are part of the core knowledge base and skill set of Emergency Medicine candidates for the American Board of Emergency Medicine Certification in this specialty and candidates are evaluated on this knowledge. Additionally, this is part of the ongoing maintenance of certification (MOC) processes for Emergency Medicine physicians. MOC is intended to keep practicing physicians current in their knowledge.

The Hospital Chairs of Emergency Medicine and Obstetrics and Gynecology have collaborated to create additional written guidance for ED providers in the form of clinical pathways for a variety of pertinent topics. On-going education and guidance will be provided as needed and as requested by the ED.

The Code White (Code White refers to the onsite hospital responses for emergencies involving mothers and babies and including precipitous deliveries in the ED) drills and continuing education being conducted in the ED in an ongoing manner directly involve the providers on duty. While focus is on the physicians, Advanced Practice Providers (APPs) are participating in the drills and training as well.

The Department also requested the Hospital's policy and plan for communicating the process by which ED staff will determine when to seek clinical consultation from Ob/Gyn providers and when it is appropriate to transfer a patient to another hospital. Emergency Physicians consult specialty services based on their expert assessment of the patient and their need for additional specialty intervention or advice. No specific policy was created to delineate this as no policy could cover the myriad of nuanced situations in which Board-Certified Emergency Physicians may consider making that call. Such consultations currently occur on an as needed basis and nothing should change in that process. A few special considerations are detailed in the remaining comments in this section of the response.

The Hospital's current Ob/Gyn providers will continue to be available in their office during business hours and have assured the Hospital's Chair of Emergency Medicine of their willingness to provide evaluation and advice during these times whether they are on the hospital's on-call schedule or not. There will be official on-call coverage for some day, nights, and weekends as well. This arrangement of intermittent call coverage exists for other specialties within the Hospital and other community EDs in the UMMH system. During times when these providers are not available or on-call, the ED providers will contact Ob/Gyn at the Medical Center by calling the Medical Center's Transfer and Access Center. In this manner, telephone consultation may still be obtained as needed; and, if transfer is deemed necessary, it may be facilitated on the same call. There is also a flowchart provided for ED providers on how they can connect with the appropriate Ob/Gyn provider should the need arise.

The Department requested particular data for each month between July 1, 2022 to June 30, 2023, for the Hospital and also for Marlborough and Harrington Hospitals. The requested data included: the number of ED visits where a pregnant person presented for care at the Hospital, and how many times an obstetric provider formally consulted on the patient's care; how many such pregnant patients presented to Marlborough and Harrington Hospitals and how many needed referrals to the Medical Center; the distance of the two hospitals to the Medical Center, and how the Hospital defines success of this model and these hospitals and what measures are used to monitor patient safety for emergency care of pregnant patients.

Table 1 (below) provides the number of pregnant and postpartum patient encounters in the Hospital's EDs (Clinton and Leominster campuses) and Marlborough Hospital (Marlborough) for the time period requested, and those that resulted in patient transfers to another acute care facility. Harrington Hospital (Harrington) is in the process of transitioning its legacy electronic health record to EPIC, and therefore the Hospital could not include the same data for Harrington in Table 1. Instead, Harrington's ED Medical Director provided information on the questions posed by the DPH response in narrative form (provided below).

TABLE 1 – ED Encounters by Gravid Status, ED Site, and Referral Disposition 7/1/022 - 6/30/23

Emergency Department Location	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Grand Total
Clinton Hospital (Total)	**14**	**8**	**10**	**9**	**15**	**14**	**19**	**6**	**13**	**9**	**12**	**13**	**142**
Postpartum (Total)	<5	<5	<5								<5	<5	9
Transfer to Another Facility (Acute Care)											<5		<5
Pregnancy (Total)	12	7	9	9	15	14	19	6	13	9	9	11	133
Transfer to Another Facility (Acute Care)			<5		<5	<5	<5		<5	<5		<5	12
Health Alliance Leominster Campus (Total)	**30**	**36**	**22**	**18**	**38**	**25**	**38**	**31**	**34**	**40**	**25**	**51**	**388**
Postpartum (Total)		5	<5	<5	<5			<5			<5	5	17
Transfer to Another Facility (Acute Care)				<5									<5
Pregnancy (Total)	30	31	20	16	37	25	38	30	34	40	24	46	371
Transfer to Another Facility (Acute Care)		<5	<5			<5		<5	<5	<5	<5		8
Marlborough Hospital (Total)	**27**	**26**	**34**	**23**	**31**	**24**	**32**	**21**	**31**	**27**	**23**	**31**	**330**
Postpartum (Total)	<5		<5		<5	<5				<5	<5		12
Transfer to Another Facility (Acute Care)	<5		<5								<5		7
Pregnancy (Total)	24	26	32	23	28	23	32	21	31	26	21	31	318
Transfer to Another Facility (Acute Care)	<5	7	<5	<5	<5	<5	6	6	7	<5	<5	8	56
Delivered in ED then Transfer to Another Facility (Acute Care)										<5			<5

