2025 Community Health Needs Assessment

Eleanor Slater Hospital

Final Report

July 2025

About Eleanor Slater Hospital and the 2025 CHNA

Eleanor Slater Hospital (ESH) is a public Long-Term Acute Care Hospital (LTACH) with campuses in Cranston and Burrillville. ESH is operated by the State of Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities, & Hospitals (BHDDH). The hospital treats patients with acute and long-term medical illnesses, as well as patients with mental health conditions. ESH provides care for those who have conditions which require care on an ongoing basis, however, no longer require intensive care or extensive diagnostic procedures.

ESH works to provide a treatment environment in which dignity, individuality, and respect are emphasized. In addition to diagnosis and treatment, the hospital focuses on issues of recovery and quality of living. Staff are dedicated to using a patient, family, and interdisciplinary-centered approach to care with a focus on recognizing each patient's individuality.

ESH emphasizes collaboration among its leadership, physicians, nurses, and rehabilitative staff reviewing all processes associated with operations and quality care. Processes are continually modified or redesigned resulting in higher quality care for our patient population and improved operations.

ESH is dedicated to understanding and addressing the most pressing health and wellness concerns for the communities we serve. ESH undertook a Community Health Needs Assessment (CHNA) for its service area. The goal of the CHNA is to monitor the health of community members and to identify common and unique challenges across the region. The CHNA informs the development of a Community Health Improvement Plan (CHIP) to address identified priority needs and align community investments with the highest needs.

Eleanor Slater Hospital 2025 CHNA Leadership

Brett M. Johnson*, MBA*, *Chairman and Chief Executive Officer*
Christopher Feisthamel, Chief Operating/Financial Officer
Sue Ferranti, DO, Chief Medical Officer
Kimberly Kane, MSN, APRN-BC, Chief Nursing Officer
Mary Ellen Benedict, MA, Chief Clinical Officer
Kellie Capobianco, Chief Quality Officer
Hector Guerreiro*, MBA, RRT,* *Associate Director of Admissions and Clinical Liaison*

Table of Contents

THE 2025 COMMUNITY HEALTH NEEDS ASSESSMENT 3
2025 CHNA LEADERSHIP AND OVERSIGHT 4
2025 CHNA STUDY AREA 5
RESEARCH METHODS 7
SOCIAL DRIVERS OF HEALTH 8
OUR STRENGTHS AND OPPORTUNITIES 9
DETERMINING COMMUNITY HEALTH PRIORITIES 12
OUR COMMUNITY AND RESIDENTS 13
MEASURING HEALTH IN OUR COMMUNITY 16
COMMUNITY HEALTH NEEDS 21
ACCESS TO CARE AND SERVICES 21
BEHAVIORAL HEALTH 27
CHRONIC DISEASE PREVENTION AND MANAGEMENT 35
HOUSING 41
MATERNAL AND CHILD HEALTH 44
OLDER ADULT HEALTH AND WELLBEING 47
BOARD APPROVAL AND NEXT STEPS 49
APPENDIX A: SECONDARY DATA REFERENCES 50
APPENDIX B: KEY STAKEHOLDER SURVEY PARTICIPANTS 51
APPENDIX C: PARTNER FORUM PARTICIPANTS 54

The 2025 Community Health Needs Assessment

The goal of the CHNA was to gather data and community input to inform strategies and policies to support a healthy and thriving Rhode Island and to foster collaboration among community organizations in developing and delivering services to the residents they serve.

CHNA Study Objectives:

- Compile a comprehensive profile of the factors that impact health and wellbeing for residents
- Compare community health indicators with previous CHNAs to document trends and changes
- Demonstrate the impact of Social Drivers of Health; document disparities experienced by populations and communities
- Strengthen community member engagement and partnerships; engage residents in the study process
- Define three-year priority areas and develop action planning
- Develop a community resource to monitor the progress of community health initiatives

The results of the CHNA will help us identify priorities and strategies to improve health and wellbeing in the region and promote health for all residents. Responding to the study findings and sharing data with other community-based organizations, HARI and its hospital members aim to ensure that all residents benefit from our local resources, robust social service network, and the high-quality healthcare available in our community to help residents live their healthiest lives.

We thank you for partnering with us in this effort. We invite our community partners to learn more about the CHNA and opportunities for collaboration to address identified health needs. Please visit our website at https://bhddh.ri.gov/eleanor-slater-hospital or contact Hector Guerreiro at hector.guerreiro@bhddh.ri.gov.

Research Partner

HARI and its member hospitals contracted with *Build Community* to conduct the CHNA. *Build Community* is a woman-owned business that specializes in conducting stakeholder research to illuminate disparities and transform data into practical and impactful strategies to advance access, support, and opportunities for all. An interdisciplinary team of researchers and planners, *Build Community* has worked with hundreds of healthcare and community-based organizations and their partners to reimagine policies and achieve measurable impact. Learn more about their work at buildcommunity.com.

2025 CHNA Leadership and Oversight

The Hospital Association of Rhode Island (HARI) is a statewide trade organization that assists member hospitals in effectively meeting the healthcare needs of Rhode Island through advocacy, representation, education, and services. HARI and its members work collaboratively to address issues impacting Rhode Island's healthcare system. Issues include increasing healthcare costs, healthcare transformation, eliminating patient harm, rising medical liability premiums, and decreasing reimbursement. Together with its members, HARI works to ensure that all Rhode Islanders receive comprehensive, high-quality care.

Since 2011, HARI has convened a steering committee of its member hospitals to collaborate on a statewide Community Health Needs Assessment (CHNA). This collaboration ensures a comprehensive study and comparisons of communities across the state and fosters collective impact to address the most pressing issues that impact health for Rhode Islanders. The following individuals served on the CHNA committee as liaisons to their organizations and the communities they serve.

