2025 - 2028

Hospital Implementation Strategy Plan

Yale NewHaven Health

Lawrence + Memorial Hospital

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Prepared by Crescendo Consulting Group

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INTRODUCTION

Lawrence + Memorial Hospital (L+M) is committed to improving the health and well-being of residents in Greater New London, Connecticut. As a not-for-profit hospital, L+M conducts a Community Health Needs Assessment (CHNA) every three years, as required by Section 501(r)(3) of the Internal Revenue Code. This assessment identifies the most pressing health needs in the community and helps guide the hospital's efforts to address them.

The CHNA process includes input from a broad range of community members, including public health experts and representatives of under-resourced populations. This collaborative approach ensures that the assessment and its findings reflect the diverse health needs and experiences of the community.

The findings in the CHNA report informed this Implementation Strategy Plan (ISP), which outlines specific actions Lawrence + Memorial Hospital will take to address identified health needs. The CHNA report was approved by the Lawrence + Memorial Hospital Board of Trustees on September 26, 2025, and the ISP on December 2, 2025. The documents are made publicly available, to ensure transparency and accountability.

About Lawrence + Memorial Hospital

L+M is a not-for-profit, acute care hospital serving southeastern Connecticut (CT) and southwestern Rhode Island. Located in New London, CT, the hospital is part of Yale New Haven Health (YNHHS) and provides comprehensive medical, surgical, and specialty services to the community.

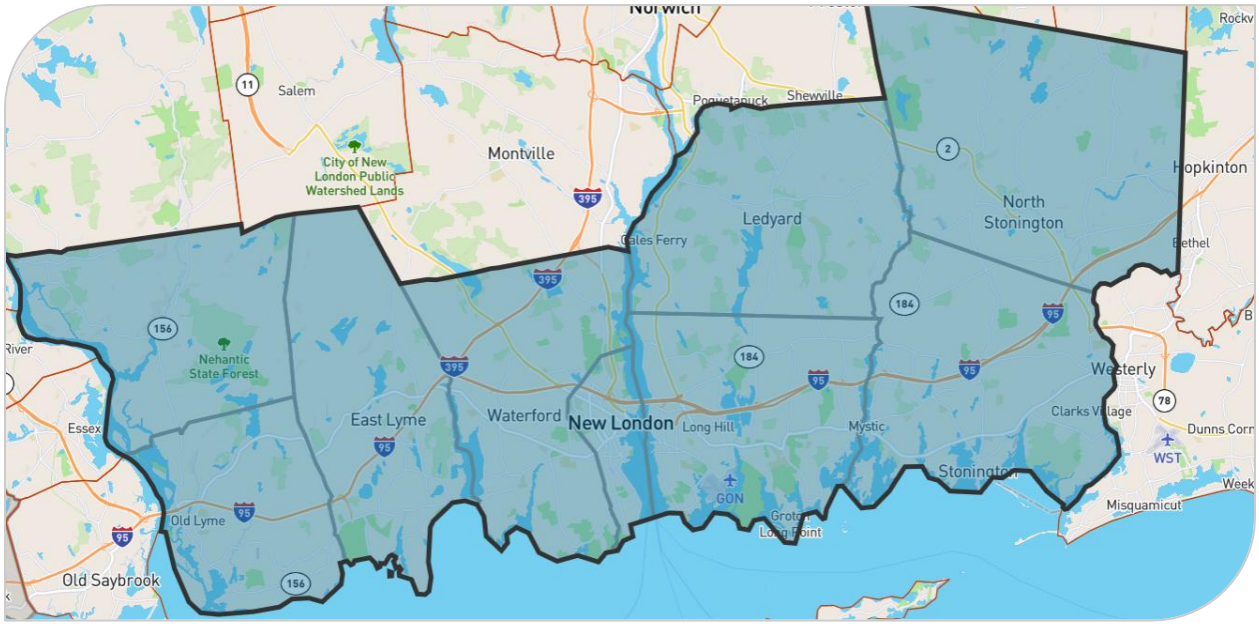
L+M offers emergency care, maternity services, advanced cardiac care, cancer treatment, orthopedics, and behavioral health services. It is a designated stroke center and has a Level III Trauma Center. The hospital is known for its commitment to quality, patient-centered care, and expanding access to healthcare through partnerships with local organizations.

As a community-focused hospital, L+M works to address regional health needs through outreach programs, preventive care, and collaborations.