Table 2 (below) provides the most common diagnoses associated with obstetrical ED patients who present to the ED and need to be transferred to an acute care hospital. Patients may be represented more than once in Table 2, as there may be more than one diagnosis for each visit to the ED.

Table 2. Principal Diagnoses Associated with Transferred Obstetrical ED Patients

Marlborough Hospital

Postpartum

Transfer to Another Facility (Acute Care)

Postpartum headache 4
Preeclampsia in postpartum period 2
Postpartum depression 1

Pregnancy

Transfer to Another Facility (Acute Care)

Abdominal pain during pregnancy in second trimester 4
Abdominal pain during pregnancy in third trimester 3
Vaginal bleeding in pregnancy, third trimester 3
Decreased fetal movements in third trimester, single or unspecified fetus 2
Depression, unspecified depression type 2
Ruptured ectopic pregnancy 2
Vaginal bleeding affecting early pregnancy 2
36 weeks gestation of pregnancy 1
38 weeks gestation of pregnancy 1
39 weeks gestation of pregnancy 1
Abdominal pain in pregnancy, first trimester 1
Abnormal pregnancy in first trimester 1
Alleged assault 1
Atrial fibrillation with RVR (CMS/HCC) (HCC) 1
Complication of pregnancy in third trimester 1
COVID-19 1
COVID-19 affecting pregnancy in second trimester 1
Decreased fetal movement during pregnancy, antepartum, single, unspecified fetus 1
DVT (deep vein thrombosis) in pregnancy 1
Fall, initial encounter 1
Generalized abdominal pain 1
Inevitable abortion 1
Intractable abdominal pain 1
Labor and delivery, indication for care 1
Left lower quadrant abdominal pain 1
Lower abdominal pain 1
Miscarriage at 8 to 28 weeks gestation 1
Motor vehicle accident, initial encounter 1
Other ectopic pregnancy without intrauterine pregnancy 1
Ovarian torsion 1
Pelvic pain in pregnancy 1
Pregnancy, unspecified gestational age 1
Premature rupture of membranes, unspecified duration to onset of labor, unspecified gestational age 1
Premature uterine contractions in second trimester, antepartum 1
Pyelonephritis of right kidney 1
Retained products of conception after miscarriage 1
Right lower quadrant abdominal pain 1
Right ovarian pregnancy without intrauterine pregnancy 1
Suprapubic abdominal pain 1
Third trimester pregnancy 1
Threatened miscarriage in early pregnancy 1
Torsion of right ovary 1
Uterine contractions 1
Vaginal bleeding in pregnancy 1
Vaginal bleeding in pregnancy, second trimester 1

Clinton Hospital

Postpartum

Transfer to Another Facility (Acute Care) 1

Suicidal ideation 1

Pregnancy

Transfer to Another Facility (Acute Care)

Exam following MVC (motor vehicle collision), no apparent inju
Hyperemesis gravidarum 1
Left lower quadrant abdominal pain 1
Metabolic acidosis 1
Motor vehicle accident, initial encounter 1
Premature uterine contractions causing threatened premature l third trimester 1
Ruptured ectopic pregnancy 1
Sepsis (HCC) 1
Sepsis without acute organ dysfunction, due to unspecified org (CMS/HCC) (HCC) 1
Spontaneous abortion 1
Vaginal bleeding in pregnancy, third trimester 2

Health Alliance Leominster Campus

Postpartum

Transfer to Another Facility (Acute Care)

Postpartum psychosis (HCC) 1

Pregnancy

Transfer to Another Facility (Acute Care)