HARI 2025 CHNA Partners and Steering Committee Members

Hospital Association of Rhode Island
Lisa Tomasso, *Senior Vice President*

Brown University Health
Carrie Bridges Feliz, *Vice President Community Health and Equity*

Care New England
Aleyra Lamarche Baez, *DEI and Community Engagement Liaison*
Kevin Martins, *Vice President and Chief Diversity Officer*

CharterCARE
Otis Brown, *Vice President Marketing and External Affairs*

Eleanor Slater Hospital
Hector Guerreiro, *Associate Director of Admissions and Clinical Liaison*

Landmark Medical Center
Carolyn Kyle, *Director of Marketing, Physician Relations, and Business Development*

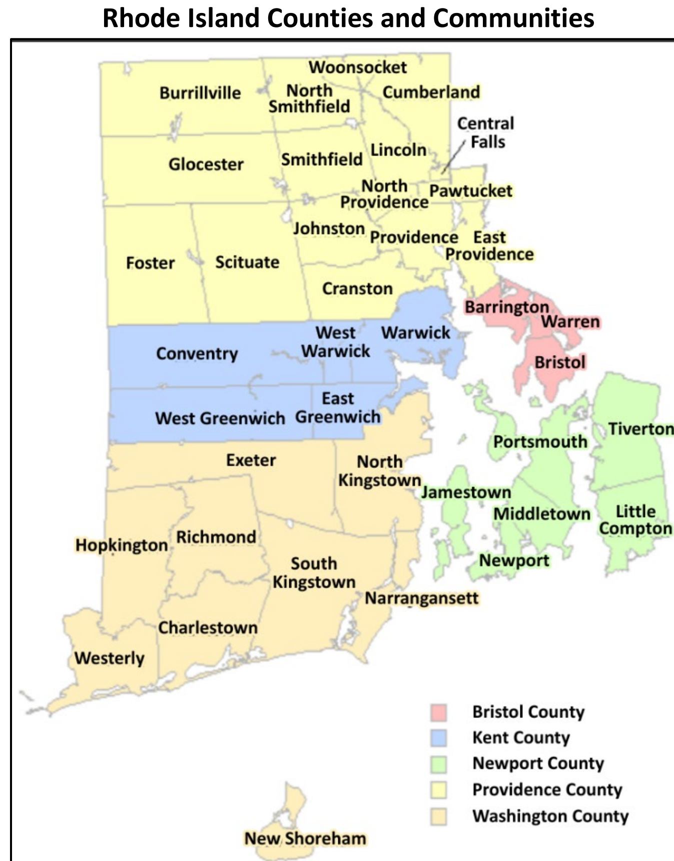
South County Health
Lynne Driscoll, *Assistant Vice President Community Health*
Holly Fuscaldo, *Clinical Medical Social Worker and Wellness Lead*
Nina Laing, *Manager Case Management*

Yale New Haven Health Westerly Hospital
Lindsey Greene-Upshaw, *Senior Manager Office of Health Equity and Community Impact*
Melissa Sigua, *Community Health Project Coordinator*

2025 CHNA Study Area

The CHNA data findings are reported for all Rhode Island counties with comparisons to state and national benchmarks.

Rhode Island Counties and Communities



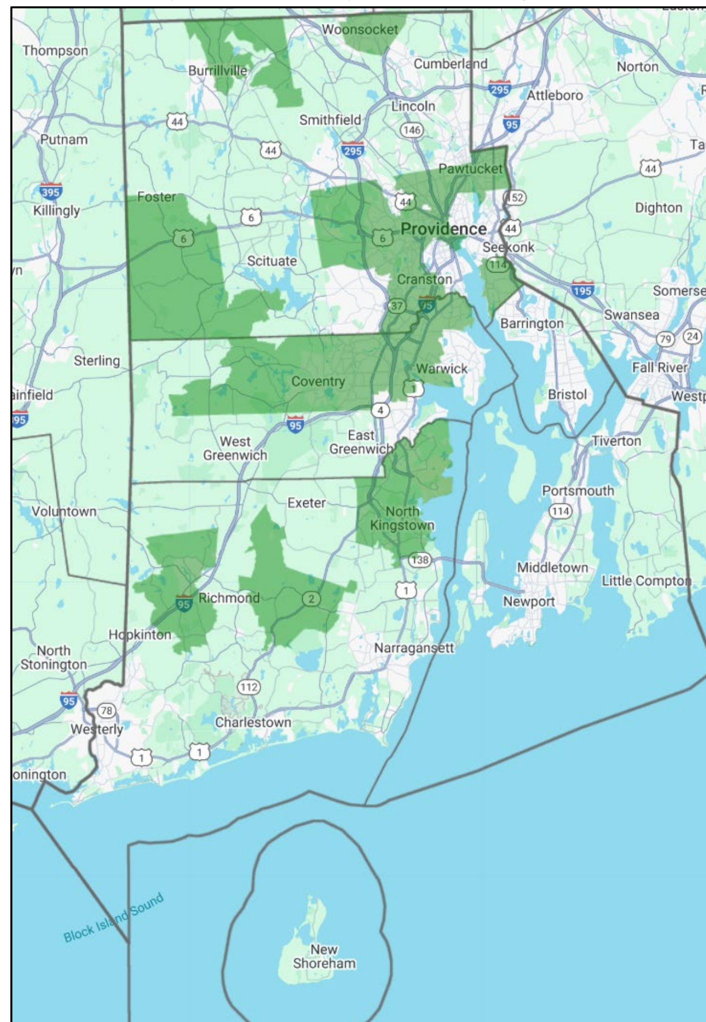
HARI 2025 CHNA Participating Member Hospitals and Locations

Health System	Member Hospital	City, Zip Code
Brown University Health	Bradley Hospital	Riverside, 02915
Brown University Health	The Miriam Hospital	Providence, 02906
Brown University Health	Newport Hospital	Newport, 02840
Brown University Health	Rhode Island Hospital	Providence, 02903
Care New England	Butler Hospital	Providence, 02906
Care New England	Kent Hospital	Warwick, 02886
Care New England	Women & Infants Hospital	Providence, 02905
CharterCARE Health Partners	Our Lady of Fatima Hospital	North Providence, 02904
CharterCARE Health Partners	Roger Williams Medical Center	Providence, 02908
Prime Healthcare	Landmark Medical Center	Woonsocket, 02895
Rhode Island Behavioral Healthcare, Developmental Disabilities & Hospitals	Eleanor Slater Hospital	Cranston, 02920
South County Health	South County Hospital	Wakefield, 02879
Yale New Haven Health	Westerly Hospital	Westerly, 02891

The hospitals defined their service areas as the county(ies) served and used the zip codes of residence for most patients seen at their facilities to define their primary service area. Demographics and other available indicators for zip codes and neighborhoods within each hospital's primary service area were analyzed to determine opportunities for prioritized interventions to address health and social disparities.

