Eleanor Slater Hospital Transition & Redesign

October 7, 2020

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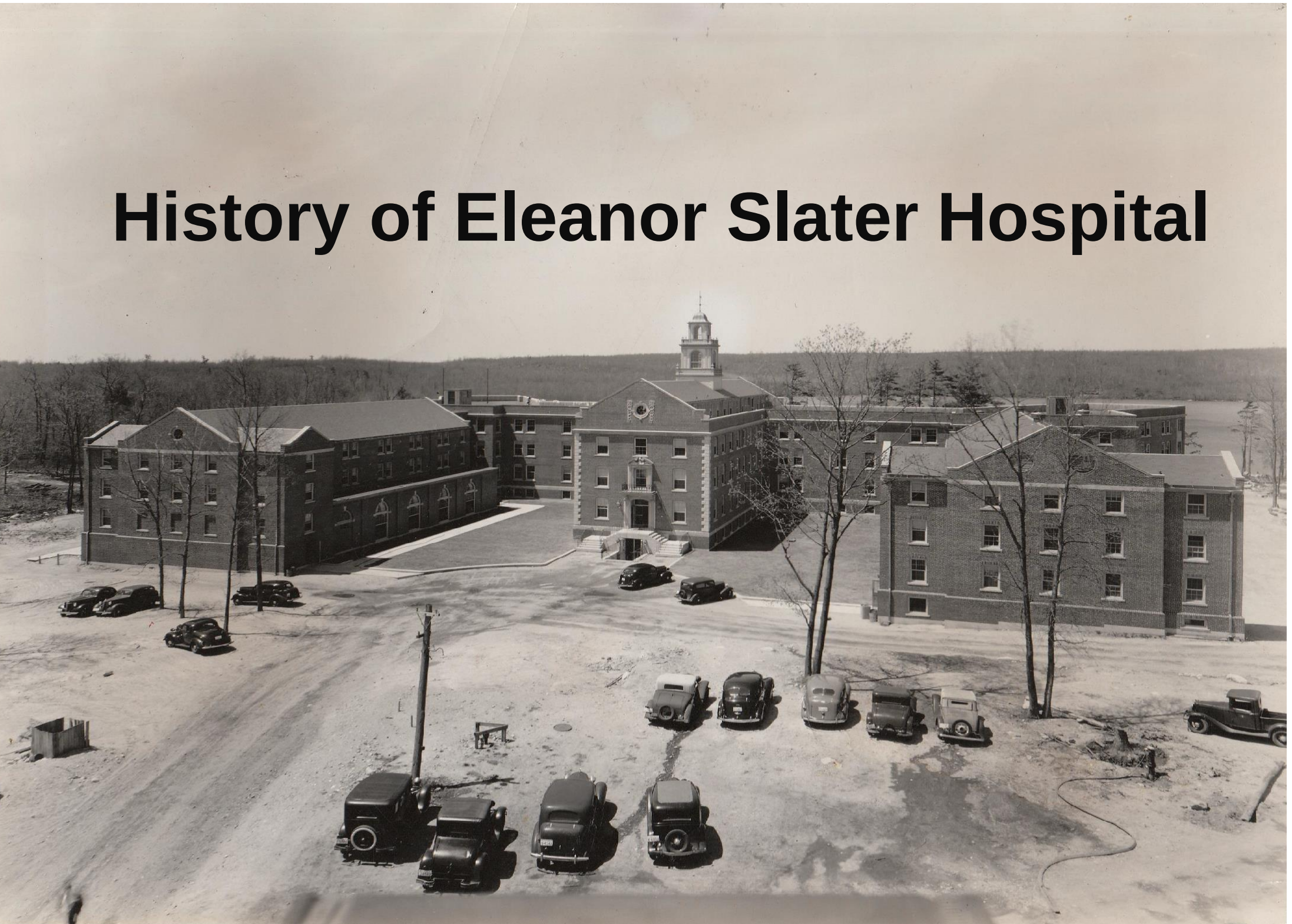