For more information, visit www.lmhospital.org.

Service Area

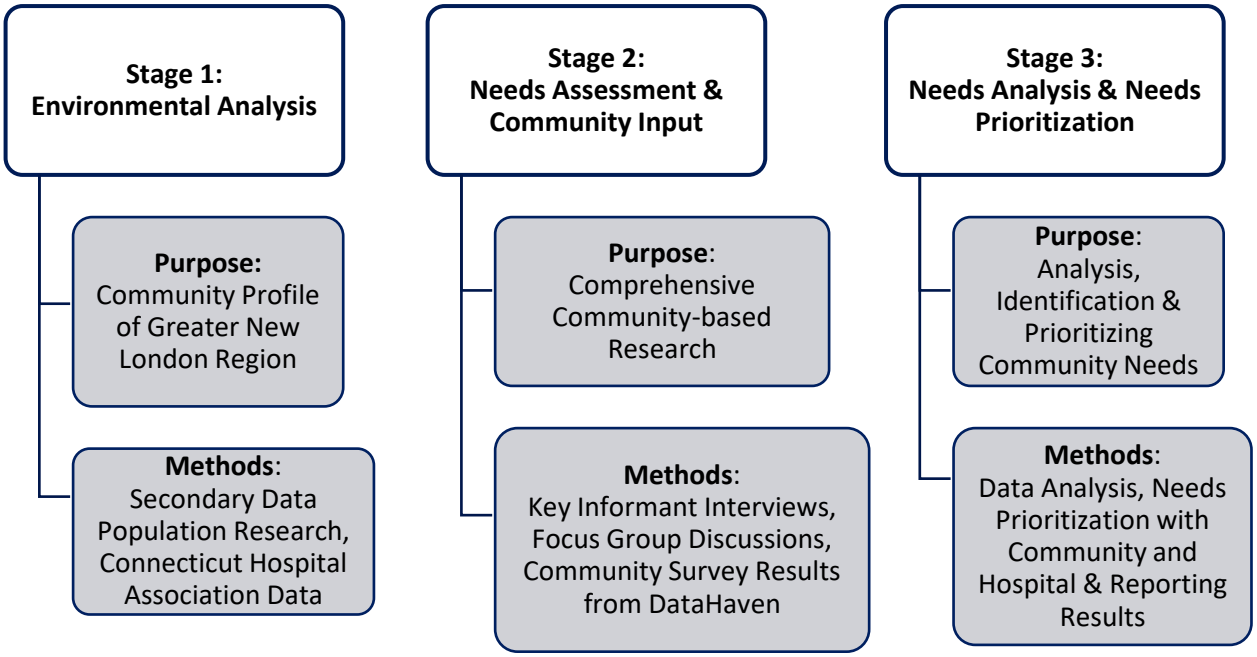
The municipalities in the Greater New London region service area include the city of New London and the towns of East Lyme, Groton, Ledyard, Lyme, North Stonington, Old Lyme, Stonington, and Waterford. These municipalities are located in New London County, Connecticut.