Eleanor Slater Hospital is a public Long-Term Acute Care Hospital (LTACH) operated by the State of Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH). The hospital treats patients with acute and long-term medical illnesses, as well as patients with mental health conditions. Eleanor Slater Hospital had 34 patient admissions in 2023 and 2024, with patients originating from 20 unique zip codes, as shown in the map below. The hospital does not define a primary service area as it serves a small number of residents across the state; throughout the report, select data are provided for patient zip codes of origin.

Eleanor Slater Hospital Patient Zip Codes of Origin for 2023 and 2024



Research Methods

The CHNA was conducted from October 2024 to June 2025 and included primary and secondary research methods to determine health trends and disparities.

Primary Research and Community Engagement

Community engagement was an integral part of the CHNA. Collaborating with community-based organizations across Rhode Island, input was invited and received from a wide array of community members with a particular focus on diverse populations, under-resourced areas, and communities that have been historically marginalized. Study participants provided perspectives on unmet health and social needs; community resources available to meet those needs; barriers to accessing services; service delivery gaps; and recommendations to improve health and wellbeing.

Key Stakeholder Survey

We conducted an online survey with 120 individuals that serve diverse communities and populations across Rhode Island to collect input about local health needs, client experiences in receiving and accessing services, and opportunities for collective impact.

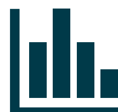
Community Conversations and Engagement

We invited wide participation with diverse stakeholders and residents through community meetings and small group discussions to share CHNA findings and gather feedback on priority health issues. Participants included Rhode Island Department of Health officials, local Health Equity Zone (HEZ) members, and other community partners and coalitions to align efforts and promote collaboration across existing initiatives.

2025 CHNA Community Engagement Partners and Events

- Health Equity Zone (HEZ) Learning Community Quarterly Conferences
- HEZ Partners Evaluation Collaboration
- HEZ Leadership Collaboration
- Rhode Island Department of Health (RIDOH), Health Equity Institute Collaboration
- RIDOH/Providence HEZ Collaboration
- Narragansett Older Adults Focus Group
- Newport Partnership for Families Partner Meeting
- Partnership to Reduce Cancer Meeting
- Washington County Healthy Bodies, Healthy Minds Collaboration
- Washington County HEZ Housing Summit
- Washington County Partner Forum
- Westerly Older Adults Focus Group
- West Warwick HEZ Partner Forum
- Woonsocket HEZ Partner Forum
- West Warwick HEZ ODPR Workgroup

Secondary Data Analysis



Secondary data are reported by county and by zip code, as available, to demonstrate localized health needs and disparities. Data for Rhode Island's "core cities," identified as Central Falls, Pawtucket, Providence, and Woonsocket, are also reported. The core cities are communities that have historically experienced greater economic distress and potential for poor health outcomes. The most recently available data at the time of publication is used throughout the study. Due to the time required to collect and analyze these data, it is typical for these data to reflect prior years rather than current year.

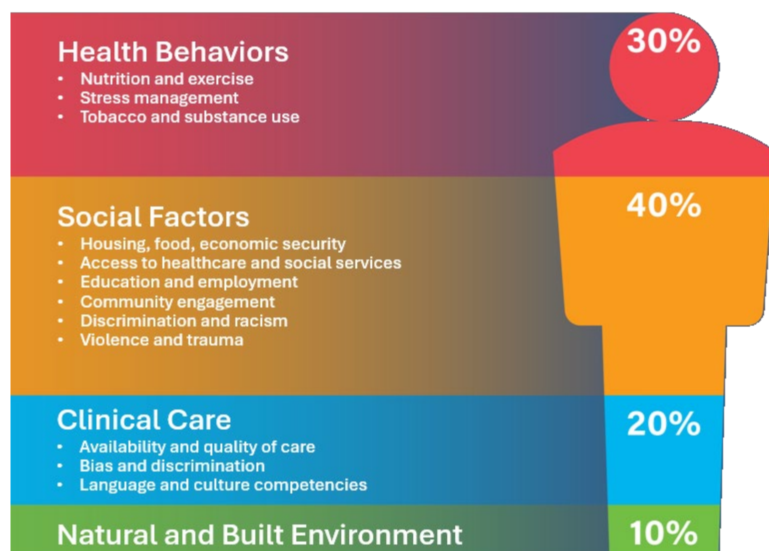
Social Drivers of Health

Where we live impacts choices available to us

The CHNA was conducted to provide deeper insights into the differences in health and wellbeing experienced between groups of people in Rhode Island. We used the Social Drivers of Health (SDoH) framework to study and document income and poverty; housing and food security; early learning and education; social factors and the environment and built community. We analyzed data across these five domains of SDoH to identify strengths and challenges in our community that impact our health and wellbeing.

Graphic Credit: U.S. Department of Health and Human Services

Social Drivers of Health are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.



50% of a person's health is determined by social factors and their environment.