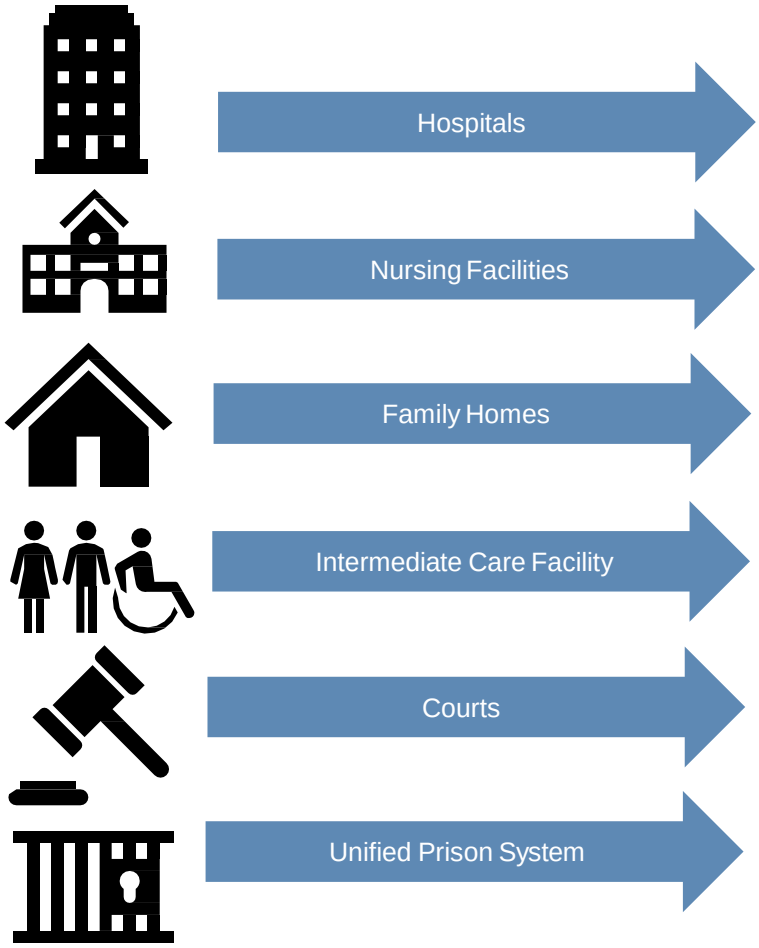
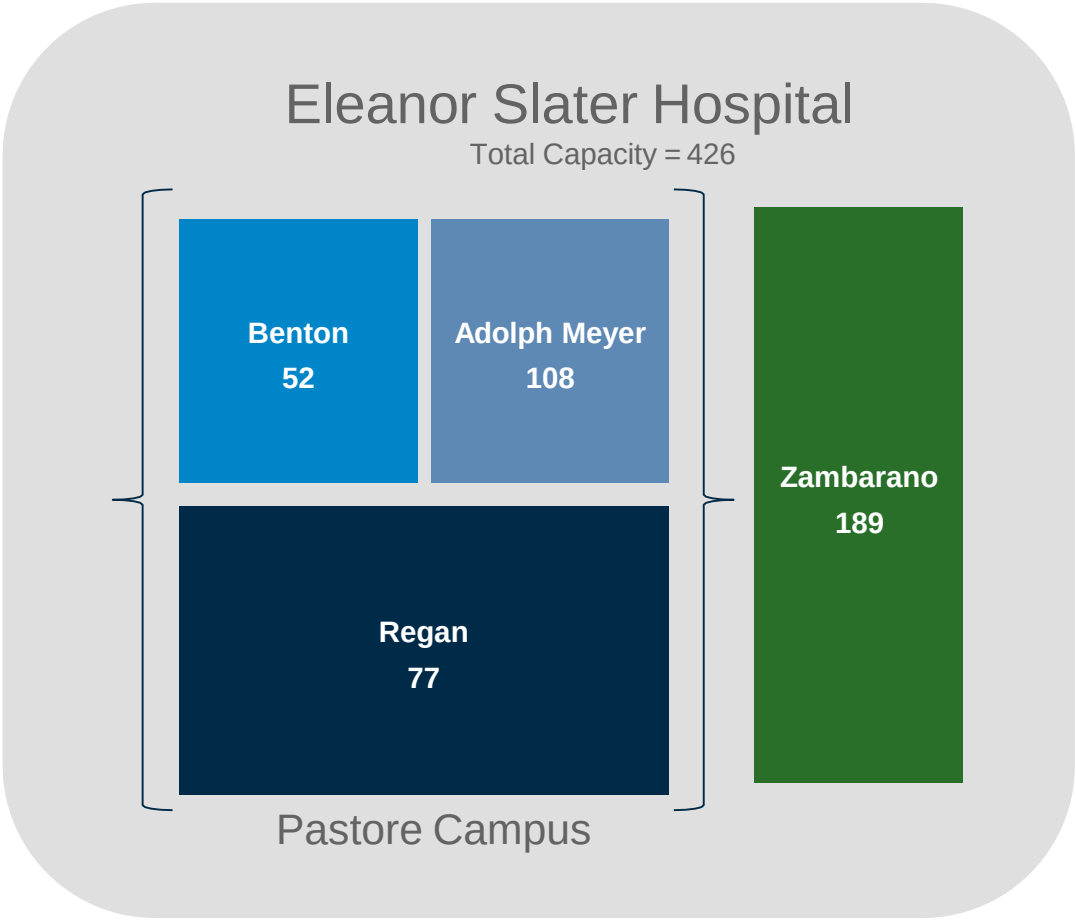
History of Eleanor Slater Hospital



