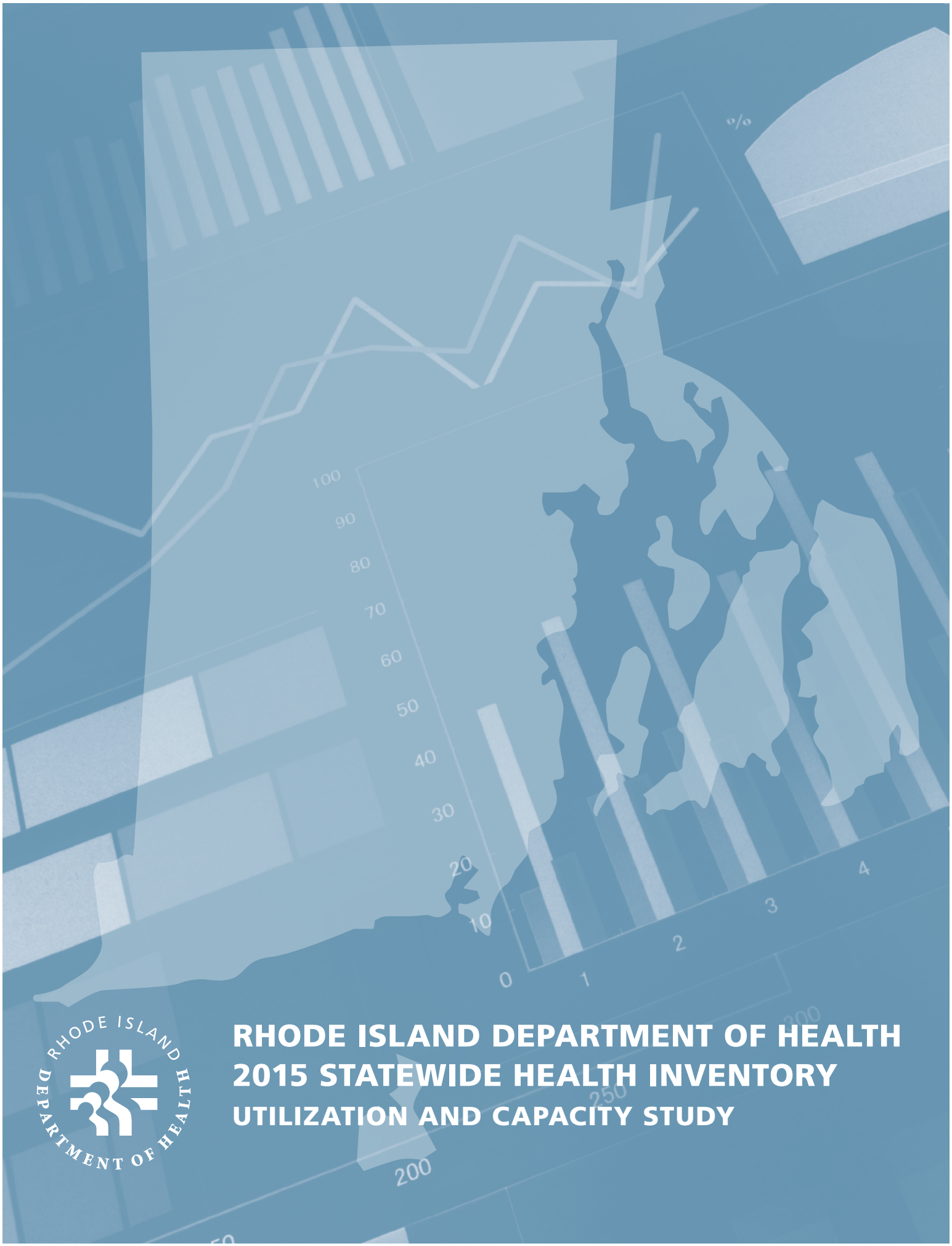

RHODE ISLAND DEPARTMENT OF HEALTH
2015 STATEWIDE HEALTH INVENTORY
UTILIZATION AND CAPACITY STUDY

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EXECUTIVE SUMMARY

In 2014, the Rhode Island General Assembly passed the Rhode Island Access to Medical Technology Innovation Act [RIGL Chapter 23-93]. This statute created new requirements for the Rhode Island Department of Health (RIDOH) to "establish and maintain an inventory of all healthcare facilities, health services, and institutional health services" with data on the location, distribution, and nature of the State's healthcare resources. The Act requires the Department to conduct a statewide healthcare utilization and capacity study, using data obtained from its health planning inventory efforts and to report that data to the Governor, the General Assembly, and the Health Care Planning and Accountability Advisory Council (HCPAAC) by November 1 of the year in which the study was done. The Act also calls for the creation of a statewide health plan, which will incorporate the extensive data collection and analysis of this Rhode Island Department of Health 2015 Statewide Health Inventory to develop the state's Population Health/Behavioral Health Plan.

In order to compile this critical data, the statute charged the Department with developing an inventory questionnaire to obtain, at minimum, information on types of healthcare facilities, number of patients served, services and treatments provided, number of visits, insurance information, patient demographic information, languages spoken, interpreter services, transportation information, hours of operation, and other information deemed appropriate by the Department. Respondents were not asked to provide patient-level data and the inventory questionnaire is to be subsequently issued on a biennial basis.

In response to the new requirements in the law, RIDOH developed an internal team that began to meet weekly and included participation from sister agencies, the Executive Office of Health and Human Services and the Office of the Health Insurance Commissioner. The Department developed twelve inventory surveys or questionnaires. The areas across the healthcare landscape that received surveys included: Primary Care, Outpatient Specialty Practices, Behavioral Health, Hospitals, Nursing Facilities, Assisted Living Residences, Adult Day Care Programs, Home Health, MRI Imaging Centers, Ambulatory Surgery Centers, and Dialysis Centers. There was an additional Patient and Community survey conducted to understand access to care from the perspective of community members. The surveys were further grouped into five sections: Outpatient Care; Hospitals; Long-Term Care; Facilities and Centers; and Patients and Community.

RIDOH engaged in significant outreach efforts for nearly every survey, seeking feedback from stakeholders in the healthcare community to make certain that each survey accurately reflected their specific area. Those stakeholders are identified in the 'survey design' section for each inventory survey. However, final decisions on the content of the survey were made by the Department.

The response rates exceed 92% for nearly all surveys. Response rates were 100% for five surveys: Nursing Facilities, Hospitals, Ambulatory Surgery Centers, Dialysis Centers, and MRI Imaging Centers. These response rates reflect the outreach efforts of the Department through identifying the correct person to complete the survey questionnaire, usually a practice or facility administrator; using a survey tool, Qualtrics, which allowed respondents to open and close the survey or share their answers with others in their organization; creating a modified survey to collect core information for those practices that did not have the information technology capacity or had other barriers to gathering the requested data; and repeatedly following up with practices and facilities to provide support with the survey.

Key findings from the Rhode Island Department of Health 2015 Statewide Health Inventory are:

- Number of full-time equivalents of primary care physicians is up to 40% lower than previous estimates and is about 10% less than national standards for adequate access to care.
- Substantially limited data exists across practices and facilities regarding race, ethnicity and primary languages of patients, as well as a lack of appropriate interpreter services at many healthcare facilities and practices.
- As the reinventing Medicaid initiative seeks to expand access to community-based settings for long-term care, 51% of assisted living residences reported they are not accepting new Medicaid patients.
- The survey of patients and communities in Rhode Island suggests that financial barriers, such as high co-pays and deductibles, may be preventing Rhode Islanders from receiving the care they need when they get sick.

Based on these findings, RIDOH recommends exploring focused efforts around recruitment and retention of primary care physicians. In addition, RIDOH recommends uniform data collection of race, ethnicity, and languages of patients, as well as identification of strategies to address cost barriers that prevent patients from receiving needed care in a timely fashion. RIDOH also recommends adopting strategies to improve access to community-based living arrangements, such as assisted living residences. Development of such strategies aligns with the "Reinventing Medicaid" initiative.

Moving forward, this report represents the first edition of the Rhode Island Department of Health 2015 Statewide Health Inventory. Through this tremendous effort, RI may be among the first states to ever produce such a comprehensive inventory of health care across the entire state. Future reports and analyses are planned to further explore additional areas of health service capacity and access to care for Rhode Islanders. This report is intended to inform development of an evidence-based population health plan for the State, which shall support the Certificate of Need process. In addition, this report aligns with the RIDOH strategic priorities to address the social and environmental determinants of health, eliminate disparities of health and promote health equity, and ensure access to quality health services for Rhode Islanders, including our vulnerable populations. The extensive data contained in this report will be utilized for further population health planning as the statewide health plan in 2016 through the State Innovation Model (SIM) Population Health/Behavioral Health Plan.

Nicole Alexander-Scott, MD, MPH
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INTRODUCTION

The purpose of this study is to comply with the provisions of section 23-93-5(b) of the Rhode Island General Laws, as amended (RIGL), that were established in 2014 by the Rhode Island General Assembly. This statute requires the Rhode Island Department of Health (RIDOH), in consultation with the Health Care Planning and Accountability Advisory Council, to complete a statewide healthcare utilization and capacity study that will, at a minimum, "establish and maintain an inventory of all healthcare facilities, health services, and institutional health services"1 in Rhode Island.

Chapter 23-93 RIGL, also known as the "Rhode Island Access to Medical Technology Innovation Act"2 also requires that RIDOH, in consultation with the Health Care Planning and Accountability Advisory Council and with other state agencies RIDOH deems appropriate, establish and maintain a statewide health plan. The statewide health plan will be fulfilled through the State Innovation Model (SIM) Population Health/Behavioral Health Plan that will be completed in 2016.

This study reports the findings from health inventory surveys across 12 areas of the health care system. They include Primary Care, Outpatient Specialty Practices, Behavioral Health, Hospitals, Nursing Facilities, Assisted Living Residences, Adult Day Care Programs, Home Health, MRI Imaging Centers, Ambulatory Surgery Centers, and Dialysis Centers. The report includes findings from a Patient and Community survey which was conducted to understand access to care from the perspective of community members. The surveys were further grouped into five sections: Outpatient Care; Hospitals; Long-Term Care; Facilities and Centers; and Patients and Community.

A study of this nature and magnitude has not been completed by RIDOH since the 1980s. The last statewide health plan was completed in 1986. These findings will inform the next iteration of a statewide health plan, along with the SIM Population Health/Behavioral Health Plan.

This study, while spearheaded by a RIDOH team, included the participation and collaboration of state agencies and numerous community providers and stakeholders. Their collaboration refined the survey design process and concomitantly enriches the findings.

1 Rhode Island General Laws, section 23-93-5 (d)(1) Available at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-93/23-93-5.HTM (Accessed: 27 October 2015).
2 Chapter 23-93 of the Rhode Island General Laws, as amended, is available in its entirety at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-93/INDEX.HTM (Accessed: 27 October 2015).

STRUCTURE OF THE REPORT

This report is arranged in five sections: Outpatient Care; Hospitals; Long-Term Care; Facilities & Centers; and Patients & Community. Each section is comprised of the relevant health planning inventory surveys. For each survey, there is an introduction, description of methods, and summary of findings. At the end of the report, conclusions and recommendations are included for each section based on the findings presented. The report concludes with summaries of services provided by the Eleanor Slater Hospital; Department of Children, Youth and Families; Rhode Island Department of Corrections; and the Providence VA Medical Center.

METHODOLOGY ACROSS SURVEYS

Each survey was designed iteratively with stakeholder engagement, and included RIDOH team members in collaboration with the Executive Office of Health & Human Services and the Office of the Health Insurance Commissioner. The surveys were built through Qualtrics and unique links were coded to each participant. This allowed for participants to close and reopen the survey, with their data being saved each time they moved to the next page in the survey. Participants could also forward their unique link to others to collaborate on completing the survey, and previously entered data would populate for each through using the same coded link. The surveys had complex skip patterns for the questions, meaning that a substantial number of questions would appear or disappear based on prior answers. This allowed for the surveys to be targeted for the participants filling them out, and ensured that irrelevant questions would not be displayed.

Data collection was completed through assembling a team and developing protocols for outreach and follow up. As a general approach to each group, contact information including the email address of the facility or practice administrator was obtained. Prior to sending out the survey, both a cover letter and series of frequently asked questions were emailed to the administrators. These documents informed the recipient of the purpose of the survey, and provided administrators with appropriate contact information for questions.

The survey was then sent electronically to facility or practice administrators via email. Follow up began one week after the survey had been sent to participants. Our team then began to make follow up phone calls to administrators regarding the survey. A description of the specific protocols for each survey group is given below. The JSI Research & Training Institute, Inc. team worked diligently to complete data cleaning and standardization for the report. The team was ably led by Steve Meersman and included Eugenie Coakley, Mihaly Imre, Fong Lui, Joseph Musolino, August Oddleifson, Steve Schaffer, and Karen Schneider, amongst other members.

OUTPATIENT CARE

Primary Care Practices

Introduction

Primary care requires an adequate workforce to give patients access to care and a high functioning delivery system model that can improve quality of care.[3] On a national level, workforce projections indicate a potential shortage of up to 31,000 adult primary care providers by the year 2025.[4] Over the next 20 years eighty million aging Americans will retire, joining an anticipated 30 million new enrollees under the Patient Protection and Affordable Care Act (ACA), creating new demands on the health care system and making an accurate assessment of the existing and needed primary care workforce essential.[5]

Current estimates of the Rhode Island primary care workforce differ substantially. The Centers for Disease Control and Prevention (CDC) estimates Rhode Island to have, using the National Ambulatory Medical Care Survey, 66.6 primary care physicians per 100,000 as of 2012.[6] This yields approximately 701 physicians in the state. In 2010, the Graham Center estimated RI to have 830 physicians, based on the American Medical Association Masterfile.[7] They stated that RI would need 99 more primary care physicians by 2030 due to population growth, aging, and increased demand from the ACA. The highest estimate is from the federal Health Resources and Services Administration (HRSA), which estimates 1,002 primary care physicians in the state.[8] These estimates are 40% different, and it is important to take into account full time equivalence of physicians.

In terms of providing appropriate access to care for a population of patients, The Henry J. Kaiser Family Foundation has published access to care indicators through its Medicaid Managed Care Organization Access Standards report.[9] In Rhode Island, the maximum number of enrollees per primary care provider in Rhode Island was designated to be 1,500. Similarly, HRSA uses the 1,500:1 population to physician ratio as part of their methodology to evaluate the impact of their workforce recruitment and retention efforts.[10]

Survey Design

The Primary Care Practice survey was written to capture information about total number of patients per practice location, sources of insurance for patients, new patient access to care, waiting list, demographics about patients, interpreter services, staffing per service category, hours of operation, chronic diseases, patients' primary residence, transportation access, disability access, providers and their full time equivalents (FTE), types of services offered, Patient-Centered Medical Home recognition, quality measure reporting, and information technology, in addition to other data elements. The survey was informed by the World Health Organization "Service Availability and Readiness Assessment" as well as stakeholder engagement and outreach.

3 Starfield B, Shi L, Macinko J. (2005). Contribution of primary care to health systems and health. Milbank Q 83: 475-502.
4 Association of American Medical Colleges. The Complexities of Physician Supply and Demand: Projections from 2013 to 2025. Washington, D.C.: AAMC;March 2015.
5 Petterson, S. M., Liaw, W. R., Phillips, R. L., Rabin, D. L., Meyers, D. S. and Bazemore, A. W. (2012). Projecting US primary care physician workforce needs: 2010-2025. The Annals of Family Medicine, 10(6), pp. 503–509.
6 Hing E, Chun-Ju H. (2014). State variability in supply of office-based primary care providers: United States, 2012. NCHS Data Brief No. 151.
7 Petterson SM, Cai A, Moore M, Bazemore A. (2013). State-level projections of primary care workforce, 2010-2030. Robert Graham Center, Washington D.C.
8 Health Resources and Services Administration (HRSA). Area Health Resource File (2012-2013). Available at: http://arf.hrsa.gov/ (Accessed: 27 October 2015).
9 Medicaid MCO access standards: Primary care (2015) Available at: http://kff.org/other/state-indicator/medicaid-mco-access-standards-primary-care/ (Accessed: 27 October 2015).
10 Health Resources and Services Administration (HRSA). Designating Places & Populations as Medically Underserved: A Proposal for a New Approach. Available at: http://bhpr.hrsa.gov/shortage/proposedrule/designatingplaces.html (Accessed: 27 October 2015).

Feedback from stakeholders was solicited at various stages of the survey construction. The survey was reviewed with Coastal Medical Inc., Lifespan Health System, the Primary Care Physician Advisory Committee to Rhode Island Department of Health, Providence Community Health Centers, the Rhode Island Health Center Association, and Thundermist Health Center. Feedback was given regarding the staff categories for primary care practices, the way information technology is used, how to ask about Medicaid access, and the length of the survey. While all of this feedback was incorporated into the survey before it was sent out, RIDOH determined the final survey instrument.

In response to the feedback and due to the number of data elements requested in the full survey, an "abbreviated" survey was created that was offered to practices that did not have the information technology capacity or had other barriers to gathering the requested data. The "abbreviated" survey included core questions about total number of patients per practice location, sources of insurance for patients, new patient access to care, interpreter services, providers and their FTEs, and information technology.

The full version of the survey was designed to take one hour to complete once data had been collected. Per the respondents that completed this version, the survey took from 30 minutes to six hours. The "abbreviated" version of the survey was designed to take 15 to 30 minutes and could be completed over the phone if data were readily available.

Data Collection

Publicly available RI licensure data for physicians was obtained from the RIDOH website. The licensure database contained more than 6,000 records and included the name of the physician, license number, practice name, practice address, personal email (when provided), phone number, and fax number. The first exclusion criterion was any physician whose practice was located outside of Rhode Island, which excluded 1,265 physicians.

The publicly available licensure database did not reliably include the physicians' specialties. Our team then used Internet searches in order to identify the specialty and practice of each provider on the licensure list. When this information was not available online, phone calls were placed to clarify a physician's specialty. This process took a team of nine interns working four days per week a total of three weeks to complete. Once all physicians' specialties were determined, a definition of primary care was operationalized that is consistent with the primary care workforce literature and federal definition.[11,12,13] This was inclusive of physicians who had a specialty of general internal medicine, general geriatrics, family medicine, or general pediatrics.

This list of potential primary care physicians was then sorted by street address location. This list of physicians was aggregated to the practice level for two reasons. First, the survey was asking for data such as insurance breakdown of patients, total number of patients, and geographic distribution of patients. This information would be difficult for a physician to answer, but a practice administrator or an office manager would be able to more readily access the data. Second, having the unit of analysis be the practice would allow for us to capture information on each physician in a practice based on the practice's single survey response, and would not require reaching out to each individual physician in each practice to accomplish this.

11 Kindig, D. A. (1994). Counting generalist physicians. JAMA: The Journal of the American Medical Association, 271(19), pp. 1505–1507.
12 CMS Manual (2011). Centers for Medicare and Medicaid Services. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2161CP.pdf (Accessed: 27 October 2015).
13 Primary Care (2011). American Academy of Family Physicians. Available at: http://www.aafp.org/about/policies/all/primary-care.html. (Accessed: 27 October 2015).

For the next step, the primary care practices were researched and contacted to confirm that they met the definition of primary care services that was established based on the Alma-Ata definition of primary care: "Primary health care is essential health care [that] is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."[14] This excluded physicians that exclusively provided inpatient services or urgent care services.

The next step was to obtain the contact information for the administrator of each of the confirmed primary care practices. To accomplish this, our RIDOH team collaborated on the annual Rhode Island Health Information Technology or HIT survey that is sent to all licensed physicians regarding their use of technology in the clinical setting. This survey was sent out prior to the primary care survey. An additional question was added to this survey, which asked for the practice administrator's email address for each physician that completed the survey. In 2015, the HIT survey had a response rate of nearly 66% of the physicians in the State.

If the administrator email, phone number, and address were consistent for a practice, then the practice was considered to have confirmed contact information for the administrator. If it was not, our team called the remaining practices in order to obtain the correct administrator contact information. The process of making phone calls to confirm the practice administrator contact information took our team of nine interns two weeks to complete. This was also done concurrently with confirming the practice administrator contact information for outpatient specialty and behavioral health practices.

Each practice was given three weeks to complete the survey. During the second week, our team began making phone calls to the 280 practices that had not yet opened the survey in order to confirm that the administrators had received the survey links. The initial follow-up calls took our team nine days to complete. After the three week period concluded, our team systematically called the 200 practices on our list that had not yet finished the survey to inform them that the deadline had been extended in order to increase engagement. Each practice received between one and four phone calls. The second round of follow up was completed over the course of two weeks. The RIDOH team finally called each administrator who had not yet completed the survey to ask if they would be able to complete our "abbreviated" primary care practice survey over the phone. Each remaining practice received between two and seven phone calls about the "abbreviated" survey.

14 Declaration of Alma-Ata. International Conference on Primary Health Care. September 1978.

Response

A total of 341 primary care practice locations were identified in Rhode Island, with data collected from 288 practices or organizations representing 307 practice locations. Data were collected for 719 out of 803 identified primary care physicians, yielding a response rate of 90% of physicians.

Note that not all respondents completed every question, or did not provide a complete response for every question, so all totals may not equal one hundred percent (100%).

Findings

Findings from the primary care practice inventory survey administered in June 2015 reveal the following:

PRIMARY CARE WORKFORCE

The total full-time equivalents (FTE) of primary care physicians in Rhode Island was found to be 602.7 in calendar year 2014. There were 803 primary care physicians identified. On average, there was one primary care FTE for every 1718.1 Rhode Islanders (civilian non-institutionalized population). The geographic distribution of primary care FTE is displayed in the following Table and Figure.

Displaying primary care FTE by town is a first step toward identifying appropriate distribution of primary care services. There are many reasons why people go to certain locations for primary care, and Table 1 shows the locations of primary care availability. *Table 1 does not imply sufficient or insufficient access for specific towns or cities.*

TABLE 1: TOTAL FTES IN PRIMARY CARE PRACTICES, BY GEOGRAPHY

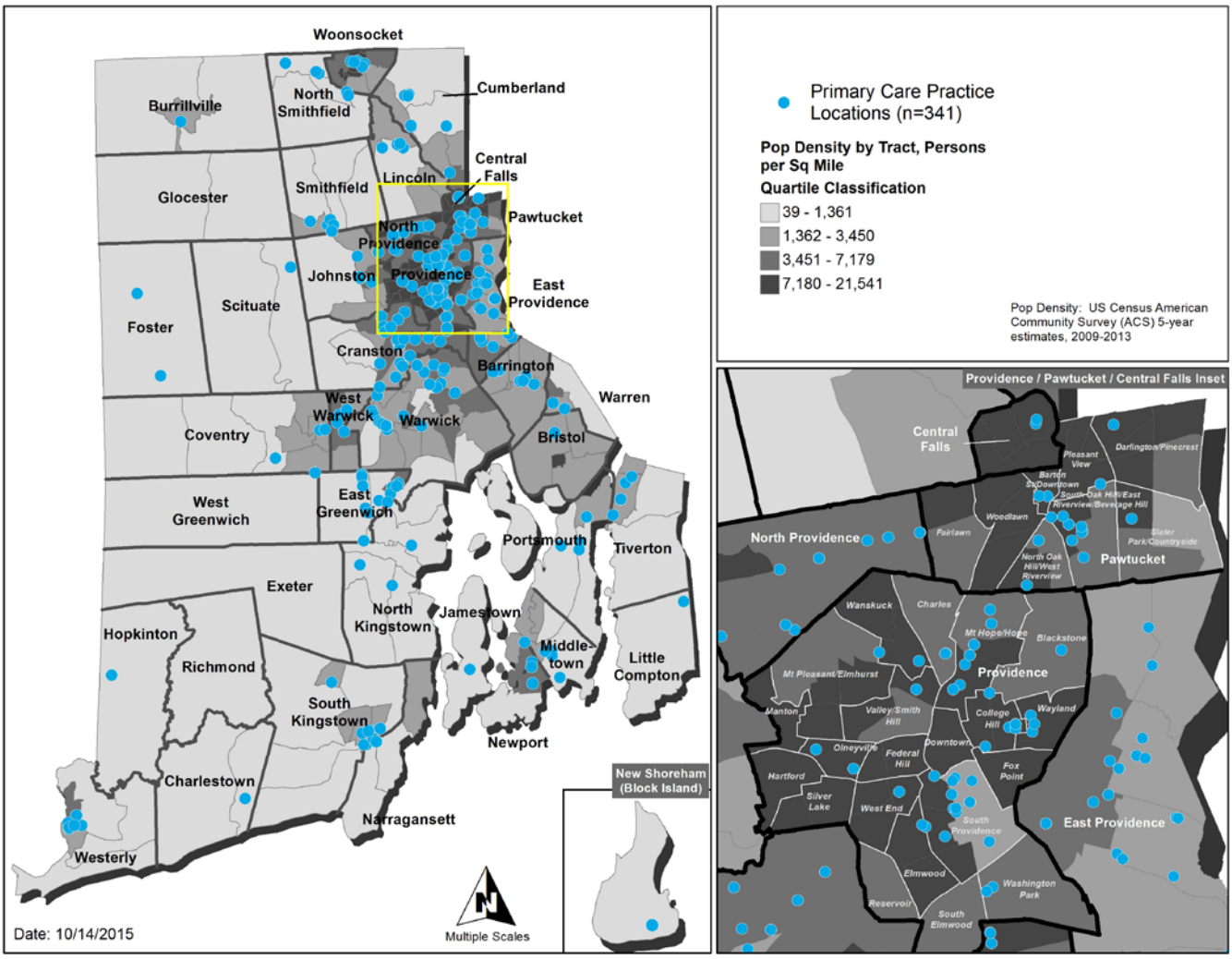
Geography name	Total hours per week	Total FTEs per week (1 FTE=40 hrs)	Civilian population non-institutionalized population	Population to 1 FTE Primary Care Provider
Barrington	574.0	14.4	16,293	1,135.4
Bristol	610.0	15.3	22,034	1,444.9
Burrillville	72.0	1.8	15,605	8,669.4
Central Falls	116	2.9	19,121	6,593.4
Charlestown	32.0	0.8	7,821	9,776.3
Coventry	460.0	11.5	34,493	2,999.4
Cranston	1,673.5	41.8	76,203	1,821.4
Cumberland	806.0	20.2	33,503	1,662.7
East Greenwich	1,801.0	45.0	13,061	290.1
East Providence	2,150.0	53.8	46,418	863.6
Exeter	-	-	6,572	-
Foster	43.0	1.1	4,609	4,287.4
Glocester	-	-	9,777	-
Hopkinton	112.0	2.8	8,134	2,905.0
Jamestown	59.0	1.5	5,423	3,676.6
Johnston	589.0	14.7	28,478	1,934.0
Lincoln	937.5	23.4	20,998	895.9
Little Compton	12.0	0.3	3,490	11,633.3
Middletown	312.8	7.8	15,515	1,984.3
Narragansett	331.0	8.3	15,734	1,901.4
New Shoreham	40.0	1.0	836	836.0
Newport	488.0	12.2	22,566.0	1,849.7
North Kingstown	363.0	9.1	26,110	2,877.1
North Providence	844.0	21.1	31,779	1,506.1
North Smithfield	294.5	7.4	11,696	1,588.6
Pawtucket	2,151.0	53.8	70,740.0	1,315.5
Barton St/Downtown	292.0	7.3	2,192	300.3
Darlington/Pinecrest	50.0	1.3	17,674	14,139.2
Fairlawn	-	-	7,790	-
North Oak Hill/West Riverview	530.0	13.3	5,354	404.1
Pleasant View	90.0	2.3	7,330	3,257.8
Slater Park/Countryside	40.0	1.0	9,539	9,539.0
South Oak Hill/East Riverview/Beverage Hill	1,149.0	28.7	7,473	260.2
Woodlawn	-	-	13,388	-
Portsmouth	311	7.8	17,067	2,196.9
Providence	3,873	96.8	176,869	1,826.9
Blackstone	64.0	1.6	5,132	3,207.5
Charles	148.0	3.7	6,679	1,805.1
College Hill	401.0	10.0	8,896	887.4
Downtown	-	-	4,084	-
Elmwood	160.0	4.0	13,155	3,288.8
Federal Hill	-	-	7,543	-
Fox Point	-	-	3,761	-
Hartford	-	-	6,582	-
Manton	-	-	7,380	-
Mt Hope/Hope	579.5	14.5	11,465	791.4
Mt Pleasant/Elmhurst	40.0	1.0	19,072	19,072.0
Olneyville	201.0	5.0	5,133	1,021.5

Geography name	Total hours per week	Total FTEs per week (1 FTE=40 hrs)	Civilian population non-institutionalized population	Population to 1 FTE Primary Care Provider
Reservoir	-	-	3,064	-
Silver Lake	-	-	12,624	-
South Elmwood	-	-	4,766 -	
South Providence	1,627.0	40.7	11,309	278.0
Valley/Smith Hill	173.0	4.3	10,932	2,527.6
Wanskuck	34.0	0.9	11,513	13,544.7
Washington Park	200.0	5.0	4,679	935.8
Wayland	70.0	1.8	4,880	2,788.6
West End	175.0	4.4	14,220	3,250.3
Richmond	-	-	7,574	-
Scituate	31.0	0.8	10,345	13,348.4
Smithfield	490.0	12.3	20,924	1,708.1
South Kingstown	999.5	25.0	30,308	1,212.9
Tiverton	200.0	5.0	15,739	3,147.8
Warren	125.0	3.1	10,387	3,323.8
Warwick	1,806.3	45.2	81,658	1,808.3
West Greenwich	-	-	6,076	-
West Warwick	315.5	7.9	28,894.0	3,663.3
Westerly	435.3	10.9	22,327	2,051.9
Woonsocket	651.6	16.3	40,339.0	2,476.3
TOTAL	**24,108.6**	**602.7**	**1,035,516**	**1,718.1**

Source Data: RIDOH 2015 Statewide Health Inventory (Primary Care); Population count from 2009-2013 American Community Survey
Note: 1.0 FTE assumed for the 84 primary care physicians for whom we do not have data
Note: Each individual physician National Provider Identifier (NPI) was linked to National Plan & Provider Enumeration System for confirmation and removal of duplicate entries

The Figure depicts the geographic distribution of primary care practices overlaying population density distributions.

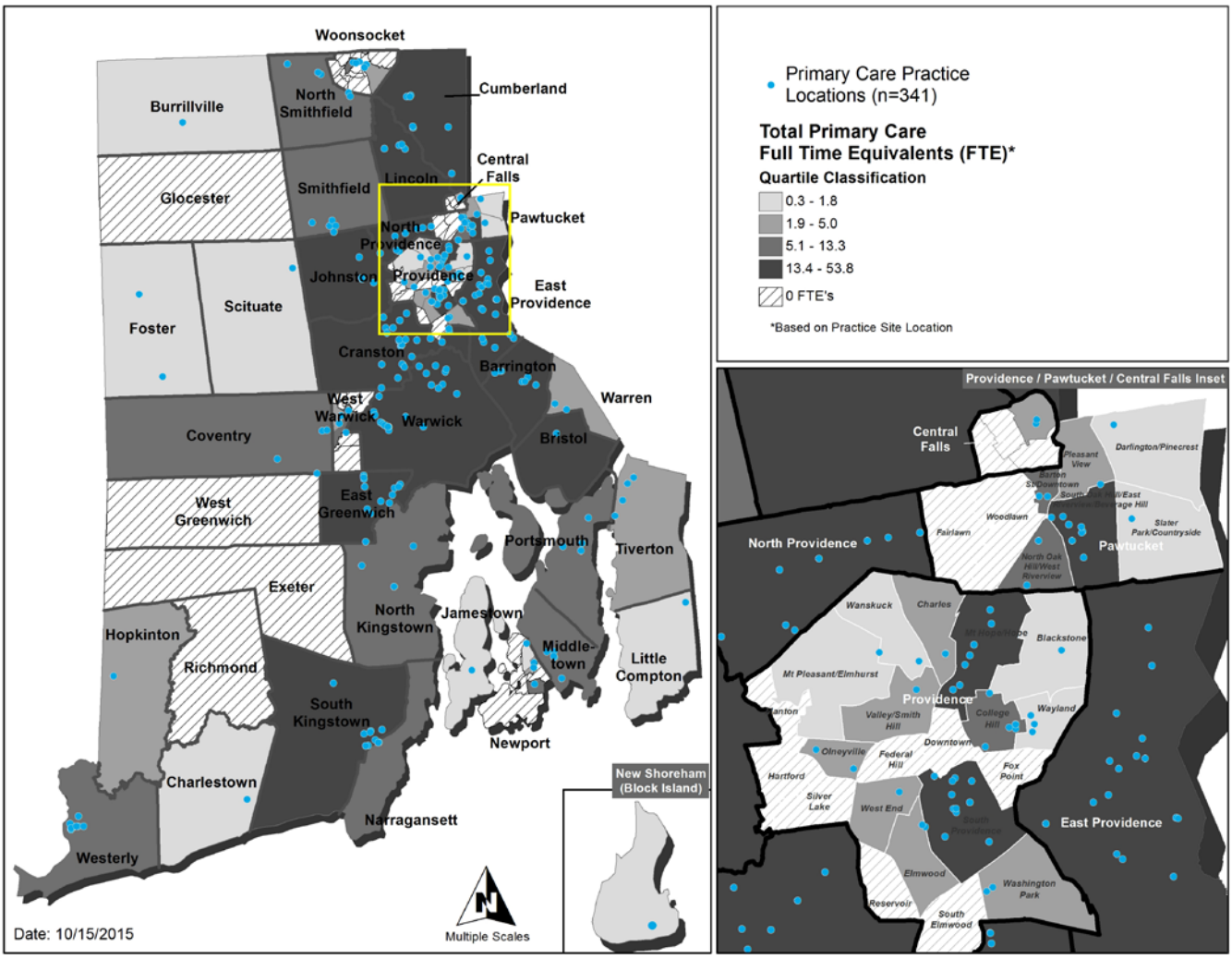
FIGURE 1: PRIMARY CARE PRACTICE LOCATIONS, 2014



Source: RIDOH 2015 Statewide Health Inventory

The Figure depicts the geographic distribution of primary care FTEs.

FIGURE 2: TOTAL PRIMARY CARE FTE ACROSS RHODE ISLAND

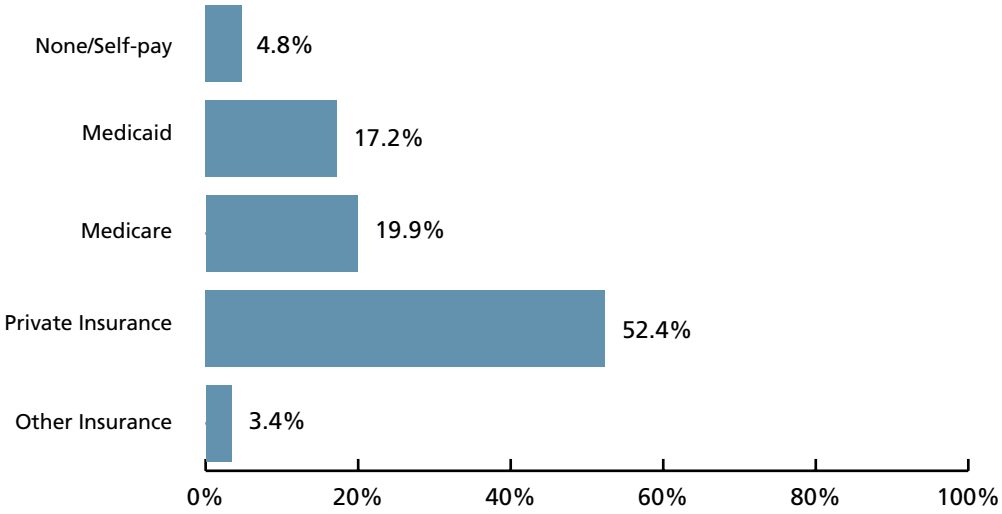


Source: RIDOH 2015 Statewide Health Inventory

MEDICAL INSURANCE TYPE

In primary care practices, the average number of patients seen in calendar year 2014 was 4,141. Payment for primary care services is derived from the following sources:

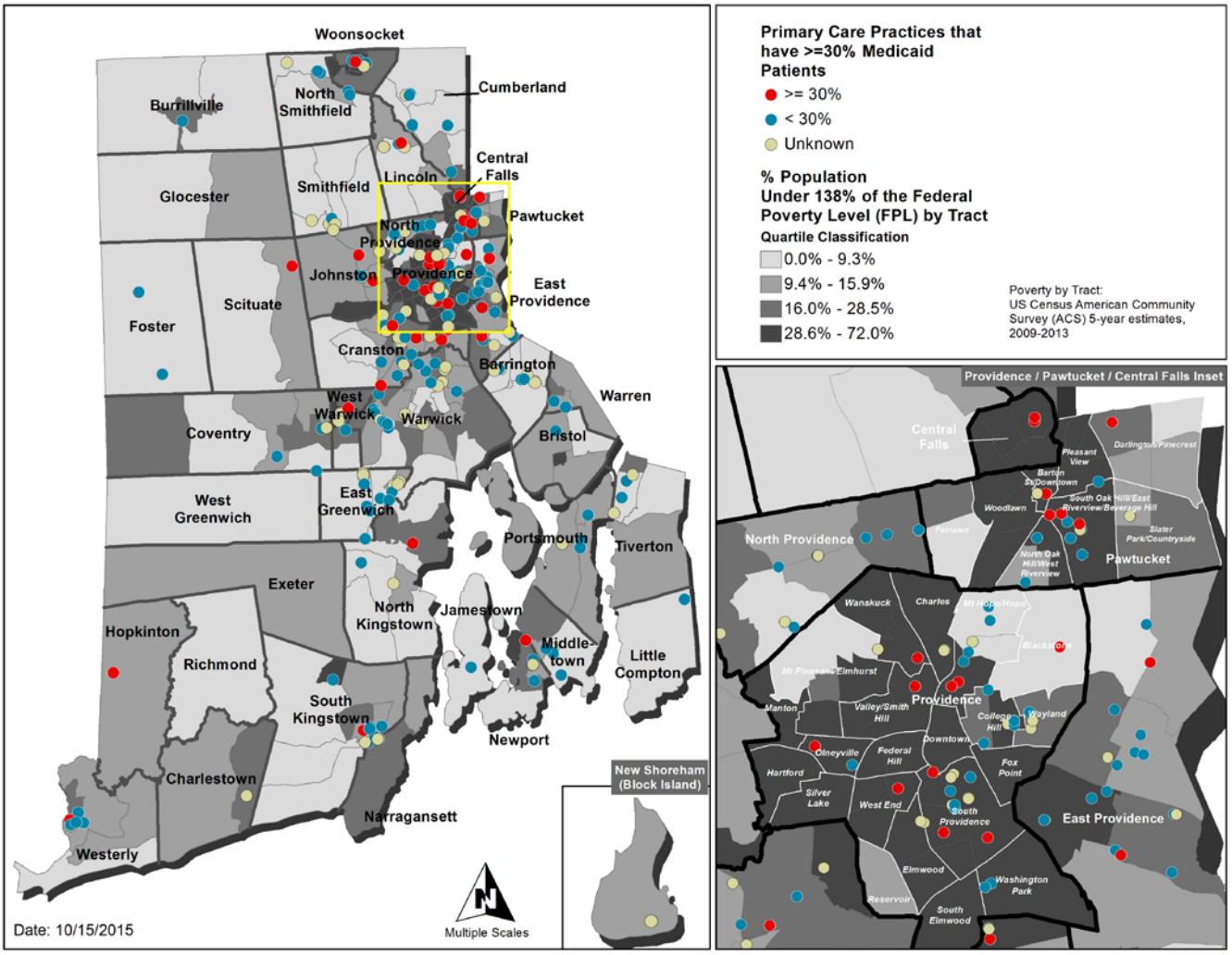
FIGURE 3: PAYMENT SOURCES FOR PRIMARY CARE PRACTICES, 2014



Source: RIDOH 2015 Statewide Health Inventory

In calendar year 2014, 81% of practices saw one or more Medicaid patients, and 19% saw no Medicaid patients. Fewer than 20% of all practices had at least 30% of patients covered by Medicaid, which is an eligibility criteria for the Medicaid Electronic Health Record Incentive Payments for Eligible Professionals. The Figure displays the primary care practices with 30% or greater Medicaid patients on a map depicting the population under 138% of the Federal Poverty Level (federal eligibility requirement for Medicaid expansion).

FIGURE 4: PRIMARY CARE PRACTICES WITH 30% OR MORE MEDICAID PATIENTS



Source: RIDOH 2015 Statewide Health Inventory

NEW PATIENTS

Sixty-six percent of practices accepted new adult patients, and 45% of practices accepted new pediatric patients. In terms of patients covered by Medicaid, 45% of practices accepted new adult Medicaid patients, and 38% of practices accepted new pediatric Medicaid patients.

TABLE 2: NEW PATIENTS BY TYPE, PRIMARY CARE, 2014

	Number of Practices	Percent of Practices
Accepting New Patients – Pediatric		
Yes	125	44.8%
No	154	55.2%
Accepting New Patients – Adult		
Yes	187	66.1%
No	96	33.9%
Accepting New Medicaid Patients – Pediatric		
Yes	107	38.5%
No	171	61.5%
Accepting New Medicaid Patients – Adult		
Yes	128	45.1%
No	156	54.9%

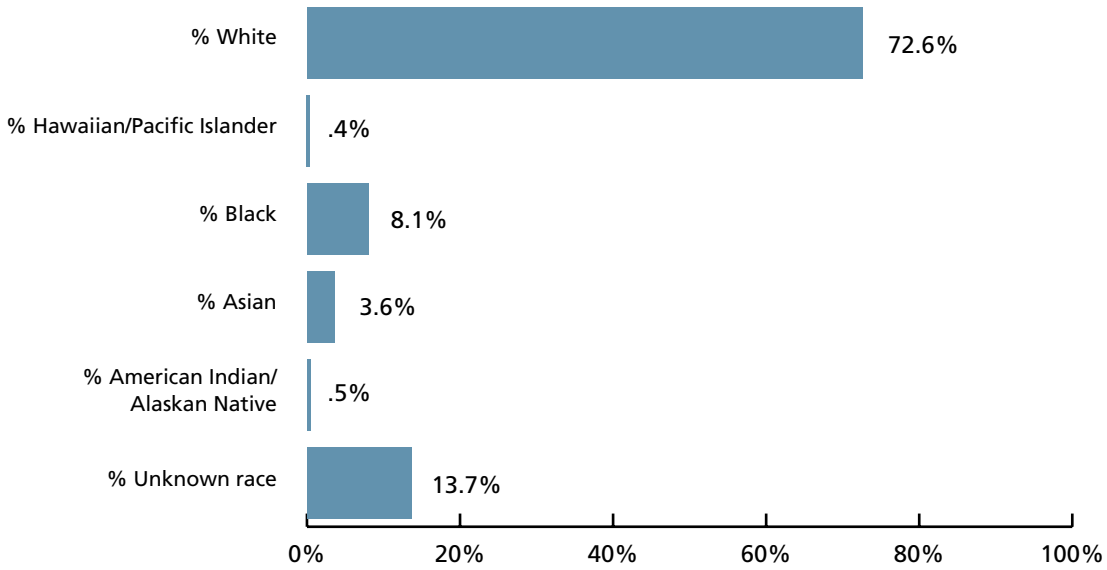
Source: RIDOH 2015 Statewide Health Inventory

Twenty percent of practices maintain a waiting list. Among the practices with a waiting list, the average number of patients on the waiting list is 62, and the average length of time on the waiting list is 32.1 weeks.