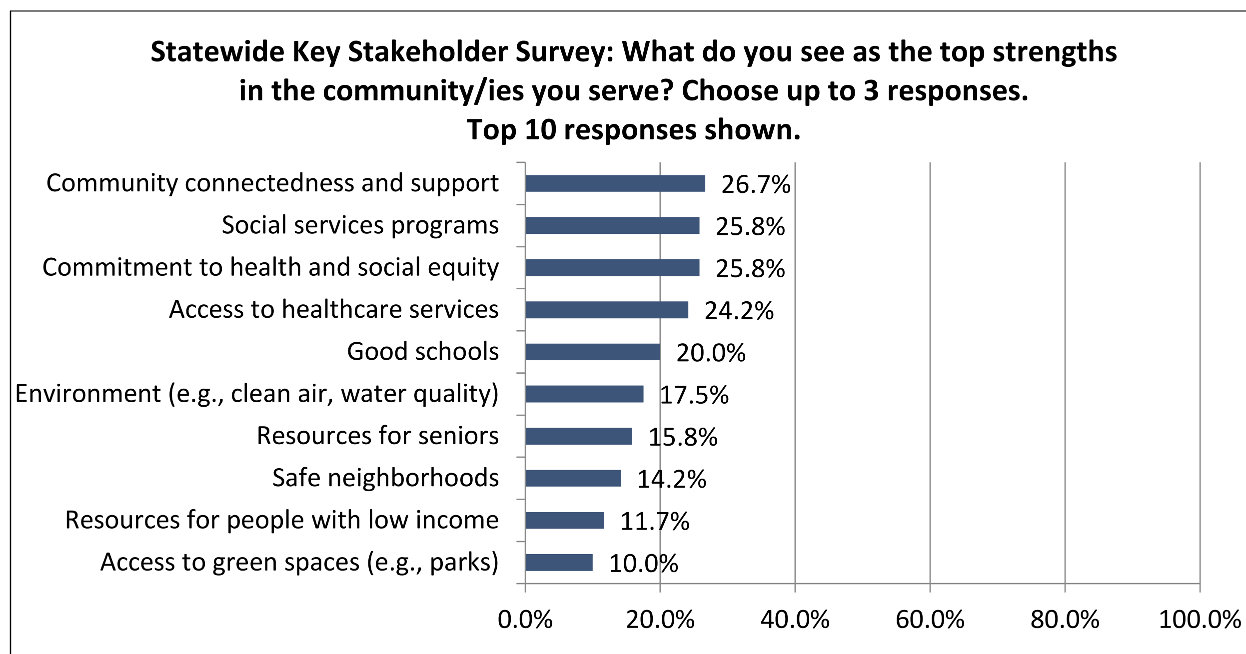
Only 20% of health outcomes are attributed to clinical care.

Examining data across SDoH domains helps us understand factors that influence differences in health status, access to healthcare, and outcomes between groups of people. These differences include higher prevalence of chronic diseases like diabetes, lack of health insurance, inability to afford essential medications, and shortened life expectancy. Advancing health for all residents means ensuring that all people in a community have the resources and care they need to achieve optimal health and wellbeing. To advance health for all, we need to look beyond the healthcare system to address "upstream" SDoH issues like education attainment, job opportunities, affordable housing, and safe environments.

Our Strengths and Opportunities

Rhode Island is one of the healthiest states in the nation. Residents live longer and enjoy better health while they're alive. When asked what they see as the top strengths for the community, participants of the statewide Key Stakeholder Survey saw social cohesion factors like *community connectedness and support* and *commitment to health and social equity* among the top attributes. Key stakeholders also identified community resources like *social service programs*, *healthcare services*, and *schools* as top strengths across the state.

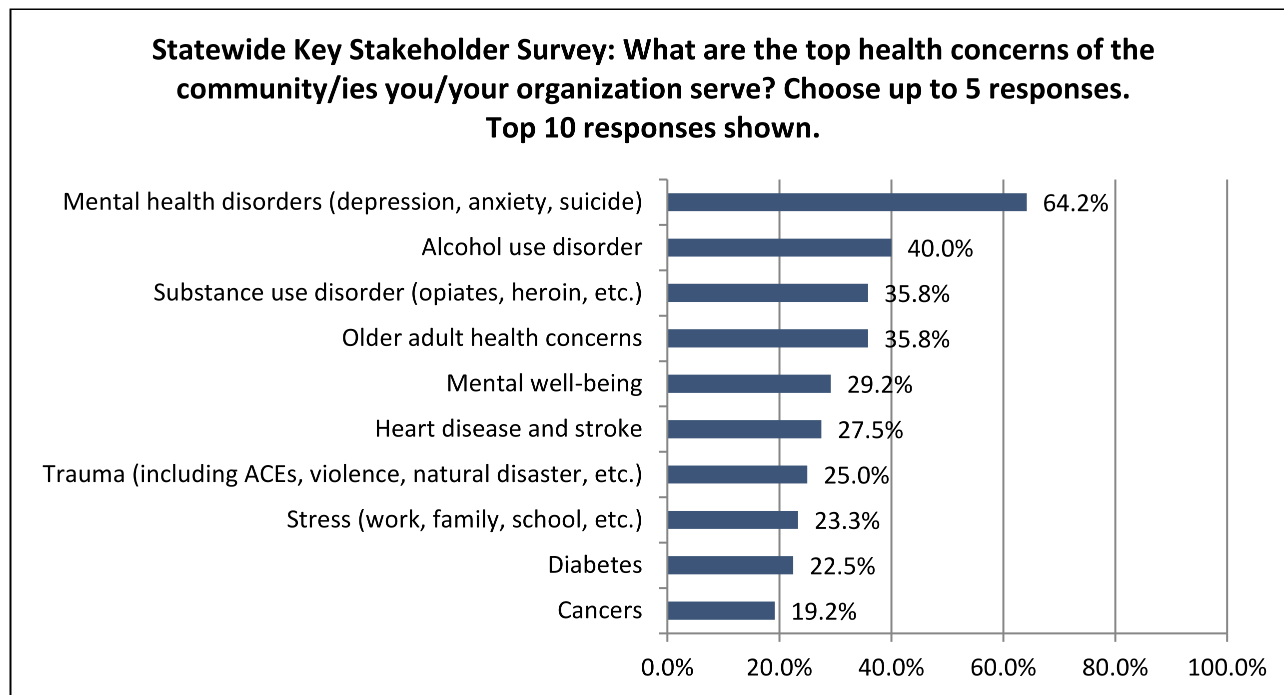
When asked to rate various SDoH factors for Rhode Island communities, approximately 50% of Key Stakeholder Survey participants rated *access to green spaces and outdoor recreation*, *community safety*, and *civic participation* as "good" or "excellent." Over one-third rated *inclusion and appreciation of diversity in people and ideas* and *job training and education opportunities* as "good" or "excellent."



