July 12, 2021

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Senior Deputy Chief of Staff
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Secretary Womazetta Jones
Office of the Secretary
3 West Road
Cranston, Rhode Island 02920
Independent Review Eleanor Slater Hospital

Dear Mr. Afonso, Mr. Almond & Secretary Jones,

The Hospital Association of Rhode Island (HARI) and Care New England (CNE) are pleased to present our report containing our review and recommendations to assist the State of Rhode Island in evaluating the quality, safety and access to care at Eleanor Slater Hospital System (ESH) and its attendant sites.

This peer evaluation included site visits by CNE administrators and clinicians to all the facilities that constitute ESH (Zambarano, Adolph Meyer, and Regan), except for the Benton site. The professional biographies of the individuals who participated in the visits and contributed to this report are included in **Appendix A**. These site visits were principally conducted during the week of June 4, 2021 with limited follow up visits. The schedule of site visits is included in **Appendix B**. Also, the team conducted formal interviews of various leadership individuals as listed in **Appendix C**.

At the outset, we extend our sincere thanks for affording us the opportunity to be involved in the assessment of the care of the patients at ESH. Much has been written in the public domain in recent months that has been critical in nature, but please be assured that we have approached this review with an open mind and the shared goals of fostering the safe and professional care of the patients of ESH. We

are grateful for the collegiality of the staff and leadership throughout ESH. All were professional, welcoming, helpful, and open to feedback.

The teams toured the units, interacted with staff members, and reviewed various reports made available by ESH. CNE clinicians did not provide any direct patient care or services during the site visits. The review of policies and reports was not extensive nor was it considered to be an essential part of the project. Our major focus was on reviewing aspects of the clinical care provided to the patients of ESH. We offer the within opinions based upon our own clinical experience within the confines of the information and observations made available to us, and we will comment on the facility, staff education, and potential future care of the residents.

As a group of experienced clinicians and administrative leaders, we are not qualified as a formal review body such as many regulatory agencies including The Joint Commission and the Rhode Island Department of Health. We were asked to assess the clinical care at ESH, and that is the lens through which we conducted our visits and present our findings in this report. We are not a certified body of any nature, and as such, we present these collective opinions based on our collective clinical experience.

This report has been prepared in fulfillment of the scope of work set forth in Section 1. of the document entitled "Independent Review of Eleanor Slater Hospital (ESH)" and such further description as set forth in the May 4, 2021 letter from M. Teresa Paiva Weed, President of HARI to this group. This report was commissioned by and prepared for the exclusive use of the State of Rhode Island, and other parties may not rely on the report or the accuracy or completeness of any opinions and recommendations set forth herein.

Where site inspections, interviews, and record reviews were conducted, the report is based solely upon the information provided to CNE by ESH during the visits and the personal observations of the visiting clinicians on the dates of the site visits. The validity, accuracy, and comprehensiveness of the information provided has not been independently verified. For the purposes of this report, CNE has assumed that the information provided by ESH is both complete and accurate and that ESH's normal activities were being undertaken at the time of the site visits that provide the basis for the factual observations contained herein, unless otherwise expressly noted.

CNE cannot warrant or guarantee the efficacy of its recommendations, if adopted, and instead provides these observations and recommendations based solely upon the information available to CNE at the time of the site visits and for informational purposes only, for the exclusive use of the State in its quality improvement endeavors at ESH.

The report will be divided into a facility by facility review with specific observations as to the clinical care delivery, focusing on the nursing and medical care, documentation, barriers to discharge and some opportunities for improvement we suggest for consideration. Following the specific comments on the clinical quality of each facility, we provide additional insights and opinions that we believe are important and hope will provide helpful insight into opportunities for growth as the State works toward improvements of the ESH system.

Zambarano Unit

Site Review Team

Idrialis (Idri) Hughes, Rachel Roach, and Drs. Fulton and Fanale

Findings:

The Zambarano site visit team toured the facility, interacted with staff and reviewed the charts of all 72 patients. Overall, the clinical care of the patients at Zambarano is high quality. The patients are treated and well cared for by the staff. The patient population is complex, presenting multiple medical and behavioral health problems.