RACE/ETHNICITY

Nearly 50% of primary care practices did not report the race of their patients. Among those who could reasonably report this information, they were often missing data on some patients. Based on the limited data available, about 72.6% of patients were of White race, 8.1% were Black, and about 3.6% were Asian.

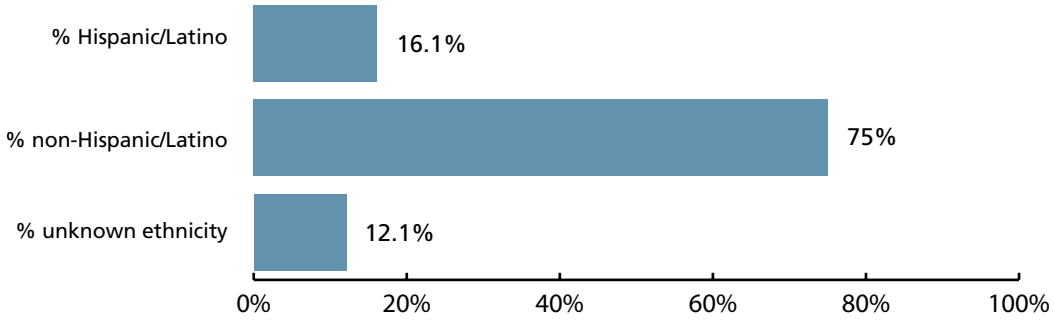
FIGURE 3: RACE OF PRIMARY CARE PATIENTS, 2014



Source: RIDOH 2015 Statewide Health Inventory

Similarly, 53% did not report Hispanic/Latino ethnicity. Sixteen percent of patients were of Hispanic/Latino ethnicity.

FIGURE 5: ETHNICITY OF PRIMARY CARE PATIENTS, 2014



Source: RIDOH 2015 Statewide Health Inventory

LANGUAGE

In terms of languages spoken by patients, 21% of practices reported the percent of patients requiring that healthcare information be provided in another language. Among those that could provide this data, the most common language was Spanish, with 13.6% of patients requiring healthcare information to be provided in Spanish.

TABLE 3: PERCENT OF PATIENTS THAT REQUIRED HEALTH CARE INFORMATION BE PROVIDED IN ANOTHER LANGUAGE, PRIMARY CARE, 2014

	Average %
Spanish	13.6%
Other language	12.8%
Portuguese	4.2%
Portuguese Creole	0.8%
Chinese	0.4%
French	0.1%
French Creole	0.1%

Source: RIDOH 2015 Statewide Health Inventory
Note: Data represents 21% of practices that responded

The most common way that interpreter services were provided to patients was with staff not formally trained but assisting with interpreting as needed (33.5%). Thirty percent of practices used interpreter services available on the telephone. In addition, 26.0% of practices did not provide interpreter services.

TABLE 4: INTERPRETER SERVICES, PRIMARY CARE, 2014

	Percent
Staff not trained but assist with interpreting as needed	33.5%
Interpreters available on the telephone	29.7%
We do not provide interpreter services	26.0%
Contracted interpreters that come on site as needed	18.2%
On-site trained interpreter	12.6%
Interpreters available through video	2.6%
I do not know	2.6%

Source: RIDOH 2015 Statewide Health Inventory

HOURS OF OPERATION

In terms of hours of operation, nearly all practices are open Monday, Tuesday, Thursday, and Friday. On Wednesday, 8% of practices are closed. Only 1% of practices are open on Sunday, and 27% of practices are open on Saturday. Twelve percent of practices are open before 8AM any time during the week, and 49% are open after 5PM during the week. The average number of hours open on weekdays for practices was 7.9 hours.

SERVICES OFFERED

The following table shows the array of services provided by practices in 2014. Of note, 97% reported providing preventive and wellness care and 90% immunizations. Fifty eight percent reported having on-site laboratory tests in 2014. Nearly one third (30.9%) offered home visits. Radiology services were provided by 9.5% of practices, and 3.0% had a dispensing pharmacy.

TABLE 5: SERVICES PROVIDED IN PRACTICES, PRIMARY CARE, 2014

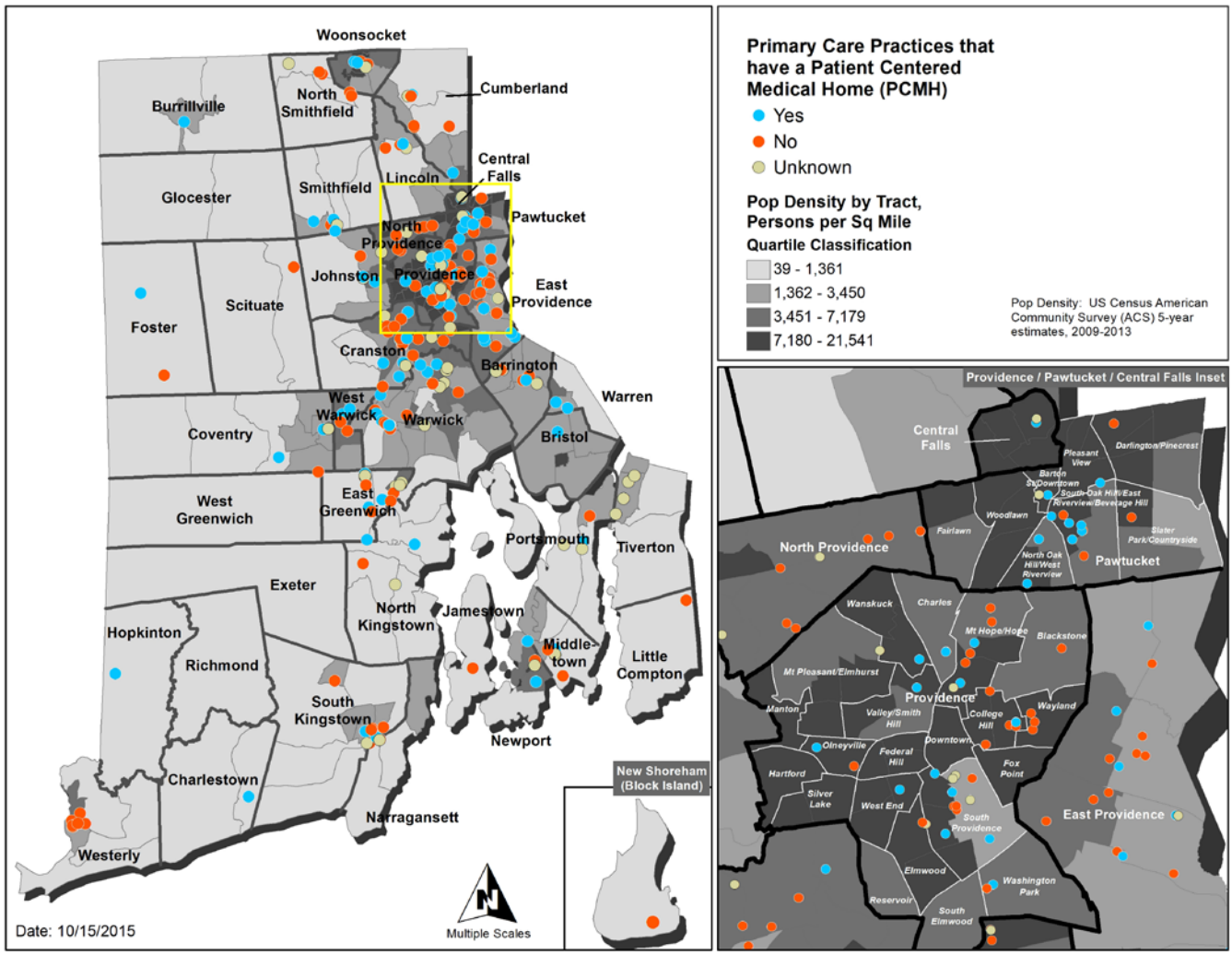
	% selecting response
Preventive and wellness care	96.8%
Immunization services	90.3%
On-site laboratory tests	58.0%
Family planning services	39.7%
Home visits	30.9%
Maternity and newborn care	29.7%
Phlebotomy	28.8%
Pain management	26.7%
Radiology services	9.5%
Complementary/alternative medicine	6.5%
Rehabilitation services	4.0%
Dispensing pharmacy	3.0%

Source: RIDOH 2015 Statewide Health Inventory

PATIENT-CENTERED MEDICAL HOME RECOGNITION

Patient-Centered Medical Home (PCMH)[15] recognition was identified for 41.0% of practices. The Figure depicts the geographic distribution of PCMHs overlaying population density distributions. Among PCMH practices, 78.7% had achieved the highest (Level 3) National Committee for Quality Assurance (NCQA) recognition. Practices recognized by the Joint Commission were less common (3.7%), and 1.9% were recognized by the Accreditation Association for Ambulatory Health Care.

FIGURE 6: PATIENT-CENTERED MEDICAL HOME RECOGNITION, PRIMARY CARE, 2014



Source: RIDOH 2015 Statewide Health Inventory

15 Per the National Committee for Quality Assurance, "The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into 'what patients want it to be.' Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care."

STAFFING CAPACITY

For evaluation of primary care practice personnel, survey respondents were asked to respond to whether they had personnel from each of 58 different categories. The five personnel categories with the greatest percentage of practices reporting that they have that personnel type are medical/nursing assistants (82.7%), management and support staff (53.6%), internists (53.0%), patient support staff (50.6%), and nurse case managers (44.4%).

Among practices reporting personnel data, 40.2% had nurse practitioners and 17.9% had physician assistants in 2014. Nurse practitioners had a mean number of clinical visits of 4063, and physician assistants had a mean number of clinical visits of 2798. The Table displays personnel FTE and mean clinical visits.

TABLE 6: PRIMARY CARE PRACTICE PERSONNEL, 2014

Do you have the following personnel?	% yes	Mean FTE in 2014	Mean Number of clinical visits in 2014
Family physicians	43.3%	1.76	6118
General practitioners	10.7%	1.58	4317
Internists	53.0%	2.22	6076
Obstetricians/Gynecologists	6.5%	0.63	5086
Pediatricians	37.3%	2.37	7665
Other specialty physicians	7.1%	0.73	3902
Nurse practitioners	40.2%	1.78	4063
Physician assistants	17.9%	1.33	2798
Nurses	38.2%	3.47	6614
Nurse case managers	44.4%	1.52	1961
Medical/nursing assistants	82.7%	4.54	42186
Nutritionists/dieticians	12.3%	0.79	.
Psychiatrists	4.0%	0.09	114
Licensed clinical psychologists	4.6%	0.90	721
Licensed clinical social workers	12.3%	1.72	3309
Marriage and family therapists	0.7%	0.00	.
Mental health counselors	7.7%	0.86	755
Clinical nurse specialists (mental health)	4.5%	0.81	.
Chemical dependency professional	0.7%	0.50	.

Source: RIDOH 2015 Statewide Health Inventory

INFORMATION TECHNOLOGY

The most common technology was the use of secure electronic e-mail which was used in 43% of practices, followed closely by text messaging which was used by 16.5% of practices. Use of video conferencing was used in only 2% of practices, audio only visits in only 4.3% of practices, and secure electronic live messaging in only 1.9% of practices.

When it comes to patient health monitoring devices, 9.4% of respondents' practices were already using them with automatic feeds to their Electronic Health Records (EHRs). Eight percent of practices had some mechanism for patients to enter their health monitoring data manually.

The technologies that practices indicated they are planning to use in the future are secure electronic e-mail at 16.8%, text messaging at 12.7%, automatic feeds from remote monitoring devices at 9.0%, and secure electronic live messaging at 6.2%.

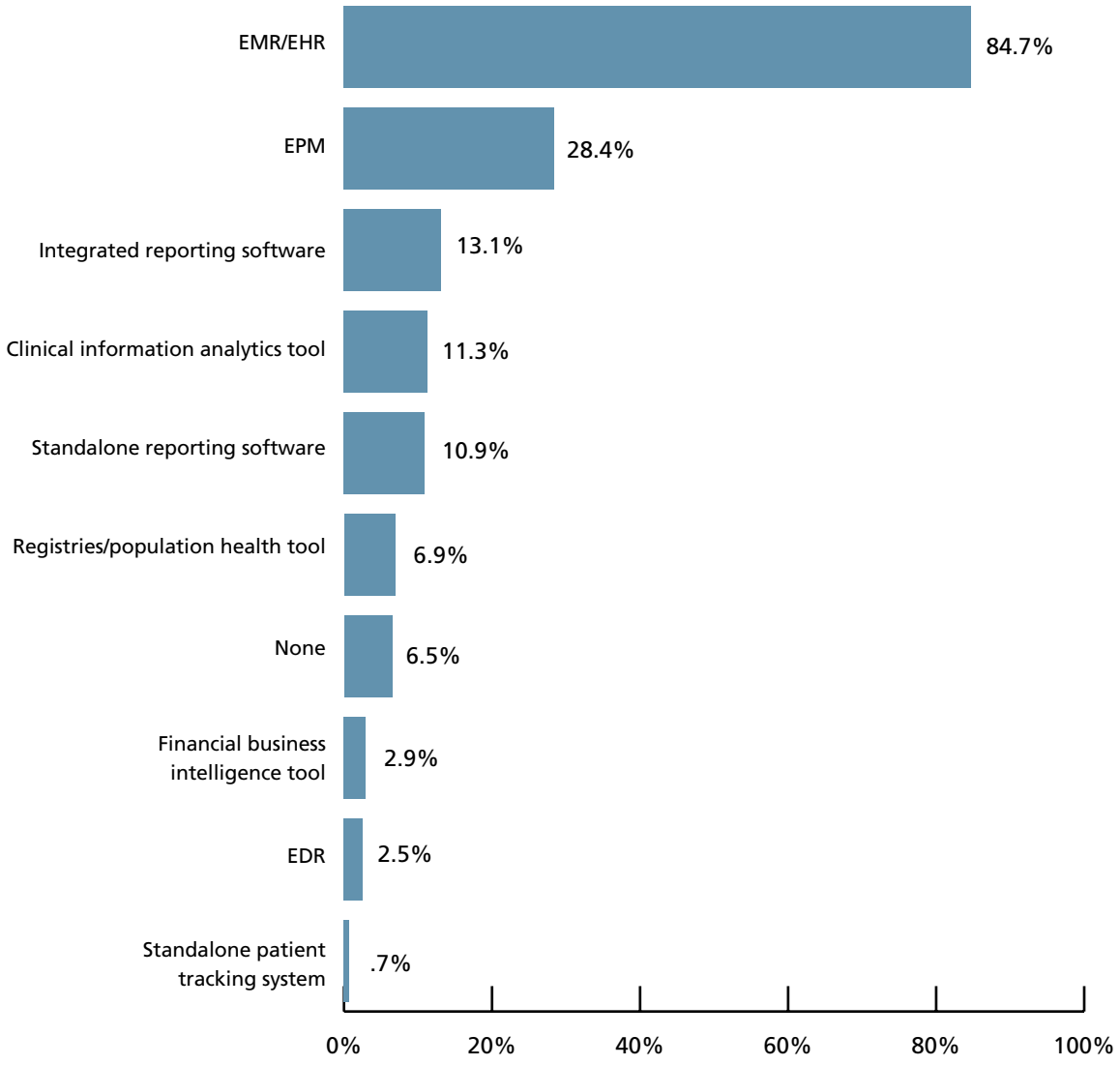
TABLE 7: USE OF TECHNOLOGY TO PROVIDE PATIENT CARE, PRIMARY CARE, 2014

	Never	Any Interested patients	Plan to Use	Majority of Patients	Pilot Group
	%	%	%	%	%
Video conferencing	92.4%	1.0%	5.7%	.	1.0%
Audio only visits	92.3%	1.9%	3.4%	1.4%	1.0%
Secure electronic live messaging	91.9%	1.4%	6.2%	0.5%	.
Other	91.4%	4.3%	1.1%	3.2%	.
Remote monitoring devices					
with manual entry by patient	86.3%	3.3%	5.7%	3.3%	1.4%
Remote monitoring devices					
with automatic feed to EHR	81.5%	4.7%	9.0%	4.7%	.
Text messaging	70.8%	11.8%	12.7%	3.8%	0.9%
Secure electronic email	40.2%	30.4%	16.8%	12.1%	0.5%

Source: RIDOH 2015 Statewide Health Inventory

Primary care practices were also asked about information software they use in their practices. A majority (84.7%) had an Electronic Medical Record/Electronic Health Record (EMR/EHR), 28.4% had Electronic Practice Management (EPM) software, 6.9% had electronic registries or population health tools, 2.5% had an Electronic Dental Record (EDR), and 0.7% had a standalone patient tracking system. Overall only 21.8% had some sort of reporting software. 13.1% had reporting software integrated in their EMR/EHR, EDR, and/or EPM, 11.3% had a clinical analytics tool, 2.9% had a business intelligence tool, and 10.9% had standalone reporting software.

FIGURE 7: INFORMATION SOFTWARE, PRIMARY CARE, 2014



Source: RIDOH 2015 Statewide Health Inventory

Among respondents, the top three EMRs were eClinicalWorks at 23.3%, Epic at 9%, and Athena at 6.3%.

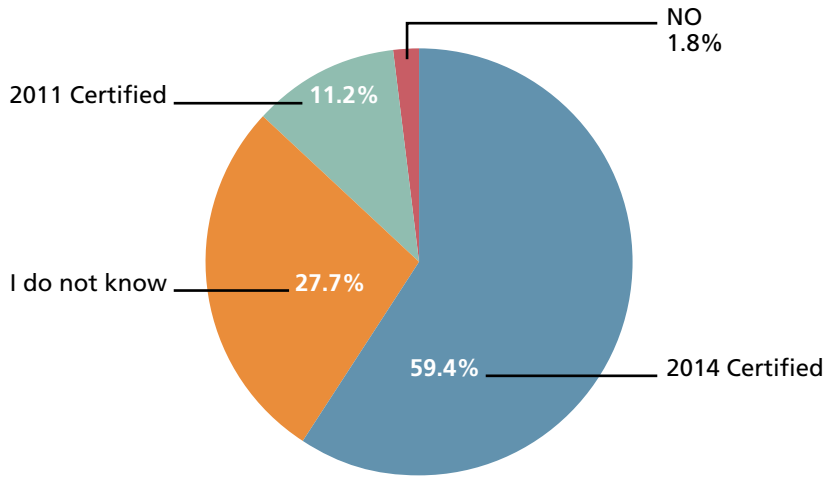
TABLE 8: NAME OF EHR/EMR, PRIMARY CARE, 2014

What is the name of your EHR/EMR system?	Percent
eClinicalWorks	23.3%
Epic	9.0%
Athena	6.3%
Amazing Charts	5.9%
EpiChart	5.6%
Greenway Medical	5.2%
Harris/Optum Caretracker	5.2%
NextGen	4.2%
Practice Fusion	2.8%
Allscripts	1.7%
Unknown	2.1%
Other (22 distinct)	11.1%

Source: RIDOH 2015 Statewide Health Inventory

Of those who responded, 59.4% are using 2014 Certified Electronic Health Record Technology (CEHRT), 11.2% are using 2011 CEHRT,[16] 1.8% are not using CEHRT, and 27.7% did not know if their EHR/EMR was CEHRT.

FIGURE 8: CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY, PRIMARY CARE, 2014



Source: RIDOH 2015 Statewide Health Inventory (Primary Care)

16 Certified Electronic Health Record Technology (CEHRT) – EHR/EMRs are certified to meet the requirements of the Meaningful Use/EHR Incentive Program, meaning that professionals and hospitals which adopt certified software can meet the requirements to receive incentive dollars using that software.

Behavioral Health Clinics and Practices

Introduction

In Rhode Island, behavioral health treatment and services include long term hospital care; mental health and psychiatric services; substance abuse prevention, education and a wide range of drug and alcohol treatment services; and residential, day programs and support services for people with developmental disabilities. For general background on behavioral health including mental health and substance use, RIDOH staff met with staff from the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH).

Survey Design

The Behavioral Health survey was written to capture information about mental health and substance abuse services and access in the State. The three study groups for this survey were licensed behavioral health clinics, outpatient psychiatrists, and outpatient psychologists. Each survey included questions regarding the total number of patients per clinic or practice location, sources of insurance for patients, new patient access to care, waiting list, demographics about patients, interpreter services, providers and their full time equivalents (FTE), types and number of services offered, integration with primary care, and information technology, in addition to other data elements. The surveys were informed by the World Health Organization "Service Availability and Readiness Assessment", Primary Care Behavioral Health-Integration Tool "Behavioral Health Integration Survey", and extensive stakeholder engagement along with collaboration with BHDDH.

Feedback from stakeholders was solicited at various stages of the survey construction. The surveys were reviewed with BHDDH and members or leadership of the Rhode Island Psychological Association, Gateway Behavioral Health Services, WellOne Primary Medical and Dental Care, Mental Health Association of Rhode Island, and The Providence Center. Feedback was received regarding the questions about integration with primary care, information technology, and the applicability of the survey to small or solo-provider practices. The feedback regarding primary care integration and use of information technology in behavioral health practices was incorporated prior to the survey being sent out. While all of the feedback was incorporated into the survey before it was sent out, RIDOH determined the final survey instrument.

In response to the feedback and due to the number of data elements requested in the full survey, an "abbreviated" survey was created that was offered to practices that did not have the information technology capacity or had other barriers to gathering the requested data. This survey had two additional versions: one for outpatient psychologists and one for outpatient psychiatrists. Of note, information about outpatient psychology and psychiatry services in hospital clinics was captured in the Hospital survey. Similarly, information about psychology and psychiatry services was also recorded in the licensed behavioral health clinic survey. The "abbreviated" survey included core questions about total number of patients per practice location, sources of insurance for patients, new patient access to care, interpreter services, providers and their FTEs, integration with primary care, and information technology.

The full version of the survey was designed to take one hour to complete once data had been collected. Per the respondents that completed this version, they reported the survey took from 15 minutes to one hour. The "abbreviated" version of the survey was designed to take 30 minutes and per respondents they reported it took five to 30 minutes to complete.

Data Collection

Behavioral health data collection had distinct protocols for the three study groups. For the first group, licensed behavioral health clinics, a list was obtained from BHDDH. Each clinic was contacted to confirm site locations, and the administrator for each clinic site was identified and their email address documented. The survey was emailed to the clinic administrators at 52 site locations, and each clinic was given three weeks to complete the survey. Two to seven follow up calls were made for the clinics that had not yet completed survey. Due to a modest response rate from clinics, two interns from the RIDOH team drove to the remaining clinics and facilitated the "abbreviated" surveys being completed through in-person contact.

The methodology used to collect information for the second group, psychiatrists, paralleled that used for primary care data collection. Publicly available RI licensure data was obtained for physicians whose practices were located in RI. After the specialties of the physicians on this list were recorded, psychiatrists and other behavioral health specialists were selected. The physicians whose data would be recorded through licensed behavioral health clinics and hospital outpatient clinics were excluded from this data collection, as their information was being collected in the respective other surveys. This left a list of predominantly psychiatrists in small or solo practices. The HIT survey results were used to inform our list of email addresses per practice. Each psychiatrist, or their administrator when possible, was contacted if they did not have an email address recorded. The full version of the survey was live for one week. However, due to concerns expressed by the stakeholder groups, the "abbreviated" survey was sent out one week later. Practices were given an additional three weeks to complete the "abbreviated" survey.

The third study group, psychologists, was approached through obtaining the publicly available RI licensure list for psychology professionals. This list was restricted to psychologists who designated their practice location in Rhode Island. The survey was sent electronically to psychologists or practice administrators who had email addresses listed. The full version of the survey was live for one week, and then the "abbreviated" survey was sent out to the same list of psychologists based on feedback from providers in the community. Practices were given an additional three weeks to complete this "abbreviated" survey. In addition, the "abbreviated" survey was sent out over the Rhode Island Psychological Association Listserv along with an update message from RIDOH.

Response

Of the 52 licensed behavioral health clinic locations, data were captured for 48 yielding a response rate of 92%.

Data were received for 187 outpatient psychologists (37 from hospital-based outpatient clinics, 138 from solo or small group practices, 12 FTE from licensed behavioral health clinics).

Data were received for 171 outpatient psychiatrists (50 from hospital-based outpatient clinics, 55 from solo or small group practices, 66 FTE from licensed behavioral health clinics).

However, further analysis is needed in order determine duplication across clinical settings. Also note that not all respondents completed every question, or did not provide a complete response for every question, so all totals may not equal one hundred percent (100%).

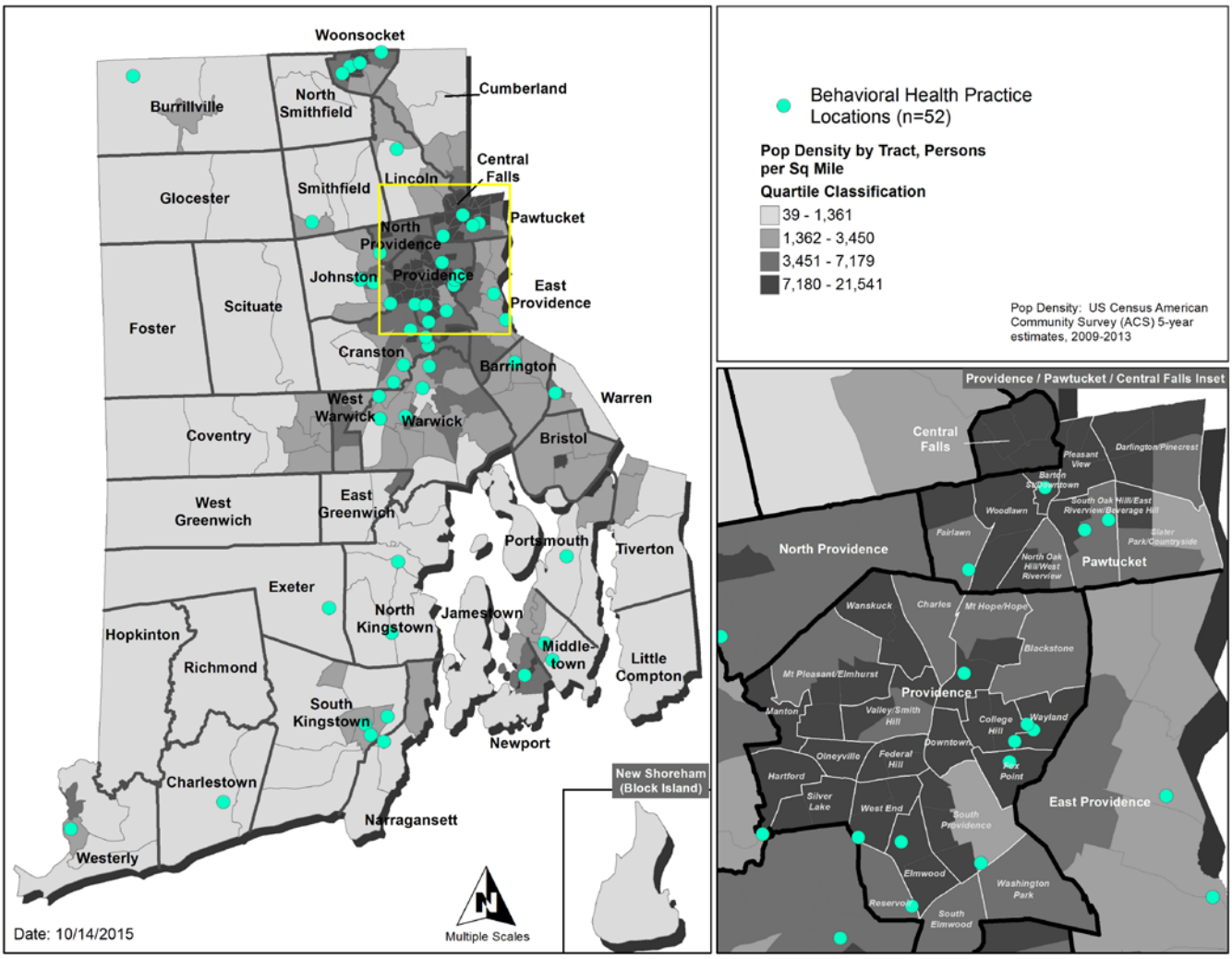
Findings

Findings from the behavioral health inventory administered to behavioral health clinics and psychologists and psychiatrists by the RIDOH in August 2015 are detailed on the next page:

Licensed Behavioral Health Clinics

Among the 48 clinics, the median number of patients seen in 2014 was 566. The Figure depicts the geographic distribution of licensed behavioral health clinics overlaying population density distributions.

FIGURE 9: LOCATIONS OF LICENSED BEHAVIORAL HEALTH CLINICS, 2014



Source: RIDOH 2015 Statewide Health Inventory

MEDICAL INSURANCE TYPE

The average percent of patients who utilize each principal insurance type at behavioral health clinics is displayed below:

TABLE 9: PERCENT OF PATIENTS SEEN IN 2014 BY PRINCIPAL MEDICAL INSURANCE SOURCE, BEHAVIORAL HEALTH, 2014

	Average
Medicaid	45.1%
Private	33.1%
Medicare	9.3%
None/Self-pay	9.3%
Other	9.3%
Tricare	0.1%

Source: RIDOH 2015 Statewide Health Inventory

OUTPATIENT CARE

There were 27.3% of clinics that reported that they collect information on whether patients in their clinic are on a sliding scale fee schedule. Of these clinics, the average percent of patients on the sliding fee schedule was 15.1%.

NEW PATIENTS

All behavioral health clinics reported they were accepting new patients.

There were 89.5% of clinics that reported they were accepting new Medicaid patients, while 10.5% reported they were not accepting new Medicaid patients.

HOURS OF OPERATION

Among the clinics that reported their hours of operation, 55.0% indicated that they are open all weekdays and 23.8% indicated that they are open on Saturdays or Sundays. There were 13.7% that reported they are open early (before 8AM) some or all weekdays, and 62.5% that reported they are open late (after 5PM) some or all weeknights.

APPOINTMENTS

There were 59.4% of clinics that indicated that they offer same-day appointments for any reason, 12.5% that indicated they offer same day appointments for acute needs only, and 28.1% that indicated they do not offer same-day appointments. Of the clinics that responded to a question asking the approximate number of same day appointments they have per day, the average number of appointments ranged from 1 to 5 with a mean of 2.0.

TRANSPORTATION

Public transportation is available to 84.4% of behavioral health clinics. Other types of transportation service were available to 65.6% of clinics such as taxi, Logisticare, and RIde.

LANGUAGE

Most clinics (68%) did not collect information on whether patients required health care information to be provided in other languages.

TABLE 10: INTERPRETER SERVICES FOR PATIENTS, BEHAVIORAL HEALTH, 2014

	Percent
Contracted interpreters that come on site as needed	40.5%
Staff not trained but assist with interpreting as needed	40.5%
Interpreters available on the telephone	16.2%
We do not provide interpreter services	16.2%
On-site trained interpreter	13.5%
Interpreters available through video	0%

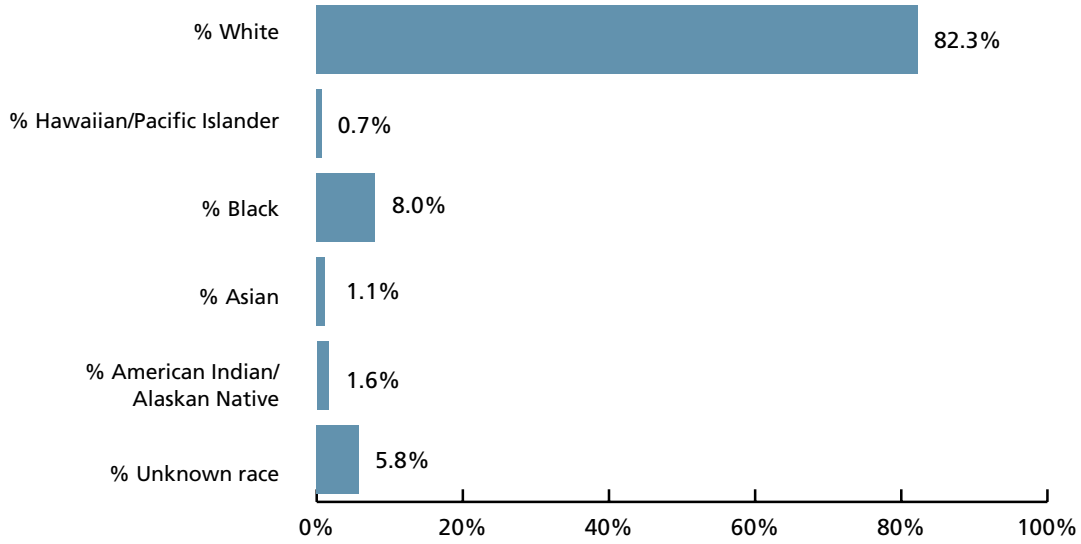
Source: RIDOH 2015 Statewide Health Inventory

On a related issue, 13.5% clinics reported that they offer an on-site trained interpreter, 40.5% indicated that they contracted interpreters who come on site as needed, 40.5% reported that they used staff not formally trained but assisting with interpreting as needed, 16.2% reported that interpreters are available by telephone, and 16.2% reported that they do not provide interpreter services (see Table).

RACE/ETHNICITY

Nearly one third of behavioral health clinics did not report the race of their patients. Among those who could reasonably report this information, they were often missing data on some patients. Based on the limited data available, about 82.3% of patients were of White race, 8.0% were Black, and about 1.6% were American Indian/Alaskan Native.

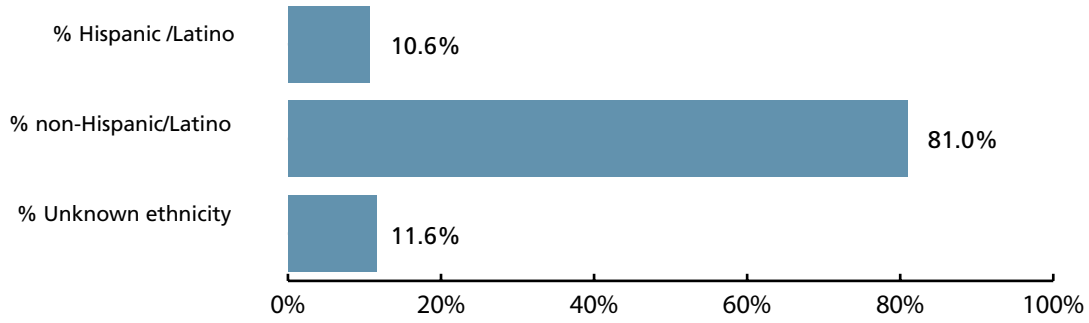
FIGURE 10: RACE OF BEHAVIORAL HEALTH PATIENTS, 2014



Source: RIDOH 2015 Statewide Health Inventory

Similarly, 31.6% did not report Hispanic/Latino ethnicity. Eleven percent of patients were of Hispanic/Latino ethnicity.

FIGURE 11: ETHNICITY OF BEHAVIORAL HEALTH PATIENTS, 2014



Source: RIDOH 2015 Statewide Health Inventory

STAFFING CAPACITY

TABLE 11: STAFFING AND CAPACITY, BEHAVIORAL HEALTH CLINICS, 2014

	Percent Yes	Capacity (Average FTE)
Chemical dependency professionals	80.0%	4.08
Mental health counselors	72.2%	2.09
Licensed clinical social workers	71.1%	3.46
Nurses	65.7%	4.23
IT staff	44.4%	1.58
Psychiatrists	44.4%	1.83
Clinical nurse specialists (MH)	40.0%	2.57
Other mental health staff	35.5%	10.08
QI/Data analytics staff	34.3%	1.82
Nurse practitioners	25.7%	1.08
Medical assistants/Nursing assistants	25.0%	2.25
Peers/recovery coaches	19.4%	1.03
Physician assistants	16.7%	0.75
Marriage/family therapists	16.2%	4.20
Nurse case managers	8.3%	1.00
Interpreter staff	8.3%	3.50
Licensed clinical psychologists	8.3%	0.33

Source: RIDOH 2015 Statewide Health Inventory

The top five current staffing capacity categories by percent of clinics who indicated that they had staff in that category are chemical dependency professionals (80.0%) with a mean capacity FTE of 4.1; mental health counselors (72.2%) with a mean capacity FTE of 2.1; licensed clinical social workers (71.1%) with a mean capacity of 3.5; nurses (65.7%) with a mean capacity FTE of 4.2; and IT staff (44.4%) with a mean capacity FTE of 1.6.

The bottom five current staffing capacity categories by percent of clinics who indicated that they had staff in that category are physician assistants (16.7%) with a mean capacity FTE of 0.8; marriage/family therapists (16.2%) with a mean capacity FTE of 4.2; nurse case managers with a mean capacity FTE of 1.0; interpreter staff with a mean capacity FTE of 3.5; and licensed clinical psychologists with a mean capacity FTE of 0.33.

INTEGRATION WITH PRIMARY CARE PRACTICES

Among behavioral health clinics, 32% of clinics reported they had some level of integration with primary care practices. These clinics were then asked which elements of integration were present. Results are displayed in the Table below. Overall there was modest integration between primary care and behavioral health clinics.

TABLE 12: STAFFING AND CAPACITY, BEHAVIORAL HEALTH CLINICS, 2014

	Not True	A Little True	Somewhat True	Very True	Always True
	%	%	%	%	%
Integrated with a PCMH	81.8%	9.1%	0%	0%	9.1%
Behavioral health and primary care providers use the same electronic medical record	75.0%	8.3%	8.3%	0%	8.3%
Scheduling strategy that allows patients to be seen by a behavioral health provider immediately after a primary care visit as necessary	72.7%	9.1%	18.2%	0%	0%
Behavioral health and primary care clinics are in the same location	66.7%	0%	8.3%	8.3%	16.7%
One system for making both primary care and behavioral health appointments	66.7%	8.3%	8.3%	.	16.7%
A system for primary care providers to communicate urgent concerns to a behavioral health provider	54.5%	9.1%	9.1%	9.1%	18.2%
Participates in Health Homes program	54.5%	0%	0%	9.1%	36.4%

Source: RIDOH 2015 Statewide Health Inventory

SERVICES OFFERED

Regarding the general types of services provided, 65.8% of clinics indicated that they provide both mental health and substance abuse services, 28.9% indicated that they provide substance abuse services only, and 5.3% indicated that they provide mental health services only.

TABLE 13: SUBSTANCE ABUSE SERVICES, BEHAVIORAL HEALTH CLINICS, 2014

	Percent
Outpatient detoxification for opioid dependence	91.4%
Dual-diagnosis treatment[16]	68.6%
Outpatient methadone treatment for opioid addiction	62.9%
Residential treatment (Levels III.1, III.3, III.5)	22.9%
Individual treatment for chemical dependency	20.0%
Outpatient suboxone treatment for opioid addiction	14.3%
Outpatient detoxification for alcohol dependence	5.7%
Group treatment for chemical dependency	2.9%

Source: RIDOH 2015 Statewide Health Inventory

Among clinics that provide substance abuse services, only 14.3% reported that they offer outpatient suboxone[17] treatment for opioid[18] addiction (see Table).

16 Dual diagnosis refers to mood disorder and substance abuse.
17 Suboxone: a product that contains both an opioid (opiate receptor agonist) and naloxone (opiate receptor antagonist) and is used in medication assisted treatment of narcotic addiction.
18 Opioid: substances such as a narcotic whose origin is not available naturally (i.e. oxycodone or hydrocodone) and acts as an opiate receptor agonist in the body.

TABLE 14: COMMUNITY SUPPORT TEAMS AND COMMUNITY HEALTH WORKERS, BEHAVIORAL HEALTH CLINICS, 2014

	Percent Yes
Opportunities to meet with a psychiatrist	100.0%
Medication management	91.7%
Assistance with finding safe, affordable housing	91.7%
Coordinating primary health care	91.7%
Employment assessment/job placement assistance	91.7%
Participate in community, therapeutic, social and recreational activities	91.7%
Individual, group and family therapy	90.9%
Substance use assessment/counseling	90.9%
Crisis intervention	90.9%
Wellness/social skills group training	83.3%
Practicing independent living skills	81.8%

Source: RIDOH 2015 Statewide Health Inventory

About one-third of all clinics (32.4%) indicated that they use community support teams or community health workers. The services offered by the clinics using community health workers or community support teams, such as peer recovery coaches, are displayed in the Table.

INTAKE METHODS

Survey results on intake methods revealed that on average, 93.4% of the time paper intake forms were used in the office, 0.3% of the time electronic intake forms on a kiosk or tablet were used, 0.3% of time electronic intake forms that can be completed prior to arrival were used, and 5.9% of the time electronic intake processes that reduce data entry were used.

INFORMATION TECHNOLOGY

There were 43.8% of clinics that indicated that providers in their clinic do not report for the Physician Quality Reporting System (PQRS)[19] and have no plans to start, 37.5% indicated that they do not know whether their providers report for PQRS, 12.5% that indicated that their providers do not currently report for PQRS but plan to start in 2015, and 6.3% that reported their providers do report for PQRS and plan to continue in 2015.

TABLE 15: INFORMATION SOFTWARE, BEHAVIORAL HEALTH, 2014

	Percent
EMR/EHR	59.1%
EPM	22.7%
Standalone reporting software	18.2%
None	18.2%
Integrated reporting software	13.6%
Financial business intelligence tool	9.1%
Clinical information analytics tool	9.1%
Standalone patient tracking system	4.5%
Electronic dental record	0%
Registries/population health tool	0%

Source: RIDOH 2015 Statewide Health Inventory

19 A quality reporting system for individual professionals and group practices to report quality information to Medicare.

There were 18.2% of clinics that reported they do not use any information software, 59.1% that reported that they use EMR/EHR information software, 22.7% that reported they use EPM, 18.2% that reported they use standalone reporting software, 13.6% that reported they use integrated reporting software, 9.1% reported that they use a financial business analytics tool, 9.1% that reported they use a clinical information analytics tool, and 4.5% that reported they use a standalone patient tracking system.

MEANINGFUL USE

Among clinics who reported on the highest level of Meaningful Use[20] to which any eligible provider in their clinic attested, 46.7% reported that they do not know, 33.3% reported none, 6.7% reported that they are not eligible for meaningful use, 6.7% reported Medicare Stage 1, and 6.7% reported Medicaid AIU.

Survey of Psychiatrists

NUMBER OF PATIENTS

The average number of patients seen in 2014 by psychiatrists was 1151.

INSURANCE TYPE

Survey results indicated that the average percent of patients on Medicaid across practices was 5.2%, the average on Medicare was 3.9%, the average not on insurance or self-paying was 41.3%, the average on other was 2.0%, the average on private was 41.3%, and the average on Tricare was 0.8%.

