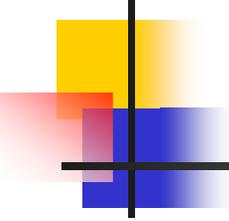


# Eleanor Slater Hospital and Rhode Island's Long Term Care System

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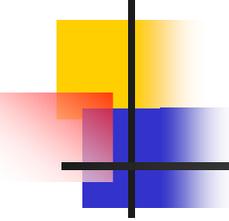
Global Waiver External Task Force  
August 12, 2009



## Basic Facts

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- ESH is a long term acute care hospital operating on two campuses (Cranston and Burrillville) serving persons (18 and older) with complex medical and behavioral needs
- ESH is licensed for 495 beds over three basic services
  - Medical
  - Long Term Care (including Geriatric/Psychiatric)
  - Adult Psychiatric (including Forensic Psychiatric)
- Current census of ~300
- FY2010 (enacted) budget: \$109.9 million (all funds)



# Comparison to Community Hospitals

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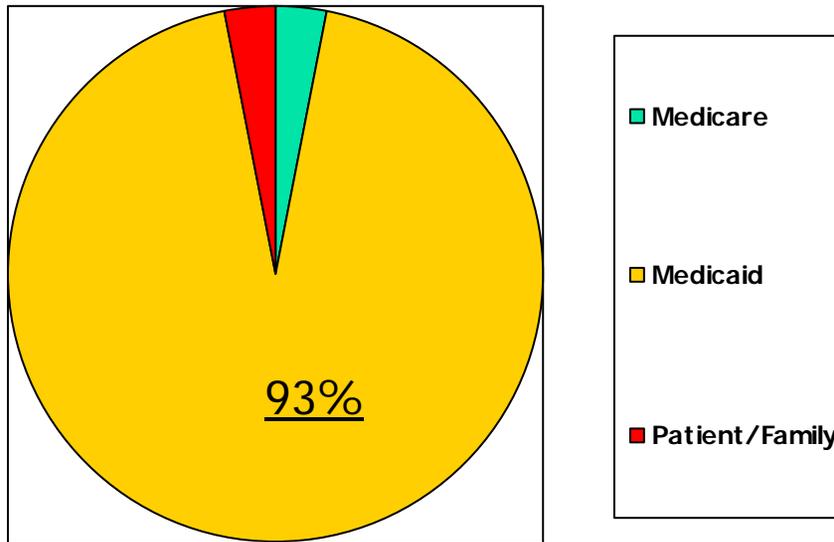
## Services offered by Slater

- Inpatient medical care
- Long term (chronic) care
- Psychiatric care (including geropsych)
- Pharmacy
- Laboratory testing

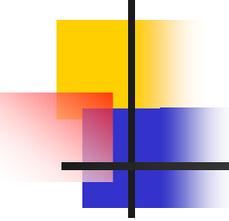
## Services NOT offered by Slater

- Surgery
- Pediatrics
- Obstetrics (OB/GYN)
- Outpatient
- Trauma care

# Hospital Revenues



- Highly dependent on Medicaid as near-single revenue source (93%)
- Medicare (A, B, & D) = ~2.5%
  - Most Medicare-eligible patients are admitted after their hospital benefit has been exhausted
- Patient and family share = 3-4%



# Perceptions

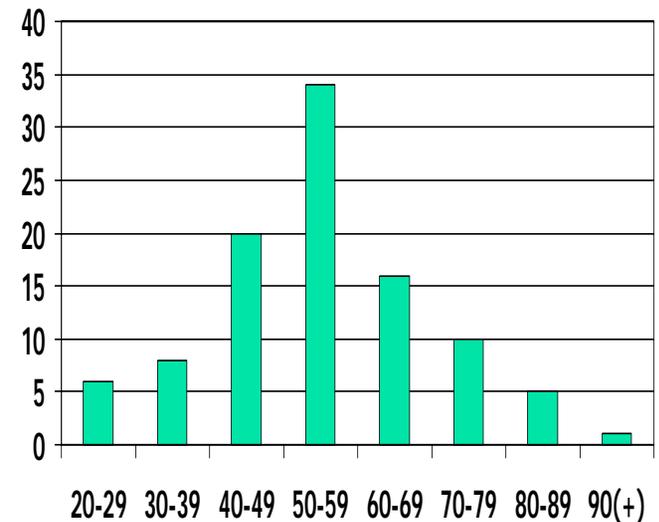
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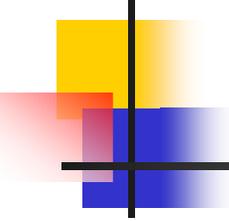
- There are many different (and conflicting) perceptions of ESH's position and role in the health care system, based upon its history
  - A hospital providing complex medical care not otherwise available in RI
  - An old-style sanitarium
  - Long term psychiatric care safety net
  - The "IMH"
  - The "institution of last resort", the essential safety net for the rest of the delivery system, caring for the indigent

# Who is Served by Slater?

- Who?
  - Legal permanent residents of RI with complex illness who require an intensive, interdisciplinary care not available in other settings
  - Many are court-ordered, or have repeated failures in other settings
- Where do they come from?
  - Nearly all come from other hospitals, but admissions can also come from the community, group homes, or nursing facilities
- What are the barriers to discharge (why do they stay)?
  - Access to the appropriate combination of services
  - Access to a discharge site with experience in meeting special needs (e.g., specialized group home)
  - Access to supports that manage certain types of behavior

% Census by Age Group





# Questions for the Future

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- Within the confines of our resources and clinical capabilities, what patient **populations** should we serve?
  - Where do they come from?
  - Where do they go to?
  - What are their **needs**, and how do we address them?
  - **Why** is ESH the ***best*** place for these patients?
- What are the **options** for patients that ESH cannot (or should not) admit?
- How will we solve the **discharge barriers** that keep some patients at ESH longer than they need to be?