41 weeks gestation of pregnancy 1
Allergic reaction, initial encounter 1
Chest pain on breathing 1
Hypertension in delivered pregnancy 1
Neurological symptoms 1
Precipitous delivery 1
Pyelonephritis affecting pregnancy in second trimester 1
Right ovarian pregnancy, unspecified whether intrauterine preg present 1

Of the two inpatient campuses of the Hospital, Leominster is the main campus and where the Services are currently located. In order to identify and provide consultation data, the Hospital would need to conduct extensive chart review of all pregnant patients who presented to the ED. Further, in the Hospital's estimation, the information provided in Table 1 and Table 2 and in the narrative below provide a more accurate understanding of how these hospitals respond to emergency visits by pregnant and postpartum patients. These numbers represent all pregnant and postpartum patients in the identified EDs by month. Consultations requested by ED providers with specialists range from telephonic advice to formal in-person consultation. The Hospital's ED providers are board-certified specialists and use their judgment regarding consultation, treatment, and discharge disposition as appropriate and as they do with all patients. We have included the principal diagnoses for all pregnant and postpartum patients transferred following ED encounters as well their frequency. This provides information regarding what is commonly seen as reasons for possible consultation for transfers to other acute care facilities for pregnant and postpartum patients (see Table 2). Please note that a significant number of the diagnoses are ones that standardly occur before pregnancy viability (e.g., hyperemesis gravidarum, threatened abortion, miscarriage,) and/or do not require maternity center care (e.g., ruptured ectopic). The predominant facility for these transfers is the Medical Center.

Maternity care providers (Ob/Gyns, Family Medicine, and CNMWs) are routinely advised of their patients ED encounters, and often consulted depending on their availability and the need at community hospitals where there is no one on-site within the specialty.

Harrington operates two ED locations. The main ED is in Southbridge and there is a satellite ED at the Webster campus. The main ED campus is approximately 25 miles and 30 minutes to the Medical Center. The Webster campus is approximately 19 miles and 21 minutes to the Medical Center. Within the period of July 2022 through June 2023, the Harrington Hospital ED Medical Director estimates 2-3 deliveries occurred within the Harrington EDs at Southbridge and Webster and 44 patient transfers to the Medical Center. After a discussion with the Harrington ED Medical Director regarding the primary diagnoses most commonly seen in their ED for obstetrical patients, the Hospital has confirmed that they are similar to and align with those listed for UMMH's other community hospitals without birthing units and which are summarized in Table 2 above. Harrington's Medical Director reinforced that their definition of success is the safety of the patients and positive outcomes of care, which would be true for all of UMMH Hospitals.

Marlborough Hospital (Marlborough) is 15 miles and 22 minutes from the Medical Center. In the time frame of July 2022 through June 2023 a total of 63 patient were transferred to the Medical Center or other acute hospitals for obstetrical (prenatal and postpartum) emergencies with the overwhelming majority going to the Medical Center. The data from the TrAC system which monitors these transfers had 48 patients transferred form Marlborough for obstetrical emergencies to the Medical Center specifically. In the last year, one delivery occurred within the Marlborough ED.

Both Harrington and Marlborough reported successful collaboration between the EDs at the community hospitals and the Medical Center. At both hospitals, timely and effective consultation is obtained with either the patient's maternity provider in the community, when available, or the Medical Center's Ob/Gyn Service, depending upon the circumstances of the case. When the Medical Center's Ob/Gyn Service is involved, cases are promptly reviewed, advice is provided, outpatient follow up case is arranged and/or transfer is facilitated. While the Medical Center collaborates with the Hospital currently on patient issues, the enhanced level of support and collaboration for obstetrical patients that is currently in place with Harrington and Marlborough will be available to the Hospital's ED providers after closure of the Services.

Post closure of the Services, when a patient presents in labor to the Hospital's EDs, the ED physician will quickly evaluate the patient for signs of active labor. If the patient is deemed to be able to safely transfer to a hospital with OB and pediatrics, ED physician will stabilize and transfer the patient as described in more detail above (see response to Question 5.)