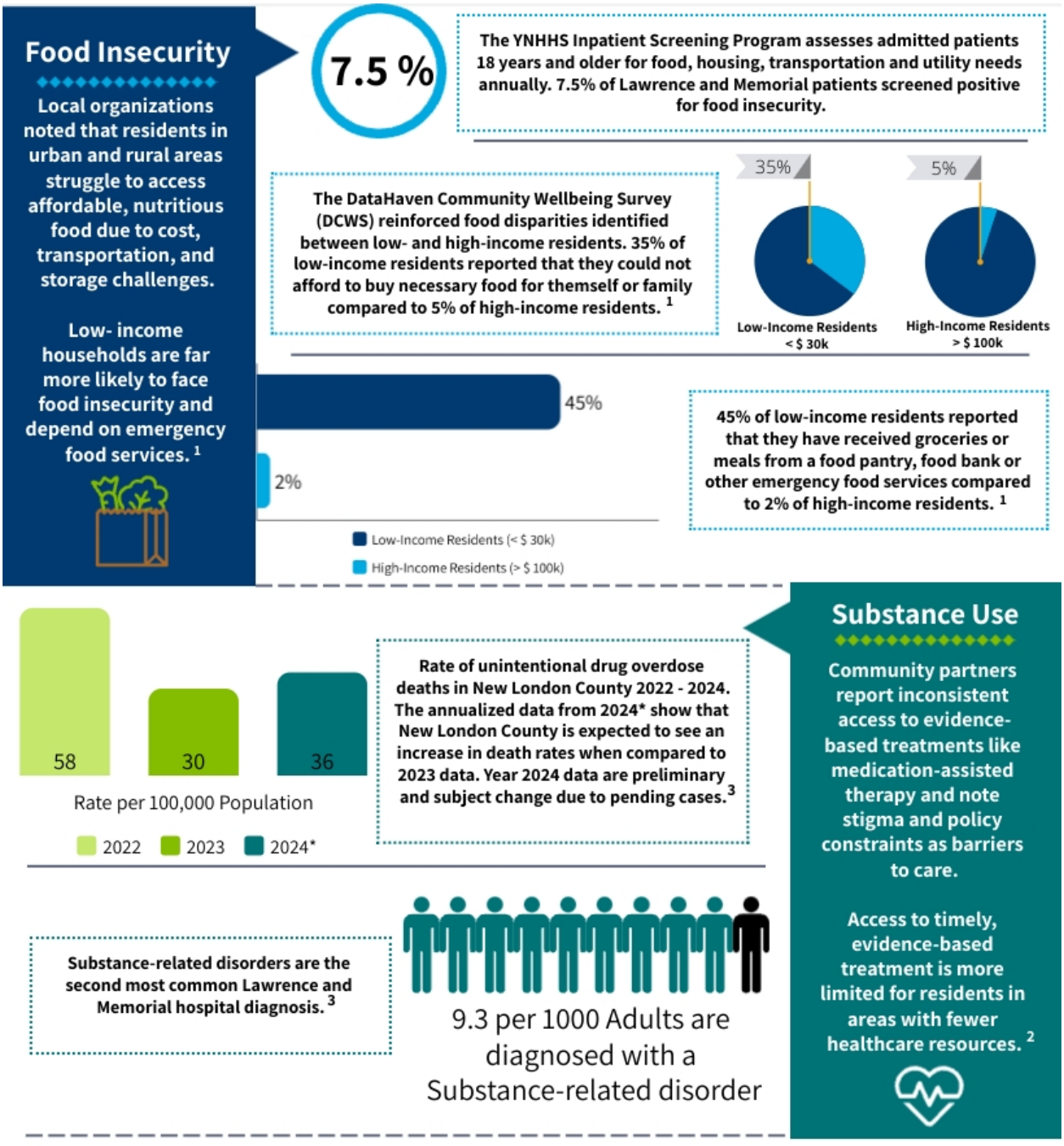
COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

The 2025 CHNA followed a three-stage methodology designed to capture a wide range of perspectives and data sources. The process incorporated input from public health professionals, community members, and communities historically marginalized from decision-making to ensure findings reflect real-world experiences and needs.

This inclusive approach is outlined in the graphic below, which summarizes the core components of each stage: environmental analysis, community input, and needs prioritization.



Data Highlights



[1] DataHaven Community Wellbeing Survey
[2] Community Health Profiles, Hospital utilization rates for key health indicators. Provided by Connecticut Hospital Association
[3] CT Department of Health Drug Overdose Report: 2019-december-2024_drug-overdose-deaths-monthly-report_connecticut_updated-1-17-2025.pdf

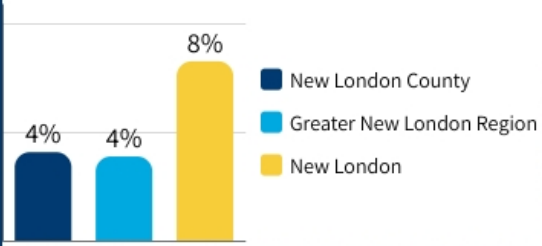
Healthcare Navigation

Key Informants described challenges navigating health systems, including difficulties finding providers who accept public insurance, which leads to delays in getting appointments.

Lower-income residents are less likely to have employer insurance and more likely to delay or forego needed care due to cost and systemic complexity.