Community Strengths

- Economic vitality and strong anchor institutions
- Sense of community and civic engagement
- Commitment to access, support, and opportunities for all
- Natural recreational resources and green spaces
- Strong social service safety net
- High quality healthcare services
- Lower prevalence of disease burden and death
- Resources for older adults
- Good schools and universities

Using these existing strengths and community assets, communities can work together to improve health. When asked to name the top health concerns affecting the people they serve, Key Stakeholder Survey participants overwhelmingly identified issues related to *behavioral health* (e.g., mental health, substance use, trauma, stress). Other identified issues included *older adult health concerns* and *chronic conditions* (e.g., heart disease, diabetes, cancer). Key stakeholders' perceptions of these health concerns were in line with the secondary data statistics for the state.

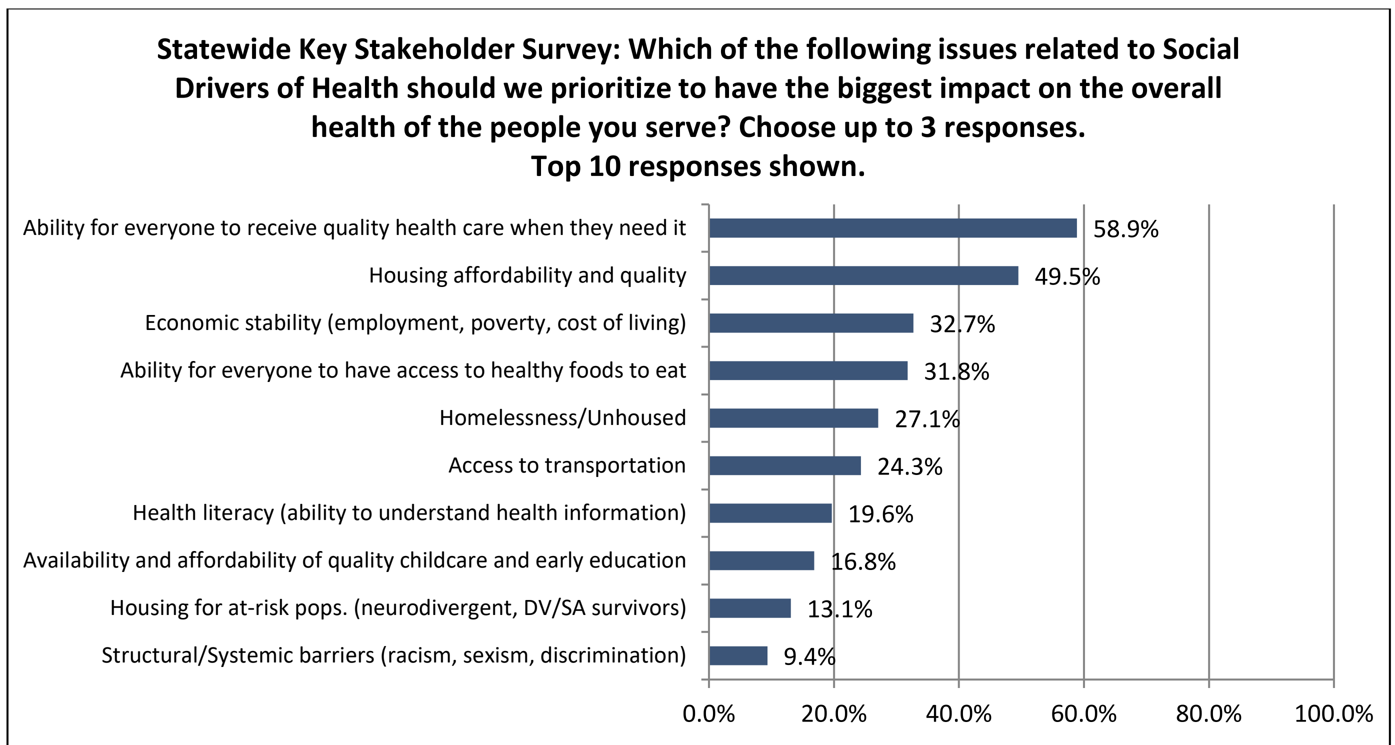


Community perception and public health data suggest that many of the identified health concerns worsened in recent years due to the lingering impact of the COVID-19 pandemic (e.g., isolation, delayed healthcare, developmental delays) and underlying SDoH factors, including rising cost of living, housing instability, and declining access to care. More than 70% of Key Stakeholder Survey participants rated *housing affordability and availability* as "poor." Approximately 75% of Key Stakeholder Survey participants rated *healthcare access and quality*, *healthy food access and affordability*, and *public transportation options* as "fair" or "poor."

> *"Access to healthcare is poor in the state (RI). We need better reimbursement rates to allow the health systems and groups to recruit and retain physicians."*
>
> *"The state needs to develop a comprehensive transportation and housing plan."*
>
> *"Make affordable housing a priority instead of a talking point that is never resolved."*
>
> *"Housing and food are extremely expensive, and this is creating a negative driver for the community's overall health"*

When asked which SDoH to prioritize to have the biggest impact on the overall health of the people they serve, nearly 60% of key stakeholders selected the *ability for everyone to receive quality healthcare when they need it*. *Housing affordability and quality* and *economic stability* were the next most selected factors.

Key Stakeholders saw healthcare access—particularly primary care access—as being at a critical point in Rhode Island due to an aging healthcare workforce, low statewide reimbursement for primary care that hinders recruitment and retention of providers, and healthcare environments that have failed to adequately support providers and staff.