How did we get here?

Multiple facilities were licensed as an inpatient hospital to maximize federal funding for psychiatric care - ESH became the placement of last resort





Transition to the “Least Restrictive Setting”

There are gaps in the current continuum of care that prevent people from “stepping down” or “stepping up” to the most appropriate, least restrictive setting

Eleanor Slater Hospital

Aged / Disabled

Severe and Persistent Mental Illness

Developmental Disabilities

Self-Harming / Restrictive Interventions

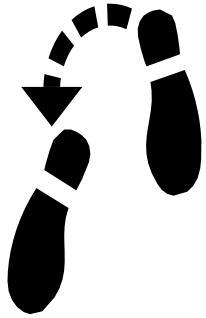
Co-occuring Disorders

Violent Offenders

Medicaid Ineligible Non-citizens

Institutionalized

Aggressive / Restrictive Interventions



Skilled Nursing Facility
Assisted Living

Mental Health PRR
Supported living

DD Group Homes
Shared Living

Summary of Redesign Proposals

Proposal	Labor	Facilities	Licensure	Investments	Federal Funding	Net Effect to GF OpEx Long-Term
Proposal: Discharge to Appropriate LOC, Close AM, Regan, Repurpose Zambarano into NF/ICF	Reduction in AM and Regan staffing Decrease Physician Labor	Close AM and Regan by mid-2021, Renovate Zam Campus into a NF/ICF (3 years min)	Relicense Zambarano as NF and ICF Benton Licensed Separately as an inpatient hospital	Est. $64-$66m in Cap Improvements to Zambarano Campus Appx. $12m EMR (to enable Medicaid/Medicare billing)	Discharged patients eligible for FMAP, Zambarano patients eligible for billing after attaining NF licensure	Decrease of approximately $788m
Alternate Proposal: Discharge to Appropriate LOC, Close AM, Regan, Zambarano	Reduction in AM, Regan and Zambarano staffing Decrease Physician Labor	Close AM, Regan and Zambarano by mid-2021	No JCAHO Accreditation needed Benton Licensed Separately as an inpatient hospital	Ongoing ligature risk remediation at Regan	Discharged patients eligible for FMAP	Decrease of approximately $1.1b
"Status Quo": Discharge to Appropriate LOC, Close AM	No Reduction in Staff	Close AM (life/safety hazards) by end of 2020	Must meet JCAHO Accreditation Benton Licensed Separately as an inpatient hospital	Appx. $11m EMR (to enable Medicaid/Medicare billing) Ongoing Capital Improvements and ligature remediation to AM, Regan and Zam	Current population does not meet hospital LOC; existing systems inadequate to support billing; Discharged patients eligible for FMAP	Decrease of approximately $584m (*largely attributable to federal match reclamation*)

Proposal: Discharge to Appropriate LOC, Close AM & Regan; Relicense Zambarano

MEDICAL		MIXED PSYCH		FORENSIC
Zambarano Capacity: 189 Census: 84 Medical	**Regan 5** Capacity: 49 Census: 12 Ventilator	**Regan 4** Capacity: 28 Census: 10 Geriatric Psych	**Adolph Meyer** Capacity: 108 Census: 54 = 12 Female Forensic + 42 Voluntary	**Benton** Capacity: 52 Census: 43
Discharge 25 AL/NF/GH/TBI 59 Remain	**Discharge 12 to SNF**	**Discharge 1 to SNF** 9 Psych to Step-Down Facility	**Discharge 21 to AL/GH/NH/MHPRR** 6 Forensic to Benton 27 Psych to Transitional Facility	

59 Community Discharges

Step-Down Receiving Facility

Expected: 36 Psych

Intent to Discharge

Future Zambarano Campus – Potential Services / Licensure Options

Skilled Nursing Facility Capacity: 8	**Custodial Care Nursing Facility** Capacity: 48-58	**ICF** ***Crisis Management & Intervention*** Capacity: 16-24	**Traumatic Brain Injury** Capacity: 10-15

Forensic IMD

Capacity: 52

Census: <52

Potential Uses of the Zambarano Campus

Zambarano remains as a specialized provider to fill gaps in the continuum of care

Patient Profile	Licensure	Complexities to Obtaining Licensure	Fills Gap in Continuum?	# of Beds	Expected Length of Stay	Staff Needs	Investments	Federal $ Eligible?
Developmental Disabilities in Need of Immediate Crisis Intervention	Intermediate Care Facility (ICF)	• RI closed its last ICF in 1994 (The Ladd School) • Capital Investments required to meet licensing standard	Yes	16-24	90-120 days	Behavioral Support Specialists Decrease physicians and nurses, may not be able to be retrained	• Capital Improvements or constructions • Personnel Training	Potential Cost-Reimbursement
Elderly / Physical Disabilities (Medical)	Skilled Nursing Facility	• Moratorium on new NF licenses by legislature [1] • Capital Investments required to meet licensing standards • Current surplus in NF beds due to COVID	Maintains	8	Long-Term (w/ step-down option	Retain CNA Decrease physicians and nurses	• Patient Information Systems • Capital improvements or construction	Potential RUG rate based on MDS
Elderly / Physical Disabilities (Medical)	Custodial Care Nursing Facility		Maintains	48-56	Long-Term (w/ step-up option)	Retain CNA Decrease physicians and nurses	• Patient Information Systems • Capital improvements or construction	Potential RUG rate based on MDS
Intermediate Step-Down from "Post-Acute Rehabilitation"	Traumatic Brain Injury (TBI)	• May require multiple levels of care	Yes	10-15	<180 days	Behavioral Support Specialists	• Capital Improvements or construction • Personnel Training	Potential Medicaid Rate
Recent ESH discharges At-risk of institutionalization	Mobile Crisis Intervention and Stabilization Unit	N/A	Yes	0	Inpatient Diversion	Retrain psychiatric attendants, mental health workers, etc.	• Equipment • Personnel Training	Potential Medicaid Rate