The medication lists were reviewed and found to be appropriate. Our review considered the total number of medications given per patient and evaluated how many antipsychotics and other central nervous system agents were being used, both standing orders and "as needed." Despite the number of medical conditions and complexity, there was no evidence of unnecessary polypharmacy. When behavioral health medications were being used, they were appropriate and clearly noted indication for them, and there did not appear to be an abundance of multiple agents, or heavy use of "as needed" agents. There does not seem to be any overuse of behavioral health medications. For example, a fair number of patients have an order for "as necessary" benzodiazepines, and the medication review lists~~,~~ reveal that these medicines are rarely given.

Additionally, many of these patients are "total care" patients, requiring two to three individuals to get them out of bed to a chair; in many facilities, this would not happen as it does at Zambarano. Due to the immobility of many of these patients, skin care is a very pressing concern. The skin care of these patients is truly excellent, in large part due to the dedication of the team to getting them out of bed and frequent position changes. Also, for the most part, family involvement was quite present, and they are very supportive of the care at Zambarano and actively advocate for their loved ones.

We found the clinical documentation in the paper medical record to be quite good and relevant. There were timely physician notes when there was a change in condition. Upon arrival on our first day, Dr. Stone mentioned that the requirement for a weekly physician note is being moved to monthly. Most of the patients had monthly notes, but there were some instances of missing or late routine physician notes, most specifically on 3 North.

Many of the patients are deemed to be "medically stable and ready for discharge". Where, technically, this may be accurate, our observations raised many potential disposition concerns that make it almost impossible to transfer any of these patients to a different facility:

- Some patients have undocumented legal/citizenship status or are from the corrections system.
- Some patients have no means of medical coverage other than their current Medicaid RI status.
- Some patients have co-existing chronic behavioral health issues, making other facilities unwilling to accept them in transfer.

- Many of these complex patients require extra staffing to care for them, which is not possible at other skilled nursing or long-term care facilities.
- Many patients have been previously discharged from nursing facilities, and their clinical and behavioral health status make them unacceptable to other nursing facilities.
- Some patients with alarming past records are found to be unacceptable to other facilities.
- Not having an electronic medical record makes discharge planning very difficult.

We would be quite concerned with a wholesale transferring of most of these long term patients given the substantial complex, specialty type of care they require. Our clinical team is concerned that this cohort of patients will deteriorate in other facilities who are not skilled nor staffed to care for these patients. However, there are a handful of the 72 patients that do have an opportunity for discharge and transfer that are actively being prepared for that inevitability.

Our general feeling is that the physician care, as evidenced by the documentation review is good, and the current physician staffing pattern is acceptable. There seems to be adequate nursing and certified nursing assistant staffing, but we did not review specific staffing levels. Interdisciplinary support from social work, therapies, etc. is quite good. Regular care planning meetings take place with strong collaborative discussion and resulting in detailed and impressive care plans that were available in the record.

The interviews of the nursing leadership emphasized the profound dedication of the staff to their patients. The staff turnover is generally low, and they are proud of the work they do. The recent negative media attention challenges their loyalty, and nursing leaders are concerned that they will lose experienced staff as a result. The positives noted include the dedication to patient care, the CNA staffing levels, the interdisciplinary support, and the effectiveness of the care planning meetings. Their concerns include the lack of an EMR and the need for operational supports as listed below.

Unit Specific Opportunities for Improvement

- Restraint reduction program (particularly focused on the use of restraints for fall prevention). The staff is quite aware of this and efforts are underway.
- More focused CNA educational support would help, not only in the area of restraint use, but perhaps in other areas as well.

Additional Observations

- Having a full-time radiologist is unnecessary.
- There are Annual Goals of Care Assessments and updated notes in most records, but more systematic attention to this would be recommended.
- Notes of the two current staff physicians at Zambarano are generally very well done.
- Use of antibiotics for changes in condition seem entirely appropriate.
- “Medically stable” status is a relative term, as described above, as the medical condition may be stable but disposition and transfer unlikely, given the overall complexity of the patient, population and the lack of appropriate options in the RI care continuum at present.

- There seems to be routine re-assessment of the use of behavioral health medications.
- Routine fall assessments and plans are documented.
- Physical restraints for some patients are in use, and there does not seem to be an overuse of "chemical" restraints. When used at Zambarano, restraints were mostly noted for fall prevention and not behavioral indications.
- The presence of a neurologist to advise and treat spasticity is in place and is commendable.
- There is very little evidence of "polypharmacy."