NEW PATIENTS

In terms of new patients, 83.7% indicated that they accepted new patients and 16.3% that they did not. Sixteen percent indicated that they accepted new Medicaid patients and 83.7% that they did not.

SERVICES PROVIDED

Among psychiatrists responding to this survey, 73.0% indicated that they provided mental health services only and 27.0% indicated that they provided both mental health and substance abuse services. No psychiatrists reported providing substance abuse treatment only.

TABLE 16: PERCENT OF PATIENTS SEEN IN 2014 BY PRINCIPAL MEDICAL INSURANCE SOURCE, PSYCHIATRISTS, 2014

	Average
None/Self-pay	41.3%
Private	41.3%
Medicaid	5.2%
Medicare	3.9%
Other	2.0%
Tricare	0.8%

Source: RIDOH 2015 Statewide Health Inventory

20 Meaningful Use/EHR Incentive Program – The Meaningful Use/EHR Incentive Program is a federal initiative providing eligible professionals and eligible hospitals with incentive dollars to adopt electronic health record technology and use them for advanced patient care.

TABLE 17: SERVICES PROVIDED, PSYCHIATRISTS, 2014

	Percent
Mental health only	73.0%
Both mental health and substance abuse	27.0%
Substance abuse only	0.0%

Source: RIDOH 2015 Statewide Health Inventory

TABLE 18: SUBSTANCE ABUSE SERVICES, PSYCHIATRISTS, 2014

	Percent
Dual-diagnosis treatment	100.0%
Outpatient detoxification for opioid dependence	80.0%
Outpatient suboxone treatment for opioid addiction	50.0%
Group treatment for chemical dependency	40.0%
Outpatient detoxification for alcohol dependence	40.0%
Outpatient methadone treatment for opioid addiction	20.0%
Individual treatment for chemical dependence	0.0%

Source: RIDOH 2015 Statewide Health Inventory

All (100%) of psychiatrists reported that their practices provided dual-diagnosis treatment, 80% that their practices provided outpatient detoxification for opioid dependence, and 50% that their practices provided outpatient suboxone treatment for opioid addiction. Methadone was provided by only 20% of practices.

INFORMATION TECHNOLOGY

For psychiatry practices, 43.5% indicated that they do not use information software, 39.1% that they use EMR/EHR, 21.7% that they use EPM, 8.7% that they use standalone reporting software, 4.3% that they use standalone patient tracking system, and 4.3% that they use a financial business intelligence tool.

TABLE 19: INFORMATION SOFTWARE, PSYCHIATRISTS, 2014

	Percent
None	43.5%
EMR/EHR	39.1%
EPM	21.7%
Standalone reporting software	8.7%
Standalone patient tracking system	4.3%
Financial business intelligence tool	4.3%
Clinical information analytics tool	0.0%
Integrated reporting software	0.0%
Registries/population health tool	0.0%

Source: RIDOH 2015 Statewide Health Inventory

INTEGRATION WITH PRIMARY CARE PRACTICES

Approximately 37% of psychiatry practices reported they had some level of integration with primary care practices. However, the integration was only to a modest degree. Among the practices with some integration, 6.3% reported that it was “somewhat true” that the behavioral health and primary care clinics are in the same location, and 18.8% reported that it was “somewhat true” that there was a system for primary care providers to communicate urgent concerns to a behavioral health provider.

TABLE 20: INTEGRATION WITH PRIMARY CARE, PSYCHIATRISTS, 2014

	Not True	A Little True	Somewhat True	Very True	Always True
	%	%	%	%	%
Behavioral health and primary care providers use the same electronic medical record	100.0%	0%	0%	0%	0%
Behavioral health and primary care clinics are in the same location	93.8%	0%	6.3%	0%	0%
One system for making both primary care and behavioral health appointments	93.8%	0%	6.3%	0%	0%
Scheduling strategy that allows patients to be seen by a behavioral health provider immediately after a primary care visit as necessary	93.8%	0%	6.3%	0%	0%
Participates in Health Homes program	93.8%	0%	6.3%	0%	0%
Integrated with a PCMH	93.3%	0%	6.7%	0%	0%
A system for primary care providers to communicate urgent concerns to a behavioral health provider	81.3%	0%	18.8%	0%	0%

Source: RIDOH 2015 Statewide Health Inventory

Survey of Psychologists

NUMBER OF PATIENTS

The average number of patients seen in 2014 by psychologists was 559.

INSURANCE TYPE

Survey results indicated that the average percent of patients on Medicaid across practices was 5.3%, the average on Medicare was 5.1%, the average not on insurance or self-paying was 17.3%, the average on other was 7.6%, the average on private was 58.0%, and the average on Tricare was 2.2%.

TABLE 21: PERCENT OF PATIENTS SEEN IN 2014 BY PRINCIPAL MEDICAL INSURANCE SOURCE, PSYCHOLOGISTS, 2014

	Average
Private	58.0%
None/Self-pay	17.3%
Other	7.6%
Medicaid	5.3%
Medicare	5.1%
Tricare	2.2%

Source: RIDOH 2015 Statewide Health Inventory

NEW PATIENTS

Among psychology practices, 86.4% indicated that they accepted new patients and 13.6% that they did not.

Fifty six percent indicated that they accepted new Medicaid patients and 43.7% that they did not.

SERVICES PROVIDED

In terms of services, 76.6% of psychologists indicated that they provided mental health services only and 23.4% indicated that they provided both mental health and substance abuse services. No psychologists indicated that they provide substance abuse treatment only.

TABLE 22: SERVICES PROVIDED, PSYCHOLOGISTS, 2014

	Percent
Mental health only	76.6%
Both mental health and substance abuse	23.4%
Substance abuse only	0.0%

Source: RIDOH 2015 Statewide Health Inventory

TABLE 23: SUBSTANCE ABUSE SERVICES, PSYCHOLOGISTS, 2014

	Percent
Outpatient detoxification for opioid dependence	81.0%
Dual-diagnosis treatment	76.2%
Outpatient methadone treatment for opioid addiction	9.5%
Outpatient suboxone treatment for opioid addiction	0.0%
Group treatment for chemical dependency	0.0%
Outpatient detoxification for alcohol dependence	0.0%
Individual treatment for chemical dependence	0.0%

Source: RIDOH 2015 Statewide Health Inventory

Of the practices that provided substance abuse services, 81.0% indicated that their practices provided outpatient detoxification for opioid dependence, 76.2% that their practice provided dual-diagnosis treatment, and 9.5% that their practice provided outpatient methadone treatment for opioid addiction.

INFORMATION TECHNOLOGY

Fifty-three percent of practices indicated that they did not use information software, 27.8% that they used EMR/EHR, 21.6% that they used EPM, 4.1% that they used a financial business intelligence tool, 3.1% that they used standalone patient tracking system, 2.1% that they used a clinical information analytics tool, 1.0% that they used integrated reporting software, and 1.0% that they used standalone reporting software.

TABLE 24: INFORMATION SOFTWARE, PSYCHOLOGISTS, 2014

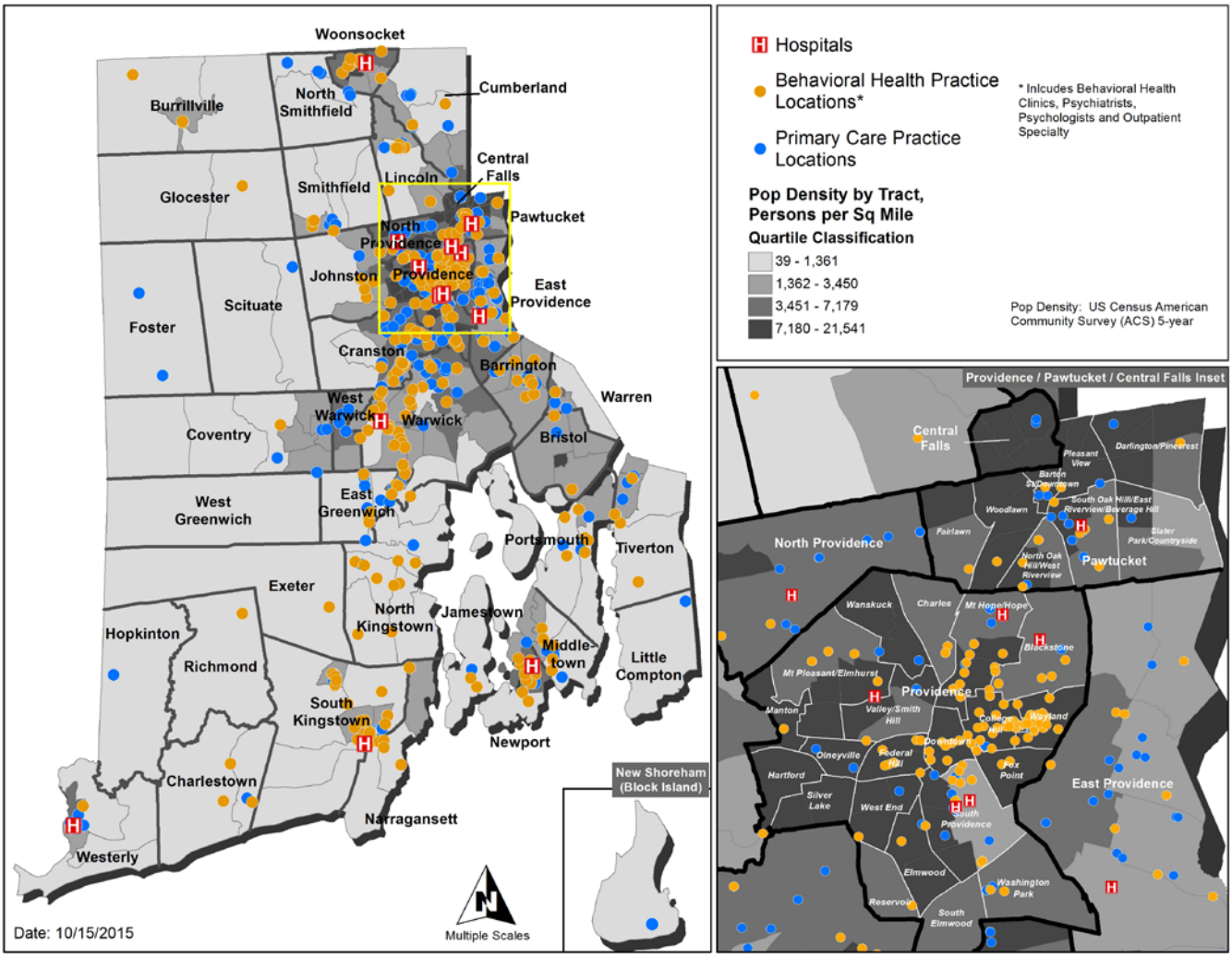
	Percent
None	52.6%
EMR/EHR	27.8%
EPM	21.6%
Financial business intelligence tool	4.1%
Standalone patient tracking system	3.1%
Clinical information analytics tool	2.1%
Integrated reporting software	1.0%
Standalone reporting software	1.0%
Registries/population health tool	0.0%

Source: RIDOH 2015 Statewide Health Inventory

INTEGRATION WITH PRIMARY CARE PRACTICES

The Figure depicts the geographic distribution of primary care and behavioral health practice locations overlaying population density distributions.

FIGURE 12: PRIMARY CARE AND BEHAVIORAL HEALTH PRACTICE LOCATIONS, 2014



Source: RIDOH 2015 Statewide Health Inventory

Among practices, 45% reported they had some level of integration with primary care practices. These practices were asked about the specific elements of integration that were present in their practice. Results are displayed in the table below.

TABLE 25: INTEGRATION WITH PRIMARY CARE, PSYCHOLOGISTS, 2014

	Not True	A Little True	Somewhat True	Very True	Always True
	%	%	%	%	%
Participates in Health Homes program	97.8%	0%	0%	2.2%	.
One system for making both primary care and behavioral health appointments	89.1%	0%	6.5%	0%	4.3%
Behavioral health and primary care providers use the same electronic medical record	89.1%	0%	2.2%	4.3%	4.3%
Integrated with a PCMH	89.1%	2.2%	2.2%	6.5%	0%
Behavioral health and primary care clinics are in the same location	82.6%	4.3%	4.3%	4.3%	4.3%
Scheduling strategy that allows patients to be seen by a behavioral health provider immediately after a primary care visit as necessary	80.4%	4.3%	6.5%	8.7%	0%
A system for primary care providers to communicate urgent concerns to a behavioral health provider	63.0%	10.9%	8.7%	13.0%	4.3%

Source: RIDOH 2015 Statewide Health Inventory

Outpatient Specialty Practices

Introduction

Outpatient specialty practices are medical and surgical physician practices that are either based in the community or in hospital-based clinics. On the medical side, examples of specialties include Cardiology, Gastroenterology, and Endocrinology. On the surgical side, examples include Orthopedics, Urology, and General Surgery. This survey was sent to practices in 34 distinct specialty fields to assess capacity and access to care from geographic, cultural, and financial perspectives.

Survey Design

The Outpatient Specialty Practice survey was written to capture information about total number of patients per practice location, sources of insurance for patients, new patient access to care, waiting list, demographics about patients, interpreter services, staffing per service category, hours of operation, transportation access, providers and their full time equivalents (FTE), types and number of specialty services in calendar year 2014, and information technology, in addition to other data elements. The survey was informed by the World Health Organization "Service Availability and Readiness Assessment" as well as stakeholder engagement.

Feedback from stakeholders included reviewing the survey with the Rhode Island Medical Society and physician specialist members of the Rhode Island Board of Medical Licensure and Discipline for initial comments and recommendations. Feedback was received that the survey was comprehensive but potentially prohibitively long for small practices to complete. In response to the feedback and due to the number of data elements requested in the full survey, an "abbreviated" survey was created that was offered to practices that did not have the information technology capacity or had other barriers to gathering the requested data. The "abbreviated" survey included core questions about total number of patients per practice location, sources of insurance for patients, new patient access to care, interpreter services, providers and their FTEs, and information technology. While all of this feedback was incorporated into the survey before it was sent out, RIDOH determined the final survey instrument.

The full version of the survey was designed to take one hour to complete once data had been collected. Per the respondents that completed this version, they reported the survey took from 20 minutes to six hours including data collection. The "abbreviated" version of the survey was designed to take 15 to 30 minutes and could be completed over the phone if data were readily available.

Data Collection

The methodology used to collect outpatient specialist data paralleled that used for primary care and behavioral health data collection. Publicly available RI licensure data was obtained for over 6,000 physicians, and 1,265 physicians were excluded because their practice was located outside of Rhode Island. Our team used Internet searches and phone calls in order to identify the specialty and practice of each provider on the licensure list. This process was completed concurrently with the primary care data collection taking a team of nine interns working four days per week a total of three weeks.

The outpatient specialty group included physicians who provided outpatient care in Anesthesiology, Cardiology, Cardiac Surgery, Dermatology, Diagnostic Radiology, Endocrinology, Gastroenterology, General Surgery, Hematology, Immunology, Infectious Disease, Nephrology, Neurology, Neurosurgery, Obstetrics and Gynecology, Oncology, Opthalmology, Oral Surgery, Orthopaedic Surgery, Otolaryngology, Pain Management, Physical Medicine and Rehabilitation, Plastic Surgery, Pulmonology, Radiology, Rheumatology, Urgent Care, Urology, and Vascular Surgery. Physicians providing primary care or behavioral health services were surveyed in the primary care and behavioral health surveys as reported above.

Consistent with the primary care methodology, the list of physicians was aggregated to the practice level, and the HIT survey results were used to inform our list of administrator email addresses per practice. If the practice administrator's email address could not be confirmed via the HIT survey, our team called each practice in order to obtain the correct administrator contact information. The process of completing phone calls to confirm this information took our team of nine interns eight days to complete.

Each practice was given three weeks to complete the survey. During the second week, our team began making phone calls to the 354 practices that had not opened the survey in order to confirm that the administrators had received the survey links. The initial follow-up calls took our team eleven days to complete. After the three week period concluded, our team systematically called the remaining practices on our list to confirm that they had received the survey and to ask if they had any questions regarding the content of the survey. Each practice received between one and six additional phone calls.

The team of interns called each administrator a final time to ask if they would be able to complete our "abbreviated" outpatient specialty survey that could be completed over the phone. Each practice received between one and five phone calls about the "abbreviated" survey.

In addition to this process for collecting data for outpatient specialty practices, outpatient data from providers operating in hospital outpatient clinics were collected as part of the hospital survey. The hospital-based practices were asked a subset of the questions including medical insurance coverage, waiting list, clinic staff, and specialty-specific questions.

Response

A total of 518 outpatient specialty practices were identified in Rhode Island. There were 62 hospital-based outpatient clinics and 456 community outpatient practices. Data were collected from 185 community practices or organizations representing 219 practice locations, as well as from each of the 62 hospital-based clinics. The overall response rate for outpatient specialty practices was 54%.

Note that not all respondents completed every question, or did not provide a complete response for every question, so all totals may not equal one hundred percent (100%).

Findings

Findings from the outpatient specialty practice inventory survey administered in June 2015 reveal the following:

MEDICAL INSURANCE COVERAGE

Across outpatient specialty practices in calendar year 2014, 7.9% of patients had Medicaid, 25.1% had Medicare, 58.3% had private insurance, 4.2% had other insurance, and 4.5% were self-pay. Results are displayed in the Table.

TABLE 26: PERCENT OF PATIENTS SEEN IN 2014 BY PRINCIPAL MEDICAL INSURANCE SOURCE, OUTPATIENT SPECIALTY, 2014

	Average
Private	58.3%
Self-pay	4.5%
Other	4.2%
Medicaid	7.9%
Medicare	25.1%

Source: RIDOH 2015 Statewide Health Inventory

The five specialty categories with the highest percentage of patients paying through self-pay were Oral Surgery with 23.2%, Plastic Surgery with 16.8%, Orthopedics with 9.1%, Ophthalmology with 5.2%, and Urgent Care with 4.5%.

WAITING LISTS

In outpatient specialty practices, 80% or more of Endocrinology, Rheumatology, and Women's Health practices had a waiting list. There were no waiting lists for Nephrology or Radiation Oncology practices that responded to this survey. The number of patients and the proportion of practices with wait lists are displayed in Table 27.

TABLE 27: COMMUNITY AND HOSPITAL-BASED OUTPATIENT SPECIALTY CLINICS, PATIENTS AND WAITING LISTS, 2014

Specialty	Number of practices	Number of patients	Number of practices with waiting list	Percentage of practices with waiting list
Allergy & Immunology	9	20,736	2	22%
Anesthesiology	4	54,680	1	25%
Cardiology	15	56,092	4	27%
Dermatology	16	99,298	7	44%
Endocrinology	6	9,660	5	83%
Gastroenterology	8	37,316	2	25%
General surgery	8	14,214	2	25%
Hematology & Oncology	9	23,694	2	22%
Infectious disease	4	5,788	1	25%
Nephrology	3	14,982	0	0%
Neurology	16	22,186	10	63%
Neurosurgery	4	39,900	1	25%
Ophthalmology	22	194,498	8	36%
Orthopedics	13	139,191	4	31%
Pulmonary Specialty	6	21,431	3	50%
Radiation Oncology	4	8,198	0	0%
Rheumatology	8	11,123	7	88%
Urology	11	96,717	5	45%
Wellness	1	291	1	100%
Women's health	5	34,724	5	100%

Source: RIDOH 2015 Statewide Health Inventory

Note: Number of practices and patients is from the 54% of outpatient specialty practices that completed the survey

NEW PATIENTS

Among the outpatient specialty practices, 96.6%, reported accepting new adult patients. A smaller percentage, 67.7%, reported accepting new adult Medicaid patients. Of the practices responding, 52.9% reported accepting new pediatric patients, and 38.6% of the practices reported accepting new pediatric Medicaid patients. The proportion of practices accepting new patients is displayed in Table 28.

TABLE 28: NEW PATIENTS BY TYPE, PRIMARY CARE, 2014

	Number of Practices	Percent of Practices
Accepting New Patients – Pediatric		
Yes	92	52.9%
No	82	47.1%
Accepting New Patients – Adult		
Yes	168	96.6%
No	6	3.5%
Accepting New Medicaid Patients – Pediatric		
Yes	69	38.6%
No	110	61.5%
Accepting New Medicaid Patients – Adult		
Yes	120	67.0%
No	59	33.0%

Source: RIDOH 2015 Statewide Health Inventory

Of the practices that accept new Medicaid patients, 51.1% indicated that they added their most recent new Medicaid patient less than one prior to completing the survey, 21.7% that it was between one week and two weeks prior, 7.6% that it was between three and four weeks prior, and 19.6% that it was more than four weeks prior.

TABLE 29: WHEN THE MOST RECENT NEW MEDICAID PATIENT WAS ADDED, OUTPATIENT SPECIALTY, 2015

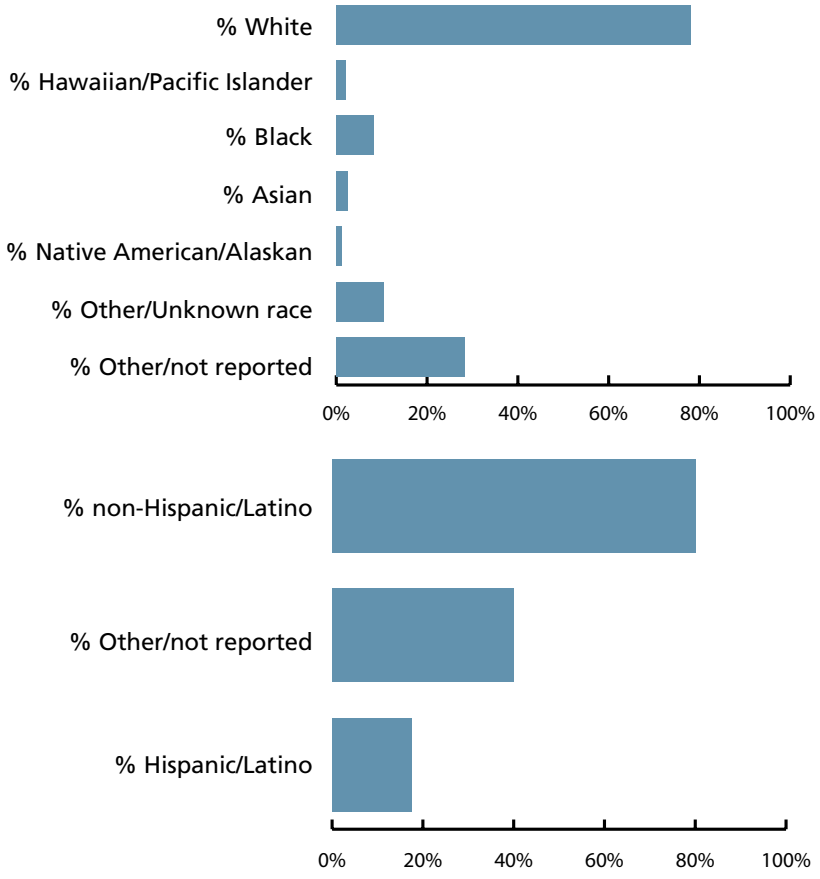
	Number of Practices	Percent
< 1 week ago	47	51.1%
1-2 weeks ago	20	21.7%
> 4 weeks ago	18	19.5%
3-4 weeks ago	7	7.6%

Source: RIDOH 2015 Statewide Health Inventory

RACE/ETHNICITY

Nearly 80% of the outpatient specialty practices did not report the race of their patients; similarly 86% did not report Hispanic/Latino ethnicity. Even among those who did report this information, they were often missing data on some patients. Figures12 displays race and ethnicity information based on the limited data available.

FIGURE 13: RACE AND ETHNICITY DATA FOR PATIENTS IN OUTPATIENT SPECIALTY PRACTICES, 2014



Source: RIDOH 2015 Statewide Health Inventory

LANGUAGE

Among the community outpatient specialty practices reporting, 15% indicated that they did collect information on patients requiring health care information to be provided in other languages. However, the data as provided did not allow accurate identification of specific languages.

In terms of interpreter availability, 37.0% of community outpatient specialty practices did not offer interpreter services and 26.5% used staff not formally trained but assisting with interpreting as needed. Table 30 shows the provision of interpreter services among outpatient specialty practices.

TABLE 30: PROVISION OF INTERPRETER SERVICES, OUTPATIENT SPECIALTY, 2014

	Percent
Do not provide interpreter services	37.0%
Staff, who are not interpreters, interpret as needed	26.5%
Interpreters available over telephone	21.0%
Contracted interpreters, on-site as needed	16.6%
On-site trained interpreters	7.7%
I do not know	5.0%
Interpreters available via video	0.6%

Source: RIDOH 2015 Statewide Health Inventory

HOURS OF OPERATION

The majority of community outpatient specialty practices are open during regular business hours only. Thirty one percent reported being open after 5PM and 12.6% reported being open before 8AM. Nearly all (99%) of community outpatient specialty practices are open five days per week. On average, practices were open 8.6 hours per day, ranging from 5 hours to 12 hours per week day.

TRANSPORTATION

Eighty percent of community outpatient specialty practices indicated that public transportation was available to their practice.

HOSPITAL-BASED OUTPATIENT SPECIALTY CARE AND WAIT LISTS

Hospitals also provide outpatient specialty services in hospital-based practices. The Table demonstrates the types of services provided in outpatient specialty practice settings.

The specialty categories with the highest number of hospital-based outpatient practices were Cardiology with 6 hospitals reporting and 63 physicians; Hematology & Oncology with 6 hospitals reporting and 102 physicians; Women's Health with 5 hospitals reporting and 38 physicians; Infectious Disease with 4 hospitals reporting and 6 physicians; Endocrinology with 4 hospitals reporting and 12 physicians; and General Surgery with 4 hospitals reporting and 70 physicians.

Many of the hospital-based outpatient clinics had a waiting list, with the exception on Nephrology, Neurosurgery, Ophthalmology, Orthopedics, and Radiation Oncology.

TABLE 31: HOSPITAL-BASED OUTPATIENT SPECIALTY PRACTICES, 2014

	# of hospitals	Total # of patients	# of physicians[1]	# clinical personnel[1]	# practices with waiting list	% practices with a wait list
Allergy & Immunology	4	6,808	19	6	1	25%
Anesthesiology	2	1,660	4	1	1	50%
Cardiology	6	35,059	63	8	1	17%
Dermatology	4	5,773	27	3	4	100%
Endocrinology	4	8,160	12	8	4	100%
Gastroenterology	2	5,028	24	10	2	100%
General surgery	4	7,769	70	4	2	50%
Hematology & Oncology	6	21,994	102	40	2	33%
Infectious disease	4	5,788	6	5	1	25%
Nephrology	2	1,470	5	1	0	0%
Neurology	3	3,779	30	5	3	100%
Neurosurgery	1	1,047	7	0	0	0%
Ophthalmology	1	3,051	8	0	0	0%
Orthopedics	2	1,717	48	0	0	0%
Pulmonary Specialty	3	6,837	6	2	2	67%
Radiation Oncology	1	2,023	6	12	0	0%
Rheumatology	4	1,299	8	1	4	100%
Urology	2	2,911	17	7	2	100%
Wellness	1	291	2	4	1	100%
Women's health	5	34,724	38	19	5	100%

1 Among hospital-based outpatient specialty clinics, some reported full time equivalents for physicians and clinical personnel, while others reported actual numbers of physicians and clinical personnel. All respondents to the section did not always record hospital-based outpatient physician or personnel answers.

Source: RIDOH 2015 Statewide Health Inventory

INFORMATION TECHNOLOGY

Among practices, 55.2% indicated that they used electronic medical/health record (EMR/EHR), 43.6% that they use electronic practice management software, 21.5% that they do not use any information software, 7.2% that they use integrated reporting software, 3.3% that they use a financial business intelligence tool, 1.7% that they use a clinical informed analytics tool, 1.1% that they use standalone reporting software, and 1.1% that they use registries/population health tool.

TABLE 32: INFORMATION SOFTWARE USED BY OUTPATIENT SPECIALTY PRACTICES, 2014

	% Selecting response
Electronic Medical/Health Record (EMR/EHR)	55.2%
Electronic Practice Management	43.6%
None	21.5%
Integrated Reporting Software	7.2%
Financial Business Intelligence Tool	3.3%
Clinical Informed Analytics Tool	1.7%
Standalone Reporting Software	1.1%
Registries/Population Health Tool	1.1%
Standalone Patient Tracking System	0%

Source: RIDOH 2015 Statewide Health Inventory

TABLE 33: NAME OF EHR/EMR, OUTPATIENT SPECIALTY, 2014

What is the name of your EMR/EHR system?	Percent
Epic	20.5%
eClinicalWorks	7.7%
GE/Centricity	5.7%
Cerner	4.3%
Greenway	3.9%
Athena	3.6%
Meditech	2.7%
Netsmart	2.3%
Harris/Optum Caretracker	2.1%
Medflow	2.1%
Unknown	3.2%
Other (30 distinct)	14.4%

Source: RIDOH 2015 Statewide Health Inventory

Regarding whether providers in their practice are currently reporting for PQRS, 41.6% indicated yes and that they will continue, 2.2% indicated yes and they will discontinue, 10.2% indicated no but they are starting in 2015, 25.6% indicated no and they have no plans to start, and 20.4% that they do not know.

TABLE 34: ARE PROVIDERS IN YOUR PRACTICE CURRENTLY REPORTING FOR PQRS?, OUTPATIENT SPECIALTY, 2014

	Percent
Yes & will continue	41.6%
No, no plans to start	25.6%
Do not know	20.4%
No, start in 2015	10.2%
Yes & discontinuing	2.2%

Source: RIDOH 2015 Statewide Health Inventory

Regarding the highest level of Meaningful Use to which any eligible provider in this practices attests, 13.2% indicated that they are not eligible, 15.1% indicated none, 16.4% indicated Medicare Stage 1, 13.8% indicated Medicare Stage 2, 0.6% indicated Medicaid AIU, 0.6% indicated Medicaid Stage 1, 0.6% indicated Medicaid Stage 2, and 39.6% indicated that they do not know.

HOSPITALS

Introduction

RIDOH licenses and regulates hospitals pursuant to the authority contained in Chapter 23-17 of the Rhode Island General Laws, as amended[22] and the related *Rules and Regulations for Licensing of Hospitals*[23]. The Rhode Island statute defines a "hospital" to mean: "a person or governmental entity licensed in accordance with this chapter to establish, maintain and operate a hospital."[24]

> "Hospital" is further defined in the aforementioned regulations to mean "a facility with a governing body, an organized medical staff and a nursing service providing equipment and services primarily for inpatient care to persons who require definitive diagnosis and treatment for injury, illness or other disabilities or pregnancy. A hospital shall provide psychiatric and/or medical and/or surgical care and at least the following services: dietetic, infection control, medical records, laboratory, pharmaceutical and radiology, except that a psychiatric facility need not provide radiology services."[25]

Rhode Island has 13 acute care hospitals as well as Eleanor Slater Hospital (state psychiatric hospital) and the Providence VA Medical Center. The 13 hospitals are Bradley Hospital, Butler Hospital, Kent Hospital, Landmark Medical Center, Memorial Hospital, Miriam Hospital, Newport Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital, Roger Williams Medical Center, South County Hospital, Westerly Hospital, and Women & Infants Hospital.

Survey Design

The Hospital survey included information about patients' primary residence location, insurance sources for patients, census and visit data for fiscal year 2014, demographics about patients, interpreter services, staffing by specialty and service category, outpatient specialty clinics and services for calendar year 2014, and information technology, in addition to other data elements. While the survey did not capture data existing through current sources, the survey was informed by the Centers for Disease Control and Prevention (CDC) "National Hospital Care Survey Facility Questionnaire" and the American Hospital Association "AHA Annual Survey of Hospitals."

Feedback from stakeholders was solicited at various stages of the survey construction. The survey was reviewed with the Hospital Association of Rhode Island, Care New England Health System, Lifespan, and South County Health for initial comments and recommendations. Feedback was given regarding how to ask about physician staffing levels, what type of interpreter data was available, and ways to align the survey with the AHA Annual Survey of Hospitals which hospitals already complete. One key change that was implemented was asking about inpatient data for fiscal year 2014 and outpatient data for calendar year 2014, which was more feasible for hospitals to provide and allowed for alignment with other outpatient data being collected. The decision was also made with the hospital stakeholders that outpatient data for hospital clinics would be captured in the Hospital survey as opposed the Outpatient Specialty Survey, as these data would be more readily available centrally for the hospitals. While all of this feedback was incorporated into the survey before it was sent out, RIDOH determined the final survey instrument.

22 "Licensing of Health Care Facilities," Chapter 23-17 of the Rhode Island General Laws, as amended. Available at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17/INDEX.HTM (Accessed October 22, 2015).

23 Rhode Island Department of Health, Rules and Regulations for Licensing of Hospitals. Last amended September 2012. Available at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7022.pdf (Accessed October 22, 2015).

24 "Licensing of Health Care Facilities," Section 23-17-2(8) of the Rhode Island General Laws, as amended. Available at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17/23-17-2.HTM (Accessed October 22, 2015).

25 Rhode Island Department of Health, Rules and Regulations for Licensing of Hospitals, Section 1.27. Last amended September 2012. Available at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7022.pdf (Accessed October 22, 2015).

The survey was designed to take two hours to input the data once the data had been collected. However, the data collection for this survey was extensive, and took several weeks.

Data Collection

In order to construct a list of hospital locations with corresponding contact information for members of the hospital administration, publicly available information from the RIDOH website was combined with contact information for Chief Executive Officers (CEO). The surveys were coded with unique links for each hospital location, and each link was sent to both the CEO and a member of the administrative staff via email. The surveys had a deadline of three weeks, with extensions granted to each hospital due to the complexity of information captured in the surveys.

Response

Of the 13 acute care hospitals, data were captured for all 13 yielding a response rate of 100%.

Note that not all respondents completed every question, or did not provide a complete response for every question, so all totals may not equal one hundred percent (100%).

Findings

Findings from the hospital inventory survey administered in August 2015 reveal the following:

STATEWIDE PATIENT VOLUME

TABLE 35: STATEWIDE PATIENT VOLUME TOTALS BY FISCAL YEAR, HOSPITALS, 2014

Service Type	2012	2013	2014
Inpatient admissions	127,756	126,578	122,013
Live births	10,138	10,293	10,869
Adult emergency dept. visits	451,341	456,425	455,189
Pediatric emergency dept. visits	64,242	62,291	61,490
Observation admissions	37,091	45,883	37,844

Source: RIDOH 2015 Statewide Health Inventory

Hospitals reported inpatient admissions, live births, adult and pediatric emergency department visits and observation admissions for fiscal years 2012 - 2014. Inpatient admissions trended downward between 2012 and 2014. Live births increased modestly each year over the same period. Adult emergency visits were the highest in 2013, but were still higher in 2014 than they were in 2012. Pediatric emergency department visits trended slightly downward each year. It is important to note that only 10 hospitals reported pediatric emergency department visits in 2012-2013 and 9 in 2014. Observation admissions were higher in 2014 than in 2012, but increased significantly in 2013.

TABLE 36: HOSPITAL PATIENT VOLUME AVERAGES BY FISCAL YEAR, HOSPITALS, 2014

Service Type	2012	2013	2014
Avg. # inpatient admissions	9,827	9,737	9,386
Avg. length of stay (days)	5.1	5.1	5.3
Avg. daily census	133	131	131
Avg. live births	780	792	836
Avg. adult emergency dept. visits	34,719	35,110	35,015
Avg. pediatric emergency dept. visits*	6,424	6,229	6,832
Avg. # observation admissions	3,091	3,530	2,911
Avg. adult ICU census	6.2	6.1	6.0

Source: RIDOH 2015 Statewide Health Inventory
*Only ten hospitals reported pediatric ED visits in 2012-2013 (nine in 2014).

The average number of inpatient admissions declined each year between 2012 and 2014. The average length of stay increased slightly from an average of 5.1 to 5.3 day. However the average patient census declined slightly from 133 to 131 patients. The average number of live births increased each year, as was indicated in the statewide patient volumes data. Hospitals averaged 34,719 adult emergency department visits in 2012, 35,110 in 2013, and 35,015 in 2014. These numbers again reflect statewide patient volume data presented above. The average number of observation admissions increased in 2013 and then declined in 2014. The average adult ICU census decreased slightly between 2012 and 2014. The average pediatric ICU census was 4.5 in 2012, reported from one hospital. The average neonatal ICU census was 66, 65, and 66 over the three year period, respectively, at one hospital.

PRINCIPAL MEDICAL INSURANCE SOURCE

TABLE 37: NUMBER OF PATIENTS BY PRINCIPAL MEDICAL INSURANCE SOURCE (FY 2014), HOSPITALS, 2014

Payment Source	Total # patients*	Percent of all patients
None/Self Pay	679	2%
Medicaid	10,589	25%
Medicare	9,237	22%
Medicare Advantage	2,483	6%
Private Insurance (Commercial)	17,858	43%
Other	696	2%
Total	**41,542**	-

Source: RIDOH 2015 Statewide Health Inventory

For hospitals reporting insurance information, the largest number of patients utilized private or commercial insurance (43%). However 25% of patients presented with Medicaid and 22% presented with Medicare as their principal insurance. Six percent of patients utilized Medicare Advantage, 2% utilized another form of insurance, and 2% were either none or self pay.

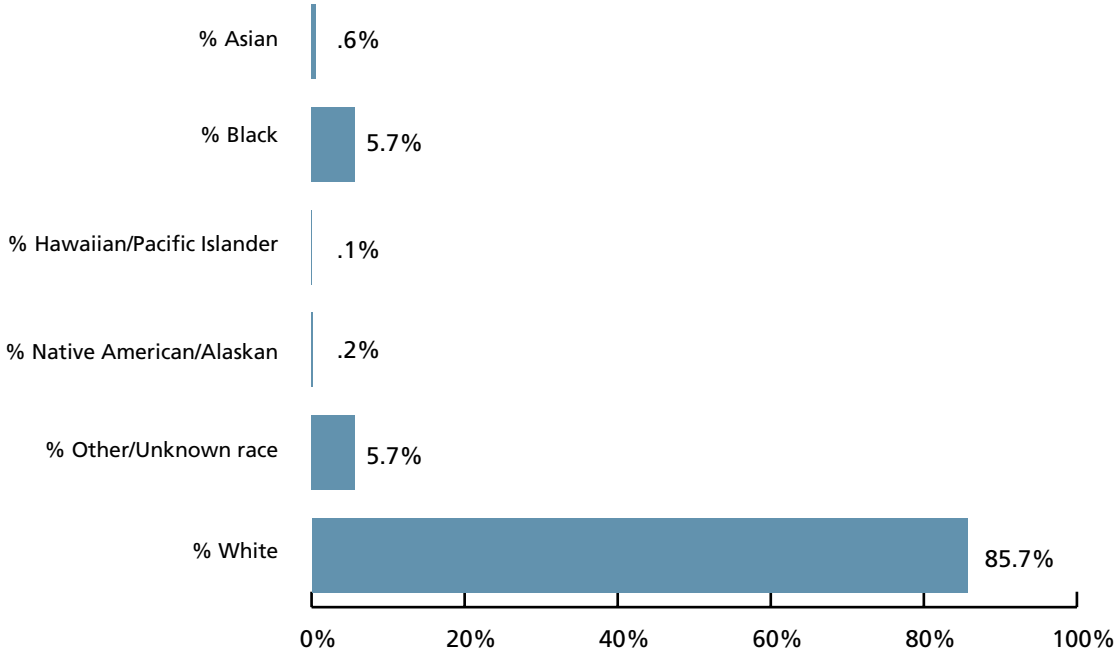
PATIENTS BILLED BASED ON A SLIDING FEE SCHEDULE

In FY 2014, 77% of hospitals reported 37,634 total patients were billed on a sliding fee schedule.

RACE/ETHNICITY

In 2014 the average percentage of patients seen by each hospital who were reported as White was 85.7%. The average percent of patients seen who were reported as Black was 5.7%. The average percent of patients who were reported as Asian was 0.6%. The average percent of patients who were reported as Hawaiian/Pacific Islander was 0.1%. The average percent who were reported as Native American/Alaskan was 0.2%. The average percent of patients who were reported as other or unknown race was 5.7%.

FIGURE 14: PERCENTAGE OF PATIENTS BY RACE, FY 2014

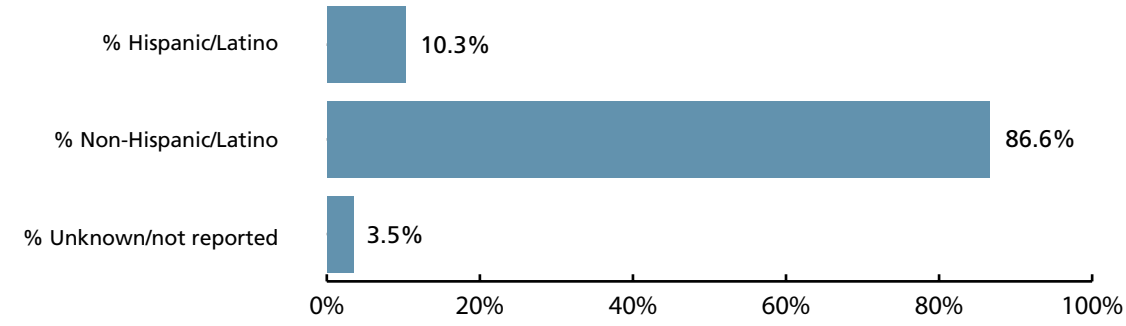


Source: RIDOH 2015 Statewide Health Inventory

PERCENTAGE OF PATIENTS BY ETHNICITY

In 2014, for hospitals 10.3% of patients were reported as Hispanic/Latino. The vast majority of patients (86.6%) were reported as Non-Hispanic/Latino, with only 3.5% of patients' ethnicity reported as unknown.

FIGURE 15: PERCENTAGE OF PATIENTS BY ETHNICITY, FY 2014



Source: RIDOH 2015 Statewide Health Inventory

INTERPRETER SERVICES

All thirteen hospitals reported they provided interpreter services for their patients. All hospitals reported interpreters are available over the phone. Nine (69.2%) used contracted interpreters when needed. Seven (53.8%) had interpreters available via video. Three (23.1%) had on-site trained interpreters, and two (15.4%) used staff not formally trained but assisting with interpreting as needed.

TABLE 38: PROVISION OF INTERPRETER SERVICES, HOSPITALS, FY 2014

	Number of Hospitals	Percent
Interpreters available over telephone	13	100.0%
Contracted interpreters, on-site as needed	9	69.2%
Interpreters available via video	7	53.8%
On-site trained interpreters	3	23.1%
Staff, who are not interpreters, interpret as needed	2	15.4%
We do not provide interpreter services	0	0%

Source: RIDOH 2015 Statewide Health Inventory

TABLE 39: NUMBER OF INTERPRETATION REQUESTS, HOSPITALS, FY 2014

Language	% of Hospitals	Total # of Requests	Average # of Requests/Hospital
Spanish	85%	67,508	6,137
French	77%	167	17
Portuguese	85%	6,660	606
Portuguese Creole	69%	217	24
French Creole	8%	6	(100% reported from 1 hospital)
Chinese	69%	405	45
Other reported:			
Cape Verdean	23%	3,383	(71% reported from 1 hospital)
Russian	8%	2,773	(100% reported from 1 hospital)
African Dialects (incl. Bambara)	15%	1,157	(95% reported from 1 hospital)
Hearing impaired/American sign	23%	271	
Haitian Creole	15%	236	

Source: RIDOH 2015 Statewide Health Inventory

Hospitals provided data on the types of interpretation requests they received. Eighty five percent of hospitals received request for Spanish or Portuguese interpretation, although requests for Spanish interpretation were ten times greater than the request for Portuguese interpretation assistance. While patients in other language groups did not request as many translation services in total, such requests were particularly concentrated at specific hospitals. Also among the hospitals reporting, there were less than 30 requests reported for Italian, Arabic, Cambodian, Laotian, and Polish interpretations. In sum, there were 82,783 requests for interpretation at hospitals in FY2014.