[1] RI currently has a moratorium on new Nursing Facility licenses (Title 23 Health and Safety §23-17-44) which can be repealed

ALVAREZ & MARSAL

Physical Infrastructure Condition

Several ESH facilities are out of compliance with Department of Health and JCAHO requirements and require capital investments if facilities will continue to be in use

Facility	Use	Year Built	Capacity	Condition	Ligature Risk	Life Safety Work Orders Present?
Benton	Forensic Psych	Renovated 2018	52	Good	Mitigated	Yes *(remediation in progress)*
Regan	Mixed Medical / Psych	1976	77	Fair	Significant	Yes
Zambarano	Medical	1901	189	Poor	Extreme	Yes *(remediation in progress)*
Adolph Meyer	Mixed Medical / Psych	1908	108	Poor	Significant	Yes

Benton: Fully renovated in 2018, compliant as a secure forensic psychiatric facility.

Regan: Significant ligature risk which limits capacity for psychiatric patients

- Short-term capital improvements would require $5M in funding, long-term est. approximately $17M

Zambarano: Requires campus infrastructure renovations and has ligature risk that currently prohibits capacity for psychiatric patients, presence of hazardous materials.

Adolph Meyer: Numerous life safety work orders/risks are in the process of being addressed

DCAMM New Construction v. Gut Rehabilitation Assessment

DCAMM recommends the approach of a new construction which is less costly and allows patients to remain in the existing building in the interim

	New Construction	Renovation of Existing Facility
Cost Estimate:	$63.6M (*see assumption 1*)	$65.5M (*see assumption 1*)
Patient Transfer Cost Estimate:	N/A	*To be determined based on availability of commercial nursing facility space for lease*
Estimated schedule (*see assumption 4)*	~3 years	~3+ years
Pros:	Less disruptive to patients Expected to be less costly for capital improvements	Continued utilization of an existing asset
Cons:	Compliance issues in existing buildings (Regan and Zambarano life/safety risks) must still be addressed	• Expected to be more costly • Displaces patients for an extended time period • Reliance on oversized utility infrastructure of Zambarano • Layout is not conducive to meeting FGI guidelines • Conversion to single patient rooms is substantially more costly than the Regan renovation • Beazley building is much older and structure does not have floor-to-floor heights to provide central HVAC distribution • Access to emergency services, response of local fire/EMT-acceptable time for emergency response

Assumptions:

1. Costs include work in the Regan building to mitigate the risks identified. Presently estimated at $5M (minimal level of reno., not full scale).
2. Zambarano new construction = 98,000 SF
3. Zambarano renovation = 96,000 SF of the 147,000 SF building.
4. Continue with existing design and construction team (NEMD, Bond) previously solicited.

Patient Information System Investments

The following systems are critical investments that must be made to be able to claim federal reimbursements

Admissions Discharge Transfer (ADT)

- Profiles all patient information including census management, demographics, guardian, next of kin, DNR orders, etc.
- Front-end of the EMR
- ESH currently utilizes antiquated, non-HIPAA compliant, P550 / Cobalt System that cannot be integrated with an EMR

Electronic Medical Record (EMR)

- ESH currently utilizes paper-based medical record systems; repurposing Zambarano into a NF requires an EMR in order to:
  - Determine billing and reimbursement for patients in compliance with federal regulations
  - Standardize screening and admission process including LOC assessments
  - Improve quality and consistency of patient care via integration with other clinical systems
- ESH can either directly procure its own service, 'lease' a system, or join an existing RI EMR service contract
- Initial proposal estimates a 3-year implementation of one-time costs of $12m plus ongoing annual costs of $50-60,000 after the transition

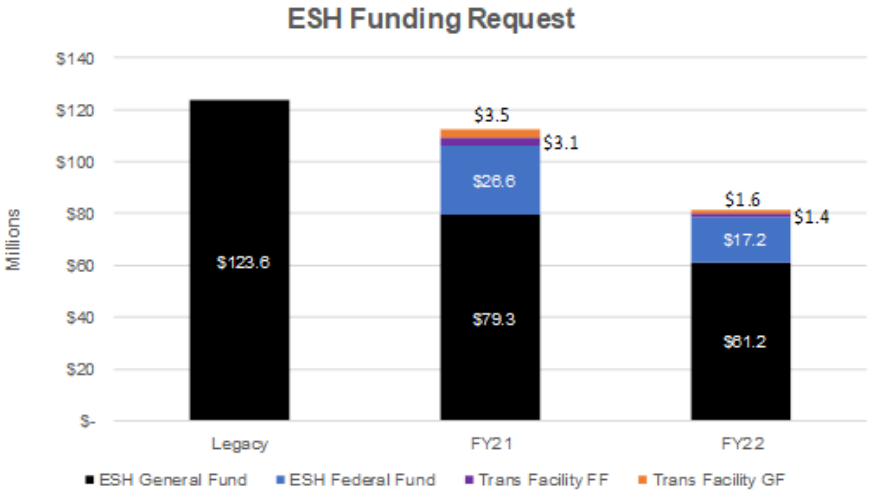
Other Critical Functionality

- Ability to bill Medicaid, Medicare, Third Party
- Ancillary services (pharmacy, lab, radiology, dental, etc.) integration into EMR
- Medication Delivery and Adjudication
- Incident Reporting
- Dietary, Scheduling, Patient Accounting