Regan 5 Unit

Site Review Team

Bob Haffey, Judy Thorpe, Dr. Paari Gopalakrishnan, Claudia Maine, Dr. Ana Tuya Fulton, Idri Hughes, Dr. Seth Koenig, Jenni LaLuz

Findings:

The Regan 5 site visit team toured the facility, interacted with treatment staff, reviewed the medical records for patients being cared for on this unit, and reviewed pertinent documents in completing this peer consultation. The professionalism and compassion exhibited by the staff and providers at this site was palpable and heartening to observe. Discussions with the staff on duty demonstrated a sense of pride in their care, which included a notable focus minimizing risk of skin breakdown and restraint use. There was also a sense of commitment to their patients including (pre-Covid) taking long term patients outside and on short field trips.

Our review of the quality and safety of care provided on Regan 5 revealed consistent documentation of care plans with appropriate, comprehensive updates made weekly. Care plans included in the medical record were comprehensive with documentation of ongoing multi-disciplinary meetings (including family members) to review and update. All patient records appear to demonstrate appropriate medical care and documentation. The patients were stable, with very long lengths of stay~~s~~, and many without a potential disposition. These barriers to discharge reflect the absence of appropriate discharge settings able and willing to meet the needs of the patients currently being cared for on Regan 5.

A review of minutes from the Medical Executive Committee, and the review of several providers' medical staff files is reflective of a solid workflow for oversight of the medical staff providers including professional practice evaluations. On the day of the site visit, the staffing on the unit appeared appropriate for the patient care delivered, both in terms of number and type of staff providing for the needs of the patient population. RN, CNA, and respiratory staffing ratios appear to be adequate for the unit size to provide quality care for patient. Physician staffing workflow were reviewed with the Chief Medical Officer and the Assistant Chief Medical Officer. They outlined a 24-hour onsite coverage plan, workflow and a review of daily responsibilities for physicians. The plans appear reasonable; however, we did not speak to any physicians outside leadership.

The Quality Improvement Program Structure includes appropriate reporting relationships between process improvement committees and the leadership committees. Quality and Patient Safety key performance indicators are consistently tracked and regularly shared through the quality program structure. Medication administration practices, as well as quality and medical event reporting would likely be improved with implementation of an electronic medical record and electronic incident reporting system.

The highest quality wins described to the site review team include an impressive 39% reduction in the use of restraints, supplemented by an active interdisciplinary committee review of all restraint episodes. Additionally, the facility-acquired pressure ulcer rate is consistently low, and in 2020 the organization achieved the reduction target. Staff was able to speak to the processes that are in place to support skin integrity and prevent skin injury. Lastly, pain assessment and pain management are consistently and robustly documented.

Reagan 5 was observed to be well-maintained. The hallways were free from clutter and common areas kept clean. Staff were able to speak to the process for regularly checking the crash cart, including how access to this piece of emergency equipment is maintained in the event of a power outage. However, the presence of innumerable ligature points presents a significant risk to patient safety. The process of room and patient checks every five minutes that was implemented to mitigate the risk of patient self-harm due to the facility's significant number of ligature risks is inadequate, given the number of patients and size of the unit. The solution to reduce ligature risks is to meet the recommendations set forth in The Joint Commission survey report.

Unit Specific Opportunities for Improvement

Immediate attention to facilities improvements is needed to eliminate ligature risks. This also will potentially achieve staffing cost savings and/or permit the reallocation of staff to other direct care functions. Consideration for expanding services to allow the unit to function as a comprehensive long-term acute care hospital (LTACH) is suggested. This is a need for the patients of our state, as there currently is no in-state LTACH option for Rhode Islanders. Regan appears to offer many of the services needed to function as a full-service LTACH. However, a full gap analysis is advisable. Additional revenue opportunities could be realized through expansion of services aimed at achieving LTACH licensure.

Regan 4 & Adolph Meyer Behavioral Health Site Visits

Site Review Team

Dr. James Sullivan, Idri Hughes, and Mary Marran

Findings:

The behavioral health team conducted a total of four site visits which included touring the units, reviewing all patient records, observing treatment team meetings, and interviewing both hospital leaders and direct care staff. The staff at both the Adolph Meyer and Regan settings were welcoming and receptive to our visits.

With a keen interest in reviewing safety and quality concerns, the behavioral health site review team found a number of notable strengths. Nursing staff were knowledgeable about the clinical needs of their patients demonstrating empathy and compassion for the complex patient population under their care. All staff that were individually interviewed expressed a sense of pride in caring for patients.