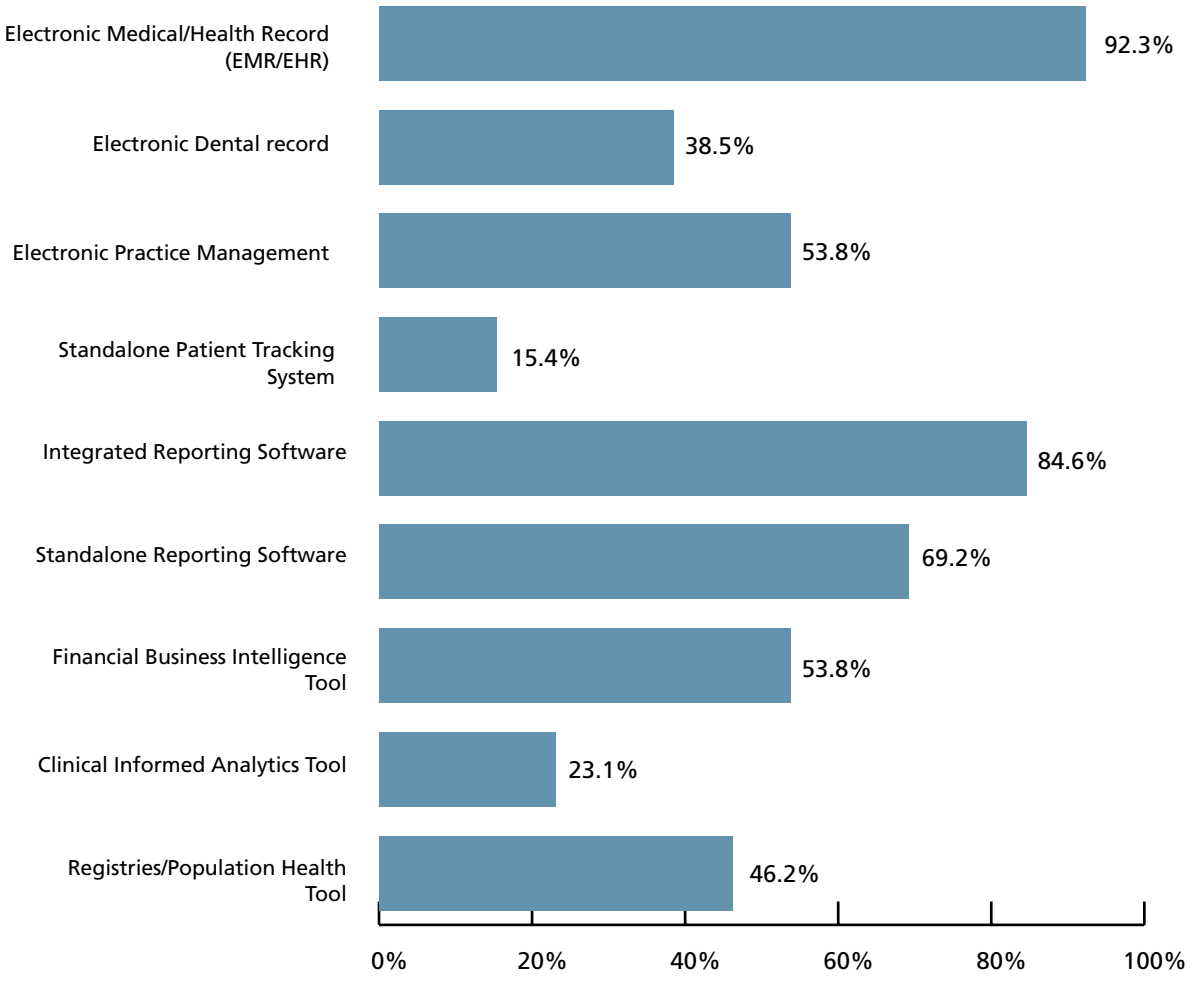
DIVERSITY AWARENESS & CULTURAL COMPETENCY TRAINING

All thirteen hospitals (100.0%) indicated that they conduct mandatory diversity awareness & cultural competency trainings. No hospital reported that it did not provide this mandatory type of training.

INFORMATION TECHNOLOGY

Hospitals were asked to identify the software used for several hospital health care/patient management functions. Hospitals were asked to indicate all programs they utilized. The majority of hospitals (92.3%) reported they used electronic medical/health records (EMR/EHR). Most (84.6%) used integrated reporting software. Sixty nine percent of hospitals used standalone reporting software. About half (53.8%) used electronic practice management, and about half (53.8%) used a financial business intelligence tool. Slightly less than half (46.2%) used a registries/population health tool. Thirty eight percent of hospitals used electronic dental records systems. About a fifth (23.1%) used a clinical informed analytics tool, and 15.4% used a standalone patient tracking system.

FIGURE 16: INFORMATION SOFTWARE USED BY HOSPITALS, HOSPITALS, 2014



Source: RIDOH 2015 Statewide Health Inventory

The top three EMRs were Epic at 30.8%, Cerner at 23.1%, and Meditech at 23.1%.

TABLE 40: NAME OF EHR/EMR, HOSPITALS, 2014

What is the name of your EMR/EHR system?	Percent
Epic	30.8%
Cerner	23.1%
Meditech	23.1%
Netsmart	7.7%
McKesson Paragon	7.7%
None	7.7%

Source: RIDOH 2015 Statewide Health Inventory

The majority of hospitals (53.9%) reported they did not know by what method providers are planning to report for PQRS in 2015. Another 30.8% indicated they would use group practice reporting. Only 7.7% of hospitals reported they would use a vendor with certified EHR technology and another 7.7% indicated they would use certified EHR technology directly.

MEANINGFUL USE

Four hospitals (30.8%) reported Medicare Stage 1 as the highest level of Meaningful Use to which any eligible provider attested, 4 (30.8%) reported Medicare Stage 2, 2 (15.4%) reported Medicaid Stage 1, 2 (15.4%) reported that they were not eligible, and 1 (7.7%) reported Medicare AIU.

TABLE 41: HIGHEST LEVEL OF MEANINGFUL USE TO WHICH ANY ELIGIBLE PROVIDER ATTESTED, HOSPITALS, 2014

	Number of Hospitals	Percent
Medicare Stage 1	4	30.8%
Medicare Stage 2	4	30.8%
Not eligible	2	15.4%
Medicaid Stage 1	2	15.4%
Medicare AIU	1	7.7%
Medicaid Stage 2	0	0%
Medicaid AIU	0	0%
None	0	0%

Source: RIDOH 2015 Statewide Health Inventory

HOSPITAL STAFFING

TABLE 42: PHYSICIAN SPECIALTY, HOSPITALS, 2014

	Employed		Non-employed (contracted)	
Physician Specialty	Total Number	Average/Hospital	Total Number	Average/Hospital
Allergy/Immunology	1	0.1	9	0.7
Anesthesia	16	1.2	136	10.5
Cardiology	121	9.3	149	11.5
Dental Services	16	1.2	35	2.6
Dermatology	4	0.3	54	4.2
Emergency Services	47	3.6	266	20.5
Endocrinology	6	0.5	37	2.8
Gastroenterology	24	1.8	127	9.8
Geriatrics	10	0.8	22	1.7
Hematology/Oncology	41	3.2	85	6.5
Infectious Disease	11	0.8	70	5.4
Internal Medicine	136	10.4	345	26.5
Nephrology	17	1.3	90	6.9
Neurology	14	1.1	84	6.5
Neurosurgery	17	1.3	23	1.8
Obstetrics/Gynecology	115	9.6	168	14.0
Ophthalmology	18	1.4	75	5.8
Orthopedics	9	0.7	230	17.7
Otolaryngology	2	0.2	55	4.2
Pathology	390	30.0	53	4.1
Plastic Surgery	18	1.4	38	2.9
Psychiatry	172	13.2	37	2.8
Pulmonology/Critical Care	17	1.3	65	5.0
Radiology	16	1.2	283	21.8
Rheumatology	7	0.5	29	2.2
Surgery	27	2.1	190	14.6
Urology	6	0.5	79	6.1

Source: RIDOH 2015 Statewide Health Inventory

Physician Specialty, Employed

The total number and average per hospital of physicians in the five categories with the highest number of reported employed physicians are as follows: the total number of employed physicians for pathology physicians is 390 with an average per hospital of 30; for psychiatry physicians is 172 with an average per hospital of 13.2; for internal medicine physicians is 136 with an average per hospital of 10.4; for cardiology physicians is 121 with an average per hospital of 9.3; for obstetrics/gynecology physicians is 115 with an average per hospital of 9.6.

The total number and average per hospital of physicians in the five categories with the lowest number of reported employed physicians are as follows: the total number of employed physicians for allergy/immunology physicians is 1 with an average per hospital of 0.1; for otolaryngology physicians is 2 with an average per hospital of 0.2; for dermatology physicians is 4 with an average per hospital of 0.3, for endocrinology physicians is 6 with an average per hospital of 0.5, and for urology physicians is 6 with an average per hospital of 0.5.

The total number of hospital employed physicians in the specialty categories totaled 1278.

Physician Specialty, Non-employed (Contracted)

The total number and average per hospital of physicians in the five categories with the highest number of reported non-employed (contracted) physicians are as follows: the total number of non-employed (contracted) physicians for internal medicine physicians is 345 with an average per hospital of 26.5; for radiology physicians is 283 with an average per hospital of 21.8; for emergency physicians is 266 with an average per hospital of 20.5; for orthopedic physicians is 230 with an average per hospital of 17.7; for obstetrics/gynecology is 168 with an average per hospital of 14.

The total number and average per hospital of physicians in the five physicians categories with the lowest number of reported non-employed (contracted) physicians are as follows: the total number of non-employed (contracted) physicians for allergy/immunology physicians is 9 with an average per hospital of 0.7; for geriatric physicians is 22 with an average per hospital of 1.7, for rheumatology physicians is 29 with an average per hospital of 2.2, for dental physicians is 35 with an average per hospital of 2.6, for endocrinology physicians is 37 with an average per hospital of 2.8.

The total number of hospital contracted physicians in the specialty categories totaled 2834.

TABLE 43: STAFF PROFESSIONALS, HOSPITALS, 2014

	Employed		Non-employed (contracted)	
Staff Professionals	Total Number	Average/Hospital	Total Number	Average/Hospital
Advance practice registered nurse	473	36.3	11	0.8
Dietary	590	45.3	25	1.9
Nursing	5,858	450.6	9	0.6
Occupational therapy	53	4.3	6	0.5
Pharmacy	420	32.3	0	0.0
Physician assistants	95	7.3	13	1.0
Physical therapy	139	11.5	13	1.1
Podiatry	13	1.0	0	0.0
Respiratory therapy	287	22.1	0	0.0
Speech/language pathology	14	1.2	7	0.6

Source: RIDOH 2015 Statewide Health Inventory

Staff Expertise, Employed

The total number of reported employees for the staff expertise category of advance practice registered nurses is 473 with an average per hospital of 36.3; for dietary it is 590 with an average per hospital of 45.3; for nursing is 5,858 with an average per hospital of 450.6; for occupational therapy it is 53 with an average per hospital of 4.3; for pharmacy it is 420 with an average per hospital of 32.3; for physician assistants it is 95 with an average per hospital of 7.3; for physical therapy it is 139 with an average per hospital of 11.5; for podiatry it is 13 with an average per hospital of 1.0; for respiratory therapy it is 287 with an average per hospital of 22.1; and for speech and language pathology it is 14 with an average per hospital of 1.2.

Staff Expertise, Non-employed (Contracted)

The total number of reported non-employed or contracted individuals in the staff expertise category of advance practice registered nurses is 11 with an average per hospital of 0.8; for dietary it is 25 with an average per hospital of 1.9; for nursing it is 9 with an average per hospital of 0.6; for occupational therapy it is 6 with an average per hospital of 0.5; for physician assistants it is 13 with an average per hospital of 1.0; for physical therapy it is 13 with an average per hospital of 1.1; and for speech and language pathology it is 7 with an average per hospital of 0.6. There were no reported contracted staff of pharmacy, respiratory therapy, and podiatry.

ROBOTICS USE IN HOSPITALS

TABLE 44: ROBOTICS, HOSPITALS, 2014

FIVE OF 13 HOSPITALS (38%) REPORTED PERFORMING ROBOT-ASSISTED SURGERY.

	Type of Surgery	Type of Robot	Number of Robots	Number of Surgeries
Rhode Island Hospital	GYN	Intuitive/da Vinci	1	90
Miriam Hospital	Urology	Intuitive/da Vinci	1	202
Woman & Infants Hospital	Hysterectomy	Intuitive/da Vinci	2	408
Kent Hospital	GYN, Urology, Gall Bladder removal	Intuitive/da Vinci	1	169
South County Hospital	Unicondylar knee arthroplasty	RIO Orthopedic System	3	443
Total			**8**	**1312**

Source: RIDOH 2015 Statewide Health Inventory

Five hospitals reported performing robot-assisted surgery. Rhode Island Hospital used an Intuitive/da Vinci robot on 90 total surgeries in Gynecology. Miriam Hospital used an Intuitive/da Vinci robot on 202 total surgeries in Urology. Women & Infants Hospital used two Intuitive/da Vinci robots on 408 total hysterectomy surgeries. Kent Hospital reported using an Intuitive/da Vinci robot on 169 total surgeries in Gynecology, Urology, and gall bladder removal. South County Hospital performed 443 unicondylar knee surgeries with three RIO Orthopedic System robots.

LONG-TERM CARE

Nursing Facilities

Introduction

Nursing facilities ("nursing homes") in Rhode Island are regulated by DOH under the legal authority contained in RIGL Chapter 23-17 ("Licensing of Health Care Facilities") and the related *Rules and Regulations for Licensing of Nursing Facilities* (R23-17-NF).[26]

Section 1.31 of the *Rules and Regulations for Licensing of Nursing Facilities* defines "nursing facility" as:

> "…a licensed health care facility or an identifiable unit or distinct part thereof, however named, that provides twenty-four (24) hour inpatient and residential nursing, therapeutic, restorative or preventive and supportive nursing care services for two (2) or more residents unrelated by blood or marriage whose assessed health condition requires continuous nursing care and supervision. Resident services shall be based on person-centered principles, however named, that enhance a resident's quality of life by ensuring the nexus of control in the living environment is resident-directed, puts the emphasis on resident autonomy and individual choices, facilitates communication and mutual respect among the residents and staff, and meets the requirements of these Regulations."[27]

Survey Design

The Nursing Facility survey was written to capture information about insurance sources for patients, census in calendar year 2014, waiting list, demographics about patients, interpreter services, staffing per service category, consultative services, diagnostic testing, interventions available, and information technology, in addition to other data elements. The survey was informed by the CDC "2004 National Nursing Home Survey Facility Questionnaire" and the "Healthcare Quality Reporting Program - Nursing Home Information" survey conducted by the Rhode Island Department of Health.

Feedback was solicited from stakeholders at several stages. The project was presented to the Nursing Home Subcommittee of the Healthcare Quality Reporting Program. The survey was additionally reviewed with LeadingAge RI and the Rhode Island Health Care Association for initial comments and recommendations. Feedback was received and implemented regarding the types of staffing, the services offered, and the phrasing of questions for nursing facilities in Rhode Island. While all of this feedback was incorporated into the survey before it was sent out, RIDOH determined the final survey instrument.

The survey was designed to take one hour to complete once data had been collected, and per the respondents having completed the survey, they reported it took from one to five hours to finish including data collection.

Data Collection

Publicly available licensure data for nursing facilities was obtained from the RIDOH website. The licensure database contained the names of 90 nursing facilities and their addresses, phone numbers, and fax numbers. In order to obtain the administrators' emails, one of our interns called each facility one to three times over the course of two weeks using the information provided by the licensure list. Each nursing facility was given three weeks to complete the survey and received one to three calls for follow up.

26 Rhode Island Secretary of State. Available at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7613.pdf Last amended December 2013. (Accessed October 9, 2015).
27 Rhode Island Department of Health, Rules and Regulations for Licensing of Nursing Facilities (R23-17-NF), Last amended December 2013 (T). Available at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7613.pdf (Accessed October 9, 2015).

Response

There were a total of 90 licensed nursing homes in Rhode Island in 2014. Completed surveys were received for 90 nursing facilities, yielding a response rate of 100%.

Note that not all respondents completed every question, or did not provide a complete response for every question, so all totals may not equal one hundred percent (100%).

Findings

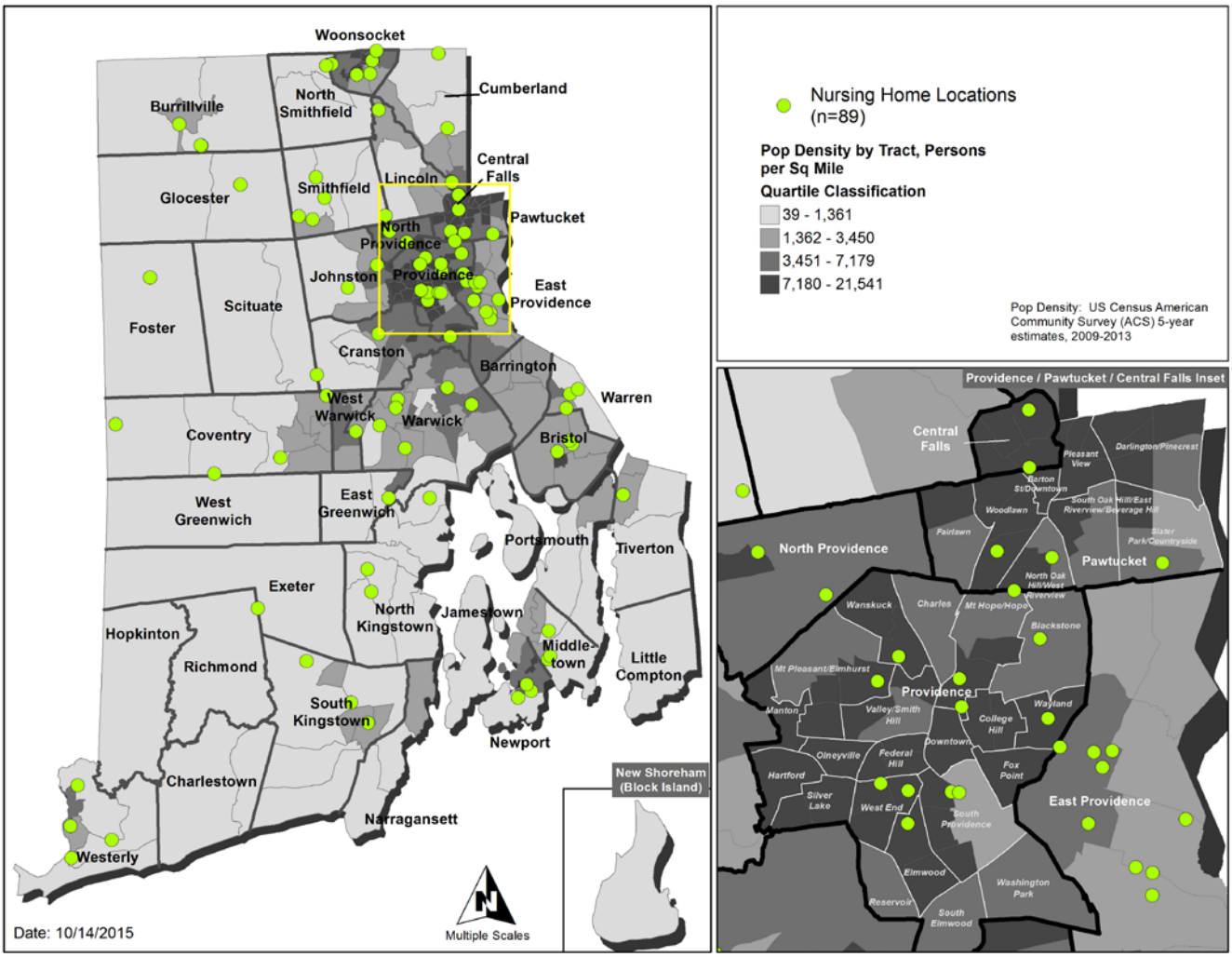
Findings from the nursing home inventory administered by RIDOH in June 2015 reveal the following:

OWNERSHIP

Almost half (47%) are operated by a parent organization with ownership controlled off-site.

The Figure depicts the geographic distribution of nursing home locations overlaying population density distributions.

FIGURE 17: NURSING HOMES BY GEOGRAPHICAL LOCATION, 2014



Source: RIDOH 2015 Statewide Health Inventory

Among the 90 facilities responding, there was a total of 8,004 persons residing in Rhode Island nursing facilities, with an average quarterly census of 94 residents per facility in 2014.

NEW PATIENTS

Almost all of the respondents (99%) indicated that new residents are accepted and 93% indicated that potential new residents with Medicaid benefits would be accepted.

TABLE 45: ACCEPTING NEW PATIENTS BY TYPE, NURSING HOMES, 2014

		Percent of Nursing Homes
Accepting New Patients		
	Yes	99%
	No	1%
Accepting New Medicaid Patients		
	Yes	93%
	No	6%

Source: RIDOH 2015 Statewide Health Inventory

WAITING LIST

Of all the survey respondents, a majority (63%) reported no waiting lists. Thirty-three (37%) of the facilities reported a waiting list. The average number of residents on a waiting list was reported to be 37 (range was two to 415 residents). The range in wait times was between two and 104 weeks, with the average wait time being 26.5 weeks.

LANGUAGE

The majority of respondents (57%) did not collect information on whether their residents require health information in a language other than English (see below).

TABLE 46: DO FACILITIES COLLECT DATA ON WHETHER PARTICIPANTS NEED HEALTH INFORMATION IN A LANGUAGE OTHER THAN ENGLISH?

	# of Homes	Percent
No	51	57%
Yes	38	43%

Source: RIDOH 2015 Statewide Health Inventory

On a related language issue, provision of interpreter services, the majority (69%) of nursing homes reported using staff not formally trained but assisted with interpreting as needed. Twenty-eight percent (28%) indicated that the facility contracts with trained interpreters, on-site and as needed. Approximately seven percent (7%) indicated that their facility does not provide interpreter services of any kind. (See Table).

TABLE 47: PROVISION OF INTERPRETER SERVICES, NURSING HOMES, 2014

	Percent
Staff, who are not interpreters, interpret as needed	68.5%
Contracted interpreters, on-site as needed	28.1%
Interpreters available over telephone	22.5%
Do not provide interpreter services	6.7%
I do not know	2.2%
Interpreters available via video	1.1%

Source: RIDOH 2015 Statewide Health Inventory

RACE/ETHNICITY

Among the 61% of facilities that reported demographic data, it was reported that only four percent (4%) of nursing home residents were of Hispanic or Latino ethnicity. Additional survey results reflect the following demographic profile:

TABLE 48: RACIAL CHARACTERISTICS OF NURSING HOME RESIDENTS

Race	Percent
White	89%
Black	4%
Asian	1%
Unknown	4%

Source: RIDOH 2015 Statewide Health Inventory

FAMILY ADVISORY COUNCIL & RESIDENT-DIRECTED HOMES

The majority (69%) of nursing facilities that responded to the survey indicated that they have a family advisory council that meets regularly. Interestingly, 93% of the nursing facilities reported that "culture change" goals that focus on "person-centered"[28] values and practices have been established.

TABLE 49: HAS YOUR FACILITY SET GOALS FOR CULTURE CHANGE-PERSON-DIRECTED VALUES & PRACTICES?

	Percent
Yes	93%
No	7%

Source: RIDOH 2015 Statewide Health Inventory

ACCREDITATION

Only 12% of Rhode Island nursing homes are accredited by the Joint Commission. An additional 8% are accredited by other national accrediting bodies. A total of 68 facilities (or 76%) report no accreditation status with an accrediting body.

TABLE 50: NURSING FACILITIES BY ACCREDITATION STATUS, 2014

	Percent
No/Not Accredited	76%
The Joint Commission	12%
Other Organization	6%
Accreditation Commission for Healthcare	1%
National Committee for Quality Assurance	1%
Healthcare Facilities Accreditation Program	0%

Source: RIDOH 2015 Statewide Health Inventory

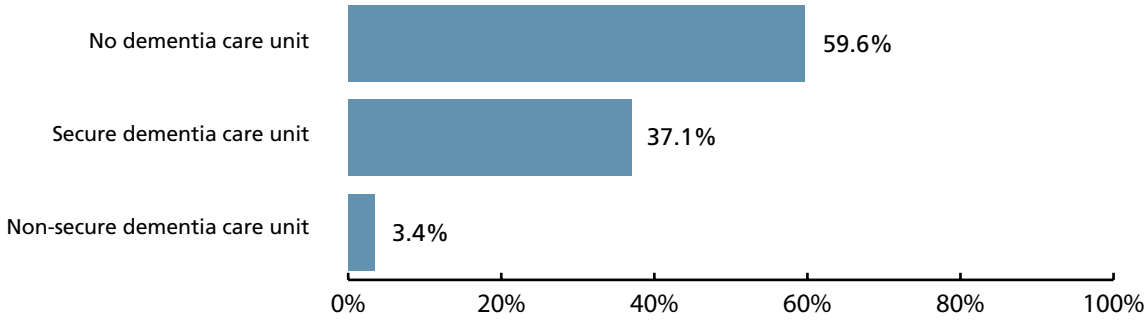
28 Rhode Island DOH defines this term in regulation as, "a holistic model that takes into consideration each resident's physical, mental, and social needs in the development of a care and treatment plan and the delivery of services that is driven to the greatest extent possible by resident choice." See: Rhode Island Department of Health, Rules and Regulations for Licensing of Nursing Facilities (R23-17-NF) at section 1.35. Available at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7613.pdf (Accessed October 9, 2015).

PERSONNEL STAFFING

Nursing facilities are staffed by nurses (mean number of FTEs per facility is 17 and the sum is 1,246); Certified Nursing Assistants (CNAs) (mean number of FTEs per facility is 45 and the sum is 3,225); dietary staff (mean number of FTEs per facility is 13 and the sum is 869); care coordinators (mean number of FTEs per facility is 1 and the sum is 63); housekeeping staff (mean number of FTEs per facility is 8 and the sum is 502); activities staff (mean number of FTEs per facility is 4 and the sum is 317); patient support staff (mean number of FTEs per facility is 4 and the sum is 304); maintenance staff (mean number of FTEs per facility is 3 and the sum is 200); physical therapists (mean number of FTEs per facility is 3 and the sum is 130); and licensed social workers (mean number of FTEs per facility is 1 and the sum is 96).

DEMENTIA CARE UNITS

FIGURE 18: NURSING FACILITIES WITH DEMENTIA CARE UNITS, 2014

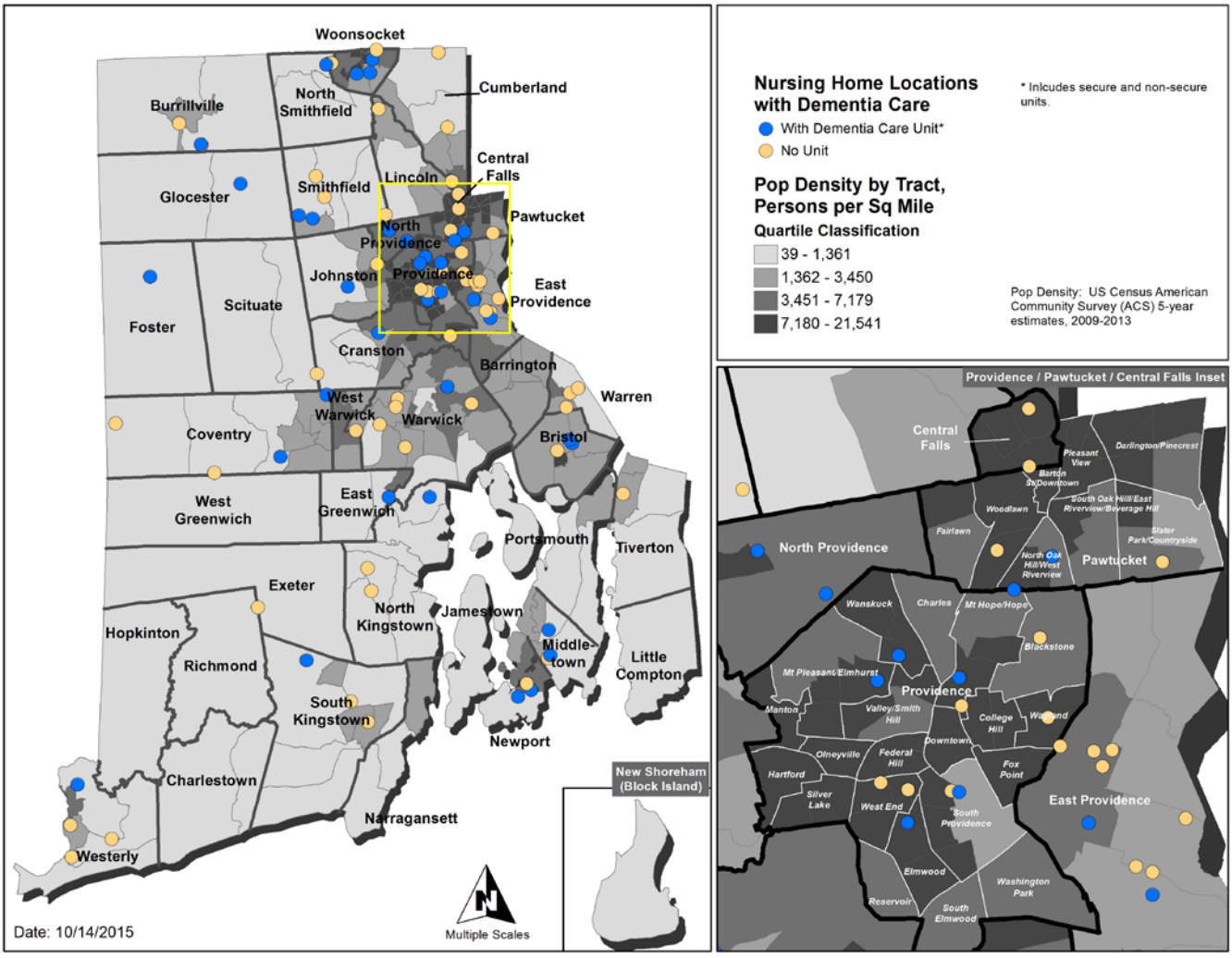


Source: RIDOH 2015 Statewide Health Inventory

Over half of the nursing facilities (60%) indicated that they do not have a dementia care unit. Of the facilities with dementia care units, 37% indicated that they have secure units, while three percent (3%) indicated that they have non-secure units (see above).

The Figure depicts the geographic distribution of nursing home locations with dementia care units overlaying population density distributions.

FIGURE 19: NURSING HOMES WITH DEMENTIA CARE UNITS BY GEOGRAPHICAL LOCATION, 2014

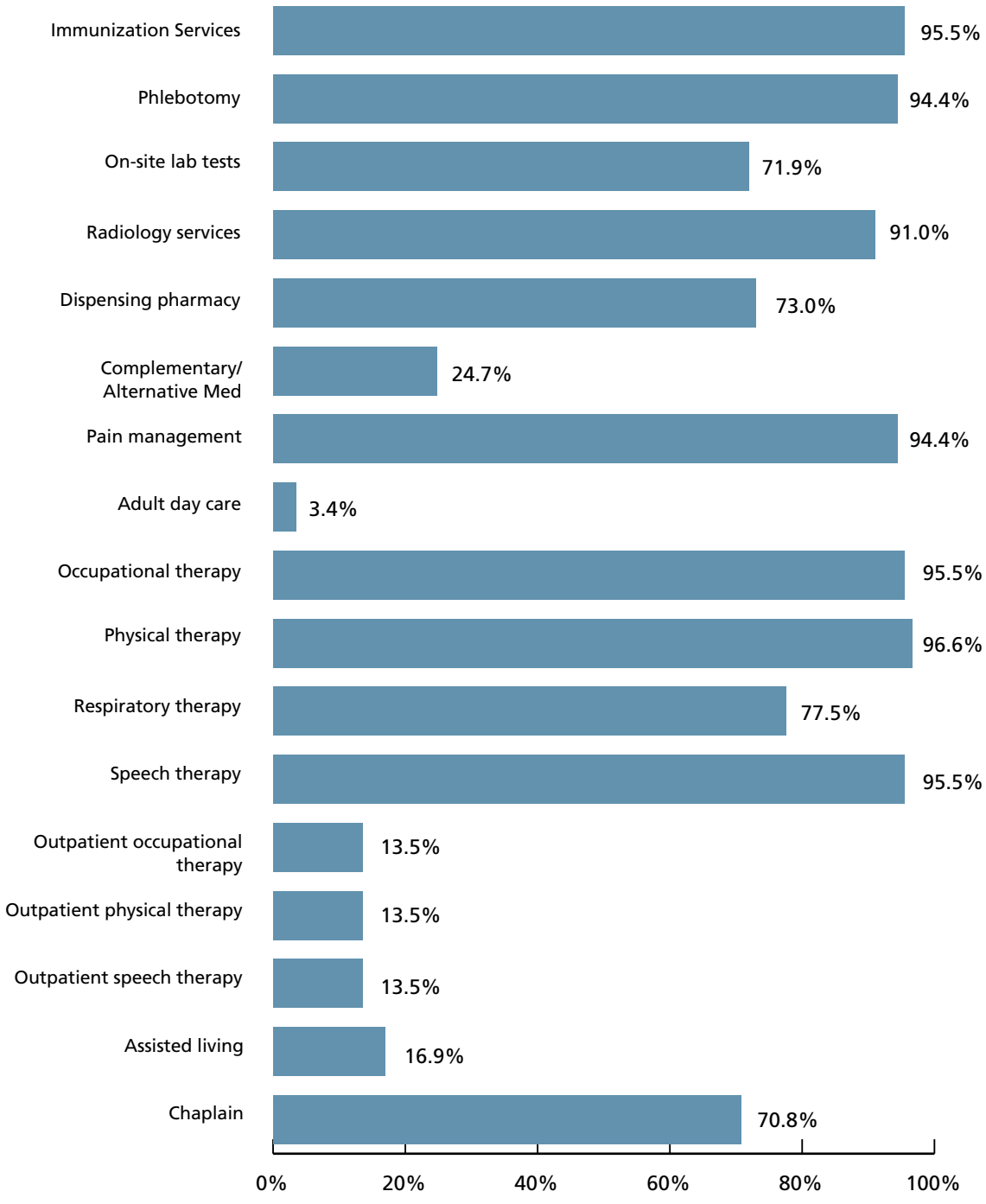


Source: RIDOH 2015 Statewide Health Inventory

PROVISION OF HEALTH SERVICES

Almost all nursing homes (96%) indicated that they offer immunization services and other health services, either by onsite staff or via contract (see Figure). Radiology was provided at 91.0% of nursing homes. Speech therapy, occupational therapy, and physical therapy were provided in over 95% of nursing facilities. Also of note is that 25% offer complementary/alternative medicine services.

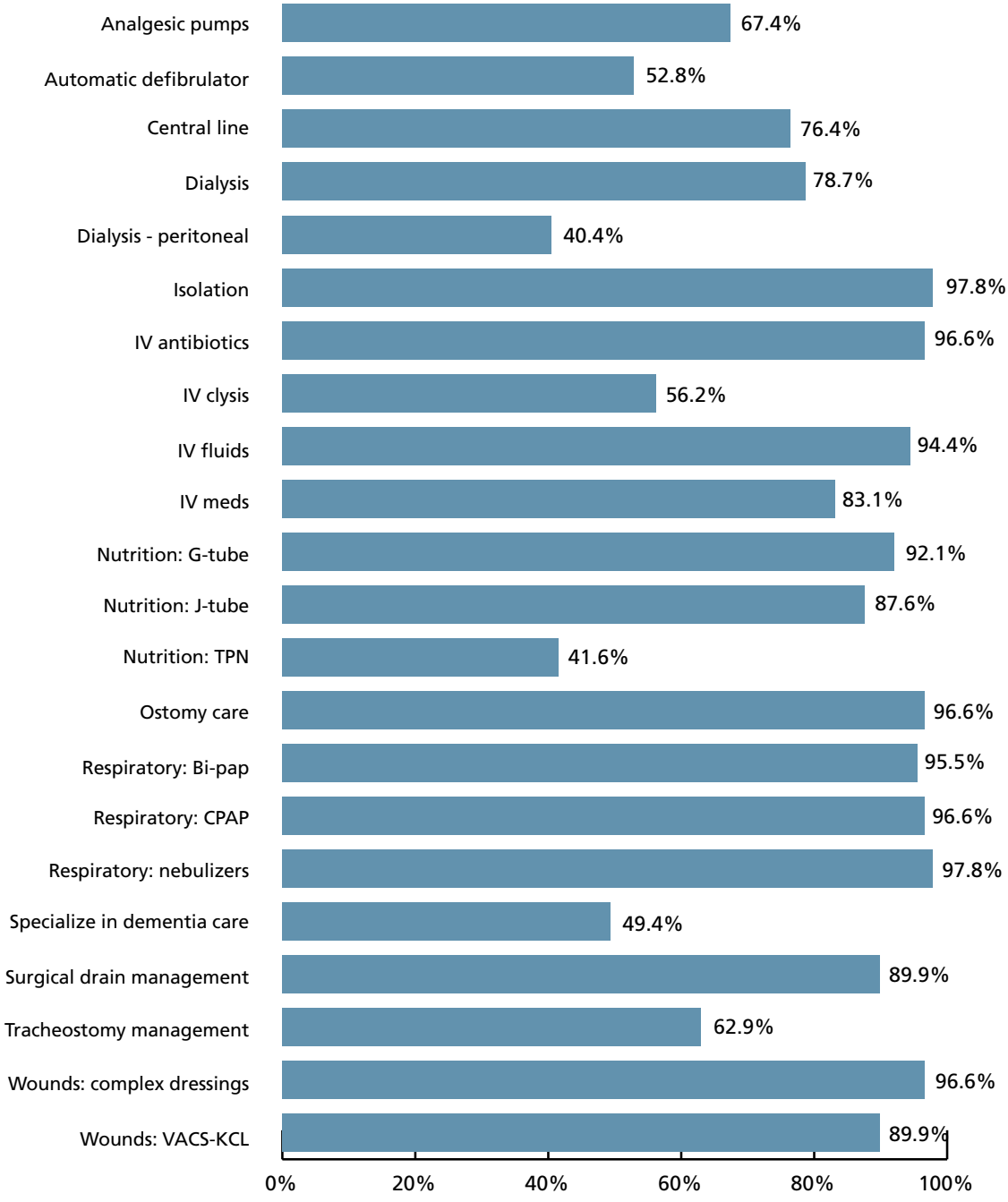
FIGURE 20: PROVISION OF HEALTH SERVICES IN NURSING FACILITIES, 2014



Source: RIDOH 2015 Statewide Health Inventory

Additionally, nursing facilities reported providing diagnostic testing, such as regular lab testing (97%); services, such as daily weights (100%); and intervention services, such as isolation precautions (98%). Sixty nine percent indicated that they have a competency-based infection control training program and 31% indicated that they do not have such a training program.

FIGURE 21: PROVISION OF HEALTH SERVICES IN NURSING FACILITIES, 2014



Source: RIDOH 2015 Statewide Health Inventory

INFORMATION TECHNOLOGY

In nursing homes, 81% reporting having EMRs. Additionally, 23% report plans for installing a new EMR record system within the next 18 months, and 23% reported the use of a stand-alone pharmacy management system.

TABLE 51: INFORMATION SOFTWARE USED BY NURSING FACILITIES, 2014

	Percent
Electronic Medical/Health Record (EMR/EHR)	81%
Electronic Practice Management	29%
Integrated Reporting Software	26%
Clinical Informed Analytics Tool	24%
Standalone Pharmacy Management System	23%
Standalone Reporting Software	12%
None	7%
Registries/Population Health Tool	3%
Electronic Dental Record	0%

Source: RIDOH 2015 Statewide Health Inventory

Assisted Living Residences

Introduction

Assisted living residences (ALRs) in Rhode Island are also regulated by RIDOH under the legal authority contained in RIGL Chapter 23-17.4 and the related Rules and Regulations for Licensing Assisted Living Residences (R23-17.4-ALR).[29] It is important to note that ALRs are not licensed as health care facilities under the provisions of Chapter 23-17 RIGL. As such, ALRs are not subject to some of the more stringent health care facility requirements (e.g., immunization and testing of health care workers) as are the 14 categories of health care facilities defined in Chapter 23-17 RIGL.

In the statute, an ALR is defined as:

> "Assisted living residence" means a publicly or privately operated residence that provides directly or indirectly by means of contracts or arrangements personal assistance and may include the delivery of limited health services, as defined under subdivision 23-17.4-2(12), to meet the resident's changing needs and preferences, lodging, and meals to six (6) or more adults who are unrelated to the licensee or administrator, excluding however, any privately operated establishment or facility licensed pursuant to chapter 17 of this title, and those facilities licensed by or under the jurisdiction of the department of behavioral healthcare developmental disabilities, and hospitals, the department of children, youth, and families, or any other state agency. The department shall develop levels of licensure for assisted living residences within this definition as provided in § 23-17.4-6. Assisted living residences include sheltered care homes, and board and care residences or any other entity by any other name providing the services listed in this subdivision which meet the definition of assisted living residences.[30]

Over the last several years, Rhode Island has amended the aforementioned ALR authorizing statute and regulations to enable those residences that qualify to provide a broader range of services, many of which are covered by Medicaid.

29 Rhode Island Secretary of State. Available at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7999.pdf. Last amended May 2015. (Accessed October 7, 2015).
30 RIGL section 23-17.4-2(4). Available at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.4/23-17.4-2.HTM (Accessed October 8, 2015).

Survey Design

The Assisted Living Residence survey was constructed to capture data about insurance sources for residents, number of residents in communities in calendar year 2014, waiting list, demographics about residents, interpreter services, staffing per service category, services available, and information technology, in addition to other data elements. The survey was informed by the CDC National Study of Long-Term Care Providers "2014 Residential Care Community Questionnaire."

Feedback was solicited from stakeholders at several points during survey construction. The survey was reviewed with the Rhode Island Assisted Living Association (RIALA) and LeadingAge RI for initial comments and recommendations. Feedback was received and implemented regarding the most appropriate language to use in describing staffing and services in assisted living communities, the types of services offered, and insurance sources for residents. While all of this feedback was incorporated into the survey before it was sent out, RIDOH determined the final survey instrument. The survey was designed to take one hour to complete once data had been collected, and per the respondents having completed the survey, they reported it took from 15 minutes to two hours to finish including data collection.