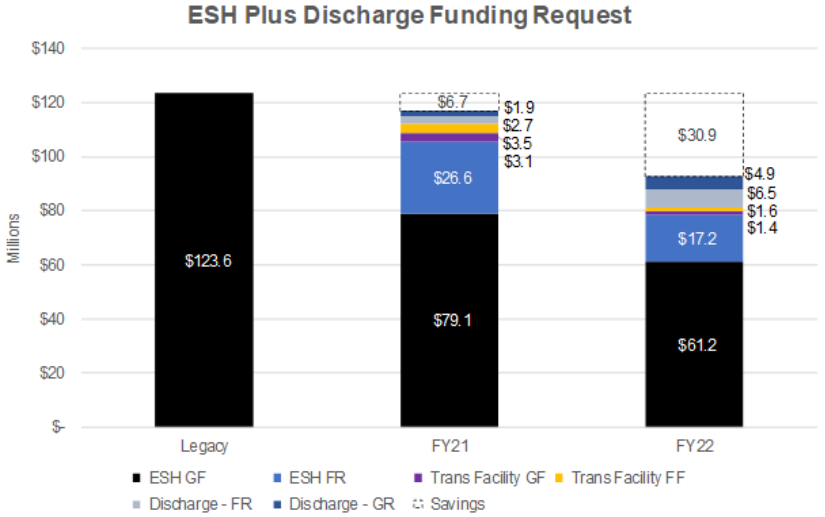
Proposal: Hospital and State Budget Impact

In this proposal, Regan and Adolf Meyer close; a step-down receiving facility is developed and Zambarano is eventually relicensed as a mixed-use NF/ICF facility

- Total ESH costs decrease from $123.6m (legacy costs) to $81.4m in FY22
- Discharge of 96 patients to facility and community-based placements reduces total costs from $123.6m to $92.7m; General fund $123.6m to $67.5M



Funding Source	Legacy[1]	FY21	FY22
General Fund	**$ 123.6**	**$ 82.2**	**$ 62.6**
GF Delta YOY		*$ 41.4*	*$ 19.6*
Federal Fund [2]	**$ -**	**$ 30.1**	**$ 18.8**
Total	**$ 123.6**	**$ 112.3**	**$ 81.4**
Total Funds Delta YOY	*$ -*	*$ 11.3*	*$ 30.9*

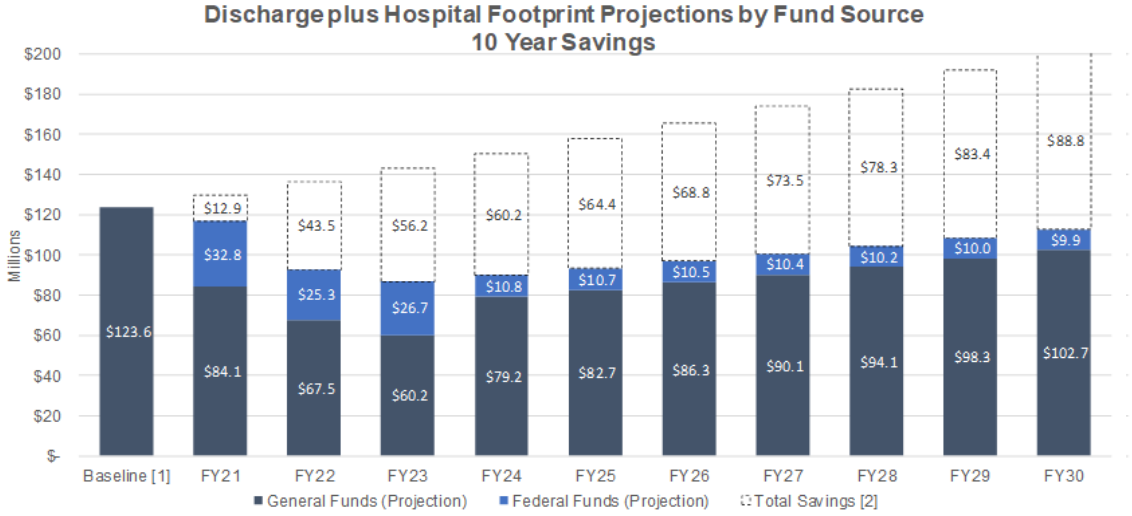


Funding Source	Legacy [1]	FY21	FY22
ESH GF	$ 123.6	$ 79.1	$ 61.2
Transitional Facility GF	$ -	$ 3.1	$ 1.4
Discharges GF	$ -	$ 1.9	$ 4.9
General Fund Total	**$ 123.6**	**$ 84.1`**	**$ 67.5**
ESH FF [2]	$ -	$ 26.6	$ 17.2
Transitional Facility FF	$ -	$ 3.5	$ 1.6
Discharges FF	$ -	$ 2.7	$ 6.5
Federal Fund Total	**$ -**	**$ 32.8**	**$ 25.3**
Total	**$ 123.6**	**$ 116.9**	**$ 92.7**
Savings	*$ -*	*$ 6.7*	*$ 30.9*