One highlight of our site visit occurred when observing an interdisciplinary team meeting in Adolph Meyer. The team, as represented by the physician, psychologists, occupational therapists, nurse and institutional attendant of psychiatry (IAP), demonstrated a comprehensive understanding of each patient's psychiatric and medical needs. Of note, discharge planning was included in each treatment plan review and discussed with family involvement.

The occupational therapy staff stood out, as they demonstrated a clear understanding of each patient's daily needs in addition to maintaining a focus on a recovery model with a goal for discharge to the community. Interventions included community-based activities to assess and prepare the patient for discharge. As an example, one treatment intervention included improving "topographical orientation" meaning improving the patient's ability to follow directions and safely navigate around their anticipated discharge destination. The OT staff also was compiling a complete inventory of group home locations to best match each individual patient's needs. In turn, this will facilitate appropriate community placement and increase the likelihood of a successful discharge transition. Additionally, the OT staff has put great thought into needed changes to the hospital's therapeutic environment including proposals for both centralized and unit-based programming, underscoring the importance of meaningful daily activities.

The psychology staff were observed to be central to the treatment planning process and treatment goal setting for each individual patient. In each of the two interdisciplinary team meetings observed in Adolph Meyer and Regan 4, the psychologists led the treatment planning discussion demonstrating knowledge of each patient's unique needs. Psychologists also developed individual behavioral plans, as appropriate, and training direct care staff to the necessity for consistent implementation of each behavioral plan. Our review of medical records also provided evidence of comprehensive discharge planning and work with families by the social services clinicians.

Psychiatrists and advanced practice clinicians in the Adolph Meyer facility demonstrated a clear understanding of patient treatment needs and interdisciplinary team efforts. Clinical chart review revealed the sound practice of medication use, appropriately targeting presenting symptoms of illness. This included daily prescribed medication as well as the use of PRN medication. Documentation of care appeared to be complete and reflective of appropriate treatment. However, the paper-based record was difficult to navigate.

Our interview with nursing and quality leadership revealed evidence of performance improvement activity most notably in the area of restraint reduction. This also was noted in our conversations with nursing staff who were able to describe the successful reduction in restraints achieved by the implementation of the Safeward Model. Staff noted that these efforts were somewhat hindered by social distancing requirements as a result of the pandemic.

Unit Specific Opportunities for Improvement

One of the more concerning observations for the behavioral health site team was the poor condition and safety concerns relating to the Adolph Meyer facility. The deteriorated condition of the building and the prevalence of ligature risks throughout is highly concerning for a psychiatric facility. The environment of care is critical to the therapeutic benefit for patients, the poor condition of the units impede patients' ability to safely achieve stabilization of symptoms. The Regan Building appears to be in far better physical condition but also has numerous ligature risks to address. As noted earlier, the 5-minute check procedure does not adequately mitigate the severity of the ligature risks present at either facility.

There is a lack of cohesion evident between paraprofessionals (i.e. CNAs, IAPs, MHWs) and professional staff (i.e. RNs, OTs, Psychologists, MDs/APPs). Several factors appear to contribute to this division. First, 60 percent of the staff is comprised of paraprofessionals with a high school education and without specialized behavioral health training. Long-term staff demonstrate resistance to training around new process and patient care strategies. Many of the staff have longevity but are accustomed to the~~,~~ "old way of doing things" and are, by human nature, resistant to change. There does not seem to be great presence of leadership in assisting with modeling and promoting change. There are annual trainings, but there is a need for increased education especially in the area of working with individuals with intellectual disabilities. There is a lack of staff with the training or skills set to work with this unique population. Additionally, there is a breakdown of information due to the lack of current technology and staff meetings. When staff were asked about staff meetings on Regan 4, they referred to treatment team and daily nurse report huddles but did not report a routine way of meeting with leadership to discuss concerns.

The Regan 4 treatment team revealed several concerns. There was an observable tension between physicians and the other members of the treatment team, which includes nurses, NPs, OTs, psychology, and discharge planning. The physicians were not receptive to team input resulting in shutting down these important discussions. Staff interviews revealed concerns relating to physician presence and productivity. The burden of patient medication oversight appeared to fall entirely to the advanced practice practitioner. There was also much confusion over access to medical consultation on Regan 4.

The paraprofessional staff described severe weekend staffing shortages resulting in a less than adequate staff to patient ratio leading to excessive overtime and staff burnout.