Data Collection

Publicly available licensure data for ALRs was obtained from the RIDOH website. The licensure database contained the names of 62 ALRs as well as their addresses, phone numbers, and fax numbers. In order to obtain the administrators' email addresses, one of our interns called each center one to four times over the course of one week using the information provided by the licensure list. Each assisted living community was given three weeks to complete the survey and received two to six phone calls as follow up. The RIDOH team also collaborated with RIALA in following up with ALRs that had not yet completed the survey.

Response

There are a total of 62 licensed ALRs in Rhode Island. Completed surveys were received from 59 of the 62 assisted living residences, yielding a response rate of 95%.

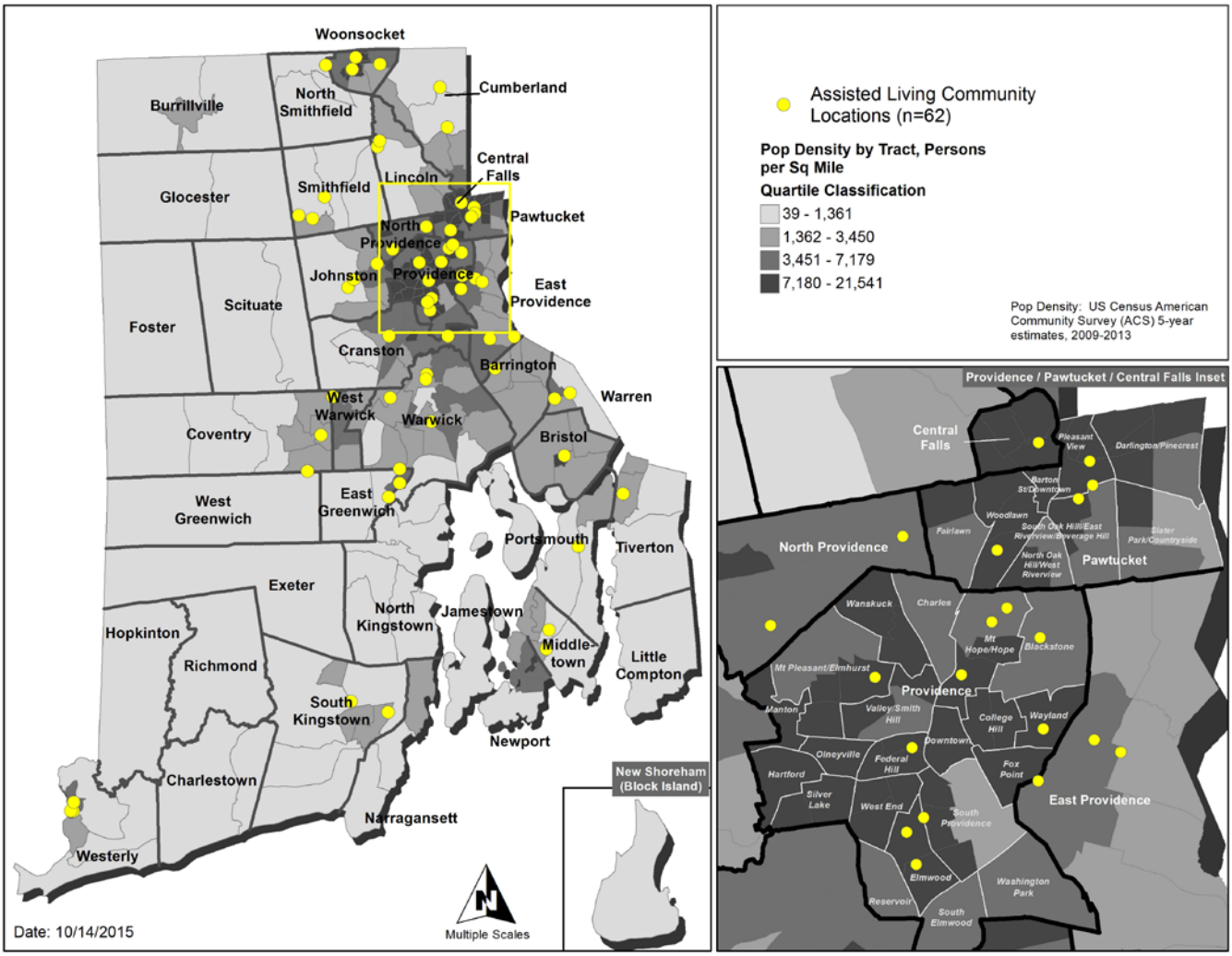
Note that not all respondents completed every question, or did not provide a complete response for every question, so all totals may not equal one hundred percent (100%).

Findings

Findings from the ALR survey administered by DOH in July 2015 reveal the following:

The Figure depicts the geographic distribution of assisted living residence locations overlaying population density distributions.

FIGURE 22: ASSISTED LIVING RESIDENCES BY GEOGRAPHICAL LOCATION, 2014



Source: RIDOH 2015 Statewide Health Inventory

Among the 59 residences responding, there was a total of 4,089 persons residing in these establishments, with 71 average residents per residence.

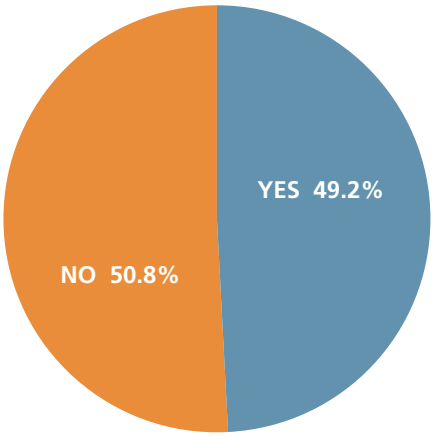
OWNERSHIP

The majority (52%) are independently operated and are not part of a larger organization with ownership controlled off-site.

NEW PATIENTS

All of the respondents (100%) generally indicated that new residents are accepted. However, 51% indicated that new residents with Medicaid benefits would not be accepted.

FIGURE 22: ACCEPTING NEW MEDICAID RESIDENTS, ASSISTED LIVING RESIDENCES, 2014



Source: RIDOH 2015 Statewide Health Inventory

WAITING LISTS

Of all the survey respondents, the majority (64%) reported no waiting lists. Twenty-one residences (36%) reported a waiting list, with an average wait time of 24 to 30 weeks.

PUBLIC TRANSPORTATION

Public transportation is widely available to these ALRs, with 86% of the residences indicating that public transportation is available to their residents.

RACE/ETHNICITY

Among the residences that reported demographic data (67%), survey results reflect the following resident demographic profile:

TABLE 52: RACE OF ASSISTED LIVING RESIDENTS, 2014

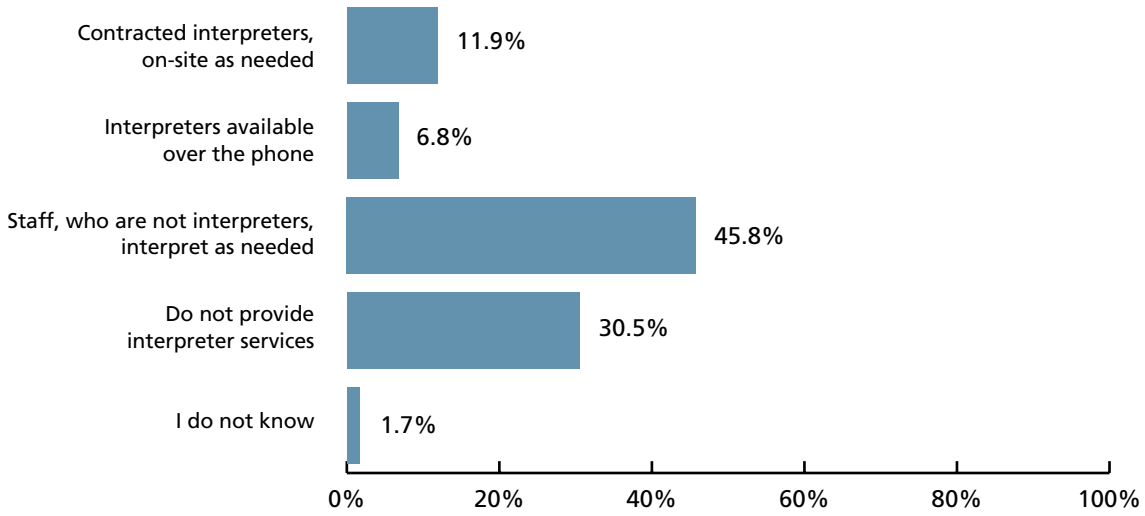
Race	Percent %
White	95
Black	5
Asian	<1
Total	100

Source: RIDOH 2015 Statewide Health Inventory

LANGUAGE

Related to the provision of interpreter services, 47% of ALRs reported using staff not formally trained but assisting with interpreting as needed. Only 12% indicated that they contract with trained interpreters, on-site as needed. Approximately 31% indicated that their ALR did not provide interpreter services of any kind. (See Figure 23).

FIGURE 23: PROVISION OF INTERPRETER SERVICES IN ASSISTED LIVING, 2014



Source: RIDOH 2015 Statewide Health Inventory

PERSONNEL STAFFING

Below is a summary of personnel staffing among the ALRs responding to the survey:

TABLE 53: PERSONNEL TYPES EMPLOYED IN ASSISTED LIVING RESIDENCES, 2014

Personnel Type	% Respondents who responded "yes" when asked if they have this personnel type at their residence
Administrator	100%
Registered Nurse (RN)	97%
Licensed Practical Nurse (LPN)	65%
Certified Nursing Assistant (CNA)	96%
Certified Nursing Assistant & Medication Technician	95%
Personal Care Attendants	53%
Activities Staff	93%
Housekeeping	91%
Transportation	83%
Office Manager	78%
Receptionist	61%

Source: RIDOH 2015 Statewide Health Inventory

DEMENTIA CARE UNITS

Interestingly, over half of the ALRs (52%) indicated that they do not have a dementia care unit. Of the residences with dementia care units, 43% indicated that they have secure units, while three percent (3%) indicated that they have non-secure units.

TABLE 54: ALRS WITH DEMENTIA CARE UNITS

	Percent
No dementia care unit	52%
Secure dementia care unit	43%
Non-secure dementia care unit	3%

Source: RIDOH 2015 Statewide Health Inventory

INFORMATION TECHNOLOGY

Similar to adult day care programs, the use of information software or EMRs by ALRs is moderately low, with 48% reporting no use of information software. Only 14 programs (24%) report the use of an EMR. Three percent (3%) reported the use of a registries/population health tool.

TABLE 55: INFORMATION SOFTWARE USED BY ASSISTED LIVING RESIDENCES, 2014

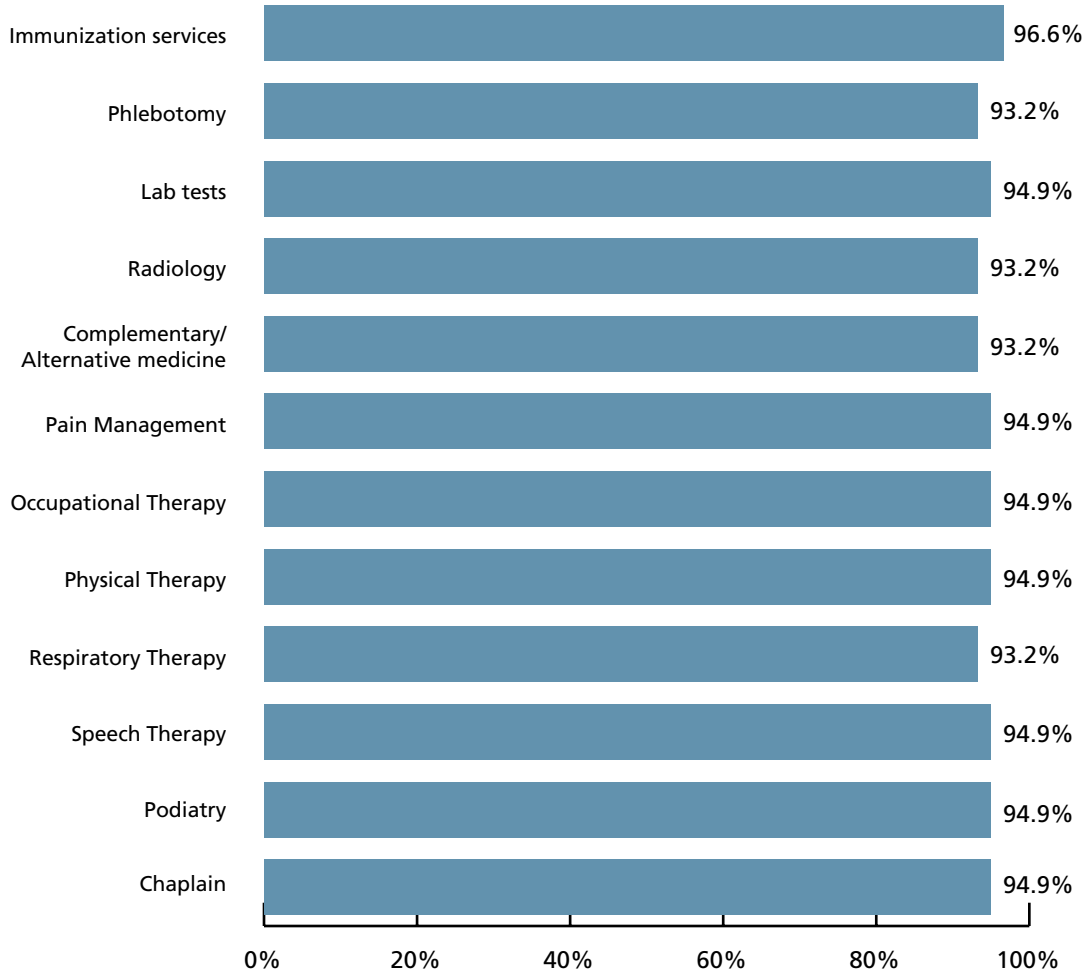
Type of Software	Percent
None/Not applicable	48%
Electronic Medical/Health Record (EMR/EHR)	24%
Standalone reporting software	14%
Integrated reporting software	7%
Electronic practice management	5%
Registries/population health tool	3%
Clinical informed analytics tool	2%

Source: RIDOH 2015 Statewide Health Inventory

PROVISION OF HEALTH SERVICES

Almost all ALRs (97%) indicated that they offer immunization services and other health services, either by onsite staff or via contract. Of note, all listed services were provided by greater than 93% of ALRs.

FIGURE 24: PROVISION OF HEALTH SERVICES IN ASSISTED LIVING RESIDENCES, 2014



Source: RIDOH 2015 Statewide Health Inventory

Adult Day Care Programs

Introduction

Since November 2008, adult day care programs in Rhode Island have been licensed and regulated by the Rhode Island Department of Health (DOH) under the legal authority contained in section 23-1-52 of the Rhode Island General Laws, as amended (RIGL) and the related Rules and Regulations for Licensing Adult Day Care Programs (R23-1-52-ADP).[31] DOH defines the prevailing standards for licensed adult day care programs in Rhode Island. Prior to this date, the Rhode Island Department of Elderly Affairs (now a division within the Rhode Island Department of Human Services) provided regulatory oversight for Rhode Island adult day care programs.

An "adult day care program" is "a comprehensive, nonresidential program designed to address the biological, psychological, and social needs of adults through individual plans of care that incorporate, as needed, a variety of health, social and related support services in a protective setting."[32] Adult day care programs provide a limited array of health care services, companionship, and socialization to persons who are generally over the age of 55 years who need assistance or supervision during the day. These programs are designed to delay or prevent institutionalization of an older person.

Survey Design

The Adult Day Care Program survey was written to capture information about insurance sources for participants, number of participants in the program in calendar year 2014, waiting list, demographics about participants, interpreter services, staffing per service category, services available, and information technology, in addition to other data elements. The survey was informed by New York State Department of Health "Adult Day Health Care Program Survey Report" as well as stakeholder feedback.

The survey was reviewed with LeadingAge RI and feedback was received regarding the services provided in adult day care programs and the use of information technology. While all of this feedback was incorporated into the survey before it was sent out, RIDOH determined the final survey instrument. The survey was designed to take one hour to complete once data had been collected, and per the respondents having completed the survey, they reported it took from 30 minutes to three hours to finish including data collection.

Data Collection

Publicly available licensure data for adult day care programs was obtained from the RIDOH website. The licensure database contained the names of 27 adult day care programs, and their addresses, phone numbers, and fax numbers. In order to obtain the administrators' email addresses, one of our interns called each program one to three times over the course of one week using the information provided by the licensure list. Each adult day care program was given two weeks to complete the survey and received one to five phone calls for follow up.

Response

There were a total of 27 licensed adult day care programs in Rhode Island in 2014. Completed surveys were received for 26 out of these 27, yielding a response rate of 96%.

Note that not all respondents completed every question, or did not provide a complete response for every question, so all totals may not equal one hundred percent (100%).

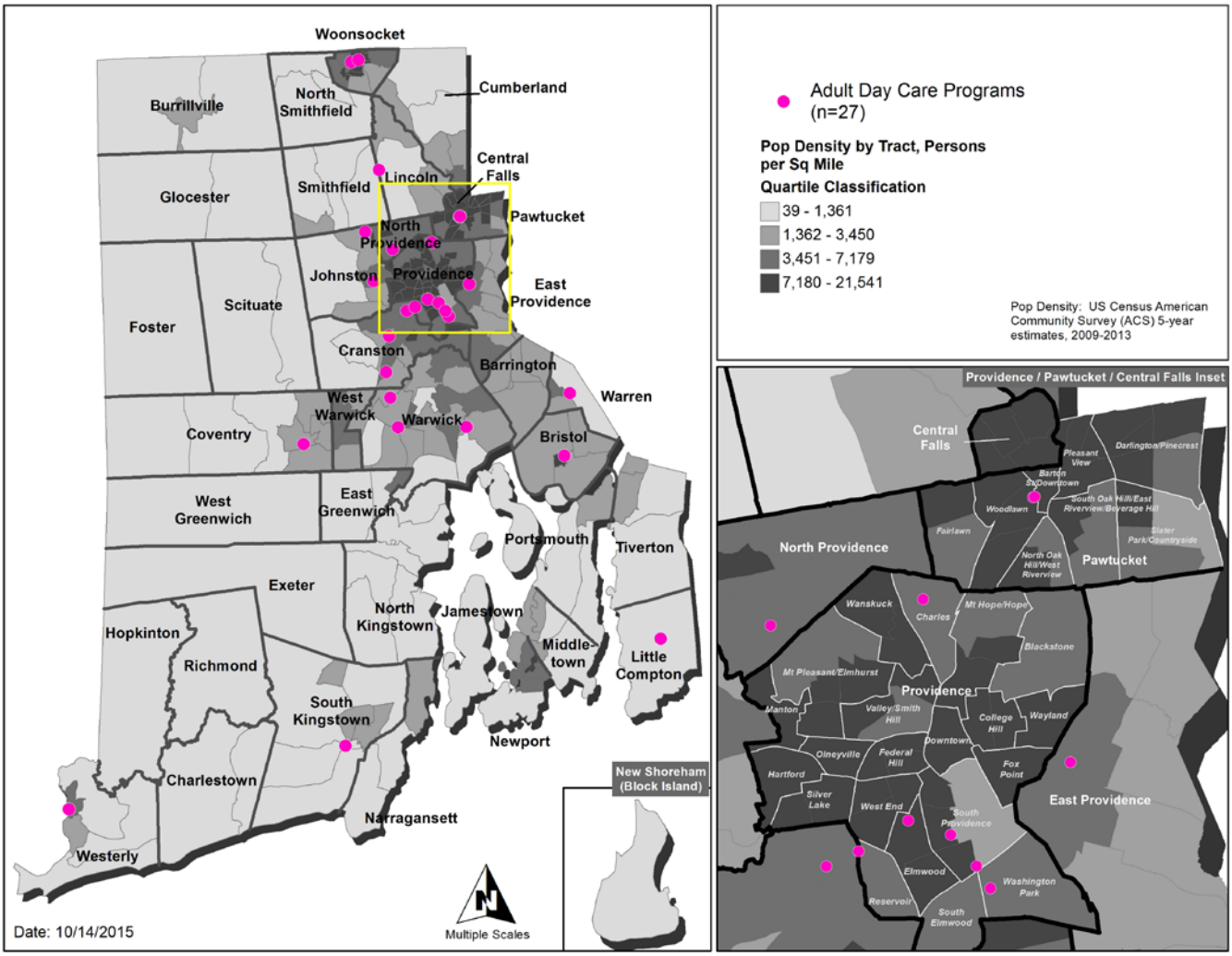
Findings

Findings from the adult day care survey administered by RIDOH in August 2015 reveal the following:

31 Rhode Island Secretary of State. Available at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/5333.pdf (Accessed October 7, 2015).
32 Rhode Island Department of Health, Rules and Regulations for Licensing Adult Day Care Programs (R23-1-52-ADP), section1.1. Available at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/5333.pdf (Accessed October 9, 2015).

The Figure depicts the geographic distribution of adult day care program locations overlaying population density distributions.

FIGURE 25: ADULT DAY CARE PROGRAMS BY GEOGRAPHICAL LOCATION, 2014



Source: RIDOH 2015 Statewide Health Inventory

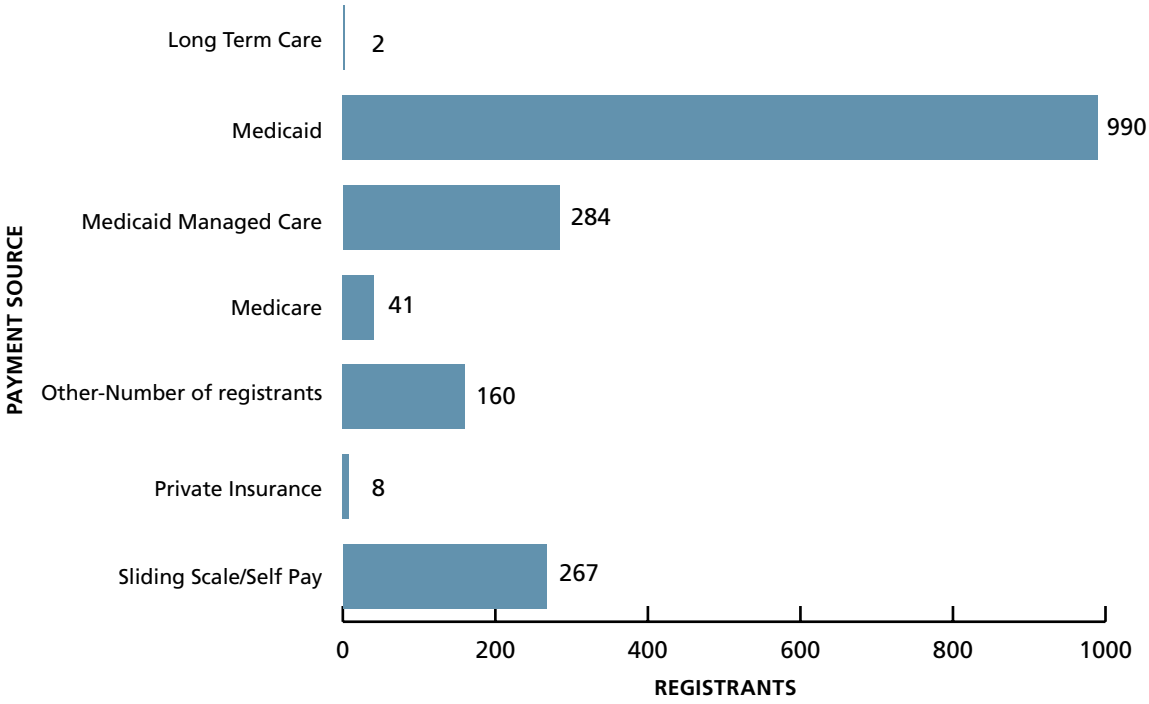
OWNERSHIP

The majority (60%) are independently operated and are not part of a larger organization with ownership controlled off-site. There was a total of 2,098 persons enrolled in these programs, with 92 average participants per program.

PAYMENT SOURCES

The predominant payment source for adult day care programs was Medicaid. Payment for adult day care services is derived from the following sources:

FIGURE 26: PAYMENT SOURCES FOR ADULT DAY CARE SERVICES, 2014



Source: RIDOH 2015 Statewide Health Inventory

HOURS OF OPERATION

The majority (92%) are open Monday – Fridays during normal business hours, between 8 AM and 5 PM. Five programs are open on Saturdays. All of the respondents (100%) indicated that new participants are accepted and 92% indicated that new participants with Medicaid benefits would be accepted.

WAITING LIST

Of all the survey respondents, almost all (96%) reported no waiting lists.

PUBLIC TRANSPORTATION

Public transportation is widely available to these adult day care programs, with 92% of the programs indicating that such transportation is available to their participants.

LANGUAGE

The majority of respondents (65%) do not collect information on whether their participants require health information in a language other than English (see below).

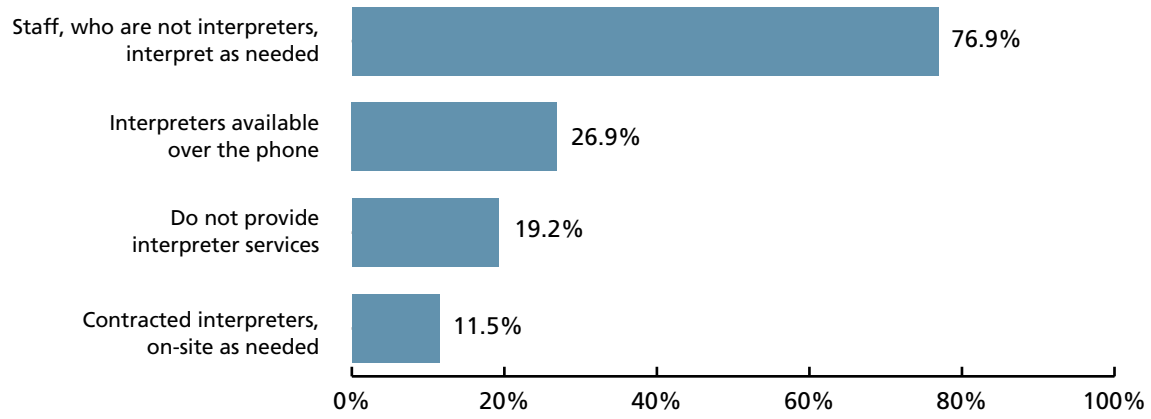
TABLE 56: DO PROGRAMS COLLECT DATA ON WHETHER PARTICIPANTS NEED HEALTH INFORMATION IN A LANGUAGE OTHER THAN ENGLISH?

	Percent
No	65.4%
Yes	34.6%

Source: RIDOH 2015 Statewide Health Inventory

On a related note, for those providing interpreter services, the majority (77%) of adult day care programs reported using staff not formally trained but assisting with interpreting as needed. Only 12% indicated that they contract with trained interpreters, on-site as needed. Approximately 19% indicated that their program did not provide any interpreter services.

FIGURE 27: PROVISION OF INTERPRETER SERVICES, 2014



Source: RIDOH 2015 Statewide Health Inventory

RACE/ETHNICITY

Not all programs collected demographic information, but among those that did, 19% of adult day care participants were of Hispanic or Latino ethnicity. Additional demographic information appears below:

TABLE 57: RACIAL CHARACTERISTICS OF ADULT DAY CARE PARTICIPANTS

Race	Percent
White	88%
Black	6%
Asian	2%
Other	4%
Total	**100%**

Source: RIDOH 2015 Statewide Health Inventory

FAMILY ADVISORY COUNCILS

The majority (60%) of adult day care programs responded that they do not have a family advisory council that meets regularly. Family advisory councils provide participants, family members, and friends with the opportunity to meet in private without the presence of program staff. Often, the councils develop recommendations concerning policies and services provided at the adult day care program.

PERSONNEL STAFFING

Below is a summary of personnel staffing among the adult day care program respondents:

TABLE 58: PERSONNEL TYPES EMPLOYED IN ADULT CARE PROGRAMS, 2014

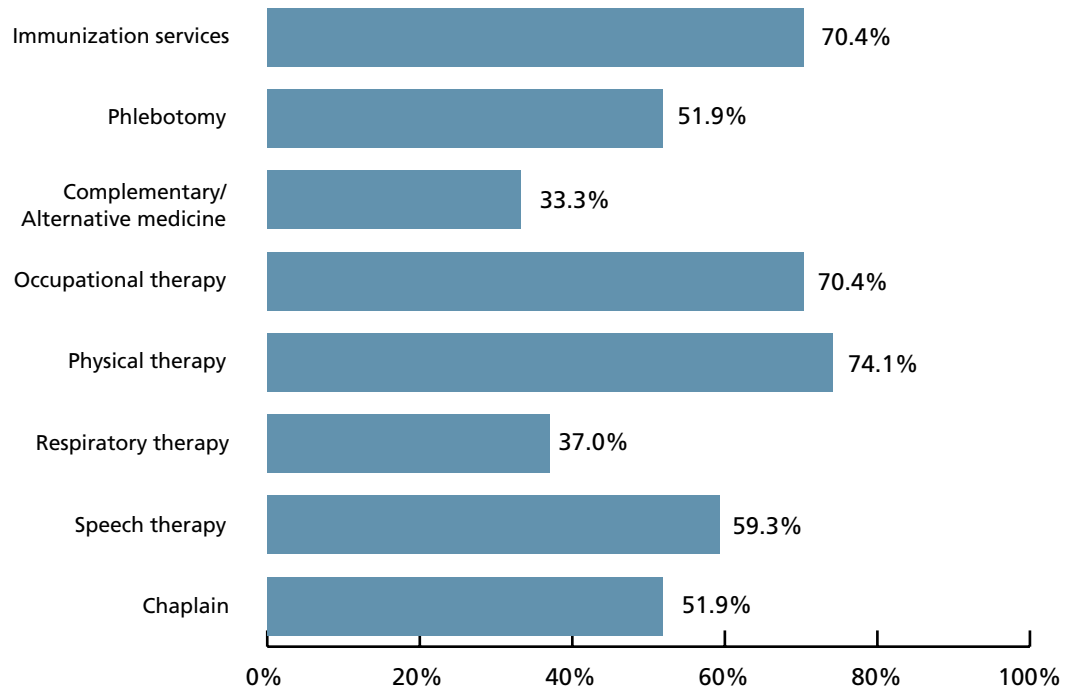
Personnel Type	% Respondents who responded "yes" when asked if they have this personnel type at their residence
Administrator	88%
Registered Nurse (RN)	88%
Licensed Practical Nurse (LPN)	23%
Certified Nursing Assistant (CNA)	88%
Certified Nursing Assistant & Medication Technician	42%
Personal Care Attendants	12%
Activities Staff	88%
Housekeeping	58%
Transportation	46%
Office Manager	50%
Receptionist	50%

Source: RIDOH 2015 Statewide Health Inventory

PROVISION OF HEALTH SERVICES

While 74.1% of programs provide physical therapy, 70.4% of programs provide immunization and occupational therapy services. Slightly more than 50% provide speech therapy and phlebotomy.

FIGURE 28: PROVISION OF HEALTH SERVICES IN ADULT DAY CARE PROGRAMS, 2014



Source: RIDOH 2015 Statewide Health Inventory

INFORMATION TECHNOLOGY

The use of information software or EMRs by adult day care programs is moderately low, with 39% reporting no use of information software or EMR. Only seven programs (27%) reported the use of an EMR.

TABLE 59: INFORMATION SOFTWARE USED BY ADULT DAY CARE PROGRAMS, 2014

Type of Software	Percent
None/Not applicable	37%
Electronic Medical/Health Record (EMR/EHR)	26%
Electronic practice management	26%
Standalone reporting system	26%
Integrated reporting software	19%
Clinical informed analytics tool	19%
Registries/Population health tool	0%

Source: RIDOH 2015 Statewide Health Inventory

Home Care Providers and Home Care Nursing Providers ("Home Care")

Introduction

Home care providers and home care nursing providers ("home care agencies") in Rhode Island are regulated by DOH under the legal authority contained in RIGL Chapter 23-17 ("Licensing of Health Care Facilities") and the related Rules and Regulations for Licensing Home Nursing Care Providers and Home Care Providers (R23-17-HNC/HC/PRO),[33] and as such, are construed to be health care facilities.

Note that there are two "levels" of home care agencies: 1/ home nursing care providers; and 2/ home care providers. Both are defined below:

> "Home nursing care provider" means any person that provides, arranges to provide, offers to provide, or in any other way provides for the delivery of direct nursing services in the home by a registered (RN) or practical (LPN) nurse. As used in these Regulations, "home nursing care provider" may include home care provider services.[34]

> "Home care provider" means any person that provides, arranges to provide, offers to provide, or in any other way provides for the delivery of any direct health care services in the home requiring supervision by a registered nurse (RN), but excludes the delivery of direct nursing care by a registered (RN) or licensed practical (LPN) nurse on an on-going basis; and includes services rendered by a licensed health care professional, including but not limited to, a speech pathologist/audiologist, physical, occupational, or respiratory therapist. Also as used in these Regulations, "home care provider" includes homemaker services as defined in §1.17 of these Regulations.

33 Rhode Island Secretary of State. Available at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7117.pdf. (Accessed October 13, 2015).
34 Rhode Island Department of Health, Rules and Regulations for Licensing Home Care Nursing Providers and Home Care Providers. Available at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7117.pdf Last amended November 2012. (Accessed October 13, 2015).

Survey Design

The Home Health Agency survey was initially developed and administered in 2014 by the Department of Health's Healthcare Quality Reporting Program, and their public reporting contractor Healthcentric Advisors. This survey was designed to capture information about Rhode Island's Home Health Agencies that could be used by patients, caregivers and providers to select an appropriate agency to meet a patient's needs. Information collected included services offered, insurance types accepted and service area. The survey design was originally informed by structured focus groups with patients and caregivers who had received home care and structured interviews with case managers responsible for patient discharge and the process for choosing a home care agency. Further guidance was provided by the Healthcare Quality Reporting Program's Home Health Subcommittee which includes representatives from home health agencies and other local stakeholders.

In order to meet the needs of RIDOH's health planning inventory process, the survey was expanded to include information about patient demographics, service capacity and agency characteristics, including use of health information technology. The current version of the survey was additionally informed by the CDC National Study of Long-Term Care Providers "2014 Residential Care Community Questionnaire."

The current version of the Home Health survey was reviewed by the Rhode Island Partnership for Home Care at various points during survey development. Feedback was received and implemented regarding descriptions of the types of services offered and identification of service areas through patient residence location. The survey instrument was built in SurveyMonkey and administered by the state Healthcare Quality Reporting Program and RIDOH's public reporting contractor, Healthcentric Advisors. The survey was administered electronically only. The survey was designed to take one hour to complete once data had been collected. Per the time that the survey was open for respondents, the median amount of time that the survey was open was 3.5 hours.

Response

There were a total of 70 home care agencies that hold a license for home nursing care provider, home care provider, or both. Completed surveys were received for 65 of the home care agencies, yielding a 93% response rate.

Note that not all respondents completed every question, or did not provide a complete response for every question, so all totals may not equal one hundred percent (100%).

Findings

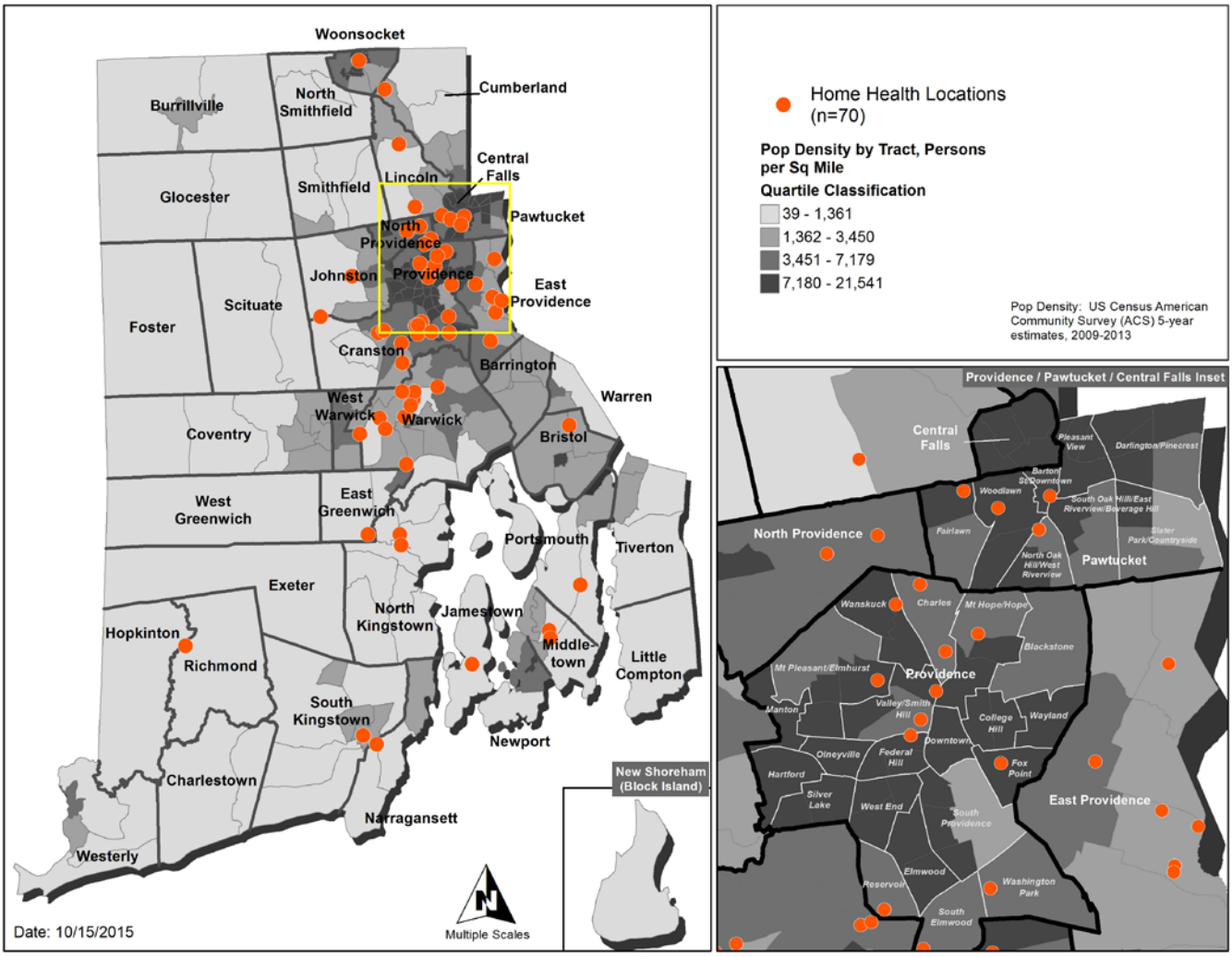
Findings from the home care agency inventory administered by RIDOH in July 2015 reveal the following:

OWNERSHIP

The majority (75%) reported that they are operated by a parent organization with ownership controlled off-site.

The Figure depicts the geographic distribution of home health agency locations overlaying population density distributions.

FIGURE 29: HOME HEALTH AGENCIES BY GEOGRAPHICAL LOCATION, 2014

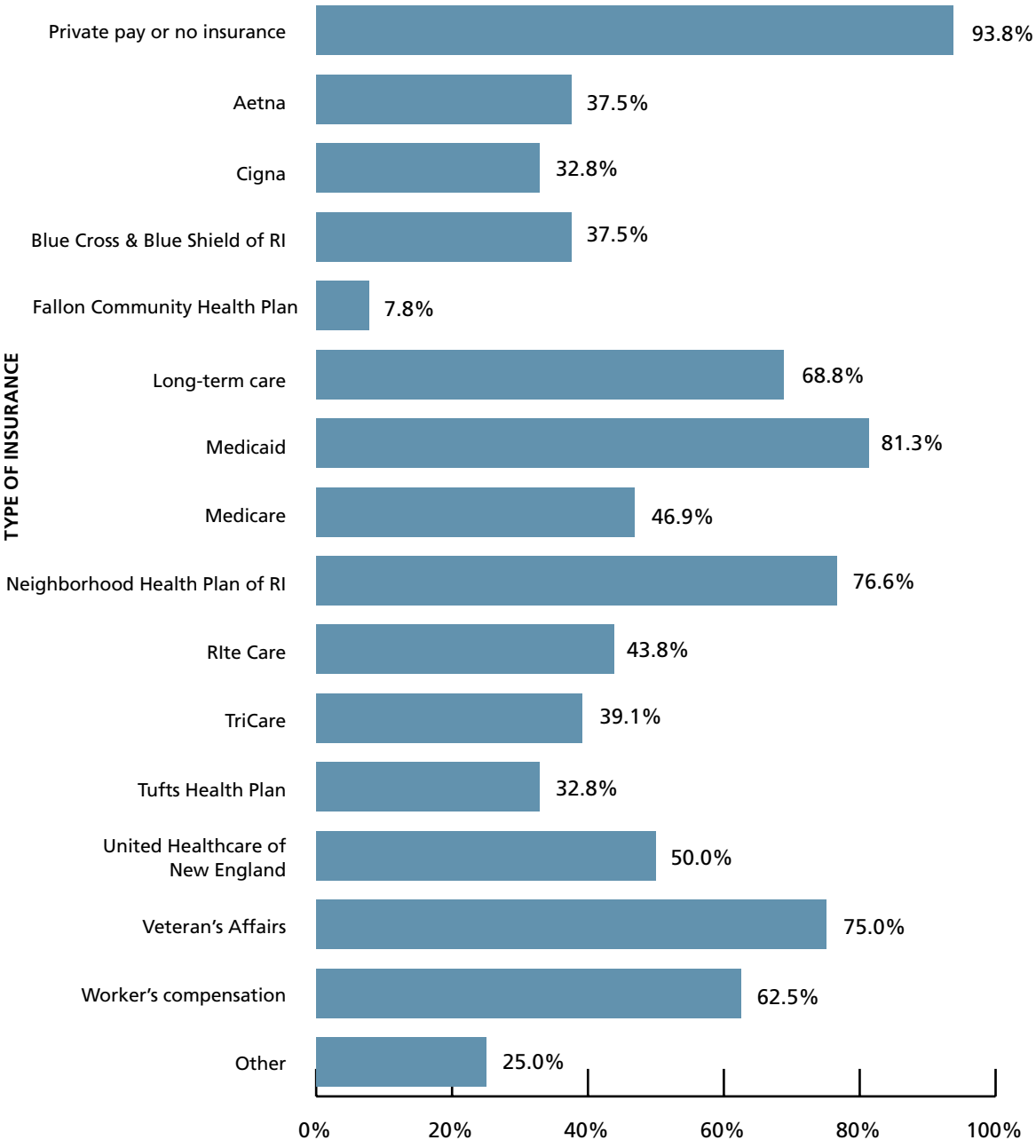


Source: RIDOH 2015 Statewide Health Inventory

PAYMENT SOURCES

The figures displays the percentage of home health agencies that accept different types of insurance or insurance plans. The data indicate that home health agencies accept a wide variety of payment types.