1Legacy costs were generally split equally between federal and state dollars, did not receive federal match in FY2020;
2Assumes approval of the State Plan Amendment that would allow federal reimbursement on ESH patient care costs on a cost-settlement basis

Proposal: Long-Term Savings Estimate

The State would save $788m in General Funds over the next ten years by discharging individuals and downsizing the physical footprint of ESH; this estimate captures ESH and EOHHS' costs but does not include the costs and savings incurred by tangential state agencies



Funds	Baseline [1]	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	Total
General Funds (Baseline)	$ 123.6	$ 129.8	$ 136.3	$ 143.1	$ 150.3	$ 157.8	$ 165.7	$ 173.9	$ 182.6	$ 191.8	$ 201.4	$ 1,632.6
Federal Funds (Baseline)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total (Baseline)	$ 123.6	$ 129.8	$ 136.3	$ 143.1	$ 150.3	$ 157.8	$ 165.7	$ 173.9	$ 182.6	$ 191.8	$ 201.4	$ 1,632.6
General Funds (Projection)	$ 123.6	$ 84.1	$ 67.5	$ 60.2	$ 79.2	$ 82.7	$ 86.3	$ 90.1	$ 94.1	$ 98.3	$ 102.7	$ 845.1
Federal Funds (Projection)	$ -	$ 32.8	$ 25.3	$ 26.7	$ 10.8	$ 10.7	$ 10.5	$ 10.4	$ 10.2	$ 10.0	$ 9.9	$ 157.3
Total (Projection)	*$ 123.6*	*$ 116.9*	*$ 92.7*	*$ 86.9*	*$ 90.0*	*$ 93.4*	*$ 96.8*	*$ 100.5*	*$ 104.3*	*$ 108.3*	*$ 112.5*	*$ 1,002.4*
General Fund Savings	N/A	*$ 45.7*	*$ 68.8*	*$ 82.9*	*$ 71.0*	*$ 75.1*	*$ 79.4*	*$ 83.8*	*$ 88.5*	*$ 93.5*	*$ 98.7*	*$ 787.5*
Federal Fund Savings	N/A	*$ (32.8)*	*$ (25.3)*	*$ (26.7)*	*$ (10.8)*	*$ (10.7)*	*$ (10.5)*	*$ (10.4)*	*$ (10.2)*	*$ (10.0)*	*$ (9.9)*	*$ (157.3)*
Total Savings [2]	***N/A***	***$ 12.9***	***$ 43.5***	***$ 56.2***	***$ 60.2***	***$ 64.4***	***$ 68.8***	***$ 73.5***	***$ 78.3***	***$ 83.4***	***$ 88.8***	***$ 630.2***

1 Legacy costs were generally split equally between General and Federal revenues; FY20 costs were fully funded through General funds
2 The savings split between General and Federal revenues is based on the assumption that Benton costs are 100% funded by General funds as required by federal regulations
3 Assumes an annual mortality rate of 6.6% based on historical data
4 Assumes annual healthcare inflation rate of 5.0% for ESH (based on ESH historical growth) and 2.5% for discharges (BLS – Nursing Home CPI)
5 Projections assume approval of the State Plan Amendment that would allow federal reimbursement of ESH patient care costs on a cost-settlement basis

Discharge Successes

A young women who was at ESH for several years due to chronic pain, impulsivity and unpredictable mood. After multiple attempts at discharge, ESH identified a MHPRR provider and worked with Medicaid to fund Assertive (mental health) Community Treatment within her new home. For the first six months of her transition the SW conducted bi-weekly follow up visits to assist her MHPRR to problem solve issues. **She has been successfully living in the community for over a year.**

A young woman with IDD and chronic pain was hospitalized with impulsive, disruptive and assaultive behavior. Her ESH team worked with a DD group home provider to develop an extensive behavior plan. Her social workers conducted several follow up visits to touch base in her new home. When her behaviors escalated, her ESH social worker was able to collaborate with the provider and **provide reassurance to this young woman of her ability to live successfully in the community. Despite multiple setbacks, she has been able to remain in the community in the least restrictive setting that can meet her needs.**

A young man with IDD and an extensive history of assaults was denied service by multiple DD group homes. ESH social workers were able to identify a MHPRR provider willing to provide increased DD supports. His team worked to decrease his reliance on medication and work with OT to gradually increase his visits to the group home and community. He earned longer passes and dinners at the MHPRR until both the group home and patient were comfortable and confident in his discharge to a less restrictive setting**. He was a patient that was "too dangerous" for the community, and with assistance and support, he has been successful in his group home with no major outbursts or hospitalizations in 6 months.**