Additionally, if the patient cannot be safely transferred and needs to be delivered at the Hospital, the Hospital will call the Medical Center NICU team. If the baby is delivered and is healthy with good APGAR scores, the Medical Center will cancel the NICU response to preserve the valuable resource. If the baby requires additional support, the NICU team will already be responding, shortening the time to specialty care. The Medical Center NICU team will travel to the Hospital, assist with any neonatal resuscitations that may need to occur, and will transport the newborn back to the Medical Center. This is the current practice for such patients, as there is no NICU at the Hospital at this time. As discussed elsewhere, Medical Center Ob/Gyn staff is available for phone discussions. All patient transfers out of the ED are reviewed by the ED Medical Director or designee, so any pregnant patient who is transferred for further care either for monitoring, delivery, or post-delivery will have their case reviewed.

7. Engagement with Community Groups.

In its first response to DPH, the Hospital described its current and ongoing activities to engage with the community regarding the closure of the Services and described how that effort fit into the broader scope of activities Health Resources in Action, Inc. (HRiA) is taking as part of the Hospital's work regarding women's health in the region. DPH has requested more detail on the community engagement specifically related to the closure of the Services and a description of how and when the Hospital is communicating updates on this work to the community.

Utilizing the Spectrum of Public Participation an internationally recognized model developed to help clarify the role of the public in planning and decision making, which is recommended and used by DPH, the Hospital's engagement strategy includes utilizing three levels of the spectrum, including **inform, consult and involve**:

Inform: With a goal to provide the public with balanced and objective information to assist them in understanding the details and impact of the closure, including the Hospital's commitment to ensure prenatal and postnatal services remain in the community, UMMH has and will continue to inform both their patient population and broader community through multiple channels. Some of these meetings were outlined in the Hospital's June 26, 2023 Notice of Closure, and others were listed in the August 22, 2023 letter to DPH. These will not be repeated here. In addition to those, the Hospital has engaged in the following additional activities:

- With a commitment to communicate with every patient in their chosen language to receive health information at every touchpoint in their care journey, the Hospital has information on its website about the closure, available in the four main languages of its patients: English, Spanish, Portuguese and Haitian Creole. (See https://www.ummhealth.org/healthalliance-clinton-hospital/information-about-inpatient-maternity-unit-closure.)
- The Hospital also provided a printout of the public testimony on the closure of the inpatient maternity unit on its website, available in the four main languages of its patients: English, Spanish, Portuguese and Haitian Creole. (See https://www.ummhealth.org/healthalliance-clinton-hospital/patients-visitors/testimony-the-closure-the-inpatient-maternity-unit)
- The Hospital developed a patient letter for Ob/Gyn and family medicine practices and offered to have the letter translated into other languages as needed by the practices.
- The Hospital has also had numerous meetings with elected officials and continues to engage them going forward.

- Over the past several months, the Hospital has communicated the position of the Hospital and UMMH to the local community and broader public by responding to 59 inquiries from multiple news outlets with media statements (16 different statements based on the nature of the inquiry) and, when appropriate, by providing leadership interviews. Additionally, the Hospital has proactively engaged select members of the media to improve accuracy of reporting and balance of perspective, while adhering to the regulatory process. Some examples of high-profile media coverage include:
  - Worcester Business Journal – "Viewpoint: Why UMass Memorial needs to close maternity services in Leominster" (June 12, 2023)
  - Hospital Leadership interviewed on the The Hank Zone on The K-Zone 105.3 FM WPKZ (June 29, 2023)
  - The Boston Globe – "Maternity units in Mass. keep closing. But is that harming care?" (August 7, 2023)
  - Worcester Business Journal – "The high cost of delivering babies: Leominster maternity center battle part of national struggle" (August 21, 2023)
  - Worcester Business Journal – "Editorial: Maternity care needs more than just an angry coalition" (August 21, 2023)
- The closure of the Services has been on the Hospital's Patient and Family Advisory Council (PFAC) agenda since the announcement.
  - As described in previous correspondence to the Department related to this closure, the Hospital has met with, among others, the following: The Office of the Attorney General
  - Local municipal leaders
  - The Hospital's PFAC
  - The Executive Office of Health and Human Services' Human Services Transportation Service
  - Montachusett Transit Authority
  - North Central Chamber of Commerce
  - North Central MA Faith Based Coalition
  - LUK, Inc.
  - Community Health Connections
  - Spanish American Center
  - Care Central VNA & Hospice
  - RCAP
  - Health Equity Partnership of North Central Massachusetts (CHNA 9)
  - New Vue Communities
  - United Way of Central MA
  - Community Foundation of Central MA
  - Ahmadiyya Muslim Community
  - WHEAT

- Making Opportunity Count

Consult: To engage public participation, hear concerns about the broader needs of birthing people in the region and to obtain feedback to inform future community investment decisions, the Hospital held listening sessions with key community stakeholders and organizations. By doing so, the Hospital could communicate details pertaining to the closure and obtain feedback from participants to better understand concerns about the impacts the closure may have on the community and receive recommendations about other stakeholders to engage in the process.