DataHaven Community Based Assets and Needs Survey (CBANS) revealed only 16% of residents earning <$30k had employer-sponsored insurance, compared to 71% of residents earning >$100k. Employer insurance often offers broader provider access and lower out-of-pocket costs than other coverage options. [5]

14% of adults reported not receiving needed care; 32% postponed it due to cost, insurance barriers, or long wait times. [6]



Uninsured rate exceeds 5% in some towns, with coverage gaps concentrated in New London. [4]

Chronic Disease

Key Informants shared that residents with chronic conditions struggle to manage their health due to high costs, transportation barriers, and a shortage of local specialists.

Asthma and other chronic diseases are more common among low-income residents, reflecting broader challenges in managing long-term health conditions.[7]

DCWS revealed residents earning under $30,000 were more than twice as likely to report asthma compared to those earning over $100,000. Asthma is a common chronic respiratory disease that can be worsened by poor housing conditions and limited access to preventive care. [7]

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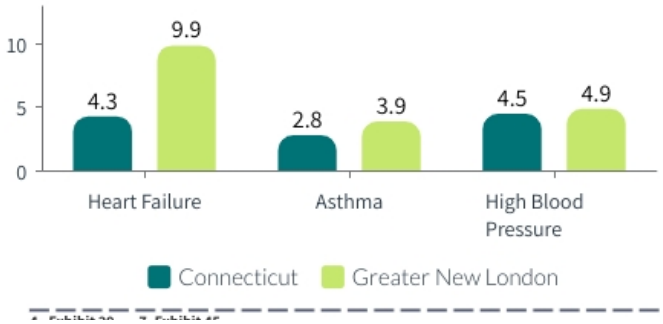


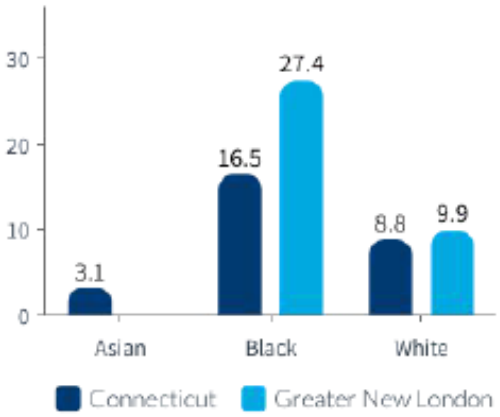
Hospitalization rates for asthma, heart failure, and high blood pressure exceed state averages. [8]

[4] DataHaven Community Based Assets and Needs Survey
[5] DataHaven Community Wellbeing Survey
[6] DataHaven Community Based Assets and Needs Survey
[7] DataHaven Community Wellbeing Survey
[8] Community Health Profiles, Hospital utilization rates for key health indicators. Provided by Connecticut Hospital Association

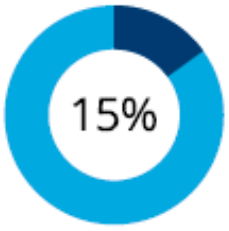
Behavioral Health

Key Informants shared that a shortage of providers, long waitlists, and limited availability of crisis services make it difficult for residents to access timely mental health care.

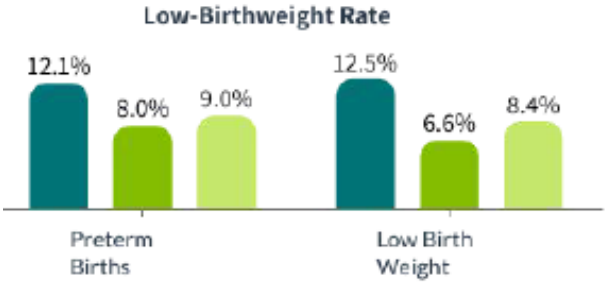
L+M has a higher than state average rate of hospitalization at 11.2 per 1,000 adult . [10]

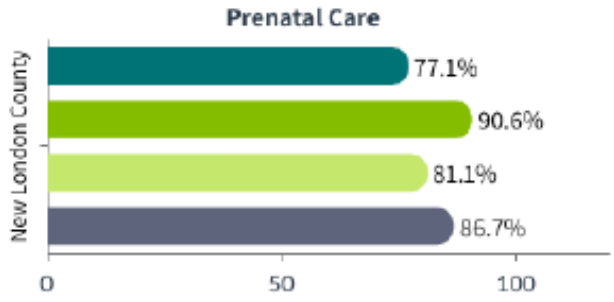


In the Greater New London Region Black adults had a hospitalization rate for mental health of 27 per 1,000, more than twice the state average of 10.4 per 1,000. [9]

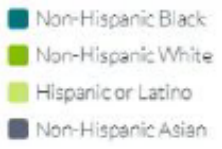


The DCWS noted that 15% of residents screened at risk for depression; anxiety rates higher among those with lower income. [11]





Black mothers are less likely to receive early prenatal care and are nearly twice as likely to have low birthweight infants compared to White mothers. Low birthweight increases risks for health complications during infancy and later life. [12]



Maternal & Prenatal Care

Community partners noted challenges accessing consistent OB/GYN care, particularly for residents in rural areas or those who lose insurance coverage during pregnancy.