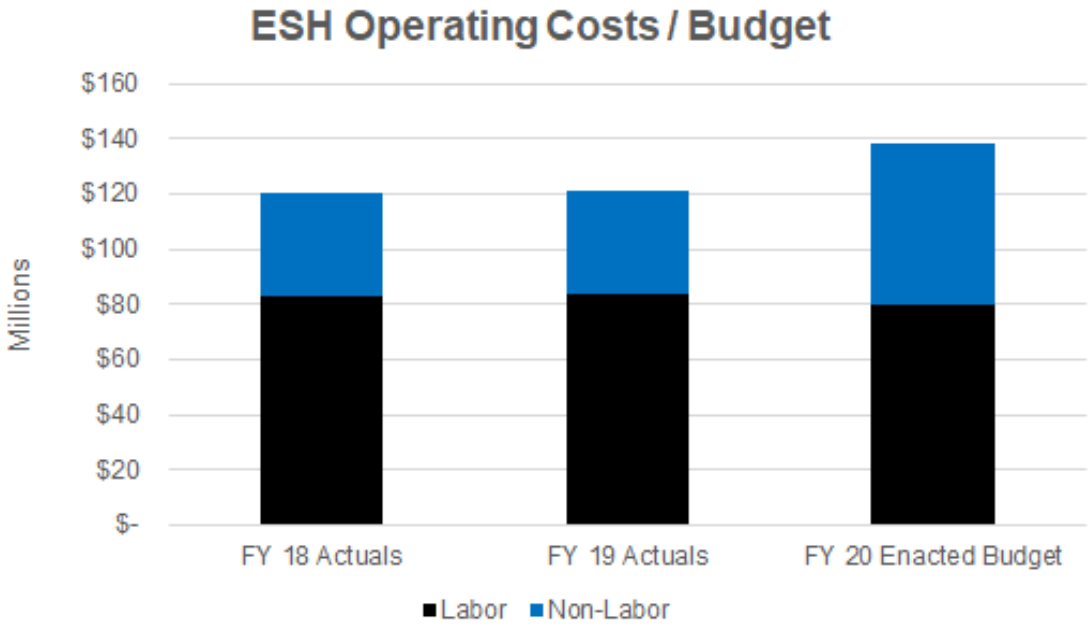
A young man with intellectual impairment was charged with sexual offenses and admitted as a forensic patient. He had a history of difficult home life and poor insight into his mental illness. He was hospitalized for over two years awaiting a finding of restored competency. When his forensic status expired, he became a voluntarily admission and within six months, he was able to identify his triggers and request treatment and supports essential to self-manage inappropriate behaviors. He worked with OT to increase his life skills and was accepted to a MHPRR. **He has been happy and thriving in his group home since discharge, taking on new responsibilities and becoming increasingly independent.**

A young women with IDD was hospitalized at ESH after her mother died. Due to unpredictable aggressive behavior, she was unable to find a community-based provider willing to work with her. ESH's social workers worked extensively with her family/guardian to identify a DD group home willing to work with her to manage her behaviors. Her team at ESH developed a behavior plan and worked with the community provider to transition the plan and acclimate her to her new home. Her social worker engaged her father and the group home in conducting several therapeutic visits until she was able to successfully transition. **She is now thriving in a community-based setting and she and her family are thrilled with her transition and her ability to live independently!**

Budget Supplement

ESH Current Budget and Expenditures

Currently, the hospital costs approximately $550k per person, almost 5x the average cost of services provided in nursing facilities and community-based placements.



Cost Category	FY18 Actuals	FY19 Actuals	FY20 Enacted Budget*
Labor	$ 82,591,680	$ 83,563,689	$ 80,070,798
Non-Labor	$ 37,826,903	$ 37,332,479	$ 58,307,300
Total	$ 120,418,583	$ 120,896,168	$ 138,378,098*
Avg Census (*approximate*)	220	220	210
Avg Cost	$ 547,357	$ 549,528	$ 658,943

- Despite a decline in patient census the hospital's total operating costs have been stable over the last few fiscal years at around $120m (FY20 enacted budget includes one-time payments for UHIP)
- Average costs per patient have increased as the census has declined over time
- Labor costs are the largest contributor to operating costs at approximately 69% of the actual operating costs.

*FY20 Enacted Budget included a one-time UHIP payment of $14.6M

General Budget Assumptions (1 of 4)

Assumptions include:

- 10% of non-labor fixed costs will continue for three months after a facility is closed (costs transferred to DCAMM after this period)
- 35% of labor fixed-costs will continue for twelve months after a facility is closed
  - These costs include executive admin, facility security/maintenance, contract/provider severance, and other expenses to maintain the facility until it is repurposed or sold.
- Licensure fees are determined by applying a 6% fee to all hospital-licensed operating costs. Fees are paid based on costs for the prior year's federal fiscal year (10/1 - 9/30).
- Community placement Medicaid rates range between $16,800 - $290,285

Care Setting	Annual Rate	Notes
SBD Individuals (ENLOC)	$ 290,285	A&M research around care settings in New England/RI
SBD Individuals (DD Group Home)	$ 274,537	A&M research around care settings in New England/RI
Enhanced Level of Nursing Home Care	$ 175,930	A&M research around care settings in New England/RI
TBI Group Homes	$ 164,250	Daily amounts given by RI Medicaid Office
Skilled Nursing Facility	$ 125,600	Avg SNF costs ($110k + highest add-on for MH $15,600)
DD Group Home	$ 100,000	A&M research around care settings in New England/RI
Nursing Home	$ 80,400	Monthly amounts given by RI Medicaid Office
MHPRR	$ 63,875	A&M research around care settings in New England/RI
HCBS	$ 20,400	Monthly amounts given by RI Medicaid Office
Supported Living	$ 28,800	Monthly amounts given by RI Medicaid Office
Assisted Living	$ 16,800	Monthly amounts given by RI Medicaid Office