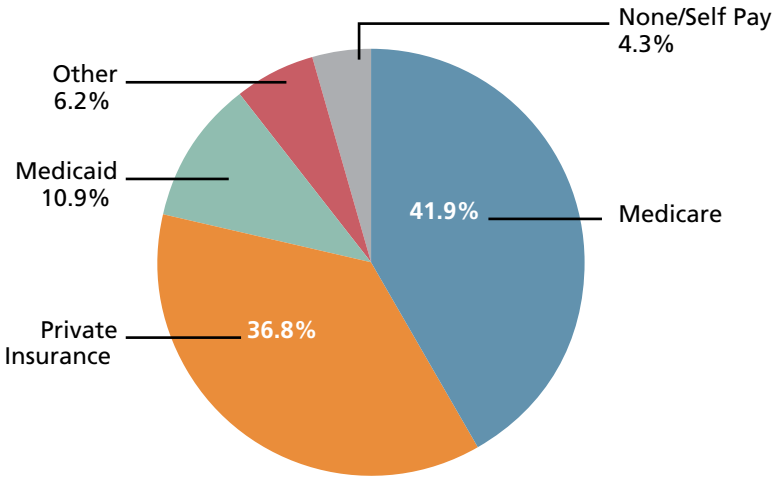
FIGURE 30: PAYMENT SOURCES FOR HOME CARE AGENCY SERVICES, 2014



Source: RIDOH 2015 Statewide Health Inventory

Survey results indicate that the average percent of patients who were on Medicare is 42%; the average for Medicaid was 11%; the average for private insurance was 37%; the average for other insurance was 6%; and the average for none or self-pay patients was 4%.

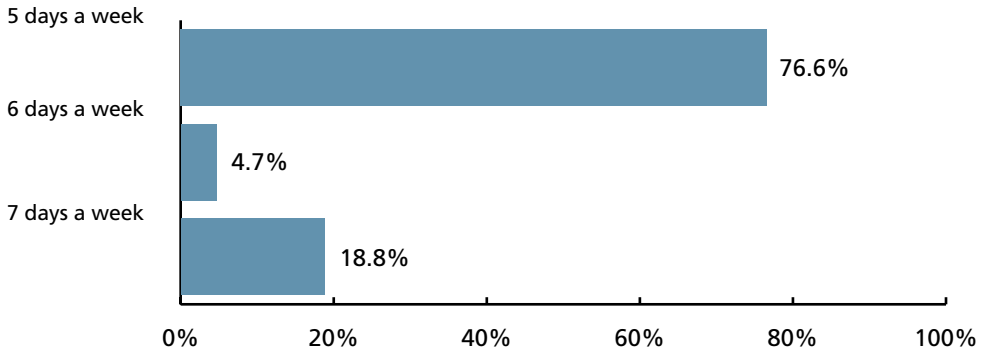
FIGURE 31: PERCENT OF CLIENTS BY INSURANCE TYPE, 2014



Source: RIDOH 2015 Statewide Health Inventory

When asked if they accept new patients, all respondents (100%) indicated that new patients/clients were accepted. Upon further review, thirty-three agencies (52%) indicated that they accepted new Medicare patients/clients, while fifty-four agencies (84%) indicated that they accepted new Medicaid patients/clients.

FIGURE 32: HOME HEALTH AGENCY DAYS OF OPERATION, 2014



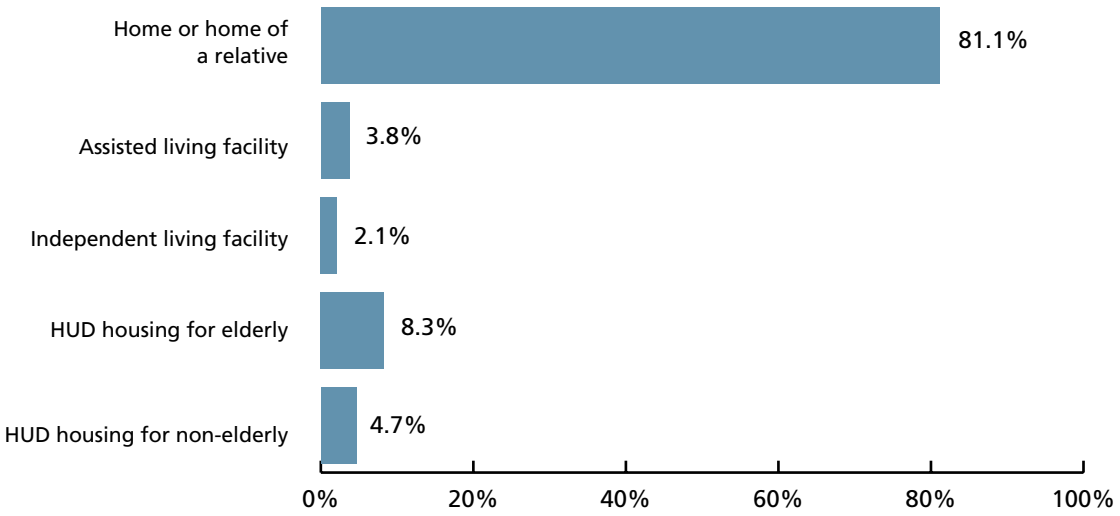
Source: RIDOH 2015 Statewide Health Inventory

The majority of agencies (92%) reported no intake business hours before 8 AM. Fifty-four agencies (84%) reported no intake business hours after 5 PM.

CARE SETTING

The home care setting where patients/clients receive services is broken down as follows:

FIGURE 33: PERCENT OF HOME CARE CLIENTS BY SETTING, 2014



Source: RIDOH 2015 Statewide Health Inventory

RACE/ETHNICITY

Among the 54% of agencies that reported demographic data, survey results reflect the following demographic profile:

TABLE 60: PERCENT OF CLIENTS BY RACE, 2014

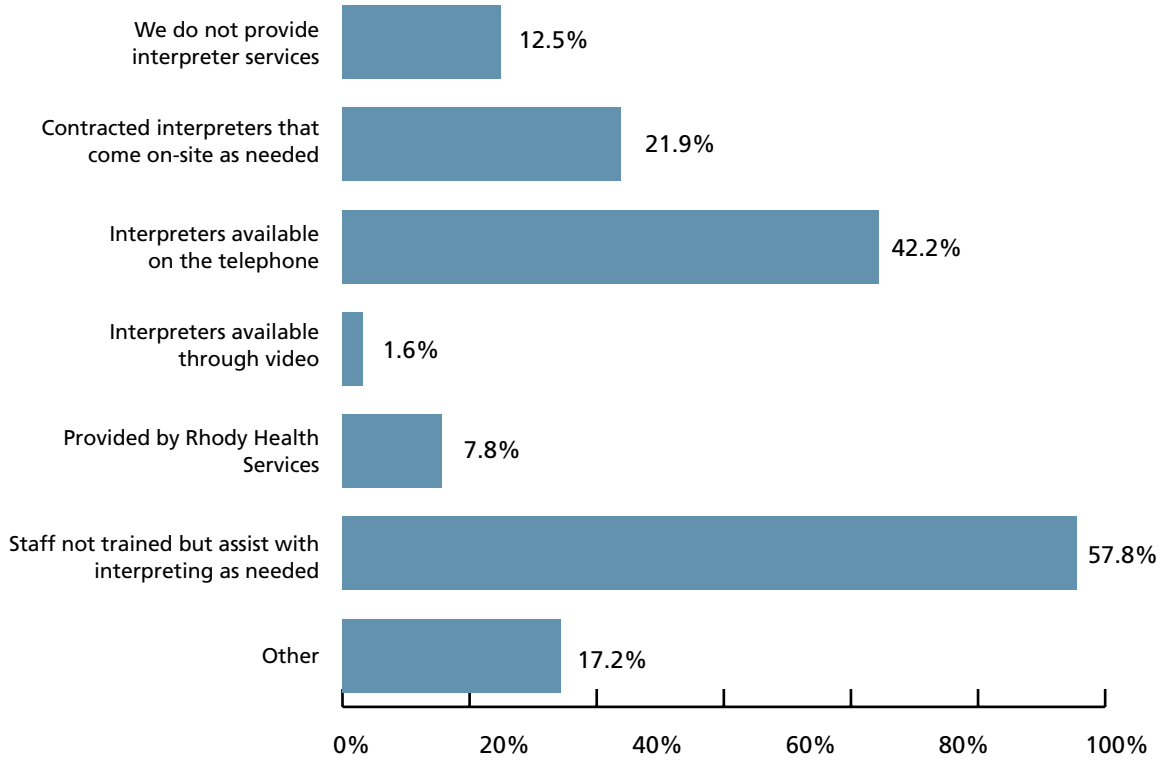
Race	Percent %
White	53%
Unknown/Not reported	41%
Black or African American	4%
Asian	1%
American Indian or Alaska Native	0.2%
Native Hawaiian or other Pacific Islander	0.0%

Source: RIDOH 2015 Statewide Health Inventory

LANGUAGE

Related to the provision of interpreter services, the majority of respondents (59%) indicated that they have staff not formally trained but assisting with interpreting as needed; 42% indicated that they have interpreters available by telephone; 22% indicated that they have contracted interpreters who come on site as needed; 17% that they have other interpreter services; 13% indicated that they do not provide interpreter services of any kind; 8% responded that they have interpreters provided by Rhody Health Services; and 2% have interpreters available via video. (See Figure next page).

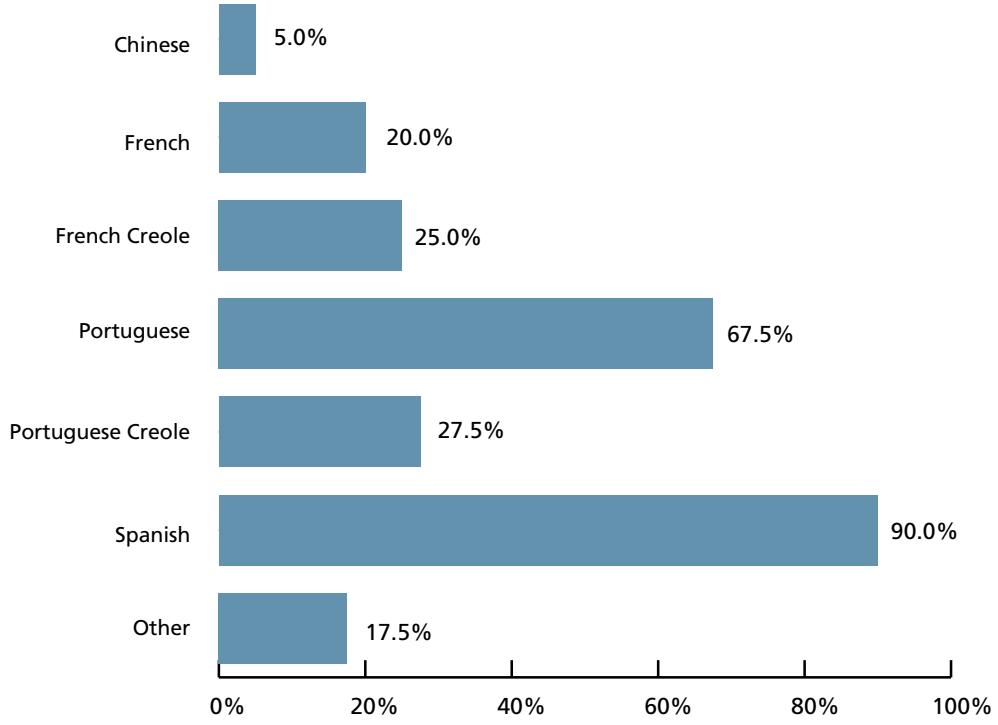
FIGURE 34: HOW INTERPRETER SERVICES ARE PROVIDED TO CLIENTS, 2014



Source: RIDOH 2015 Statewide Health Inventory

Regarding types of interpreter services, 5% indicated that they had an interpreter on staff for Chinese-speaking clients; 20% for French-speaking; 25% for French Creole-speaking; 68% for Portuguese-speaking; 28% for Portuguese Creole-speaking, 90% for Spanish-speaking-speaking and 18% for other languages.

FIGURE 35: SELECTED LANGUAGES FOR WHICH INTERPRETERS AVAILABLE, 2014

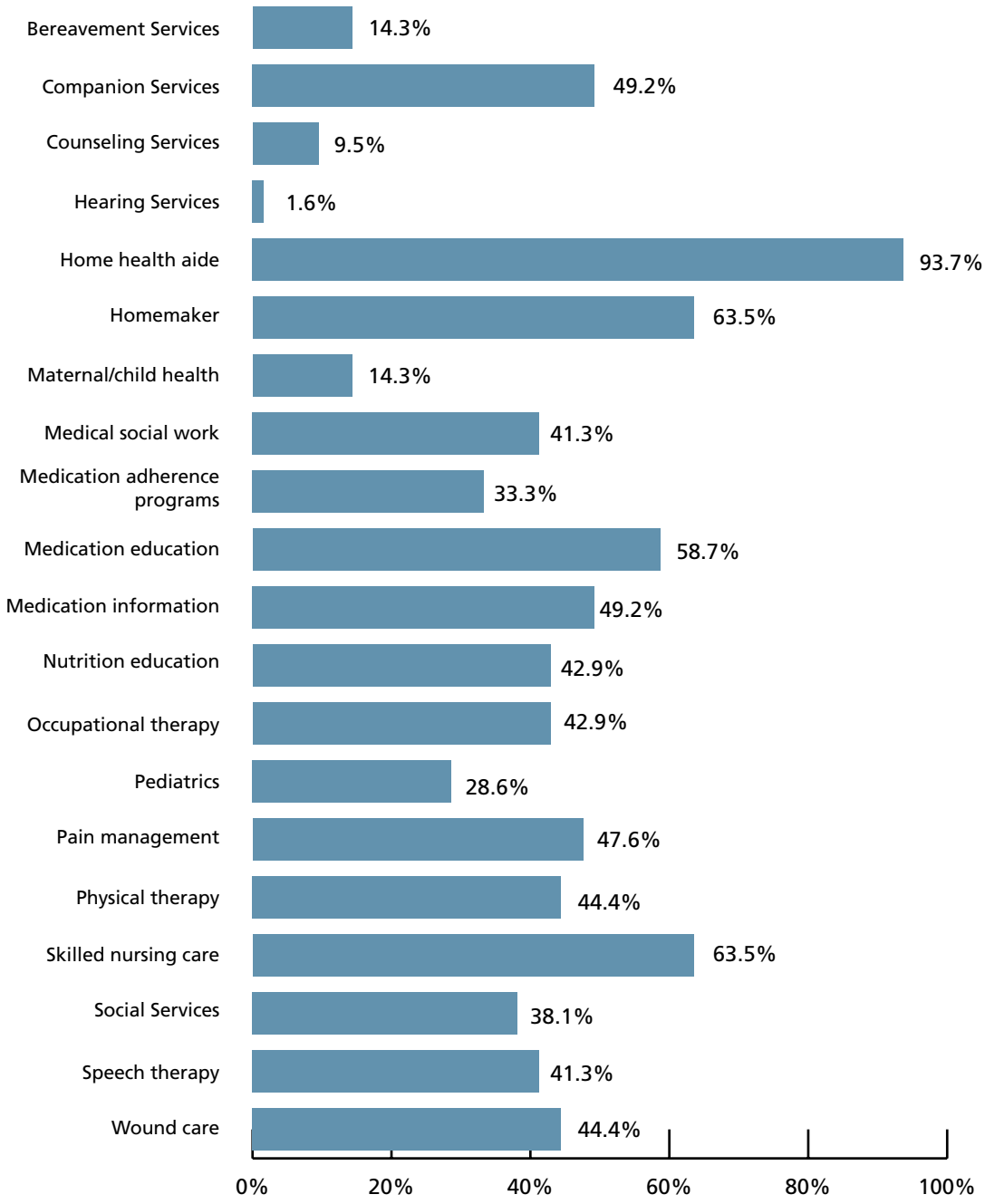


Source: RIDOH 2015 Statewide Health Inventory

PROVISION OF HEALTH SERVICES

When queried about services, home care agencies indicated that they provided a wide range of health care services, including 94% that provide home health aide services; 63% that provided skilled nursing care; 63% that provided homemaker services; 49% that provided companion services; and 43% that provided nutrition education.

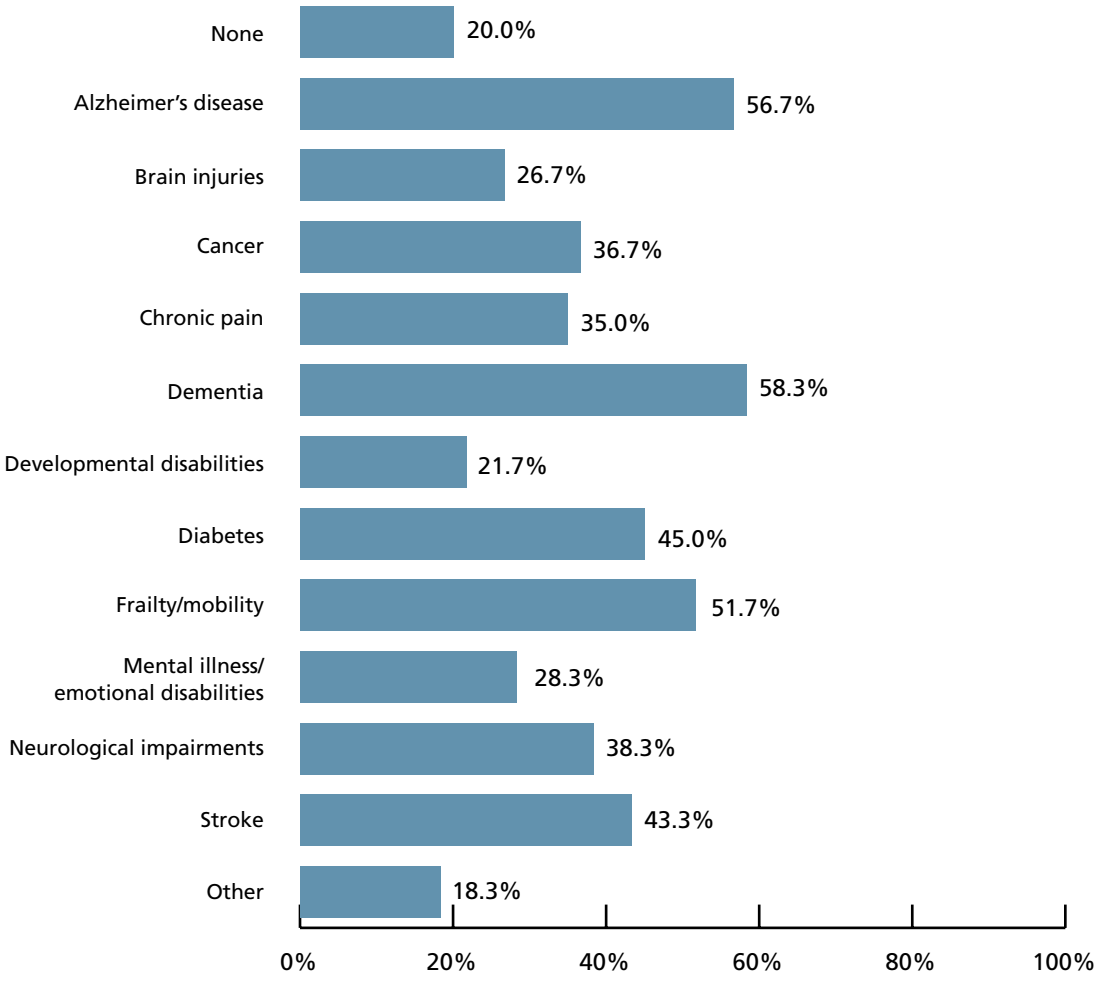
FIGURE 36: HEALTH CARE SERVICES PROVIDED BY HOME HEALTH CARE AGENCIES, 2014



Source: RIDOH 2015 Statewide Health Inventory

When asked about the provision of services for specialty health conditions, 20% reported that they did not have services for specialty health conditions; 57% provided services for Alzheimer's disease; 27% provided services for brain injuries; 37% provided services for cancer; 35% provided services for chronic pain; 58% provided services for dementia; 22% provided services for developmental disabilities; 45% provided services for diabetes; 52% provided services for frailty/mobility; 28% provided services for mental illness/emotional disabilities; 38% provided services for neurological impairments; 43% provided services for stroke; and 18% indicated that they provide other services.

FIGURE 37: SERVICES PROVIDED FOR SPECIALTY HEALTH CONDITIONS, 2014



Source: RIDOH 2015 Statewide Health Inventory

PERSONNEL STAFFING

Staffing Levels: Survey results reflect average measures for 2014 as below:

TABLE 61: AVERAGE STAFFING AT HOME HEALTH AGENCIES, 2014

Measure	Average Number (Persons)
Average # staff members/agency	102
Average # total FTEs	82
Average # Nurse FTEs	11
Average # Certified Nursing Assistant FTEs	47
Average # Homemaker FTEs	6
Average # PT/OT/SLT FTEs	7
Average # Office Staff FTEs	9
Average # Management FTEs	4

Source: RIDOH 2015 Statewide Health Inventory

DAILY CENSUS

Average Daily Census: Survey results reflect average measures for 2014 as below:

TABLE 62: AVERAGE NUMBER OF PATIENTS BY TYPE OF CARE PROVIDED, 2014

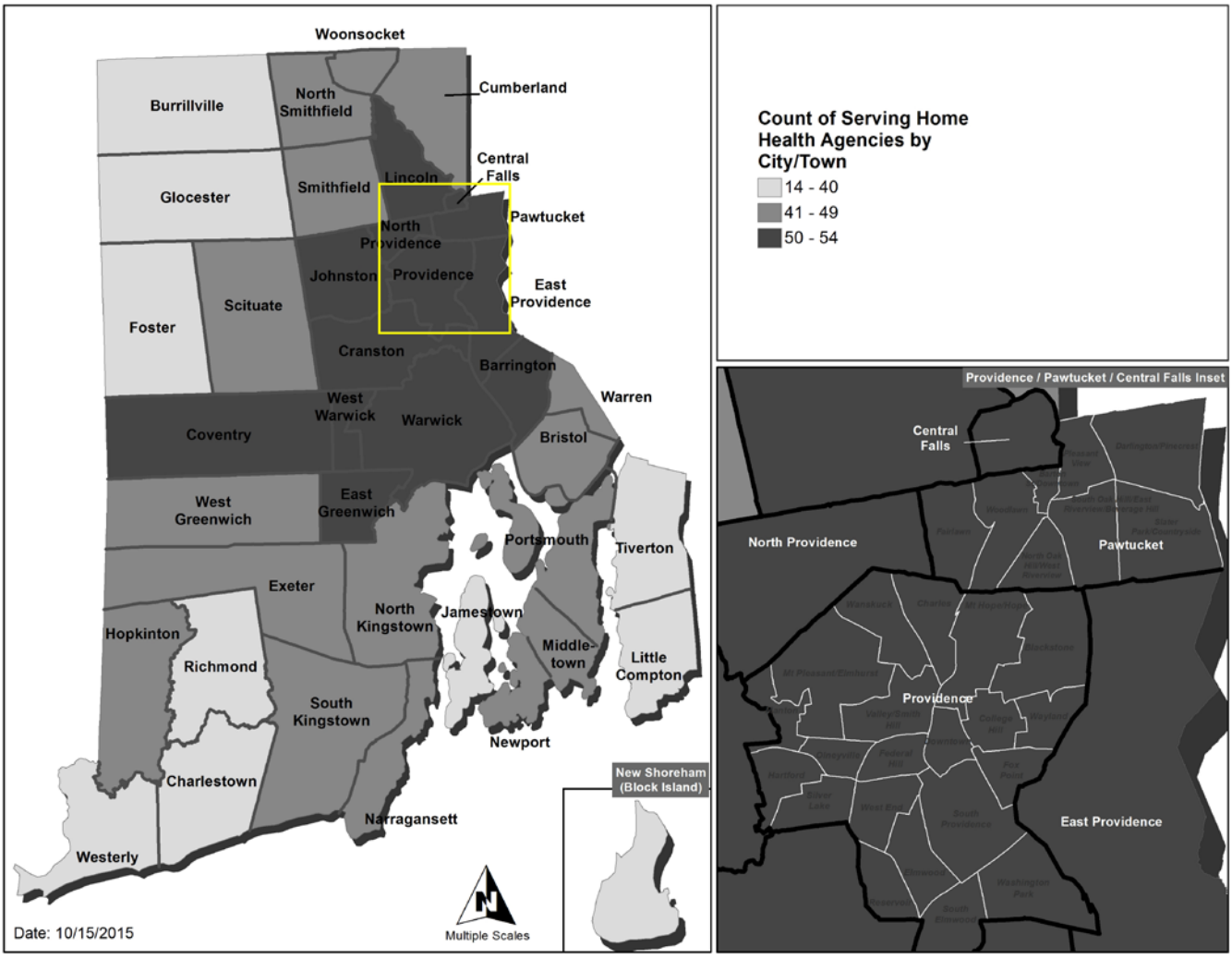
Measure	Average Number of Patients
Average number of post-acute patients	135
Average number of long-term care patients	92
Average number of patients receiving personal care	67
Average number of patients receiving both skilled and personal care	45
Average number of hospice patients	15

Source: RIDOH 2015 Statewide Health Inventory

HOME HEALTH AGENCIES BY LOCATION

The Figure shows a geographical depiction of the number of home health agency services by Rhode Island city/town:

FIGURE 38: HOME HEALTH AGENCY SERVICE AREAS, 2014

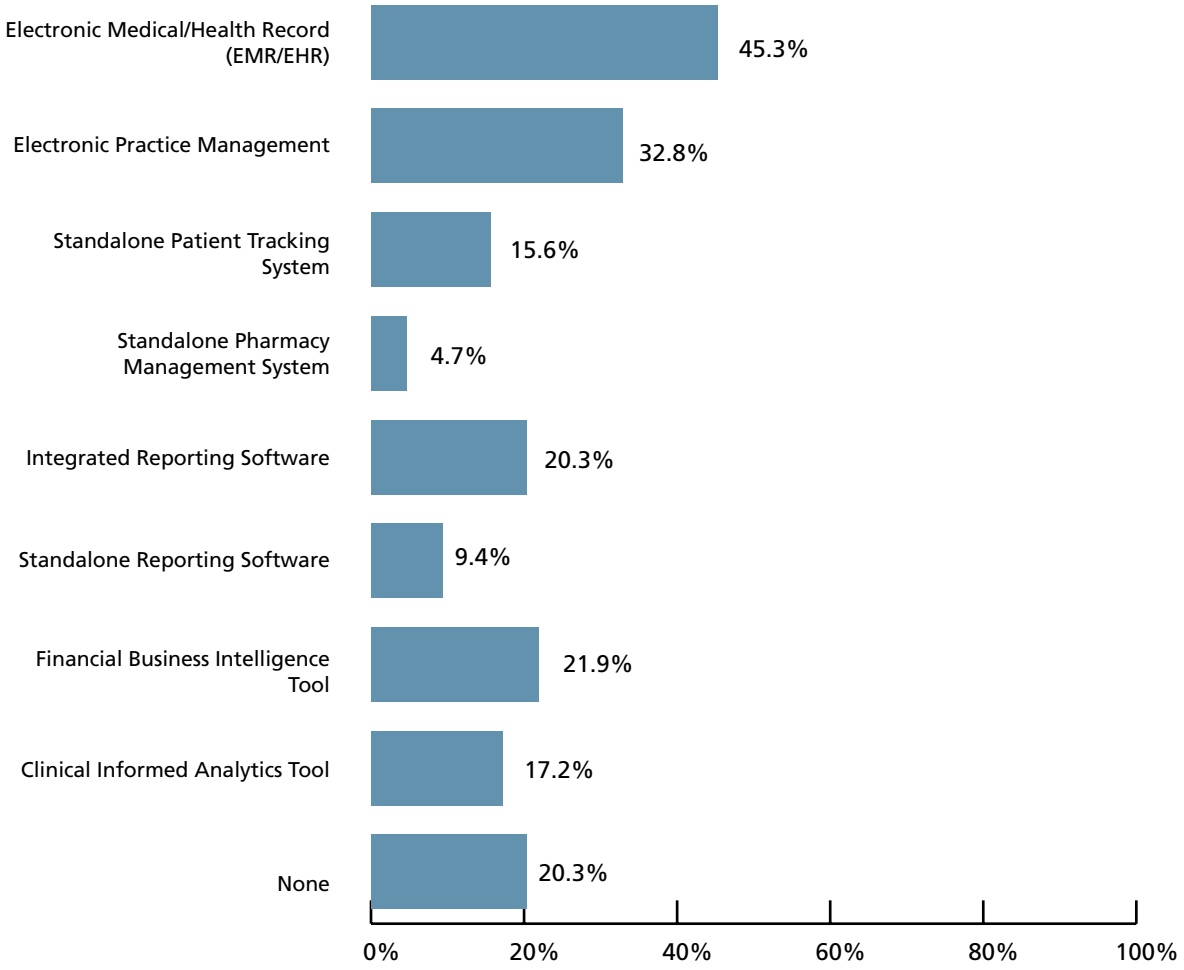


Source: RIDOH 2015 Statewide Health Inventory

INFORMATION TECHNOLOGY

The use of information software or EMRs by home care agencies is reported to be around 45%. Only 5% reported the use of a stand-alone pharmacy management system and 22% reported the use of a financial business intelligence tool.

FIGURE 39: INFORMATION SOFTWARE USED BY HOME CARE AGENCIES, 2014



Source: RIDOH 2015 Statewide Health Inventory

FACILITIES AND CENTERS

MRI Imaging Centers

Introduction

Magnetic Resonance Imaging (MRI) is a type of medical imaging technology that uses magnetic fields as opposed to ionizing radiation to create images of the body. Due to the fact that MRI machines do not use radiation, there is not a requisite license for Radiologic Technology as there is for other imaging modalities such as Computed Tomography (CT).

Survey Design

The Imaging Center survey was written to capture information about centers offering magnetic resonance imaging (MRI) services. The survey included questions regarding insurance sources for patients, ownership status of the center, hours of operation, number and type and strength of MRI machines, number of imaging studies completed in calendar year 2014, and information technology, in addition to other data elements. While all of feedback from stakeholders was incorporated into the survey before it was sent out, RIDOH determined the final survey instrument. The survey was designed to take 30 minutes to complete once data had been collected, and per the respondents having completed the survey, they reported it took from five minutes to one hour to finish.

Data Collection

In order to construct a list of locations with potential MRI machines, the RIDOH team worked with Blue Cross & Blue Shield of Rhode Island to create a list based on claims data and their provider database. Each MRI center was called to confirm that they had an MRI machine at that location. Several centers reported that they either no longer had MRI machines or only had CT machines. The name and email address for each center administrator was requested for the centers with confirmed MRI machines. Each MRI center was given two weeks to complete the survey and received one to three phone calls as follow up.

Response

There were a total of 26 MRI Imaging Centers in Rhode Island, and each completed the survey giving a response rate of 100%. In addition, 13 hospitals recorded data on outpatient MRI use (100% response rate).

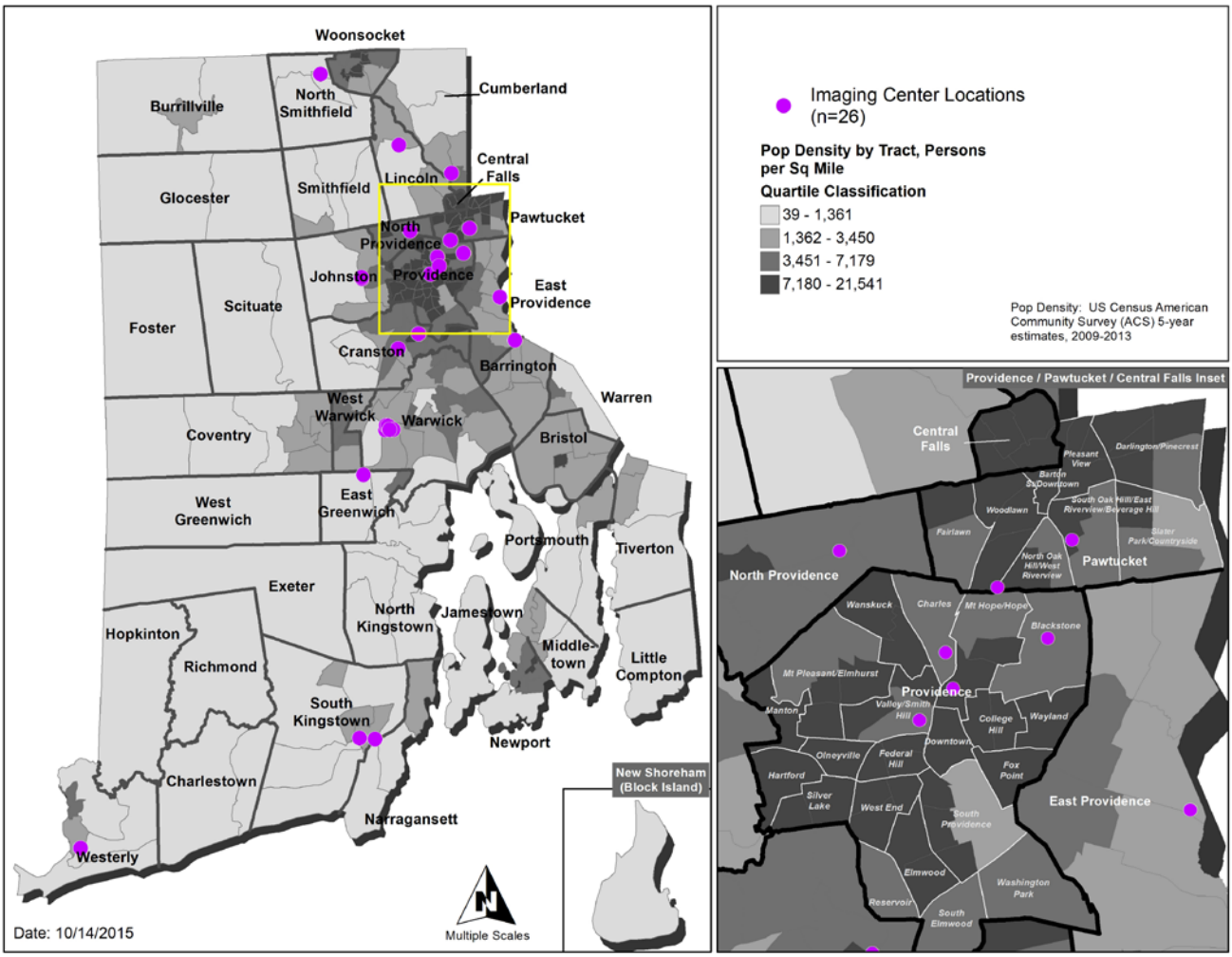
Note that not all respondents completed every question, or did not provide a complete response for every question, so all totals may not equal one hundred percent (100%).

Findings

Findings from the MRI Imaging Centers inventory administered by RIDOH in August 2015 reveal the following:

The Figure depicts the geographic distribution of MRI imaging center locations overlaying population density distributions.

FIGURE 40: LOCATIONS OF MRI IMAGING CENTERS IN RHODE ISLAND, 2014

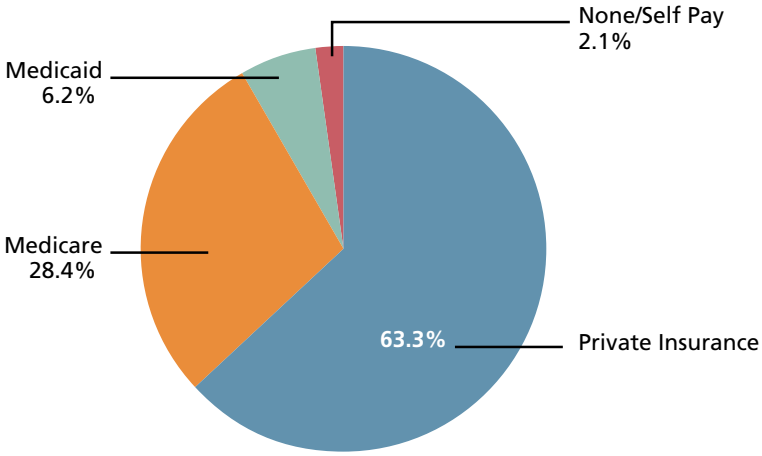


Source: RIDOH 2015 Statewide Health Inventory

PAYMENT SOURCE

Patients who received services at imaging centers were almost always insured (97.9%), with Private Insurance covering 63.3% of patients, Medicare covering 28.4% of patients, and Medicaid covering 6.2% of patients.

FIGURE 41: IMAGING PATIENTS BY INSURANCE TYPE



Source: RIDOH 2015 Statewide Health Inventory

HOURS OF OPERATION

MRI Imaging Centers were more likely to have had extended business hours in the evening than in the morning. The majority of the MRI Imaging Centers (69.2%) had no service hours before 8AM, with 26.9% having daily service hours before 8AM, and 3.8% having some service hours before 8AM. Conversely, 34.6% had no service hours after 5PM, while 50% had some service hours after 5PM and 15.4% had daily service hours after 5PM.

TABLE 63: EXTENDED SERVICE HOURS, IMAGING CENTERS, 2014

Hours Before 8 AM	Percent
No Service Hours Before 8AM	69.2%
Daily Service Hours Before 8AM	26.9%
Some Service Hours Before 8AM	3.9%
Hours After 5PM	
No Service Hours After 5PM	34.6%
Some Service Hours After 5PM	50.0%
Daily Service Hours After 5PM	15.4%

Source: RIDOH 2015 Statewide Health Inventory

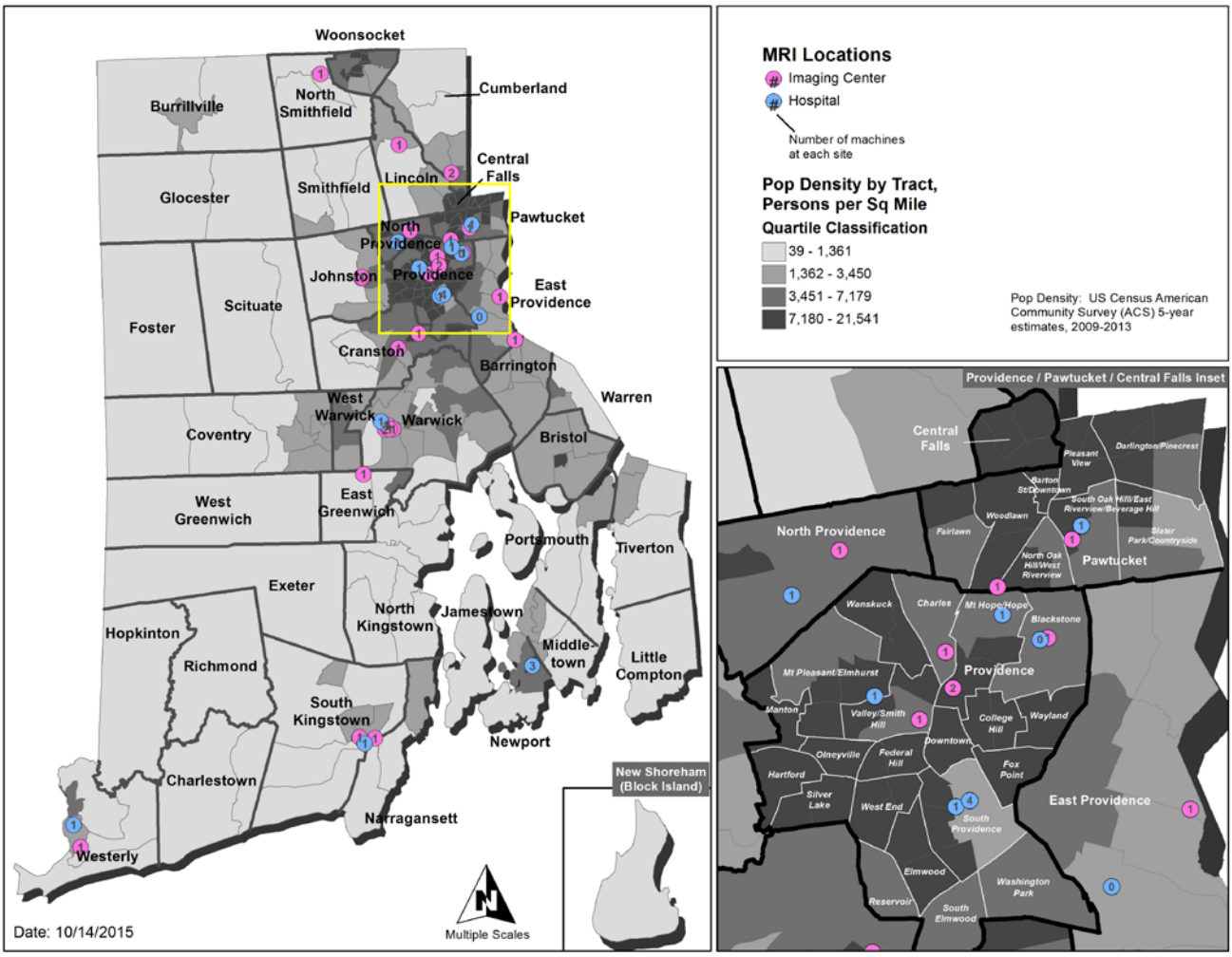
Most (96.15%) MRI Imaging Centers were open 5 days a week, with the remaining MRI Imaging Center open 4 days a week. The average number of hours on a weekday that the centers were open was 9.7 hours.

MRI MACHINES AND UTILIZATION

There were a total of 45 MRI machines in Rhode Island, with 11 hospitals reporting 16 (35.5%) machines. Of the non-hospital MRI Imaging Centers, 23 centers (88.5%) indicated that they had 1 MRI machine in use and 3 (11.5%) indicated that they had 2 MRI machines in use, for a total of 29 (64.4%) MRI machines.

The Figure depicts the geographic distribution of hospital versus imaging center locations for MRI machines overlaying population density distributions.

FIGURE 42: LOCATIONS OF MRI MACHINES IN RHODE ISLAND, 2014



Source: RIDOH 2015 Statewide Health Inventory

In calendar year 2014, the average number of MRI studies per center was 2118.5 with a maximum of 5903, while the average of outpatient MRI studies per hospital was 1,112 with a maximum of 5,895.

Of the MRI Imaging Centers surveyed, 25 reported the magnet strength of their MRI Machines, with 24% of centers indicating they had a low strength magnet in use and 76.0% indicating they had a medium to high strength magnet in use. Specific magnet strengths are displayed in the Table.