[9] Community Health Profiles, Hospital utilization rates for key health indicators. Provided by Connecticut Hospital Association
[10] Community Health Profiles, Hospital utilization rates for key health indicators. Provided by Connecticut Hospital Association
[11] DataHaven Community Wellbeing Survey
[12] CDC WONDER Natality 2019-2023

IMPLEMENTATION STRATEGY PLAN METHODOLOGY

L+M developed this Implementation Strategy Plan through a structured, multi-phase process that integrated data analysis, evidence-based research, and community input to identify and address community health priorities.

Prioritization of Community Health Needs

A two-part structured needs prioritization process was conducted with community members, integrating community feedback and evidence-based decision-making. This included HIC members, regional community partners and community members.

Session 1: Reviewed 2022 CHNA report data and the updated 2025 CHNA data and findings.

Session 2: Participants identified the most pressing health needs based on a structured scoring method.

After completing this process, the top six health priority areas were identified:

1. Food Insecurity
2. Overdose
3. Health Insurance and Healthcare Navigation
4. Behavioral Health
5. Chronic Disease
6. Prenatal and Maternal Care

Lawrence + Memorial Hospital prioritization session: Hospital leaders considered the regional community prioritization findings to select organizational priorities for the Implementation Strategy plan.

Hospital Priority Areas

The community priorities identified were presented to the Lawrence + Memorial Hospital leadership who agreed to adopt the three community identified priorities.

Health System Priority Area

Community members, from across our hospital regions, identified cultural competency as a need during the 2025 CHNA process. This valuable feedback revealed opportunities to improve patient care by expanding language access and cultural sensitivity training and education for staff.

In response, Yale New Haven Health (YNHHS) selected Culturally Competent Care as a 2025-2028 priority area and will be implementing national standards for Culturally and Linguistically Appropriate Services (CLAS) at each of our hospitals. These standards will enhance the existing quality of service provided to all patients, ensuring respect for every patient's health needs and preferences. The progress of these standards will be measured with both process and outcome measures aligned with system Patient Experience metrics connected to our Press Ganey Surveys.

The Press Ganey Survey gathers patient feedback on the care and services received during their hospital stay or ambulatory visit. This valuable input helps us identify opportunities for improvement, ensure the highest quality of care, and enhance the overall patient experience. The survey addresses key aspects of the patient experience, including communication with health care staff, the care environment, and overall satisfaction with treatment.

Culturally Competent Care

Development of Strategies and Actions

To formulate effective strategies for prioritized health needs, L+M undertook the following steps:

- **Best Practices Literature Review**: Conducted a comprehensive review of current best practices and evidence-based interventions related to Chronic Disease, Behavioral Health, and Maternal & Prenatal Care.
- **Subject Matter Expert Interviews**: Engaged with internal and external experts to gather insights and recommendations on feasible and impactful strategies.
- **Review of Existing Hospital Programs**: Assessed current L+M programs and initiatives addressing the identified health needs to identify opportunities for enhancement and alignment with best practices.

Community Engagement and Strategy Refinement

L+M and Crescendo Consulting Group facilitated a dedicated virtual strategy session with hospital leadership to discuss the goals and strategies for the prioritized hospital health needs.

Participants collaboratively discussed goals using the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) framework, brainstormed potential interventions, and refined strategies. This collaborative approach ensured that the selected strategies are both evidence-based and tailored to the specific needs and capacities of the community and the hospital.

Definition of Terms

To ensure clarity and consistency throughout the Implementation Strategy Plan, the following terms are defined. These terms describe how the hospital organized its approach to addressing community health needs, setting goals, and identifying strategies and actions for the 2025–2028 planning cycle.

Term	Definition
Priority Areas	Selected community health needs for the 2025-2028 ISP.
Goal	Future desired result of each priority area written as a SMART goal statement.
Strategy	What the hospital is doing to reach the priority area goal.
Action	Approximately 1-5 for each strategy, though not all strategies may have actions.