Community Challenges

- Growing behavioral health concerns for adults and youth
- Rising cost of living and lack of affordable housing, childcare, food, and other basic needs
- Declining primary care access
- Healthcare and social service recruitment and retention
- Aging community with more health and social concerns
- Chronic condition prevention and management
- Economic and health disparities for people of color and income constrained households
- Care and support for growing unhoused population
- Limited public transportation options
- Political engagement and financial investment in systemic issues

Determining Community Health Priorities

To improve community health, it is imperative to prioritize resources and activities toward the most pressing and cross-cutting health needs. In determining health priorities on which to focus its efforts over the next three-year cycle, ESH leadership reviewed findings from the CHNA and sought to align with its health improvement programs and population health management strategies.

ESH applied the following rationale and criteria to define priorities:

- Prevalence of disease and number of community members affected.
- Rate of disease compared to state and national benchmarks
- Health differences between community members.
- Existing programs, resources, and expertise to address the issue.
- Input from community partners and representatives.
- Alignment with concurrent public health and social service organization initiatives.

Based on the CHNA findings, ESH will focus on the following priority areas, addressing underlying Social Drivers of Health and the needs of distinct population groups as cross-cutting strategies:

Within these areas, distinct needs for patient populations were examined, including housing access and affordability, care and services to help older adults maintain their health and wellbeing, and reducing disparities in maternal and child health outcomes.

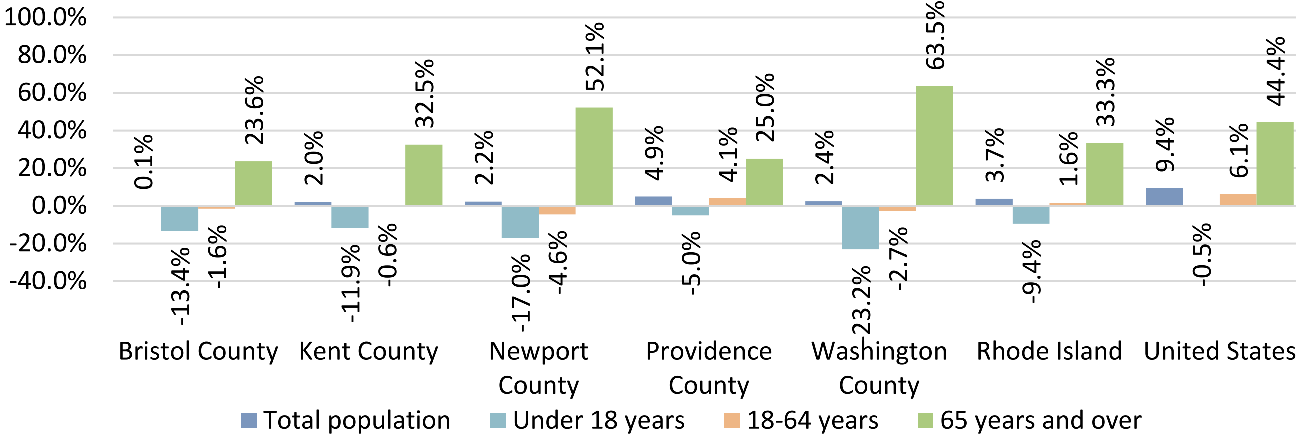
As a public long-term acute care hospital, ESH is dedicated to whole-person strategies to improve access to care, behavioral health, and chronic disease for its patients. ESH is often a bridge between the hospital setting and the community, collaborating with community agencies to help people recover and receive the services they need to return to their home.

Our Community and Residents

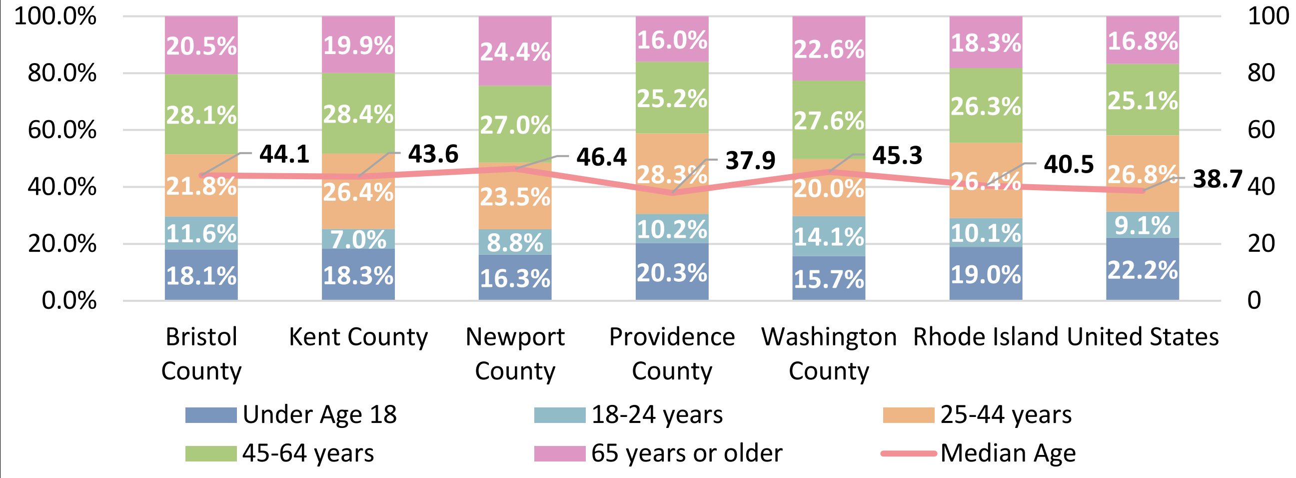
Rhode Island had a total population of 1,095,371 people in 2023 and overall population growth of approximately 3.7% from 2010 to 2023. The total population of Rhode Island and its counties is growing at a slower rate than the nation. However, the state saw a 33.3% increase in older adults aged 65 from 2010 to 2023. Rhode Island is one of the oldest states in the nation with nearly 1 in 5 residents aged 65 or older. Older Rhode Islanders are choosing to stay in their communities, while low birth rates and increased longevity contribute to the overall aging trend.