Many patients on Regan 4 and in the Adolph Meyer building did not require hospital level/Institution for Medical Disease (IMD) services, but the lack of appropriate community-based alternatives necessitates their extended stay. Several patients require secured community-based settings that simply do not exist. The sexual offender population is a unique cohort of individuals that could be placed in an appropriate lower level secured facility. The campus itself could afford the ability to meet lower level needs through development of residential care sites for the chronically and intractably ill patients requiring intermediate level care. The intellectually and developmentally disabled cohort should also be considered appropriate for cohorting in similar residential level programs. Lastly, many of the geriatric patients on Regan 4 could be managed in a specialized psychiatric nursing home setting. Consideration of "leveling" these patients in a place on the campus could be considered. ESH staff resources could be

reallocated to more appropriate levels of care to meet these needs in a more therapeutic and cost-effective manner.

When contemplating facility needs and program design, it is important to recognize the curative impact of the environment for this population. This includes consideration of the condition of the physical space, as well as, the need for meaningful activities and positive interactions. The expertise of the existing professional staff (OT, Psychology, Social Work) should be leveraged for both program design and staff training around therapeutic interactions. A well-designed therapeutic environment will serve to reduce acuity while reducing overall staff burden and/or costs.

Interviews

As noted in the unit reviews, we had the opportunity to conduct both formal and informal interviews with members of the ESH leadership team, providers, and front-line staff. See **Appendix C** for the schedule of formal interviews. Informal staff interviews will remain anonymous, but provided valuable insight in the preparation of this report. The recitation contained herein is summary in nature, and the analysis provided is intended to provide constructive suggestions for clinical and operational improvements. These observations and analyses are opinions only, offered to assist in the overall quality improvement efforts of the State at ESH.

The interviews with the physician leaders Stone and Daly left both interviewers with the impression that within the clinical leadership team at ESH and Zambarano, there is a significant amount of leadership challenge in both reporting directions. Drs. Stone and Daly expressed a lack of trust in ESH and BHDDH leadership, which seems to sow a great deal of this discontent throughout the organization. While they each seemed to have clinical strengths, the themes throughout the conversations were a lack of trust, poor communications, and frustrated attempts to bring change. When speaking with the front-line care physicians, the individual presence of physician leadership at the hospital is lacking, most especially at the Burrillville campus. While the current physician staffing complement seems rational, the apparent lack of communication and collegiality has led to a negative public reaction and seemingly disheartening decrease in overall morale. It is also important to point out that the two physician leaders do not actively and routinely care for patients at the hospital. This was noted by chart review (no clinical notes with those doctor's names on them) and in asking the other physicians about presence and workload sharing.

The overall sentiment of the physician leadership seems to focus on the status as a "hospital" and that the patients can be clinically served at alternate locations because they do not require hospital level of care. When pushed on this, due to the extensive care needs and discharge barriers that we noted on chart reviews, they stated that the state should be able to provide alternate clinical settings. They emphasized this while fully recognizing that few sites exist that could care for the Zambarano campus patients.

While it is understandable that the physician leadership is frustrated on many fronts, being in a clinical leadership role requires pulling staff and others together with a goal to address the gaps in the provision

of care and facilities. It is our opinion that these two leaders, based on our interviews of clinical providers and staff, have not been effective in showing this trait in their execution of the roles.

Nancy Fogarty, Quality Director, seems to have a firm hold on quality improvement and performance. She has extensive experience in this field. There are extreme limitations on the collection of data on clinical outcomes and performance due to the paper charts. The lack of systems to monitor care significantly impedes progress on quality improvement. Nonetheless, Ms. Fogarty seems able to maximize the utility of the information and provide an overall positive direction.

Eileen Dobbing has been the CNO at ESH for approximately three years and has attempted to make several areas of improvement. When queried as to the clinical involvement of the physician leadership, she did not seem to know of their lack of participation in clinical care on a routine basis. Ms. Dobbing was challenged to focus her answers during the interview, and it is this lack of focus that may impede progress in the nursing activities of ESH.