[1] Enhanced FMAP due to COVID; increases standard FMAP of 52.95% by 6.2%

General Budget Assumptions (2 of 4)

Assumptions are based on the hospital's discharge planning, labor and facility closure strategy:

Proposal	Discharges	Transitional Facility [1]	Physician Labor	Exec Labor	Adolph Meyer	Regan	Zambarano
Proposal: Zambarano Re-Purposed	60	36	Eliminate Oct 31, 2020	Eliminate Nov 2020	**Facility**: Close Sept 2020 **Staff**: 20% reduction in clinical labor in December, Remaining reduction in February	**Facility:** Close Feb 2021 **Staff:** 20% reduction in clinical labor in December, Remaining reduction in February	**Facility:** Convert to NF/ICF **Staff:** *No action*

[1] Option #3: Remaining individuals at AM and Regan move to a Contracted Transitional Facility by end of Feb 2021 at a rate estimated at 80% of the cost of the daily AM/Regan rate)

General Budget Assumptions (3 of 4)

Category	Example	Action
Physician / Executive Tier Labor	Physicians (psychiatrists and general physicians – non-contract), certain executive positions	Eliminated at point of indicated staff reduction / date
Variable Labor	Clinicians (doctors, nurses, attendants, therapists, social workers)	Eliminated at point of indicated staff reduction date
Fixed Labor	Hospital Executive Staff, custodial staff, office administration)	At point of staff reduction / facility closure, fixed labor is assumed at 35% of historical costs for twelve months
Fixed Non-Labor [1]	Physical asset costs (utilities, maintenance, security, admin, etc.)	At point of staff reduction / facility closure, non-labor fixed costs decrease to 10% of historical costs for three months before being transferred to DCAMM
Variable Non-Labor	Laundry, food service, contracts, etc.	Declines with census, eliminated when census declines to zero

General Budget Assumptions (4 of 4)

Federal Match Assumptions include:

- General Federal Match assumptions that apply where SPA is included:
  - Medicare billing is not accessible due to (1) rules around Medicare admin billing and (2) the inpatient setting voids Part D Pharmacy costs claims)
  - Enhanced FMAP [1] of 59.15%for Q1 and Q2 of FY21 after which it decreases to the standard rate of 52.95%
  - Federal match cannot be claimed for approximately eight undocumented patients and approximately six high-profile voluntary commitments
  - Match cannot be claimed for certain Medicaid qualified non-recoverable costs (leisure, outpatient services, telecom, utilities, etc.), which comprise around 12% of current operating costs
  - Match is not claimed once patient census for a building declines to zero as patient care is no longer being rendered
  - Match is not claimed for any costs associated with the Benton (forensic) facility

- Federal Match Assumptions with Proposal (Regan and Adolf Meyer close; a step-down receiving facility is developed and Zambarano is eventually relicensed as a mixed-use NF/ICF facility)
  - 59 patients reside in Zambarano starting in FY22; this census is carried out in perpetuity
  - These individuals receive federal match related to the SPA (52.95% in FY22 and FY23). The SPA based cost-settlement reimbursement ends at the end of FY23.
  - Zambarano renovations (SNF/ICF) are assumed to be complete by the beginning of FY24. Starting in FY24, these patients receive the standard federal match of $52.95% related to the skilled nursing facility (8 individuals with an annual rate of $125.6K) and general custodial settings (51 individuals with an annual rate of $100,000)

- Enhanced Money Follows the Person (MFP) federal match assumptions (76.48%) apply for one-year when patients are discharged to the following settings – DD Group Home, HCBS, Supported Living, Assisted Living, TBI Group Homes

[1] Enhanced FMAP due to COVID; increases standard FMAP of 52.95% by 6.2%

Next Steps to Refine Estimates of Facility Closing Costs

Given currently-available data and the tight timeline to produce **preliminary** directionally-accurate forecasts, for expediency purposes, facility closure estimates were calculated based on ratios. These estimates require further refinement in the coming weeks.

- A&M prepared closure forecasts in this deck to provide preliminary directional estimates for budget planning. In the coming weeks, A&M intends to work with the State with additional areas of focus/work required to narrow the +/- directional numbers into a more precise model (run rate, post-wind down, and one-time non-recurring). Some illustrative examples are:

  - ✓ A/P - Invoice and service payout/runout analysis
  - ✓ One-time patient transition costs (discharge, transportation, etc.) estimates
  - ✓ Severance and potential union negotiation and benefit accrual payouts
  - ✓ Closure management and disposition/cost estimates:
    - ➢ Medical supply disposition
    - ➢ Equipment/supply
    - ➢ Inventory control management
    - ➢ Medical coverage policies and right sizing
    - ➢ Other considerations (A&M has a list of approximately 70 areas to consider when shutting a facility that have cost implications – need to understand which may apply to ESH and then understand data availability)

- A&M's conversations to date suggest that the plan is for the state to transfer the to-be-closed assets from BHDDH to another state-controlled holding entity (e.g. **DCAMM**: **D**ivision of **C**apital **A**sset **M**anagement & **M**aintenance). If executed, this fact pattern would lead to a budget shift – and while it would be a reduction for BHDDH, the budget impact would be net-neutral at the state level.