Total Population by Year

	2010	2023
Bristol County	50,501	50,568
Kent County	167,235	170,658
Newport County	83,253	85,095
Providence County	628,413	658,977
Washington County	126,987	130,073
Rhode Island	1,056,389	1,095,371
United States	303,965,272	332,387,540



Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

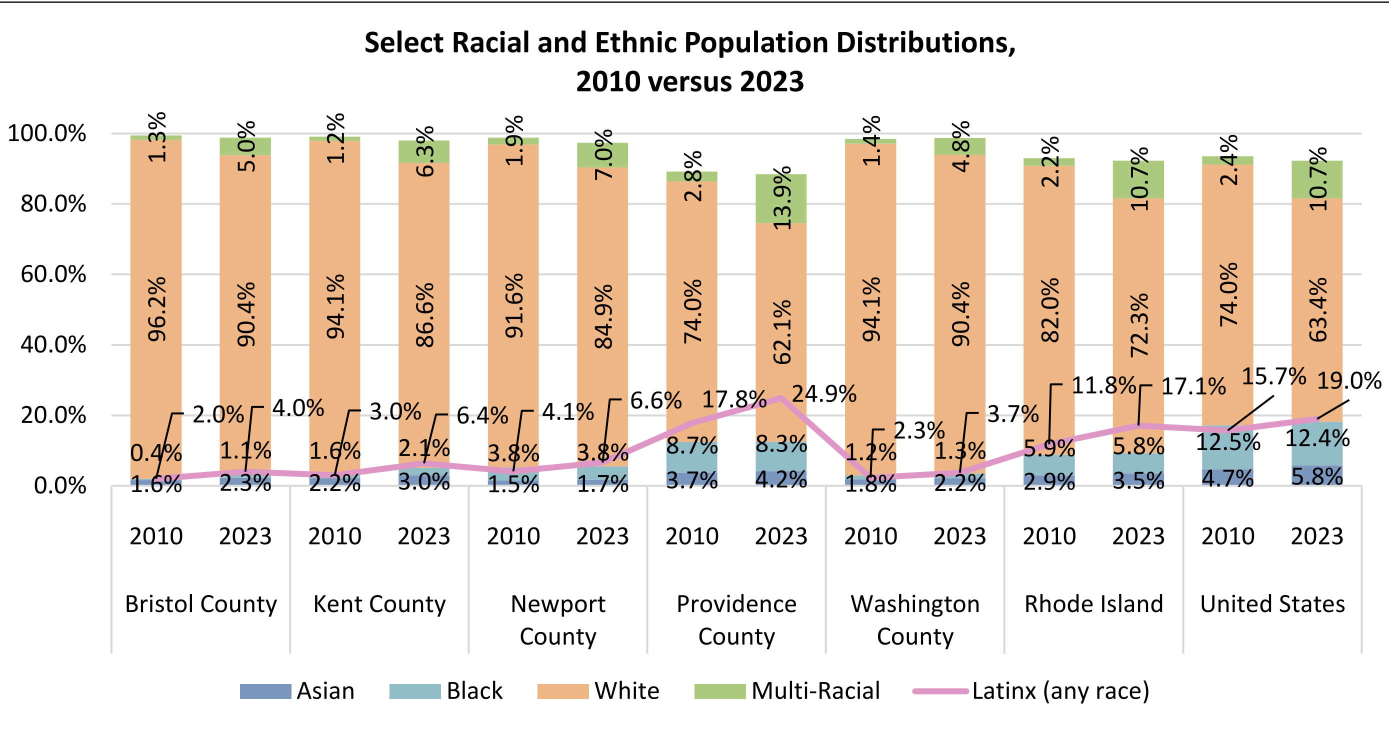
Disability is a physical or mental condition that limits a person's movements, senses, or activities. Across the US, 13% of the population and about 33% of older adults live with a disability. Rhode Island state averages are in line with the nation. Experiences of disability, particularly among older adults, varies by county with higher prevalence in Kent and Providence counties.

2019-2023 Population with a Disability

	Bristol County	Kent County	Newport County	Providence County	Washington County	Rhode Island	United States
Total population	11.6%	15.1%	11.7%	14.2%	10.7%	13.6%	13.0%
Youth under 18 years	4.0%	6.3%	5.6%	5.9%	3.6%	5.6%	4.7%
Older adults 65+ years	29.4%	32.3%	24.6%	33.6%	24.7%	30.9%	32.9%

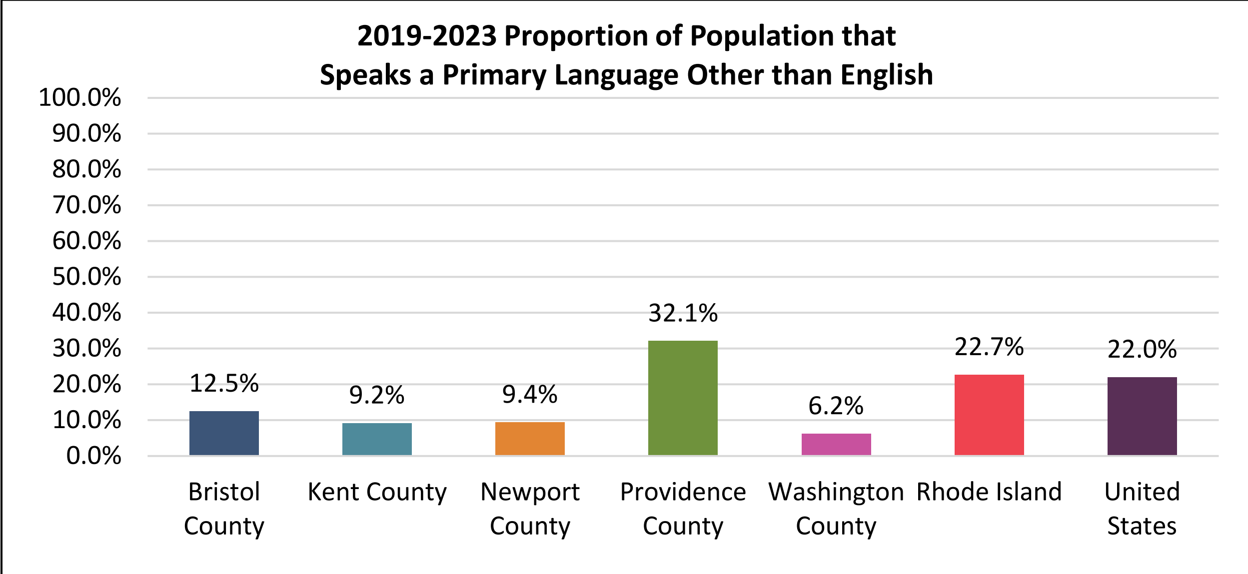
Source: US Census Bureau, American Community Survey