We also interviewed the two full time physicians seeing patients on the Zambarano campus, Drs. Chokshi and Panneerselvam. They seemed to have a good clinical grasp on the patients and provided overall competent and high-quality care to the patients as evidenced by chart reviews. Chart reviews demonstrated detailed clinical notes that told the story of each patient well. Medication and order list review did not show evidence of substantial polypharmacy, or overuse of agents such as antipsychotics. They expressed frustration with the physician and nursing leadership, emphasizing poor communication as well as frequent policy and rules changes with ineffective discussion. Their understanding of the rationale for such changes escaped them. The recent downsizing in physician staffing was concerning to them due to limited coverage available for their vacations and sick time. They felt that their voices were not being heard~~,~~ and that their leaders, by not being present on the clinical units, lacked the necessary context to make changes with good judgement. However, we do not have any opinion on the appropriate level of physician staffing on the units at this time.

Overall Recommendations

1. **Electronic Medical Record**: The lack of an electronic medical record (EMR) makes just about everything more difficult from documentation, discharge planning, quality improvement trending, and tracking of care, etc. Making the investment to transition to an EMR will support a more efficient exchange of patient information across the care team, as well as provide the opportunity to generate and trend data to demonstrate compliance with clinical best practices and to identify potential gaps in care.

2. **Facility Improvements**: The removal of ligature risks and updating or replacement of facilities to meet the specific needs of the populations served is needed. A dedicated facility maintenance staff, under the direction of the hospital leadership, should be considered to prevent the negative impact on the environment of care as it relates to life safety and the promotion of the therapeutic environment of care for patients when facility needs are not prioritized by hospital leadership.

3. **Medical Provider Compensation Structure**: In order to maximize the resources of physicians and advanced practitioners, productivity-based compensation for physician and advanced practice providers could be explored.

4. **Technology Enhancements**: Additional technological enhancements would improve efficiency, productivity, and accountability. Some suggestions include:

- Enhanced communication devices would help make the staff more efficient and productive. Suggestions include WiFi, more computer terminals, Vocera.
- A time and attendance system is sorely needed to track staffing.
- Increased availability of email addresses for all staff (CNAs do not get one) to share educational opportunities and policy change or care model information noted as a key area of opportunity.
- Implementation of clinical and operational computer-based solutions is sorely needed. This begins with the obvious need for an electronic health record but includes the need for a computerized staff scheduling system, a time and attendance system, and computerized event reporting system.

Conclusion

In conclusion, the care at ESH is of high clinical quality. The staff is dedicated and seems to become a part of the individual patient's family. We were very impressed by the high quality of care and the compassionate dedication of the staff overall to a complex and high need population of patients. Their work is commendable and merits recognition to reassure all Rhode Islanders that these patients are in good hands.

Certainly, there are opportunities for improvement, as there are in every health care facility. However, despite the severe facilities limitations and the absence of an EMR, there is evidence of great work and high-quality nursing and medical care delivered by the staff at Eleanor Slater Hospital.

We hope that our observations and recommendations are of assistance to the State as it works to improve the services that ESH can offer to the citizens of Rhode Island and thank you for the opportunity to offer our insights into this important work.

Sincerely,

M. Teresa Paiva Weed
President
Hospital Association of Rhode Island

James E. Fanale, MD
President, CEO
Care New England Health System

APPENDIX A
Site Visit Team Members

JAMES FANALE, MD

- President and chief executive officer for Care New England
    - Creation of Care New England Medical Group
    - Developed the Integra ACO, including the establishment of Integra as a Medicaid Accountable Entity (AE)
- Served as Senior Vice President for System Development and COO at Jordan Hospital
    - Development of one of the nation's first Medicare Shared Savings Programs – Accountable Care Organizations (ACO)
    - Assisted in the merger of Jordan Hospital into Beth Israel Medical Center
- Associate professor of medicine at the University of Massachusetts Medical School
- Fellow in the American College of Physicians and the American Geriatrics Society

MARY MARRAN

- President & COO of Butler Hospital & responsible for CNE Behavioral Health Service Line
- Over 35 years experience in behavioral health in Rhode Island
- 25 years of management experience in behavioral health directing a variety of departments including: Occupational Therapy, Admissions, Nursing Operations, Social Services and Utilization Review, Medical Records, Partial Hospital Services, and Informatics.
- Served as Care New England Privacy Officer & Vice President of Behavioral Health Integration
- Masters in Occupational Therapy and Masters in Business Administration
- Clinical experience in adult and geriatric psychiatry providing functional assessment to determine capacity for independent living for severely ill adult and geriatric behavioral health patients.
- Helped lead the implementation of Butler's first Electronic Medical Records
- Achieved an $5M financial turnaround at Butler Hospital in the first two years as President & COO