TABLE 64: MAGNET STRENGTH OF MRI MACHINES IN USE AT IMAGING CENTERS, 2014

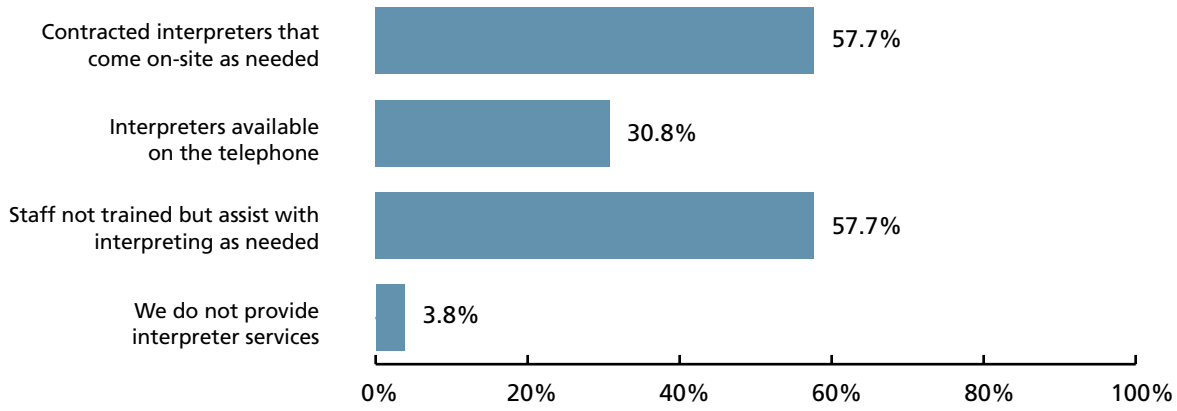
	Magnet Strength	Percent
	.2T	4.0%
Low	.3T	12.0%
	.6T	8.0%
	1.2T and 1.5T	4.0%
	1.2T and 3T	4.0%
Medium to High	1.5T	52.0%
	1.5T and .23T	4.0%
	3T	12.0%

Source: RIDOH 2015 Statewide Health Inventory

INTERPRETING SERVICES

Among centers, 57.7% indicated that they contracted interpreters that come on site as needed, 30.8% that interpreters were available on the telephone, 57.7% that staff not formally trained assisted with interpreting as needed, and 3.8% indicated that they do not provide interpreter services.

FIGURE 43: TRANSLATION SERVICES IN MRI IMAGING CENTERS, 2014

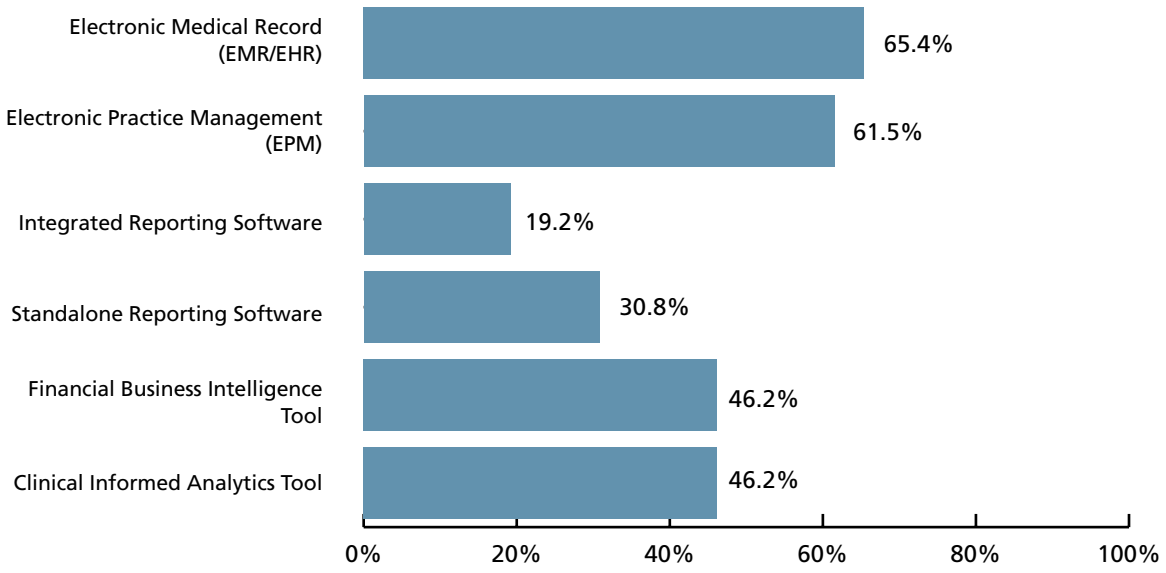


Source: RIDOH 2015 Statewide Health Inventory

HEALTH INFORMATION TECHNOLOGY

All Imaging centers used some type of information software, with 65.4% utilizing an Electronic Medical Record and 61.5% utilizing Electronic Practice Management (EPM). In terms of reporting, 19.2% had reporting software integrated into their systems, 30.8% had standalone reporting software, 46.2% had financial business intelligence tools, and 46.2% had clinical informed analytics tools.

FIGURE 44: TYPES OF INFORMATION SOFTWARE IN IMAGING CENTERS



Source: RIDOH 2015 Statewide Health Inventory

Ambulatory Surgery Centers

Introduction

Freestanding ambulatory surgical centers are also cited in Chapter 23-17 RIGL as a class of "health care facility." They are loosely defined in statute as, "facilities providing surgical treatment to patients not requiring hospitalization (surgi-centers)."[35]

> The Rhode Island Rules and Regulations for the Licensing of Freestanding Ambulatory Surgical Centers (R23-17-FASC) further define such centers as an, "establishment or place which may be a public or private organization equipped and operated exclusively for ambulatory patients for the purpose of performing surgical procedures which have the approval of the governing body and which in the opinion of the surgeon and anesthesiologist can be performed safely without requiring extensive anesthesia or overnight stay."[36]

Survey Design

The Ambulatory Surgery Center (ASC) survey was written to capture ownership status, hours of operation, waiting list, interpreter services, information technology, quality measurement, sources of insurance for patients, and number of services provided, in addition to other data elements. The survey was informed by the CDC "2006 National Survey of Ambulatory Surgery." Prior to sending out the survey, feedback was solicited from stakeholders amongst ASCs. Recommendations were offered regarding how to ask about quality measurement and information technology for ASCs. While all of this feedback was incorporated into the survey before it was sent out, RIDOH determined the final survey instrument. The survey was designed to take 30 minutes to complete once data was collected, and per the respondents having completed the survey, they reported it took from 30 minutes to two hours to finish including data collection.

Data Collection

Publicly available licensure data for ASCs was obtained from the RIDOH website. The licensure database contained the names of 16 ambulatory surgery centers and their addresses, phone numbers, and fax numbers. In order to obtain the administrators' emails, one of our interns called each center one to three times over the course of one week using the information provided by the licensure list. Through this process, one ASC reported that ambulatory surgery services were not currently being offered. Each remaining ambulatory surgery center was given two weeks to complete the survey and received one to four phone calls as follow up.

Response

There were a total of 16 licensed ASCs in Rhode Island. One ASC was not currently active, and all 15 active ASCs responded to the survey for a response rate of 100%.

Note that not all respondents completed every question, or did not provide a complete response for every question, so all totals may not equal one hundred percent (100%).

Findings

Findings from the ASC survey administered by RIDOH in August 2015 reveal the following:

35 "Licensing of Health Care Facilities," Section 23-17-2(6) of the Rhode Island General Laws, as amended. Available at: http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17/23-17-2.HTM (Accessed October 22, 2015).

36 Rhode Island Department of Health, Rules and Regulations for Licensing of Freestanding Ambulatory Surgical Centers, Section 1.5. Last amended September 2012. Available at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/6995.pdf (Accessed October 22, 2015).

OWNERSHIP

Fifty percent of responding centers indicated they were owned by one or more physicians, 21.4% indicated that they were owned by a healthcare corporation that owns multiple facilities, and 28.6% indicated that they had other ownership.

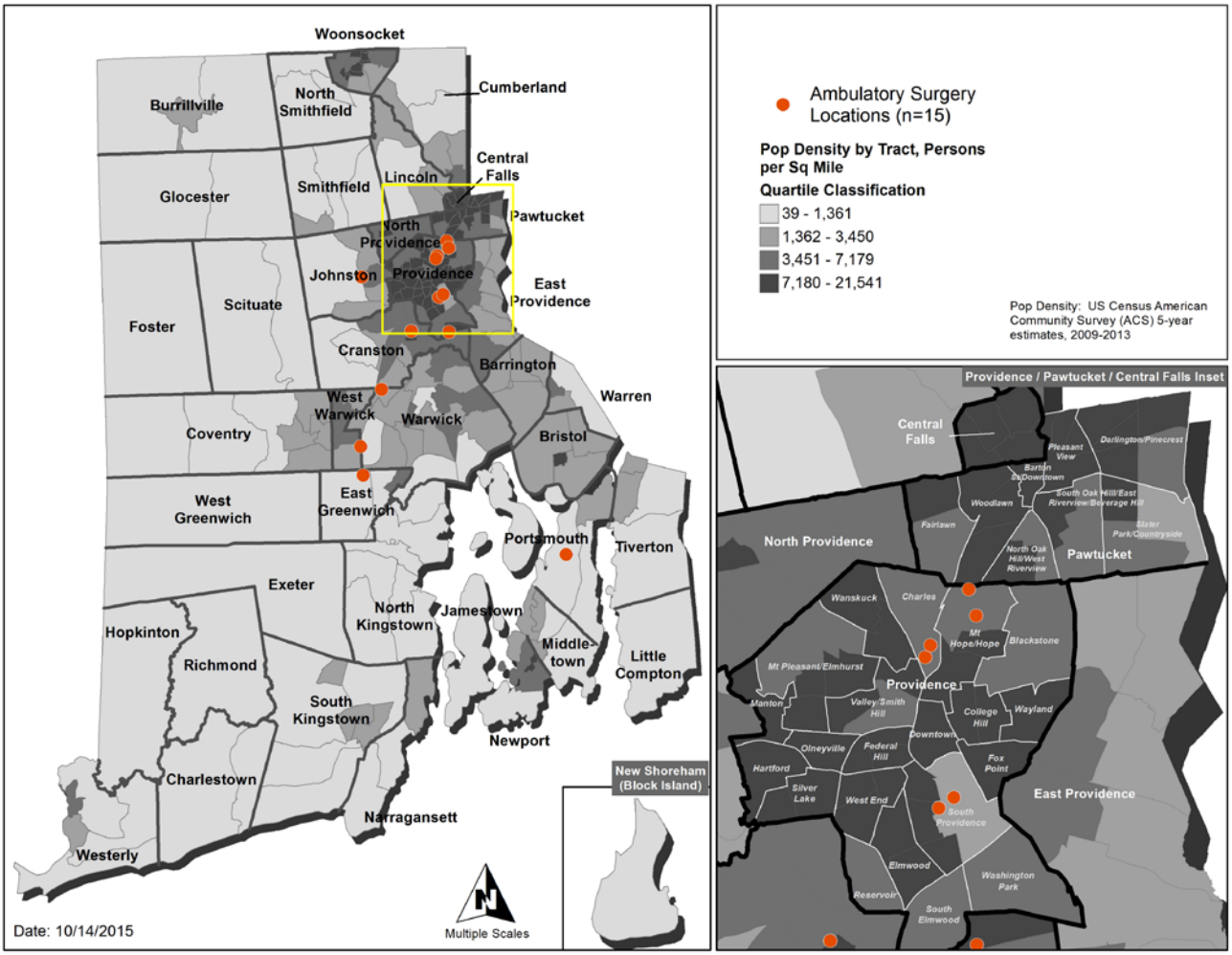
TABLE 65: OWNERSHIP OF AMBULATORY SURGERY CENTER, 2014

	Percent
One or more physicians	50.0%
Other (specify)	28.6%
A healthcare corporation that owns multiple facilities	21.4%

Source: RIDOH 2015 Statewide Health Inventory

The Figure depicts the geographic distribution of ASC locations overlaying population density distributions.

FIGURE 45: LOCATION OF AMBULATORY SURGERY CENTERS IN RHODE ISLAND, 2014

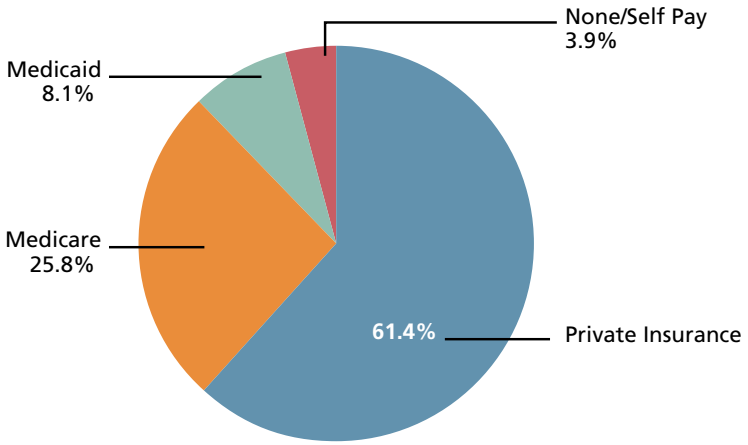


Source: RIDOH 2015 Statewide Health Inventory

PAYMENT SOURCE

Patients receiving services at ASCs were almost always insured, with 61.4% holding private insurance, 25.8% covered by Medicare, 8.1% covered by Medicaid, while the remaining 3.9% had no insurance and/or paid for services themselves.

FIGURE 46: PRINCIPAL PAYMENT SOURCES IN AMBULATORY SURGICAL CENTERS, 2014



Source: RIDOH 2015 Statewide Health Inventory

ACCREDITATION

All ASCs indicated that they were accredited, with 46.7% accredited by the Accreditation Association for Ambulatory Health (AAAHC), 6.7% accredited by the Joint Commission on Accreditation of Health Organizations, 20% accredited by the American Association for Accreditation for Ambulatory Surgery Facilities (AAAASF), and the remaining 20% accredited by other bodies.

TABLE 66: ACCREDITATION OF AMBULATORY SURGICAL CENTERS, AMBULATORY SURGICAL CENTERS, 2014

	Percent
American Association for Accreditation for Ambulatory Surgery Facilities (AAAASF)	20.0%
Joint Commission on Accreditation of Healthcare Organizations	6.7%
Accreditation Association for Ambulatory Health (AAAHC)	46.7%
American Osteopathic Association (AOA)	0%
Other	20.0%

Source: RIDOH 2015 Statewide Health Inventory

HOURS OF OPERATION

Among ASCs that responded to the survey, 93.3% reported having no regular weekend hours. Fifteen percent indicated that they did not have service hours before 8 AM, 15.4% that they had some service hours before 8 AM, and 69.2% that they had daily service hours before 8 AM. All centers indicated that they did not have service hours after 5PM.

TABLE 67: EXTENDED SERVICE HOURS, AMBULATORY SURGICAL CENTERS, 2014

Hours Before 8 AM	Percent
Daily Service Hours Before 8AM	69.2%
NoService Hours Before 8AM	15.4%
Some Service Hours Before 8AM	15.4%
Hours After 5PM	
No Service Hours After 5PM	100.0%

Source: RIDOH 2015 Statewide Health Inventory

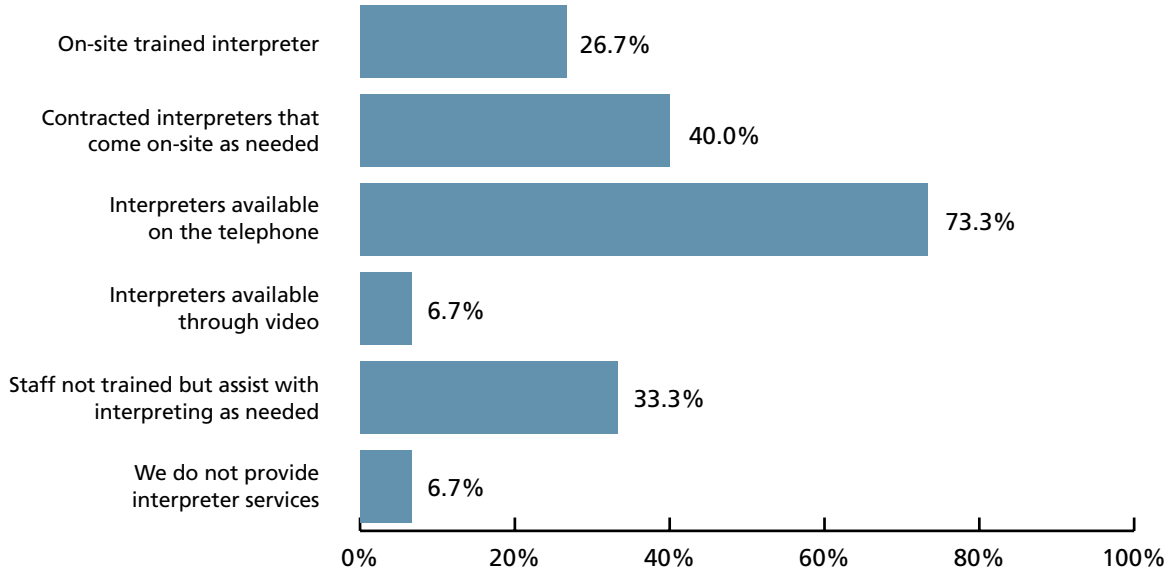
The average number of hours per day that centers reported being open on weekdays was 9.4 hours. Of those that responded about days of the week, 7.7% were open only two days a week, with the remaining 92.3% being open five days a week.

Only one ASC reported having a waiting list which was approximately 60 patients long and expected to be 3-4 weeks.

INTERPRETER SERVICES

Patients who need interpreting services can expect to encounter some type of service at 93.3% of ASCs that answered the question. One quarter, or 26.7%, indicated that they had an on-site trained interpreter, 40.0% indicated that they contract interpreters that come on site as needed, 73.3% responded that they had interpreters available on the telephone, 6.7% that they had interpreters available through video, 33.3% reported that had staff not formally trained but assisted with interpreting as needed, and 6.7% indicated that they did not provider interpreter services.

FIGURE 47: INTERPRETER SERVICES IN AMBULATORY SURGICAL CENTERS, 2014

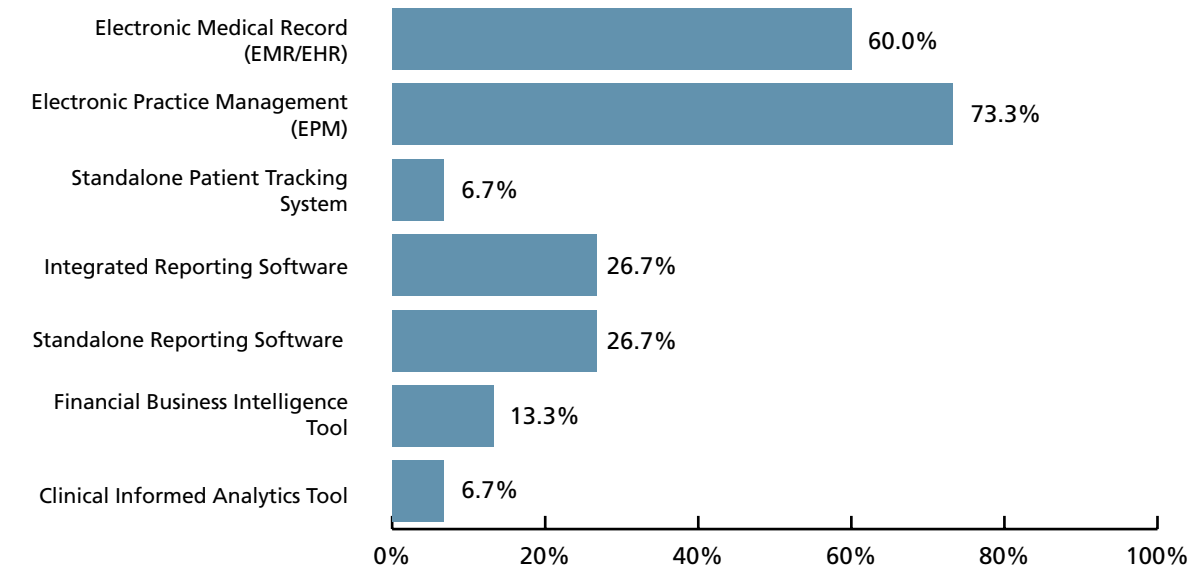


Source: RIDOH 2015 Statewide Health Inventory

HEALTH INFORMATION TECHNOLOGY

Most ASCs had some sort of information software, with 60% having electronic medical records, 73.3% having some sort of electronic practice management, and 6.7% having a standalone patient tracking system. For those reporting, 26.7% had integrated reporting software in their other systems, 26.7% had standalone reporting software, 13.3% had a financial business intelligence tool, and 6.7% had a clinical informed analytics tool.

FIGURE 48: TYPES OF INFORMATION SOFTWARE IN IMAGING CENTERS

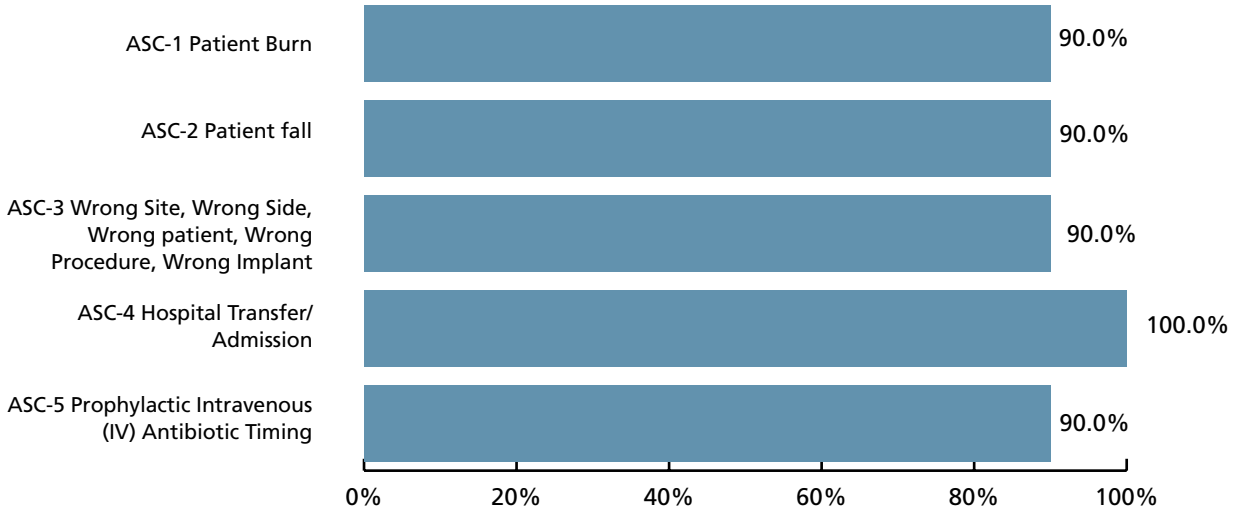


Source: RIDOH 2015 Statewide Health Inventory

PARTICIPATION IN ASC QUALITY REPORTING

Of the 66.7% of respondents that answered questions regarding their participation in Ambulatory Surgical Center Quality Reporting (ASCQR) to the Centers for Medicare and Medicaid Services (CMS), 90.0% indicated that they reported the ASC-1 Burn measure, 90.0% that they reported the ASEC-2 Patient Fall measure, 90.0% that they reported the ASC-3 Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant measure, all 100.0% reported the ASC-4 Hospital Transfer/Admission measure, and 90.0% reported the Prophylactic Intravenous (IV) Antibiotic Timing measure.

FIGURE 49: PARTICIPATION IN AMBULATORY SURGICAL CENTER QUALITY REPORTING, 2014

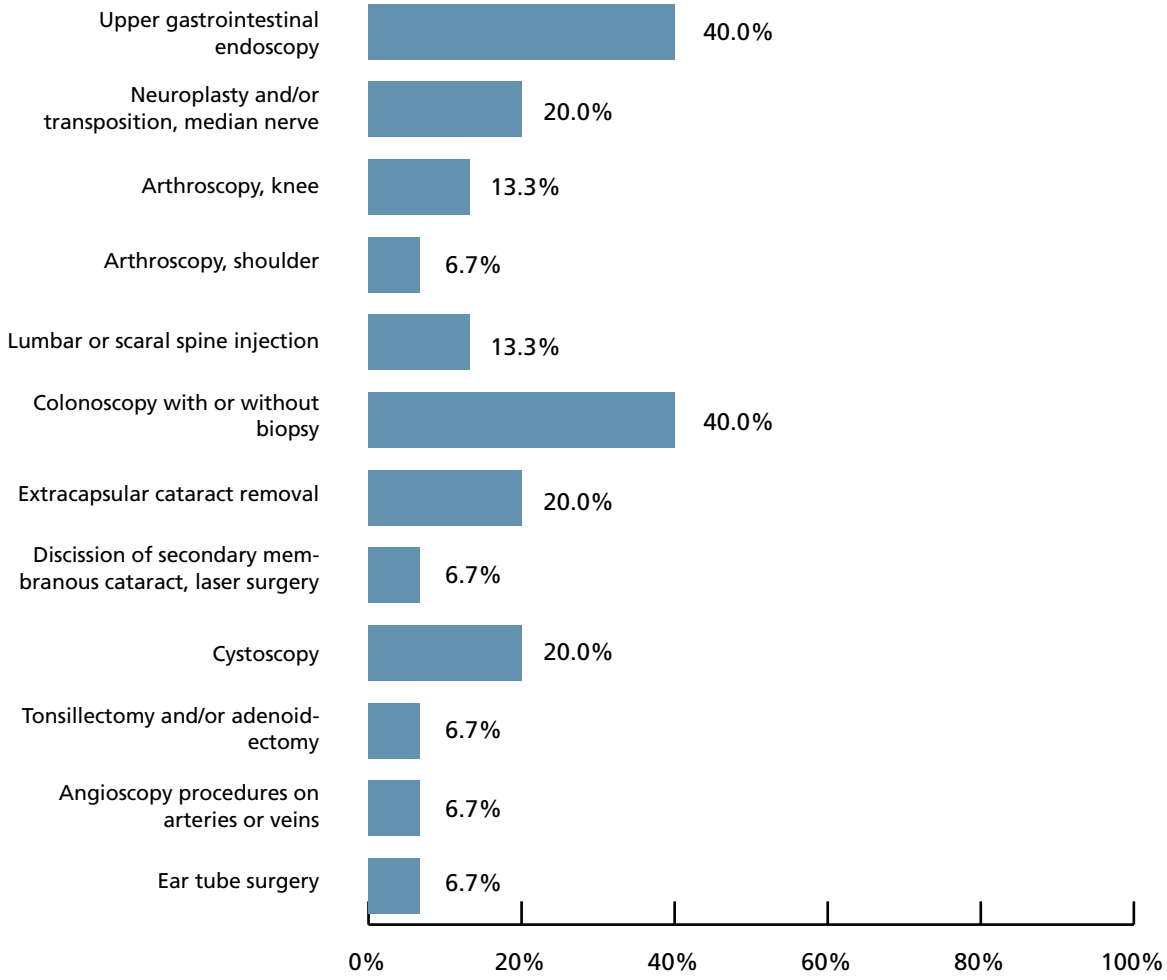


Source: RIDOH 2015 Statewide Health Inventory

SERVICES PROVIDED

The most commonly performed procedures at ASCs were upper gastrointestinal endoscopy or colonoscopy with or without biopsy which were each performed by 40% of ASCs; and neuroplasty and/or transposition of the median nerve, extracapsular cataract removal, or cystoscopy which were each performed at 20% of ASCs.

FIGURE 50: PERCENT OF AMBULATORY SURGERY CENTERS THAT PERFORMED THE FOLLOWING TYPES OF PROCEDURES, 2014



Source: RIDOH 2015 Statewide Health Inventory

Among ASCs which reported on procedures performed. The most common procedures were colonoscopy with or without biopsy at 48.8%, upper gastrointestinal endoscopy at 26.5%, and extracapsular cataract removal at 10.6% of procedures.

TABLE 68: NUMBER OF PROCEDURES PERFORMED, AMBULATORY SURGICAL CENTERS, 2014

	Number of Procedures	Percent of Total Procedures
Colonoscopy with or without biopsy	23,468	48.8%
Upper gastrointestinal endoscopy	12,737	26.5%
Extracapsular cataract removal	5,095	10.6%
Tonsillectomy and/or adenoidectomy	1,514	3.1%
Ear tube surgery	1,110	2.3%
Angioscopy procedures on arteries or veins	989	2.1%
Neuroplasty and/or transposition, median nerve	917	1.9%
Arthroscopy, shoulder	654	1.4%
Discission of secondary membranous cataract, laser surgery	690	1.4%
Cystoscopy	546	1.1%
Arthroscopy, knee	193	0.4%
Lumbar or sacral spine injection	208	0.4%

Source: RIDOH 2015 Statewide Health Inventory

Kidney Disease Treatment Centers

Introduction

Kidney disease treatment centers are cited as one of the classes of health care facilities set forth in Chapter 23-17 RIGL, but are not defined by statute. Rather, the Rhode Island Rules and Regulations for Licensing of Kidney Disease Treatment Centers, promulgated by RIDOH, define a "kidney disease treatment center" as a "free-standing (non-hospital) dialysis facility for renal disease which may be a public or private organization or sub-unit of such an agency or organization providing chronic maintenance dialysis to ambulatory patients on the premises of the facility or in the patient's place of residence." (R23-17-DIAL).[37]

Survey Design

The Dialysis Center survey was constructed to capture ownership status, number of dialysis machines, number of maintenance (non-transient) dialysis patients, waiting list, hours of operation, and information technology, in addition to other data elements. The survey was informed by the CDC "Outpatient Dialysis Center Practices Survey." RIDOH determined the final survey instrument. The survey was designed to take 30 minutes to complete once data had been collected. Data was not submitted as to the length of time needed to complete the survey.

Data Collection

Publicly available licensure data for dialysis centers was obtained from the RIDOH website. The licensure database contained the names of 15 dialysis centers and their addresses, phone numbers, and fax numbers. In order to obtain the administrators' email addresses, one of our interns called each center one to three times over the course of one week using the information provided by the licensure list. Each dialysis center was given two weeks to complete the survey and received one to three phone calls as follow up.

37 Rhode Island Department of Health, Rules and Regulations for Licensing of Kidney Disease Treatment Centers, Section 1.10. Last amended September 2012. Available at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7014.pdf (Accessed October 22, 2015).

Response

Rhode Island has 15 Dialysis Centers, and all 15 centers responded to the survey for a 100% response rate.

Note that not all respondents completed every question, or did not provide a complete response for every question, so all totals may not equal one hundred percent (100%).

Findings

Findings from the Dialysis Center inventory administered by RIDOH in August 2015 reveal the following:

OWNERSHIP

Of these 15 centers, 86.7% were for profit entities and 13.3% were not for profit entities. All 15 were freestanding centers, but two were owned by a hospital. Thirteen centers (86.7%) indicated that they were part of a group of chain of dialysis centers and two (13.3%) indicated that they were not.

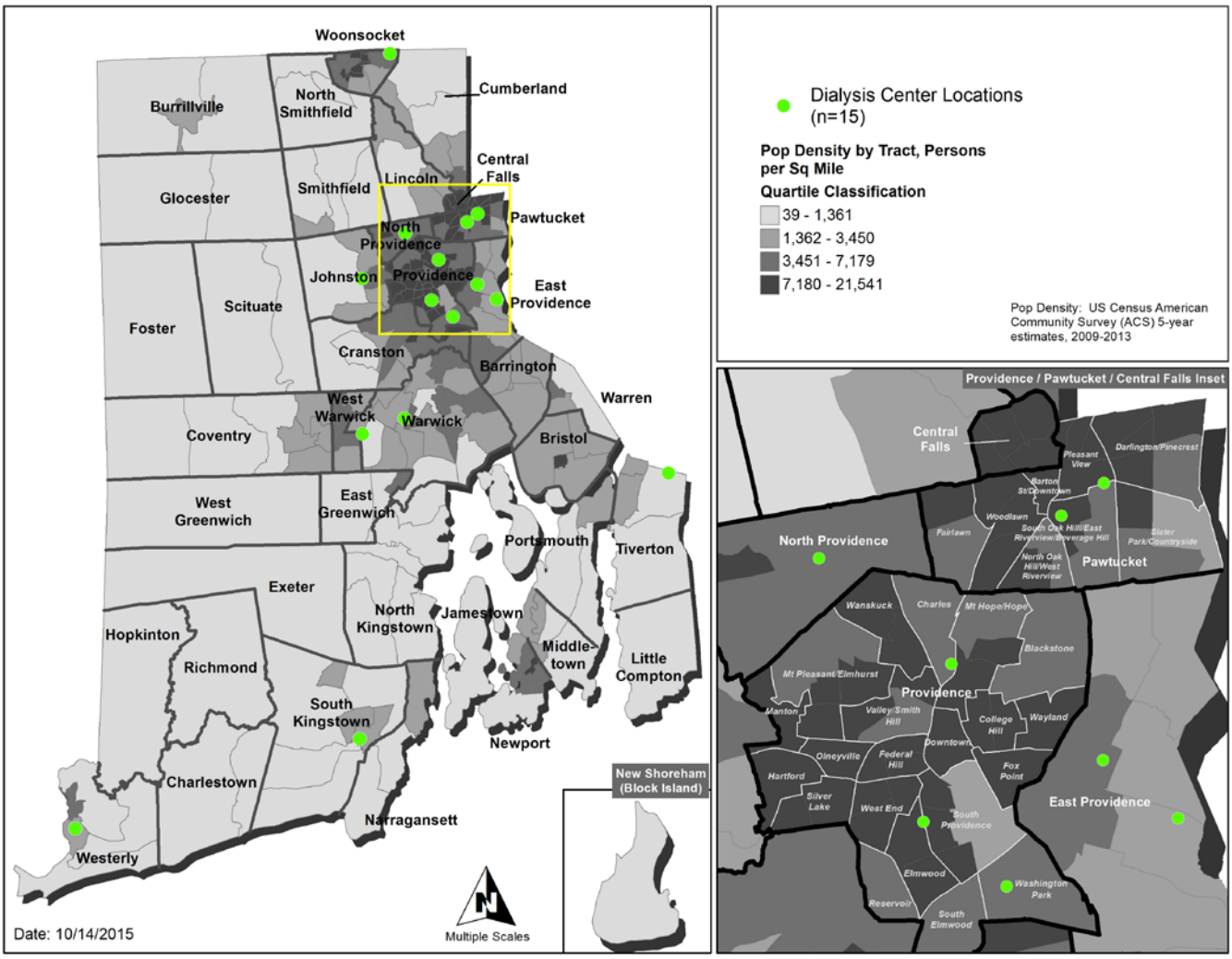
TABLE 69: OWNERSHIP OF DIALYSIS CENTER, 2014

Type	Percent
For Profit	86.7%
Not-For-Profit	13.3%
Government	0%

Source: RIDOH 2015 Statewide Health Inventory

The Figure depicts the geographic distribution of dialysis center locations overlaying population density distributions.

FIGURE 51: DIALYSIS CENTER LOCATIONS, 2014

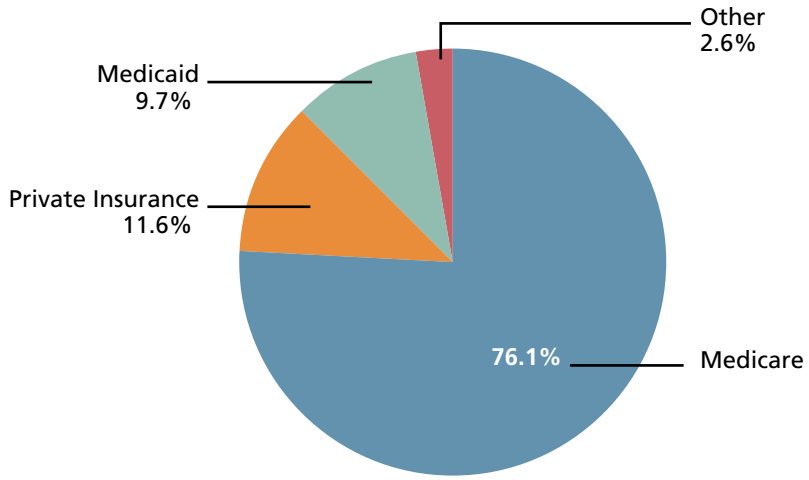


Source: RIDOH 2015 Statewide Health Inventory

PAYMENT SOURCE

Patients receiving services at Dialysis centers in 2014 predominantly were covered by Medicare at 76.1%, while 9.7% had Medicaid, 11.6% had private insurance, and the remaining 2.6% had Other, while no patients were reported as uninsured or paid for services themselves.

FIGURE 52: PRINCIPAL PAYMENT SOURCE, DIALYSIS CENTERS, 2014

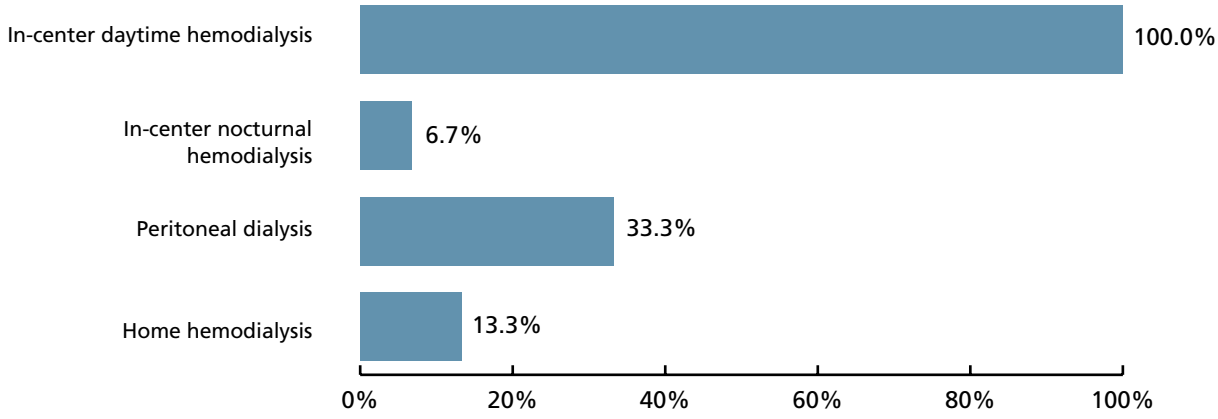


Source: RIDOH 2015 Statewide Health Inventory

SERVICES OFFERED

All 15 centers indicated that they offered in-center daytime hemodialysis, 6.7% that they offered in-center nocturnal hemodialysis, 33.3% that they offered peritoneal dialysis, and 13.3% that they offered home hemodialysis.

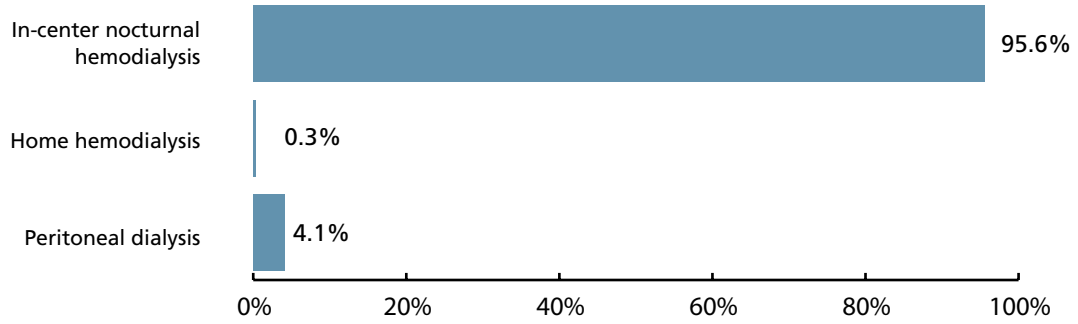
FIGURE 53: TYPES OF DIALYSIS SERVICES OFFERED BY DIALYSIS CENTERS, 2014



Source: RIDOH 2015 Statewide Health Inventory

The dialysis centers reported a total of 1224 maintenance, non-transient hemodialysis patients, with the average number of patients being 81.6 with a minimum of 40, and maximum of 161. The survey results indicated that 95.6% of maintenance patients required in-center hemodialysis, 0.3% required home hemodialysis, and 4.1% required peritoneal dialysis.

FIGURE 54: TYPES OF DIALYSIS SERVICES PROVIDED FOR MAINTENANCE PATIENTS, DIALYSIS CENTERS, 2014



Source: RIDOH 2015 Statewide Health Inventory

All dialysis centers combined had a total of 316 in-center hemodialysis stations, with the average number of in-center hemodialysis stations being 21.1 with a minimum of 12, and maximum of 34.

TABLE 70: NUMBER OF IN-CENTER HEMODIALYSIS STATIONS, DIALYSIS CENTERS, 2014

Number of Stations	Percent
12	13.3%
16	6.7%
18	6.7%
19	13.3%
21	26.7%
22	6.7%
23	6.7%
25	6.7%
32	6.7%
34	6.7%

Source: RIDOH 2015 Statewide Health Inventory

HOURS OF OPERATION

None of the dialysis centers reported that they had waiting lists. Of the 14 that reported detailed business hours, all had daily service hours before 8AM and 28.57% had daily service hours after 5PM. On average the dialysis centers were open 9.2 hours per weekday, with a minimum of 7.8 hours and a maximum of 13 hours.

TABLE 71: EXTENDED SERVICE HOURS, DIALYSIS CENTERS, 2014

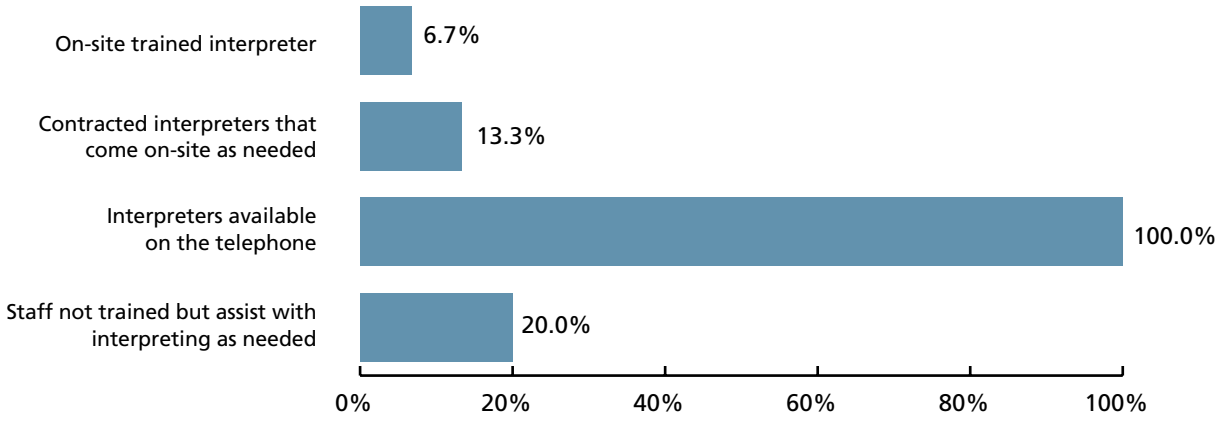
Hours Before 8 AM	Percent
Daily Service Hours Before 8AM	100.0%
Hours After 5PM	
No Service Hours After 5PM	71.4%
Daily Service Hours After 5PM	28.6%

Source: RIDOH 2015 Statewide Health Inventory

INTERPRETER SERVICES

All centers provided some type of interpreter service. All centers provided interpreters via the telephone, 6.7% via an on-site trained interpreter, 13.3% via interpreters that come on site as needed, and 20.0% via staff not formally trained but assisting with interpreting as needed.