To ensure the public could attend and participate in the public hearing on the closure of the Services, the Hospital arranged and rented an accessible location in the community and hosted both an in-person hearing and a telephonic hearing, to accommodate individuals who could not attend in person. The Hospital arranged to have interpreter services available: in addition to American Sign Language interpreters, there were interpreters in the three main languages of the Hospital's patients, other than English: Spanish, Portuguese and Haitian Creole. This was the first time any hospital has provided this level of access to an essential services closure hearing.

In addition, as described in detail in this letter, the Hospital has met with the private and community EMS services and CMED, in order to understand how the closure will impact ambulance services and collaborate on executable solutions.

The Hospital's significant efforts to inform and consult with the community have confirmed that the community has identified transportation as the most significant barrier to maternity services after the closure of the Services. This information has led the hospital to develop and fund transportation services for the patients and their families in the Hospital's service area who are affected by the closure of the Services and who need access to one of the four birthing centers.

The Hospital's assessment of community concerns related to the closure of the Services and the Hospital's access plan, as described in this letter and the August 22, 2023 letter to the Department is complete. As requested by the Department, the Hospital will continue to engage with the community and inform the community with ongoing updates on available services, transportation options, and other pertinent updates based on the impact of the closure.

Involve: In an effort to engage community members to ensure that public concerns and aspirations are consistently understood and considered, the Hospital has committed to spending $600,000 to address needs while strengthening existing resources in the community that relate to prenatal and postnatal services, over three years. While a portion of those funds are dedicated to the transportation solutions mentioned earlier, the balance of those funds will be dedicated to the

creation of a community investment strategy that will provide funding to community-based organizations through an RFP process. The Hospital will utilize its Community Benefits Committee (CBC) to assist with this, including prioritizing those needs identified in the assessment, development of the RFP, selection of grantees and annual assessment of impact. The Hospital will seek to expand the membership of the CBC to ensure that end users of these resources are represented. In no event will the community commitment be less than $600,000; that is, to the extent transportation costs are less due to lower than expected utilization, all such savings would be redirected toward the RFP process.

These activities are fully developed and meet the Department's request that the access plan related to the closure of the Services include: ongoing engagement with the local community on the impact of the closure of the Services; solicitation of the community's input into the development and implementation of the ensure plan, and a plan to provide ongoing updates on available services, transportation options, and other pertinent updates based on the impact of the closure. The communication with the community is ongoing, as requested and as is best practice, but the plan is complete.

Although not required for the access plan as one has already been developed as described herein, the Hospital has decided to engage further, and has hired Health Resources in Action (HRiA) to conduct a targeted needs assessment focused on maternal health in the service area. To clarify HRiA's community engagement and assessment work for the Hospital, HRiA was hired by the Hospital in late June 2023, after the Hospital notified the Department in May 2023 of its intention to close the Services on September 22, 2023. HRiA was awarded the contract in late June 2023 to conduct an assessment to inform the Hospital's leadership and Community Benefits Advisory Committee on the future investments from the Hospital to address broader needs of birthing people in the community.

HRiA's approach aims to lift up the community's voice in the hospital's future decision making for investments in community organizations to improve health services for women and birthing people. In this assessment, HRiA is reviewing secondary data, asset mapping of prenatal and postnatal services in the service area and conducting five focus groups and seven interviews. While this activity will inform broader future work, the Hospital has also used this activity to understand the potential barriers to access the Services that have been identified by the community. The HRiA Team expects to complete the assessment phase of its work in October of 2023. Again, this assessment and HRiA's work is not designed to inform the decision of the Hospital to close its maternity unit.

After the Hospital has decided on their strategy for future investments, HRiA will partner with the Hospital to design an evaluation plan for these investments. Evaluation activities are expected to start in 2024 and continue into 2026.