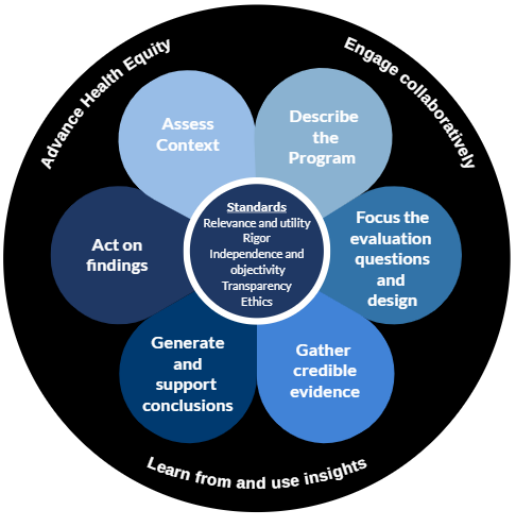
Hospital Response to Top Regional Needs

Health Need Identified by Community in CHNA	Hospital's Response
▶ Chronic Disease	This need has been identified as a priority health need. See page 12 for our plan to address it.
Food Insecurity	This need is being addressed by community organizations specializing in this area.
Health Insurance & Healthcare Navigation	Services are provided by L+M in this area, however other areas offer a greater opportunity for the hospital to have a direct impact.
▶ Behavioral Health	This need has been identified as a priority health need. See page 14 for our plan to address it.
Overdose	This need is being addressed by community organizations specializing in this area.
▶ Prenatal and Maternal Care	This need has been identified as a priority health need. See page 15 for our plan to address it.

▶ Indicates hospital priority health need.

Evaluation Plan

Evaluation of any Implementation Strategy Plan (ISP) is just as critical as the implementation of strategies, programs, and initiatives. To measure progress of goals, Yale New Haven Health (YNHHS) will utilize an adapted framework from the Center for Disease Control and Prevention (CDC) for Program Evaluation (2024). The three foundational principles of the Framework are: work collaboratively, improved health outcomes for all, and learn from and apply insights.



The Framework includes six steps to complete a successful evaluation:

1. Assess the context
2. Describe the program
3. Focus the evaluation question and design
4. Gather credible evidence
5. Generate and support conclusions

6. Act on findings

YNHHS will evaluate the progress on each goal on an annual basis. Starting at Year 0, YNHHS will determine the baseline for each goal. Each year after Year 0, the progress will be measured against the baseline. Whenever possible, YNHHS will use local, state, and national benchmarks, such as Healthy People 2030 or County Health Rankings, as additional benchmarks to measure against each year.

The evaluation of the ISP should include both quantitative and qualitative assessments as not every goal can be successfully measured quantitatively. It is important to learn qualitative findings, such as the human stories to each.

IMPLEMENTATION STRATEGY PLAN SUMMARY

Priority Area 1: Chronic Disease	
Goal	**Support efforts that address chronic disease outcomes and associated SDoH concerns by 2028.**
Strategy 1	**Support community organizations that promote prevention and self-management of chronic conditions.**
Action 1.1	Continue support of chronic disease, education, and navigation programs.
Action 1.2	Provide nutritional counseling and education about access to healthy food and other needed support.
Action 1.3	Offer healthy food options in the cafeteria for patients, staff, and visitors. Provided healthy options through the mindful item's menu.
Action 1.4	Support asthma intervention and management programs in the Greater New London area.
Action 1.5	Expand opportunity for physical activity in urban areas by investing in New London community center.
Strategy 2	**Strengthen care coordination and follow-up patients with multiple/complex conditions.**
Action 2.1	Continue to maximize Heart Failure Clinics to provide education and management for heart failure patients.
Action 2.2	Develop individualized care plans for multi-visit patients including Connecticut Early Detection Program (CEDPP) and Wise Woman.
Strategy 3	**Enhance Screening and Interventions for Social Drivers of Health**
Action 3.1	Continue to screen all adult inpatients at L+M for food, housing, transportation, and utility needs every 12 months.
Action 3.2	Continue to identify adult inpatients at L+M who screen positive for food, transportation, housing, and/or utility needs in the last 12 months.