ANA TUYA FULTON, MD, MBA, FACP, AGSF

- Executive Chief of Geriatrics & Palliative Care, Care New England
- Chief Medical Officer, Integra Community Care Network
    - Executive sponsor and clinical leader to "Reduce Unplanned Acute Events in Older Adults"
    - Formation of Integra@ Home, a hospital at home model of care to serve frail older adults
    - Focuses on improving serious illness care for persons with cognitive impairment as well as in integrating geriatrics and palliative care best practices into primary care, hospital-based care, and accountable care entities
- Associate Professor, Clinician Educator, Department of Medicine, Geriatrics and Palliative Care & Associate Professor, Clinician Educator, Department of Psychiatry and Behavioral Health. Warren Alpert Medical School of Brown University
- The George Washington University Washington DC. Major in Psychology, BA. Graduation Summa Cum Laude
- The George Washington University School of Medicine Washington
- Masters of Business Administration, Healthcare Management. Western Governor's University

ROBERT HAFFEY

- 5 years of experience as a Chief Executive Officer operating 35-50 bed LTACs including start-up experience
- 7 years of experience as a general medical/surgical acute care hospital president and COO
    - Expertise in turn-around of finances, quality, safety and patient experience of care
- 10 years of experience as a chief nursing officer
    - Expertise in staffing models, managing labor and other expenses, installation of nursing professional practice models, care delivery systems and quality models
- Clinical background in critical care nursing

JUDITH THORPE

- 25 years of progressive leadership experience---Most recent:
- 4 Years as Associate Chief Nursing Officer at Hallmark Health System, MA
    - Two hospital system with a broad range of services including inpatient psychiatry and geriatric psychiatry
    - Focus on inpatient operations
    - Interim Chief Nursing Officer 6 months
    - Magnet Designation during this period of time
- 4 Years as CNO at UMassMemorial Health Care, MA
    - Services included geriatric medical psychiatry
- 2 Years as CNO at Kent Hospital, RI
- Nurse Executive Professional Certification

JIM SULLIVAN, MD, PhD

- Chief Medical Officer, Butler Hospital, 7 years experience
- Executive Chief of Psychiatry, Care New England Health System (CNE). 3 years experience
- Physician Lead for Utilization Management , Butler Hospital , 10 years experience
- Staff Psychiatrist, 25 years experience
    - Butler Hospital
    - The Providence Center
- Core member of the Health Path Development Team
    - Health Path is an innovative program, offered through partnership with BCBSRI and Care New England designed to provide BCBSRI members with comprehensive behavioral health services.

IDRIALIS HUGHES, MS, RN

- Nursing Director, Senior Specialty Unit - Butler Hospital
- Master of Science in Gerontology with a track in management from the University of Massachusetts, Boston
- Hospital Hero Award for Excellence in Hospital Care from the Hospital Association of Rhode Island - 2018

SETH KOENIG, MD

- Chief of Pulmonary, Critical Care, and Sleep Medicine, since 9/2021 at Kent Hospital
- Past Experience:
    - Medical Director of MICU, Northwell Health
    - Medical Director of ECMO, Northwell Health

PAARI GOPALAKRISHNAN, MD

- Kent Cranston Field Hospital**:** responsible for operations of facility from November 2020-March 2021 during second Rhode Island surge during the Covid-19 pandemic.
- Chief Medical Officer at Kent Hospital (2018-present)
    - Operational and budgetary oversight for quality department, risk department, Infection control, medical staff office, cardiology technical services, care management, pharmacy, graduate medical education, and oversight of providers (ED, Hospitalist, ICU, etc.).
    - Part of leadership team instrumental in improving quality including recent Leapfrog B classification.
- Chief of Hospitalist Medicine (Greenville Health System—now PRISMA Health) (1/2016-12/2018)
    - Championed a rapidly growing division encompassing sections of Acute care hospital medicine, post-acute care medicine, inpatient psychiatry, and inpatient ultrasound for Greenville Health System.
    - Provided leadership for 95+ MD, 13 Advanced Practice Providers across 12 practice sites including 7 acute care hospitals with an annual budget of $34 million.
- Director of Inpatient Medical Group (Kent Hospital) (2009-2015)
    - Oversaw a practice at Kent hospital including ICU care and hospitalist car. This practice included over 30 providers with an annual budget of $10.5 Million.
- Associate Chief, Division of Hospitalist Medicine (Miriam Hospital) (2007-2009