In addition, the Hospital will begin to conduct its next community health needs assessment (CHNA) later this year and to adopt an implementation strategy to meet the community health needs identified through the CHNA. Public input is a valuable and necessary component of the CHNA and will certainly include a detailed focus on maternal health.

8. Staffing

This is answered in more detail in response to Question 6 above. ED staff is taken here to mean the physician as the nursing and ancillary staff do not make the decision to obtain specialty consults. The need for Ob/Gyn Consultation will be determined by the professional judgment of the residency-trained and Board-Certified or Board-Prepared Emergency Physicians on duty in the ED and caring for the patient. There are common practices that are generally followed (e.g., speaking with Ob/Gyn when post viability patients present to the ED) as community standards of care.

In the event of a physician needing advice on how to proceed, the ED Administrator On Call (AOC) for the Hospital may be contacted 24/7. This role is held by the Chairs of Emergency Medicine at HealthAlliance-Clinton and Marlborough and by the Assistant and Associate Clinical Directors at those sites in a rotating manner. The ED AOC for the day is an ED Physician and noted on the hospital's on-call schedule.

9. Alternative Solutions.

The Hospital has continually reviewed and adjusted staffing over the past 7 plus years to reflect the changing demand in volume and needs for the patients who have utilized the Services in Leominster. All birthing centers are required to sustain at least a minimum staffing level at all times to meet the 24/7/365 coverage requirement. Staff are needed in all of the following roles to provide a safe environment for patients: Providers (Ob/Gyns, Family Practice OBs, Pediatricians, Nurse Midwives, Nurse Practitioners, and Anesthesiologists); RNs (both Labor & Delivery and Post-Partum); Surgical Technicians/LPNs; Respiratory Therapists; Nurse Aides; Educators; Lactation Consultants, and Administrative staff. Over the past few years, the Hospital has increasingly relied on Locum Tenens and Temporary Agency staff to meet the

necessary staffing for the unit. Obstetrics patients need consistent, stable and appropriate staffing with the necessary training and skills.

The minimum staffing required to run the Services full time requires all of the following:

Ob/Gyn or Family Practice O/Gyn Coverage:

One Primary Call Provider and one Secondary Call Provider available within 30 minutes.

> **Primary Provider** can be Certified Nurse Midwives; Family medicine physicians with maternity credentialing plus preferably additional OB fellowship training; or Ob/Gyn.
>
> **Secondary Provider** must be Ob/Gyn physician, because someone needs to be present or available within 30 minutes to attend to complicated deliveries, repairs and other high acuity needs (e.g. cesarean-hysterectomy).

Current Status: The Hospital has 5 providers that can fill the primary provider responsibilities: four physicians and one Certified Nurse Midwife. DPH requires (105 Mass. Reg. section 130.630), for a Level I Community-based Maternal and Newborn Services), 'an obstetrician with full privileges shall be available on-call 24 hours a day' – there are only 2 providers that meet these requirements. This is the primary reason why we must make the closure recommendation. Two Ob/Gyn providers are not sufficient to fill this need – that level of call is not only very demanding, it is not feasible, nor safe. To cover all shifts for the Services by an obstetrician with full privileges would require a minimum of 5.2 Ob/Gyns if they are only responsible for clinical coverage of the maternity center, but rather and as is standard, the current two Ob/Gyns also provide ambulatory prenatal, postpartum, and gynecologic care, perform inpatient and ED consults, and perform gynecologic surgery.

In the short term the Hospital has been supplementing this coverage through Locum tenens but this staffing is not consistently available and should normally only be used as vacation or short-term coverage needs, as a supplement to a stable team, not as primary coverage, as they do not have the consistency and familiarity with the unit, personnel and policies and procedures that are critical to quality and safety.

Pediatric Coverage:

One Pediatrician or Pediatric Nurse Practitioner in house 24x7 with one Pediatrician back-up.

Current Status: The Hospital has an agreement with 4 providers for this coverage. Due to the announcement of the closure all of these providers have taken other opportunities effective after 9/24/23. Finding Pediatric Nurse Practitioners for this role is very challenging due to the

specialty training required. In addition, it is difficult to maintain these skill sets with the low volume of births seen in Leominster.

Anesthesia Coverage:

One on-call Anesthesiologist and one back-up CRNA.