Priority Area 1: Chronic Disease	
Action 3.3	Continue to provide automatic resource recommendations for community-based support in patient's after visit summary for those who screen positive for food, housing, transportation, and/or utility needs.
Action 3.4	Incorporate a focus on fairness and improved health outcomes into health system performance improvement work groups.
Strategy 4	**Continue to build outreach initiatives to increase awareness and early detection of chronic disease.**
Action 4.1	Maintain community outreach for CT lung screening program.
Action 4.2	Provide nutrition education focused on obesity awareness and its relationship to cancer.
Action 4.3	Continue to offer screenings for chronic disease for employees and in community settings, including CEDPP and Wise Woman.
Action 4.4	Work with post-acute care to facilitate effective transitions of care.
Action 4.5	Establish Family Care Residency program.

Priority Area 2: Behavioral Health	
Goal	**Collaborate with programs that provide education, prevention, and management for chronic conditions by 2028.**
Strategy 1	**Support behavioral health education and awareness efforts.**
Action 1.1	Provide training to healthcare and other providers to prevent suicide.
Action 1.2	Enhance resource sharing and education to align and promote existing resources.
Action 1.3	Enhance the Intensive Outpatient Program (IOP) to include medically complex patients with limited behavioral health access due to comorbidities.
Action 1.4	Psychiatric Emergency Services (PES): increase coverage for medication providers to initiate treatment faster while patients are in the ER, decreasing the need for inpatient psychiatric hospitalization.
Action 1.5	Nursing APNA Training: Provide psychiatric care training for nursing staff to enhance their ability to support patients with behavioral health needs.
Strategy 2	**Support families and caregivers through peer education and behavioral health resources through partnerships with community organizations.**
Action 2.1	Organize a yearly Mental Health Symposium featuring educational lectures from mental health providers (social workers, therapists, psychiatrists, APRNs).
Strategy 3	**Advocate for behavioral health supports and access.**
Action 3.1	Work and partner with organizations and government to advocate for behavioral health.

Priority Area 3: Prenatal and Maternal Care	
Goal	**Support programs that improve access to equitable, coordinated prenatal and postpartum care by 2028.**
Strategy 1	**Support parents and organizations with training and supplies.**
Action 1.1	Maintain access to specialty care by enhancing Maternal Fetal Medicine care in the Greater New London region.
Action 1.2	Continue to implement the intensive in-home program for children through the Nurturing Families program.
Action 1.3	Connect families to SDOH resources (applying to programs such as WIC, SNAP, Care 4 Kids, etc.).
Action 1.4	Connect with community partners to support distributing baby supplies.
Action 1.5	Host the annual holiday toy drive and adopt-a-family event.
Action 1.6	Support and conduct parent groups and parent trainings.
Action 1.7	Continue collaboration with York Correctional Institution to support babies and caregivers after delivery.
Action 1.8	Continue to conduct health reviews, depression Screening, IPV screenings, children's developmental and social-emotional screenings, parent-child interaction screenings.
Strategy 2	**Promote access to equitable and culturally responsive prenatal and maternal care services.**
Action 2.1	Implement Behavioral Health Screening with real-time social work support (in person or virtually) as part of the Pediatric Specialty Center Initiatives.
Action 2.2	Prioritize staff participation in cultural competency training, professional development and tribal community engagements to deepen our understanding of traditions, values, and needs.
Action 2.3	Proactively engage with diverse community partners through targeted outreach events to disseminate information about prenatal and maternal care services available.
Action 2.4	Continue to compile and provide a linguistically and culturally appropriate folder for new mothers, offering bilingual (English/Spanish) guidance on local services, support groups and healthcare options.

System Priority Area: Culturally Competent Care	
Goal	**Support improvement of quality of service and patient experience performance at L+M Hospital and its regional ambulatory sites by 5% by 2028 as measured by meeting the target goal for "Likelihood of Recommending" on Press Ganey Surveys.**
Strategy 1	**Implement National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care at L+M Hospital.**
Action 1.1	Create System / L+M Hospital CLAS Advisory Council with a focus on oversight and implementation.
Action 1.2	Centralize interpreter dispatch system and real-time dashboards.
Action 1.3	Co-design three culturally responsive care protocols.
Action 1.4	Launch simulation training focused on respect and inclusive practices.
Action 1.5	Expand Patient Family Advisory Councils (PFACs).
Action 1.6	Identify health care gaps for closure by patient demographics.