RACHEL ROACH NP, APRN-CNP

- Inpatient geriatric consultant, Acute Care for the Elderly (ACE) Unit, Kent Hospital, 2 years experience
- Geriatric primary care provider (CNEMG), 2 years experience
- Travelling geriatric nurse practitioner, New England region, (UHC, OPTUM), 1 year experience
- Complex illness nurse practitioner (Integra), 3 years experience
- Palliative consultant (Rhode Island Hospital), 6 years experience
- Geriatric nurse practitioner (Lifespan). Co-director of geriatric/palliative intern block, teaching associate, Brown University. 16 years experience

CLAUDIA MAINE MHA, RN, NE-BC

- Associate Chief Nursing Officer of Inpatient Services at Kent Hospital since January 2019.
    - Interim Chief Nursing Officer for 2 months
    - Focus on inpatient operations, throughput, position control stabilization, and improvement in nurse sensitive quality indicator, such as Falls, HAPI, and CAUTI prevention
- Over 7 years of progressive nursing leadership experience at Kent Hospital
    - Nurse Director of the Cardiac Care Unit, Cardiac Telemetry Unit, and Progressive Care Unit.
    - Oversight of the development and build of the Progressive Care Unit.
    - Chair of the CNE Clinical Effectiveness Committee
- Nurse Executive Professional Certification
- Masters in Healthcare Administration
- Currently pursuing Doctorate in Healthcare Administration
- Clinical background in cardiac nursing.

JENNIFER LA LUZ, MBA, CPHQ

- Director of Quality & Performance Improvement, Kent Hospital 2019 – present
- Led three successful triennial Joint Commission accreditation surveys, and multiple Department of Health on-site surveys with successful conclusion over the course of more than a decade in hospital quality leadership
- Developed and deployed a hospital-based Mock Survey program at Kent Hospital to support continuous readiness for survey activity and patient safety
- Led patient safety program improvement efforts at Kent Hospital to outperform more than 43% of hospitals, nationally, according to the Leapfrog Hospital Safety Grade in 2020 and 2021.

APPENDIX B

Site Visit Schedule

Site	Unit	Description	Census (as of 5/14/21)	CNE Team	Site Visit 1	Site Visit 2
Adolf Meyer	AM 7 -12	General Psych	29/83	Dr. James Sullivan Mary Marran	6/1/21 7:30am-12pm	6/1/21 1pm-5pm
Regan	R4	Geriatric Psych	24/28	Dr. James Sullivan Mary Marran Idri Hughes	6/2/21 11am-3pm	6/8/21 1pm-5pm
Regan	R5	Geri Psych / Vent / Med.	16/24	Bob Haffey Judy Thorpe Dr. Paari Gopalakrishnan Claudia Maine Dr. Ana Tuya Fulton Idri Hughes Dr. Seth Koenig Jenni LaLuz	6/3/21 12pm -4pm	NOT NEEDED
Regan	R6	Medical / Swing / COVID	0/20-26	Bob Haffey Judy Thorpe Dr. Paari Gopalakrishnan Claudia Maine Dr. Ana Tuya Fulton Idri Hughes Dr. Seth Koenig	NOT NEEDED	NOT NEEDED
Benton	All	Forensic	49/52	Out of Scope	NA	NA
Zambarano	All	Mixed / Locked / COVID	72/189	Dr. James Fanale Dr. Ana Tuya Fulton Idri Hughes Rachel Roach	6/1/21 7:30am – 12pm	6/2/21 7:30am – 12pm

APPENDIX C

Interview Participants

	Interview 1		Interview 2	
Interviewee	**Date**	**Interviewer**	**Date**	**Interviewer**
Brian Daley	6/21/21	Drs. Fanale and Fulton	6/24/21	Dr. Sullivan, M. Marran, I. Hughes
Eileen Dobbing	6/17/21	Drs. Fanale and Fulton	7/1/21	Dr. Sullivan, M. Marran, I. Hughes
Nancy Fogarty	6/21/21	Drs. Fanale and Fulton	7/1/21	Dr. Sullivan, M. Marran, I. Hughes
Stone	6/21/21	Drs. Fanale and Fulton		
Chokshi/Panneerselvam	6/14/21	Drs. Fanale and Fulton		