Current Status: The Hospital has an agreement with a national provider of Anesthesia Care, and we are currently fully staffed. The CRNA back up who is needed for the Services, is expected to leave on 9/23/23. Finding new CRNAs will be particularly challenging. The Hospital's vendor for this service is reporting significant difficulty recruiting and retaining CRNAs. To fully cover all shifts and account for paid time off, the Hospital would need 5.2 FTE staff.

Respiratory Therapists:

One Respiratory Therapist who is certified in pediatric respiratory therapy and one Respiratory Therapist back-up.

Current status: Fully staffed, but over 65% of the respiratory therapists are contracted agency staff. To fully cover all shifts and account for paid time off, the Hospital would need 5.2 FTE staff.

Other Staffing Requirements:

The current core staffing plan (RN and Surgical Tech/LPN) for the Hospital is based on the current volumes and is summarized below:

	L&D	Post-Partum
Day Shift (7a-7p)	3 RNs +1 Surg Tech	2 RNs
Night Shift (7p-7a)	2 RNs + 1 Surg Tech	2 RNs

The extra RN on L&D during the day shift provides Fetal Stress Testing and General Patient Checks.

In addition to the staffing requirements above we also have Aides, Administrative Support, Lactation Consultants, and Educators. Overall staffing demand for Clinical Hospital staff and administrative staff is approximately 32 total FTEs to meet the minimum necessary staffing.

Current Status: The Hospital is currently sufficiently staffed to meet the minimum necessary staffing requirements through September 23 due to our efforts in increasing agency staffing for the short term. Relying on agency staff to maintain these minimum levels has proven to be a

challenge due to unreliable agency staff and their lack of commitment beyond the contract term. Our unit currently has 8 RN Travelers and 2 Surgical Tech travelers all working full time assignments resulting in about 1/3 of the staff on contracts that end in September.

Additional Staffing Required to Maintain Program:

In order to maintain the current service at the minimum base level, we would need the following staff additions:

3+ Ob/Gyns – to supplement the 2 Ob/Gyns with additional support provided through locum tenens coverage.

4+ Pediatric Hospitalists – to replace those that have accepted roles in other markets/states.

8+ RN's – to replace the Agency staff and provide a more stable staff, supplemented with Agency for leaves/vacations/Etc.

2 Surgical Techs

1 back up CRNA

This level of staffing would allow the program to run but would require high levels of on-call duty for all staff.

Alternative Staffing Models Considered:

Historically the providers (Ob/Gyn and Family Medicine OB) used to cover their own patients when each group had many more providers. As the number of providers has dropped over the past few years, the two groups decided to share the burden of call. This effort was initially very beneficial in managing the workload for the provider at the Hospital. However, as this group has continued to lose providers the burden on those who have remained in place has increased.

Multiple times over the past few years the Hospital has tried to work with the MNA Leominster Unit to evaluate the opportunity of cross training L&D RNs with Post-Natal RNs which is a model that works in many other community hospitals. The Leominster Unit RN staff rejected this model each time the Hospital tried to implement the training, and only revived their consideration of this option after the announcement of the closure of the Services. The model would not result in a reduction in minimum necessary staffing, but it would improve the Hospital's ability to adjust to staff call outs and volume fluctuations. The Hospital would still need to recruit the 8+ RNs listed even if we achieved the model change.

In addition to the approach on adjusting RNs as described above, the Hospital also tried to hire LPNs with an interest in advancing their skills to be Surgical Techs. The Hospital did hire one LPN to train as a Surgical Tech, but that individual decided to take another job after a few months of training. Surgical Tech staffing is in short supply and the Hospital was willing to make the investment in hiring and training LPNs to supplement our Surgical Tech staff.

The Hospital appreciates the opportunity provided by the Department's questions to more fully describe the Hospital's plan for preserving access after the closure of the Services. As described in response to Question 9, there will not be sufficient staff to operate this Service after September 23, 2023. At this time, the Hospital has completed the regulatory process required prior to closing an essential service and intends to discontinue the Services with the previously identified closure date of September 23, 2023.

We thank you for your attention to this matter.

Sincerely,

HUSCH BLACKWELL LLP

Rebecca Rodman

cc: J. Bernice, DPH
M. Bramanate, DPH
S. Carlson, DPH
R. Kaye, Esq., DPH
E. Kelley, DPH
W. Mackie, Esq., DPH