FIGURE 55: INTERPRETER SERVICES IN DIALYSIS CENTERS, 2014

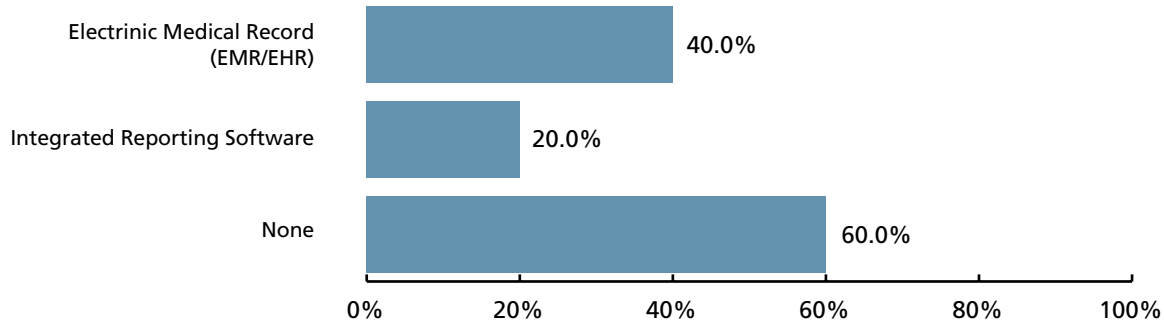


Source: RIDOH 2015 Statewide Health Inventory

HEALTH INFORMATION TECHNOLOGY

Most dialysis centers (60%) indicated that they do not use any information software, while 40% had an electronic health record. Twenty percent had integrated reporting software in that electronic health record.

FIGURE 56: INFORMATION SOFTWARE IN DIALYSIS CENTERS, 2014



Source: RIDOH 2015 Statewide Health Inventory

PATIENTS AND COMMUNITY

Introduction

One of the purposes of this study is to determine subpopulations that may be underserved or have reduced access to specific types of healthcare services. Efforts to improve health care services must take into consideration input from people who represent the broad interests of the community, including at-risk populations. Involvement of the public in setting public health priorities is increasingly recognized as an essential aspect of advancing the health of populations.[38] The general public has a wealth of information based on actual experiences with Rhode Island's health care systems. It is for this reason that a survey method was utilized to obtain public input.

Survey Design

The Patient and Community survey was written to capture health priorities, experiences with health care, and financial issues pertaining to access to care from the perspectives of community members. The survey was constructed in three sections. First, selected questions from the validated RAND Corporation "Short-Form Patient Satisfaction Questionnaire (PSQ-18)"[39] were used to evaluate community member experiences with health care. Second, questions developed by the Office of the Health Insurance Commissioner were used to study financial barriers to access to care. Third, based on former qualitative work that the Department of Health completed as community health assessments in Rhode Island, health priorities that were found to be consistent across communities in that study were displayed for participants to rank. Such priorities included making healthcare more affordable and expanding access to public transportation to access medical services. While all community input was incorporated into the survey before it was sent out, RIDOH determined the final survey instrument (see Appendix 1). The survey was designed to take about five minutes and could also be completed over the phone. Respondents reported that it took less than five minutes to complete the survey.

Data Collection

The survey, which was available in English and Spanish, was disseminated through a variety of venues. Interns traveled to a number of community events being held throughout the state and locations and administered surveys directly to individuals. Locations included were Kennedy Plaza in Providence and the local Famer's Markets.

Throughout June, July, and August 2015, surveys were distributed to patients and community members served by several federally qualified health centers (FQHCs); Women, Infants, and Children (WIC) programs; and community-based multi-service organizations. These entities included the Tri-Town Community Action Program WIC Program (located in Johnston and North Providence); Children's Friend (located in Providence); Providence Community Health Centers, Inc. (a FQHC located in Providence); the West Bay Community Action Program WIC Program (located in Warwick); East Bay Community Action Program (located in East Providence and Newport); the Thundermist Health Center WIC Program (located in Woonsocket); the Comprehensive Community Action Program (located in Cranston and Coventry); the Rhode Island Parent Information Network (serving families statewide); Well One (a FQHC located in Burrillville, North Kingstown, and Foster); Blackstone Valley Community Action Program (serving families in Pawtucket/Central Falls); Genesis Center (located in Providence); and Wood River Health Center (located in Wakefield).

Surveys in English and Spanish were also placed in the public seating area outside of the RIDOH's Office of Vital Records along with a box for individuals to deposit completed surveys. Additionally, the survey was posted on

38 Florin, D. (2004) 'Public involvement in health care', BMJ, 328(7432), pp. 159–161.
39 This survey was reprinted with permission from the RAND Corporation. Copyright © the RAND Corporation. RAND's permission to reproduce the survey is not an endorsement of the products, services, or other uses in which the survey appears or is applied.

the RIDOH website in August 2015 and a press release encouraging people to complete the online survey was distributed widely through the RIDOH's public communications venues. The online survey was also available in English and Spanish.

Response

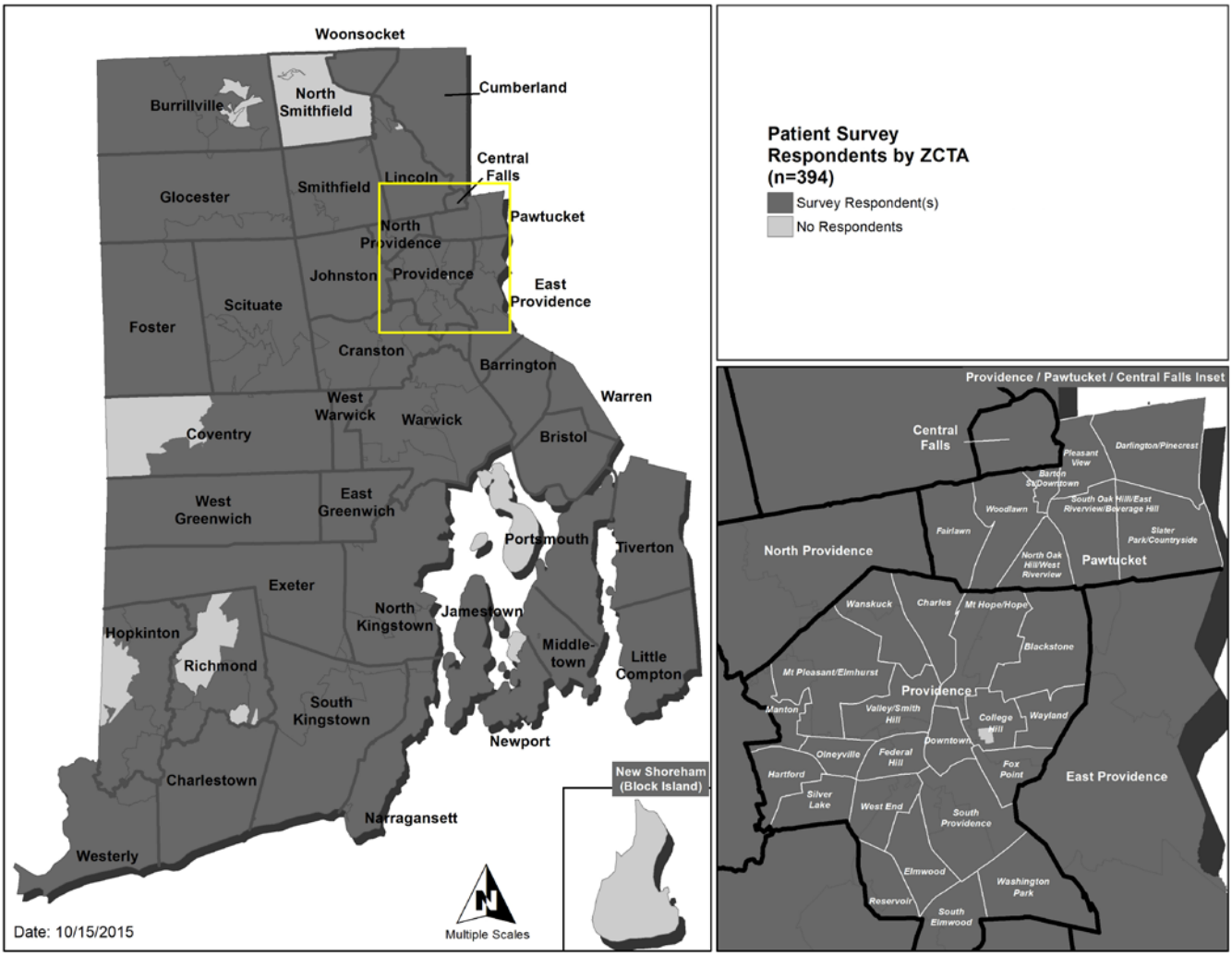
Two hundred and fifty-eight (258) respondents completed a paper version of the patient survey; 146 completed an on-line version; and two (2) completed a Spanish version. The total number of surveys completed was 404.

Note that not all respondents completed every question, or did not provide a complete response for every question, so all totals may not equal one hundred percent (100%).

Findings

The Figure depicts the geographic distribution of community survey respondents across RI.

FIGURE 57: COMMUNITY SURVEY RESPONDENTS BY ZIP CODE TABULATION AREA (ZCTA), 2015



Source: RIDOH 2015 Statewide Health Inventory

With respect to age, 0.8% of the respondents reported they were under 18 years, 24.7% were 18-29 years, 41.4% were 30-49 years, 24.7% were 50-64 years, and 8.3% were 65 years and over. A total of 396 respondents reported their age.

TABLE 72: AGE OF PATIENT SURVEY PARTICIPANTS, 2015

Age	Percent
Under 18 years	0.8%
18-29 years	24.7%
30-49 years	41.4%
50-64 years	24.7%
65 years and over	8.3%
Prefer not to answer	0%

Source: RIDOH 2015 Statewide Health Inventory

Of the 135 respondents who reported their race, 91.9% reported their race as White, 1.5% as Black/African-American, 1.5% as American Indian/Alaska Native, 0.7% as Asian, and 4.4% reported their race as "other."

TABLE 73: RACE OF PATIENT SURVEY PARTICIPANTS, 2015

Race (Web Version Only)	Percent
White	91.9%
Other race	4.4%
Black/African-American	1.5%
American Indian/Alaska Native	1.5%
Asian	0.7%
Native Hawaiian/Pacific Islander	0%

Source: RIDOH 2015 Statewide Health Inventory

A total of 124 respondents completed the ethnicity question. Of those that answered it, 97.6% reported themselves as being Not Hispanic/Latino and 2.4% reported themselves as being Hispanic/Latino.

Of the 399 respondents who answered the question regarding health insurance status, 54.4% reported that they had private insurance, 20.1% had other insurance (including uninsured), 14% had Medicare, and 11.5% had Medicaid.

TABLE 74: PATIENT SURVEY PARTICIPANTS BY INSURANCE TYPE, 2015

Insurance Type	Percent
Private insurance	54.4%
Other (including uninsured)	20.1%
Medicare	14.0%
Medicaid	11.5%

Source: RIDOH 2015 Statewide Health Inventory

Four hundred and one (401) respondents answered the question: "What was your total household income before taxes during the past 12 months?" Of the respondents, 26.9% reported that their total household income was less than $25,000, 11.2% reported their income between $25,000-$34,999, 7.5% reported their income between $35,000-$49,999, 10.0% their income between $50,000-$74,999, 10.2% reported their income between $75,000-$99,999, and 13.7% reported their income as more than $100,000. Another 20.4% reported that they did not know or refused to answer.

TABLE 75: HOUSEHOLD INCOME (BEFORE TAXES DURING PAST 12 MONTHS) OF PATIENT SURVEY PARTICIPANTS, 2015

Household Income	Percent
Less than $25,000	26.9%
$25,000-$34,999	11.2%
$35,000-$49,999	7.5%
$50,000-$74,999	10.0%
$75,000-$99,999	10.2%
More than $100,000	13.7%
Don't know/refuse to answer	20.4%

Source: RIDOH 2015 Statewide Health Inventory

Of the 400 respondents who answered the question: "What is the approximate cost of your co-pay for a doctor's office visit," 17.3% indicated that the approximate cost of their co-pay for a doctor's office visit was less than $20, 30.3% that it was between $20-$30, 9.8% that it was between $30-$50, 2.8% that it was between $50-$100, 0.3% that it was more than $100, 8.5% that did not know, and 31.3% that they did not have a copay.

TABLE 76: APPROXIMATE COST OF PATIENT CO-PAY FOR A DOCTOR'S OFFICE VISIT, 2015

Doctor's Office Co-Pay	Percent
Less than $20	17.3%
$20-$30	30.3%
$30-$50	9.8%
$50-$100	2.8%
More than $100	0.3%
Don't know	8.5%
No co-pay	31.3%

Source: RIDOH 2015 Statewide Health Inventory

All respondents (100%) reported on the approximate cost of their deductible. The largest number (30.4%) reported no deductible. Another 24.5% reported that they did not know the approximate cost of their deductible, and 11.4% reported a deductible of $500. Overall, 33% had deductibles over $500.

TABLE 77: APPROXIMATE COST OF PATIENT DEDUCTIBLE, 2015

Deductible	Percent
$100	4.7%
$250	4.7%
$500	11.4%
$1,000	4.0%
Under $1,000 (can't specify)	2.7%
Between $1,000 and $2,500	9.7%
Between $2,500 and $5,000	5.7%
Over $5,000	2.2%
Don't know	24.5%
No deductible	30.4%

Source: RIDOH 2015 Statewide Health Inventory

Respondents were asked to report the extent to which they agreed with several statements. The following choices were offered as possible answers (1=strongly agree, 2=agree, 3=uncertain, 4=disagree, and 5=strongly disagree).

The majority of respondents (79.6%) strongly agreed or agreed that their doctor's office had everything needed to provide complete medical care. Almost 10% (9.6%) either disagreed or strongly disagreed and 10.8% were uncertain.

The majority (77.1%) also strongly agreed or agreed that the office hours when they can get medical care were convenient (good) for them. However, 15.5% disagreed or strongly disagreed with this statement and 7.2% were uncertain.

A smaller majority (62.1%) strongly agreed or agreed that they felt confident that they could get the medical care they need without being set back financially. The percentage of respondents who reported that they were uncertain was 17.3%, and 20.6% reported that they disagreed or strongly disagreed with this statement.

A majority of respondents (71.3%) strongly agreed or agreed that the medical care that they have been receiving is just about perfect. A total of 14.6% felt uncertain, and 14.1% disagreed or strongly disagreed with this statement.

Most respondents (70.8%) also strongly agreed or agreed that they had easy access to the medical specialists they need. Sixteen percent felt uncertain and 13.6 disagreed or strongly disagreed.

One quarter of the respondents (26.3%) strongly agreed or agreed that where they get medical care, people have to wait too long for emergency treatment. A similar percentage (26.6%) were uncertain and 47.1% disagreed or strongly disagreed with this statement.

One quarter of the respondents reported that they strongly agreed or agreed (26.7%) that they have to pay for more of my medical care than they can afford and 15.3% felt uncertain. The majority (57.9%) disagreed or strongly disagreed with this statement.

Although a majority of the respondents disagreed or strongly disagreed (55.2%) that they were dissatisfied with some things about the medical care they receive, almost one-third of the respondents (32.5%) strongly agreed or agreed with this statement.

TABLE 78: TO WHAT EXTENT DO YOU AGREE WITH THE FOLLOWING STATEMENTS?, COMMUNITY SURVEY, 2015

	% strongly agree	% agree	% uncertain	% disagree	% strongly disagree
I think my doctor's office has everything needed to provide complete medical care	36.5% (N=149)	43.1% (N=174)	10.8% (N=44)	8.1% (N=30)	1.5% (N=6)
The office hours when I can get medical care are convenient (good) for me	28.7% (N=115)	48.4% (N=194)	7.2% (N=29)	12.2% (N=49)	3.5% (N=14)
I feel confident that I can get the medical care I need without being set back financially	26.5% (N=107)	35.6% (N=144)	17.3% (N=70)	12.9% (N=52)	7.7% (N=31)
The medical care I have been receiving is just about perfect	24.9% (N=101)	46.4% (N=108)	14.6% (N=59)	11.6% (N=47)	2.5% (N=10)
I have easy access to the medical specialists I need	23.5% (N=95)	47.3% (N=191)	15.6% (N=63)	11.1% (N=45)	2.5% (N=10)
Where I get medical care, people have to wait too long for emergency treatment	8.4% N=34)	17.9% (N=72)	26.6% (N=107)	33.5% (N=135)	13.6% (N=55)
I have to pay for more of my medical care than I can afford	8.4%	18.3%	15.3%	37.6%	20.3%
I am dissatisfied with some things about the medical care I receive	7.7% (N=31)	24.8% (N=100)	12.4% (N=50)	38.4% (N=155)	16.8% (N=68)

Source: RIDOH 2015 Statewide Health Inventory

When asked if the participant or a member of their household delayed or put off any sort of medical care going to the doctor because of the cost they would have to pay, almost one-third of the 404 respondents (31.1%) answered that they delayed medical care because of cost and had changes in their condition before receiving care. Of those 31.1% who reported that they delayed care, nearly half (46.7%) reported that they either got sicker before they got care or ended up going to the emergency room. Twenty seven percent of the respondents reported that they got better on their own.

TABLE 79: PATIENTS WHO DELAYED MEDICAL CARE DUE TO COST AND CHANGES IN THEIR CONDITION PRIOR TO RECEIPT OF CARE, COMMUNITY SURVEY, 2015

	Percent
I got sicker before I got care	28.2%
Nothing - I got better on my own	27.4%
Don't know	25.8%
I ended up going to the emergency room	18.5%

Source: RIDOH 2015 Statewide Health Inventory

Of those who got sicker before they received care or ended up going to the emergency room, 57.1% had private health insurance, 12.5% had Medicare, 10.7% had Medicaid, and 19.6% reported other.

When asked to rank community health issues, the majority of respondents reported that making health care more affordable (79.5%), increasing access to health care (69.9%), addressing drug and alcohol abuse (57.9%), and expanding public transportation (50.8%) were extremely important to them.

TABLE 80: RANK THE FOLLOWING COMMUNITY HEALTH ISSUES FROM ONE (NOT IMPORTANT TO YOU) TO FIVE (EXTREMELY IMPORTANT), PHONE SURVEY ONLY, PATIENTS, 2015

	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5
Making health care more affordable	1.2%	1.2%	7.2%	10.8%	79.5%
Increasing access to health care	2.0%	2.8%	9.2%	16.1%	69.9%
Addressing drug and alcohol abuse	6.9%	3.2%	16.6%	15.4%	57.9%
Expanding public transportation to access medical services	4.5%	2.5%	20.9%	21.3%	50.8%
Bringing the community together and creating opportunities for healthy living	2.0%	6.1%	22.7%	20.2%	49.0%

Source: RIDOH 2015 Statewide Health Inventory

Outpatient Care

CONCLUSIONS

1. The precise counting of 602.7 full time equivalents of primary care physicians is substantially lower than other previous estimates by up to 40%.

2. The data demonstrate a gap in collection of information on race/ethnicity reporting.

3. The data reflect significant gaps in information surrounding the ability of primary care, behavioral health, and outpatient specialty practices to identify patient needs for language and interpreter services.

4. The rates of usage of electronic medical records (EMR) are 84.7% in primary care, 59.1% in behavioral health clinics, and 55.2% in community outpatient specialty clinics indicating substantial variation in EMR use.

5. Psychiatrists reported that only 5.2% and 3.9% of their patient profile were Medicaid and Medicare beneficiaries, respectively. The corresponding data for psychologists was 5.3% and 5.1%.

6. There is limited integration between primary care and behavioral health. Using the same EMR for behavioral health and primary care providers as an indicator of integration, no integration was reported by 75.0%, 89.1%, and 100% of licensed behavioral health clinics, psychology practices, and psychiatry practices, respectively.

RECOMMENDATIONS

1. Based on the Henry J. Kaiser Family Foundation recommendation and the Health Resources and Services Administration evaluation methodology, the data indicate an approximate 10% shortage of full time equivalents of primary care physicians. Thus, the State should continue to explore ways to increase the number of primary care physicians, particularly for vulnerable populations. Focused efforts should be made to educate, recruit, and retain primary care physicians and providers to address these shortages.

2. Mechanisms to achieve uniform data collection related to race and ethnicity in primary care, behavioral health, and outpatient specialty settings should be developed.

3. Increase the use of certified medical interpreters to improve clinical care for patients with limited English proficiency.

4. Support greater use of EMRs in outpatient practices.

5. Increase behavioral health parity through improving access to care for Medicare and Medicaid patients among psychiatry and psychology services.

6. Encourage increased integration between primary care and behavioral health to improve patient access and outcomes.

Hospitals

CONCLUSIONS

1. Hospitals reported 37,634 total patients were billed on a sliding fee schedule.

RECOMMENDATIONS

1. Further research is needed to identify the services and the impact on access to care for vulnerable populations.

Long-Term Care

CONCLUSIONS

1. The data indicate that the majority of assisted living residences (51%) are not accepting new additional Medicaid beneficiaries. This creates a barrier to achieving the Medicaid goal of providing the "right care in the right setting at the right time"[1] and transferring residents out of institutional and into community-based settings.

2. The data indicate that 60% of nursing facilities and 52% of assisted living residences do not have dementia care units.

3. The data demonstrate a gap in collection of information on race/ethnicity reporting.

4. The data reflect significant gaps in information surrounding the ability of nursing homes, assisted living residences, adult day care programs, and home health agencies to identify patient needs for language and interpreter services.

RECOMMENDATIONS

1. Support the work on the "Reinventing Medicaid" initiative to decrease the number of Medicaid beneficiaries who reside in institutional long-term care settings but might be appropriately placed in other community-based living arrangements, such as assisted living residences.

2. Conduct further research to explore how many dementia care units in long-term care settings are needed, their ideal geographical location, and how the current supply will affect Rhode Island's aging population.

3. Mechanisms to achieve uniform data collection related to race and ethnicity in the long-term care setting should be developed.

4. Increase the use of certified medical interpreters to improve clinical care for patients with limited English proficiency.

1 Rhode Island 1115 Waiver Comprehensive Quality Strategy, March 2014, p. 4. Available at: www.eohhs.ri.gov

Facilities and Centers

CONCLUSIONS

1. Based on the low percentage of Medicaid utilization by MRI imaging centers and providers (6.2%) and ambulatory surgery centers (8.1%), Medicaid beneficiaries are not accessing these referred services to the extent that would be expected given the proportion of Rhode Island Medicaid beneficiaries.

2. The data reflect limitations in availability of trained interpreters and significant use of staff not trained but assisting with interpreting as needed. While there are a variety of methods of interpretation, the use of staff not trained but assisting was 57.7%, 33.3%, and 20.0% for MRI centers, ambulatory surgery centers, and dialysis centers, respectively. Of note, 100% of dialysis centers reported using interpreters available on the phone.

RECOMMENDATION

1. Ambulatory surgery centers and MRI imaging centers and providers should establish referral agreements with licensed community health centers to increase access to referred services for Medicaid beneficiaries and the uninsured.

2. Increase the use of certified medical interpreters to improve clinical care for patients with limited English proficiency.

Patients and Community

CONCLUSIONS

1. Forty percent of respondents had copays per visit between $20 and $50, and one third had deductibles over $500. Nearly one third (31.1%) of participants reported that they delayed or put off medical care because of cost, and of these 46.7% got sicker before they received care or ended up going to emergency room.

RECOMMENDATIONS

1. Strategies are needed to address cost barriers including deductibles and copays that prevent patients from accessing needed care in a timely manner.

SUMMARY OF OTHER STATE DEPARTMENT AND VA SERVICES

The following section includes brief summaries of the types and number of services offered by other state departments and the Veterans Administration. The data presented in this section is in addition to the survey data collected and analyzed in this report. This section is not intended to be a complete evaluation of other health services in RI, but rather a concise overview of selected other state and federal services.

Eleanor Slater Unified Hospital System

In March of 1994, the three state hospitals operated by the former Rhode Island Department of Mental Health, Retardation and Hospitals (renamed the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals) integrated into one hospital system - the Eleanor Slater Unified Hospital System (ESH). The 495 bed public hospital consists of two campus locations: the Eleanor Slater Hospital at the John O. Pastore Center in Cranston, Rhode Island and the Eleanor Slater Hospital/Zambarano Unit in Burrillville, Rhode Island. ESH is licensed by the Rhode Island Department of Health and accredited by the Joint Commission.

ESH treats patients with acute and long term medical illnesses as well as patients with psychiatric disorders. Most of the patients are admitted from community hospitals or other health care facilities and require hospital-level long-term care. ESH provides forensic services, psychiatric services, and long-term medical care. Forensic services are provided to patients who have been court ordered to ESH. In addition, ESH accepts psychiatric and medical admissions from community hospitals. ESH also accepts admissions from residential care facilities and nursing homes. In 2014, ESH had 82 admissions. Of the 82 admissions, 57 were forensic patients, 20 were medical patients, and 5 were psychiatric patients. The average patient age was 53 years old. ESH's budget consists of approximately 51% Medicaid funds and 49% state funds.

Department of Children, Youth and Families

The Rhode Island Department of Children, Youth and Families (DCYF), is the unified state agency with combined responsibility for child welfare, children's behavioral health and juvenile corrections. The Department is statutorily designated (RIGL 42-72-5) as the "*principal agency of the state to mobilize the human, physical, and financial resources available to plan, develop, and evaluate a comprehensive and integrated statewide program of services designed to ensure the opportunity for children to reach their full potential. Such services shall include prevention, early intervention, outreach, placement, care and treatment, and aftercare programs. The Department shall also serve as an advocate for the needs of children.*"

DCYF refined its vision and mission to reflect DCYF's system transformation as follows:

> **Vision –** *Healthy Children and Youth, Strong Families, Diverse Caring Communities.*
>
> **Mission –** *Partner with families and communities to raise safe and healthy children and youth in a caring environment.*

Through multiple programs extending through a range of community-based care to residential treatment, the DCYF provides child protection, child welfare, children's behavioral health and education, preventive services to children at risk of abuse/neglect, support services for children and families in need, and services for youth

requiring community supervision or incarceration due to delinquency. Programs and Direct Services are delivered through three service divisions:

- Child Welfare which includes Child Protective Services (including Intake) and Family Services;
- Juvenile Probation/Parole and Juvenile Corrections (Rhode Island Training School); and
- Children's Community Services and Behavioral Health

Child Welfare: When children and youth are removed from their home and placed into DCYF care and custody, Neighborhood Health Plan becomes their health plan provider. DCYF is responsible for all out of home care for children and youth except for psychiatric hospitalization and other medical treatment that is managed by EOHHS/Medicaid. DCYF monitors psychotropic medications, behavioral health services and behavioral health diagnosis of children and youth in Foster Care through data provided by the State's Managed Medicaid, Neighborhood Health Plan.

Preliminary analysis of data collected from Neighborhood Health Plan for CY 2013 and 2014 indicates that 21% of 2360 children quarterly in out of home placement were on at least one psychotropic medication and about 33% had at least one Behavioral Health diagnosis. Over 60% of children and youth were on ADHD medication. The next most prescribed medications were antidepressants and antipsychotics.

Juvenile Corrections: The Division of Juvenile Corrections is comprised of the Thomas C. Slater Training School for Youth (Training School) and Probation and Parole Services. This facility houses both male and female offenders through age 18. The Training School's mission is to provide a structured environment to enable youth to progress toward successful reintegration within the community.

The Training School addresses both the mental health and substance use treatment issues of their residents as well as rehabilitative and vocational needs. According to the 2015 Rhode Island Kids Count, in 2013, 155 youth (139 males and 16 females) were under the care of the training School's psychiatrist. Psychiatric medications were prescribed to 137. Outpatient or residential substance abuse services were provided to 188 residents at the Training School through contract.

The Home Confinement/Electronic Monitoring Program: In calendar year 2014, 242 youth were served by this program with a success rate of youth remaining in their community of 82%.

Probation and Parole: The number of youth on probation has been decreasing over the past 8 years. A 55% reduction in the number of youth on probation occurred from 2009 to 2014. In FY 2014, the average daily number of youth on probation is 530 versus 1,371 in 2007. An array of services are available to help youth including MST, Preserving Families Network, Youth Transition Centers or temporary placement in a residential setting.

The Division of Community Services and Behavioral Health (CSBH): Community Services and Behavioral Health focuses on ensuring that effective services are provided to support children in the least restrictive environment possible to support child safety, permanency and wellbeing, and overall family functioning. CSBH assists children and families involved with DCYF to access an array of behavioral health services based on assessments and needs of the child. CSBH provides oversight for DCYF funded services and programs.

Chafee Foster Care Independence Program: DCYF is the state agency responsible for the administration, supervision and oversight of all programs and services required and funded under the Chafee Foster Care Independence Program (CFCIP). The Consolidated Youth Services (CYS) Program ensures that older youth in the

care and custody of the DCYF, as well as youth aging out and former foster youth have the tools, resources and opportunities that will increase the likelihood they will successfully transition from DCYF care. The CYS program provides financial support, housing, counseling, employment, mental/physical/sexual health, food assistance, educational and other services to former foster care recipients.

SYSTEM OF CARE DEVELOPMENT

DCYF contracts with a broad range of vendors to provide a continuum of services for children and families. DCYF provides services to approximately 9,000 children/families annually.

TREATMENT SERVICES FOR CHILDREN FUNDED BY PRIVATE AND PUBLIC INSURANCE

A range of treatment options is available to children and adolescents statewide through the Community Mental Health Centers (CMHC) and other community based family service or mental health organizations. Available treatment options include outpatient individual, family and group therapy; intensive home-based services; respite services; behavior management; psychiatric assessment; and treatment, including medication management, psychological assessment, inpatient services and sexual and substance abuse treatment. During 2014, 6099 children under age 18 were treated at CMHCs. 24% of these children had a primary diagnosis of attention deficit disorder, 22% had depressive – related disorders, 16% had anxiety disorders and 13% had conduct disorders (RI KIDS COUNT Factbook).

Other services include inpatient psychiatric services, Acute Residential Treatment Services (ARTS), Partial Hospitalization Programs (PHP) and Early Childhood Day Treatment Programs, Enhanced Outpatient Services (EOS), and Emergency Services Hotline and Mental Health Emergency Interventions for Children. Mental Health Emergency Interventions for Children are provided by ten provider agencies. In CY 2014 provider agencies received 2872 phone calls and reported seeing 3897 children and youth.

TREATMENT SERVICES FUNDED THROUGH DCYF

Residential Treatment Programs (RTPs): Residential treatment programs are long term sub-acute psychiatric step down programs. RTPs are self-contained campus settings providing an intensive level of casework, therapy and educational programs. The RTPs in state include Harmony Hill School, St. Mary's Home for Children and ACE and Ocean Tides for youth in the juvenile justice system with Severe Emotional Disturbance (SED) or at risk for SED.

Residential Counseling Centers (RCCs) and Staff Secure Group Homes: RCCs and staff secure group homes are community-based psychiatric hospital step-down and diversionary programs designed to address the needs of SED youth and children. Services include on-site group, individual and family counseling, medication maintenance, psychiatric evaluations and case management. There is a high staff to resident ratio with overnight awake staff.

Group Home Special Population-Sex Abusing Youth: These specialized group home programs provide a structured treatment milieu as an alternative to residential treatment for youth who have sexually abused in a community based program. These programs provide special treatment approaches for sexually reactive/offender youth and intense supervision.

Group Homes: Group homes provide a structured and supportive community placement for children and youth that utilizes local schools, recreational and cultural services. Intensive mental health services are available as part of DCYF's hospital diversion and step down programming.

Therapeutic Foster Care: Specialized foster care programs provide professional support services to children, youth and foster parents within a supportive and structured home environment. These programs help to foster positive relationship skills, ameliorate emotional conflicts and prepare youth for transition to home, adoption, adult living or other settings.

Emergency Shelters/Stabilization Respite and Assessment Centers: There are 6 emergency shelters available across the state for children and youth from birth to eighteen years of age. These are temporary placements that provide both social and mental health services.

Transitional Living Services: Formerly the Independent Living Program, this program assists adolescents diagnosed as SED by developing skills needed to function independently in the community and to develop adult living skills while receiving mental health treatment.

OTHER CLINICAL AND PREVENTION SERVICES FUNDED THROUGH DCYF

Diagnostic Assessment Service (DAS): DCYF oversees and funds the Diagnostic Assessment Service for youth, age 12 to 18 referred by family and truancy court who require intensive diagnostic assessment to determine appropriate case planning. Outpatient DAS allows youth to remain at home while being evaluated. Recommendations are developed to guide the court's disposition based on a comprehensive assessment. During CY 2014, 162 DAS were completed.

Evidence Based Practices: DCYF has collaborated with various providers to implement additional evidence-based or evidence-informed programs. These programs include Multi-systemic Therapy (MST), Parenting with Love and Limits (PLL).Trauma System Therapy, Positive Parenting Program (Triple P), Alternative for Families – Cognitive Behavioral Therapy (AF-CBT), Trauma Focused Cognitive Behavioral Therapy, Teen Assertive Community Treatment (TACT), Family Centered Treatment, and Trauma System Therapy. MST, PLL, FCT and TST models engage family while youth are in placement setting with the goal of supporting and preparing families for reunification.

FCCP (Family Care Community Partnerships): The FCCP were developed to provide necessary community based support and wraparound services for children and families who are at risk for DCYF involvement for child maltreatment; children who are mentally, emotionally, and behaviorally challenged; or youth who are involved with juvenile corrections. An estimated 20% of the children receiving services through the FCCP are children with SED. Referrals are made by DCYF, community agencies or are self-referrals. Project Early Start services for children birth to age 5 are available through the FCCPs; services include care management, child development, education, parent aides and recreational activities.

Wayward/Disobedient Diversion Services: Community programs and services have been developed to divert youth from the juvenile justice system by providing services in the community. These programs have assisted in reducing the number of youth in the RI training school and on probation.

Legislative Initiative Article 23: This initiative ensures that appropriate community services have been offered to families and children prior to the filing of a wayward petition. A referral is made through the local police department to the local agency approved by DCYF for an initial screening/assessment. An assessment and service plan are provided at no cost to the family. In FY 2014, seven community agencies provided services to 420 youth.

Youth Diversionary Programs (YDP): YDP diverts youth ages 9 to 17 from the juvenile justice system and DCYF involvement through crisis intervention, family mediation, advocacy, counseling and referrals provided for up to 90 days. 245 youth were served in FY 2014.

Youth Transition Centers (YTC): YTC is a public/private collaboration for high risk youth on probation or leaving the Rhode Island Training School. 85 youth per year receive rehabilitative, outreach and tracking, prevention services, with an emphasis on strengthening families.

Other Community Prevention: DCYF administers several programs and services through other federal funding to protect the most vulnerable population of children and to promote family strengths and healthy functioning. The Safe Families Collaboration Program with the Coalition Against Domestic Violence co-locate Domestic Violence liaisons at DCYF and the FCCPs to provide families support, consultation and advocacy concerning domestic violence.

Rhode Island Child Welfare-Early Care Partnership: DCYF implemented an early childhood mental health competency and endorsement system that provides a framework of knowledge, skills, and reflective practice experiences for the early childhood workforce. This infrastructure across early care systems ensures that infants and young children in the child welfare system receive quality early care and education services which ameliorate the effects of exposure to trauma and improve their social and emotional well-being.

Rhode Island Department of Corrections

The Health Care Services unit at the RI Department of Corrections is constitutionally mandated to provide medical, dental, and behavioral health care to the incarcerated inmate population who are either sentenced or awaiting trial within all facilities of the Rhode Island Department of Corrections (RIDOC). Health Care Services also has a secondary public health function for the State of Rhode Island, as it serves Rhode Island's highest risk population, a population unlikely to receive regular medical or dental care while in the community, and therefore at risk for contracting and spreading untreated infectious disease.

The daily inmate population is many times more likely than the general population to have infectious and other diseases and conditions. Approximately 1% of the population is HIV positive, approximately 25% of the inmate population is infected with Hepatitis C, 15 – 20% of the incarcerated population has serious mental illness and up to 80% of the population are substance abusers. We have diagnosed more HIV infections in the state than any other testing site.

The Health Care Services unit must provide important medical, behavioral and dental care services for inmates in each facility on a daily basis. Each offender must be evaluated by a nurse and a behavioral health specialist at commitment and then re-evaluated by a physician and/or a psychiatrist if they are found to have underlying disease. Inmates who require medication must have a secure method of receiving that medication 24 hours a day. Inmates who become ill while incarcerated must be promptly evaluated and treated. New commitments offer special challenges since many of them experience potentially life-threatening withdrawal from substances taken in the community. Female offenders also require an array of gender specific medical and mental health needs. It is more likely for a person with a serious mental illness to be housed at the RIDOC than it is for that person to be housed in a psychiatric inpatient facility elsewhere in the state. RIDOC, though not it's primary role or responsibility, provides custodial care for more people with behavioral illnesses than any other inpatient psychiatric institution in Rhode Island.

The RIDOC currently has two infirmaries that operate 24-hours per day, 7-days per week, located at the commitment centers in the Women's Facility and Intake Service Center, and six on-site dispensaries, staffed by 47 nurses (including 4 nursing supervisors), 5.0 full-time equivalent physicians (both state employed and consultants), and 2.5 Physician Extenders who provide on-site primary care services and telephone coverage 24-hours a day. We have a capacity for 15.0 FTE mental health workers (1 Clinical Director Behavioral Health Services, 1 Supervising Psychologist, 1 Mental Health Discharge Planner and 11 Social Workers), and contract 2.75 FTE psychiatrists, who provide on-site behavioral health services. There are also health educators, x-ray technicians, and medical records personnel providing necessary support services.

Once an individual is incarcerated their health insurance is "suspended" RIDOC does not collect reimbursement from health insurers and only if an individual is hospitalized for 24 hours and 1 minute does it reinstate to pay the community hospital for services.

PROGRAM GOALS/OBJECTIVES:

The broad goal of the Health Care Services unit is to provide constitutionally mandated medical services to all inmates who are in our care and custody. For each of the distinct populations in custody, the following objectives are the foundation for day-to-day operations:

For sentenced inmates: To provide needed diagnosis and medical care for chronic medical conditions that will prevent more serious conditions from developing; care that is focused on insuring the best possible function in the correctional setting, and that allows successful reintegration into family and community.

For the pre-sentenced population: To provide open access to acute care services so that offenders can move through the legal process without impairment from health problems; to provide continuing care for chronic medical conditions precisely and effectively so that behavioral health is preserved, and more serious conditions are prevented from developing; and to provide the community with case findings and public health services and intervention so the health of all Rhode Islanders is protected.

Health Care Services is divided into areas of Administrative, Nursing, Dental, Pharmacy, Physician Services, Behavioral Health, Public Health Education and Medical Records. The comprehensive goal of the unit is to deliver the same level of care to an inmate that would be provided if he/she were in the community and covered by the medical assistance program. We also provide transportation to outside clinics for treatment not available under the medical assistance guidelines; however, inmates are required to pay for services that are not provided under those guidelines.

The Jailed population in 2014:

of Commitments 16,252; while the average pretrial length of stay is 23 days, the median is only 3 days.

The Sentenced population:

- Average # of sentenced inmates for FY 2014 was 3,214

There are 202 inmates sentenced to life and 32 are sentenced to life without parole. Two of those inmates are women. These 234 inmates constitute 8.6% of the total sentenced population. 20 of the lifers are inmates from other states or inmates for which RI shares jurisdiction.

Over two thirds of all RIDOC offenders are between the ages of 20-39. The average age of male and female sentenced inmates is 35.

Patients by older age groups included:

- 50-59 averaged 411 inmates
- 60-69 averaged 96 inmates
- 70-79 averaged 29 inmates
- 80-89 averaged 4 inmates

The vast majority of offenders (commitments, awaiting trial, and sentenced) are white, followed by black and Hispanic. Offenders who identify themselves as Asian, Native American, other or their race is unknown make up less than 2% of the population for each category of offenders.

- There were 19,151 Primary Care encounters in calendar year 2014.
- There were 1,864 on site Specialist encounters in calendar year 2014.
- There were 2,394 off site specialty encounters.
- There were 153 hospital admissions.

Characteristics of a Typical RIDOC Sentenced Offender

Characteristics of Male offenders

- Twenty-six percent (26%) entered RIDOC as probation violators in FY14.
- Six percent (6%) entered prison as parole violators in FY14.
- The largest group are white (46%), single (73%), and self-identified as Catholic (38%).
- About half (48%) have a high school diploma or GED, 42% have less than a 12th grade education; and an additional 8% have completed some college.
- Fifty-two percent (52%) are fathers; the average number of children fathered is 2.
- Forty-eight percent (48%) were unemployed at the time they became incarcerated.
- Fifty percent (50%) of males were re-sentenced within 36 months of release.

Most common misdemeanor offenses were driving with a suspended license, while the most common felony offense was breaking and entering into a dwelling.

Characteristics of Female offenders

- Twenty-five percent (25%) entered RIDOC as probation violators in FY14.
- Three percent (3%) entered prison as parole violators in FY14.
- The majority are white (62%), single (70%), and self-identify as Catholic (44%).
- Thirty-four percent (34%) have less than a 12th grade education; 36% have a high school diploma or GED and an additional 21% have completed some college.
- Sixty-four percent (64%) are mothers; average number of children is 2 per offender.
- Sixty-nine percent (69%) were unemployed at the time of incarceration.
- Forty-one percent (41%) of females were resentenced within 36 months of release.

Most common misdemeanor offenses were driving while intoxicated and shoplifting, while the most common felony offense was robbery.

Providence VA Medical Center

Providence VA Medical Center (VAMC) consists of the Medical Center located at 830 Chalkstone Avenue, Providence, RI, and community-based outpatient clinics (CBOCs) in Middletown, RI, New Bedford, Mass., and Hyannis, Mass. Providence VAMC was built in 1948 and accepted its first patient in 1949. An additional hospital wing was added in 1977, and an ambulatory care building was completed in February 1998. The New Bedford CBOC was opened in 1985; the Hyannis CBOC was opened in February 1998 and moved to a newly-renovated location in November 2008. The Middletown CBOC was opened on Veterans Day in 2000.

Providence VAMC is a primary and secondary health care facility providing a full range of patient care services with state-of-the-art technology. Providence VAMC is a community leader in medical education and research. Comprehensive health care is provided in areas of medicine, surgery and psychiatry, including more than 32 sub-specialty clinics. Providence VAMC is a part of VA New England Healthcare System (VISN 1), which includes facilities in Rhode Island, Connecticut, Massachusetts, Vermont, New Hampshire and Maine. The facility also provides administrative support to three Veteran Outreach Centers.

In FY 15, there were 34,419 patients seen at the Providence VAMC with 433,646 visits. In the VAMC hospital, there were 3,305 admissions. There were 53,446 Surgery clinic visits and 50,644 Medicine clinic visits. For behavioral health services, there were 9,364 patients receiving mental health services with 71,787 encounters in FY 15. In terms of substance abuse services, there were 1,221 unique patients and 31,884 encounters. In FY 15, there were 2,112 new patients at VAMC.

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