Consistent with national trends, population diversity is increasing across Rhode Island. People of color, particularly those that identify as Latinx and/or multiracial, make up a larger portion of the population than in prior years. Providence County has the most diverse population in Rhode Island; more than 1 in 3 residents identify as a person of color and 1 in 4 residents identify as Latinx (of any race). Across all other Rhode Island counties, approximately 9 in 10 residents identify as white.



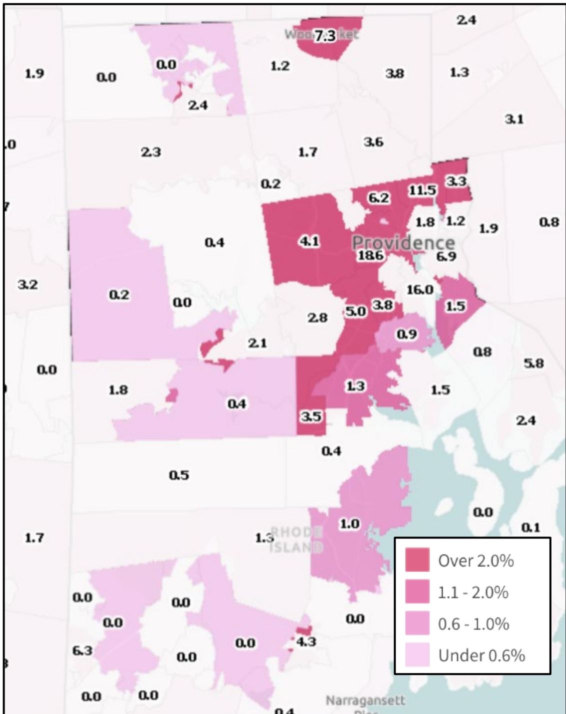
Source: US Census Bureau, American Community Survey

Nearly 1 in 4 Rhode Island residents speak a primary language other than English; in Providence County, the proportion is 1 in 3 residents. Within the City of Providence, 20% or more of households speak a language other than English at home, and household occupants over age 14 report limited or no proficiency in English. These findings inform a heightened need for multilingual communications, culturally appropriate services, and workforce development to reflect the community served.



Source: US Census Bureau, American Community Survey

2019-2023 Linguistically Isolated Households by Zip Code^



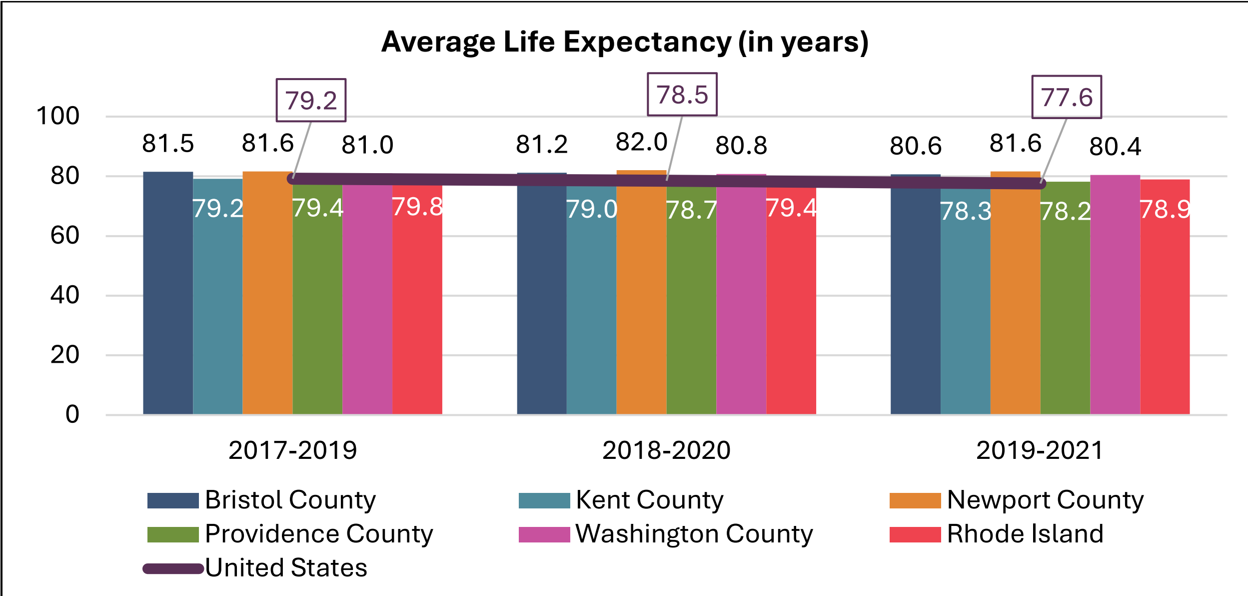
Source: US Census Bureau, American Community Survey

^Defined as households with no one aged 14 or older who speaks English "very well."

Measuring Health in Our Community

Rhode Island is one of the healthiest states in the nation, and all Rhode Island counties report overall better health outcomes and higher average life expectancy than the national average. Life expectancy is a key measure of health and wellbeing within a community, often reflecting the underlying socioeconomic and environmental factors.

Life expectancy measures how long people generally live within the defined geography and is the culmination of living conditions, health status, economic security, and the overall experience of residents within a community.



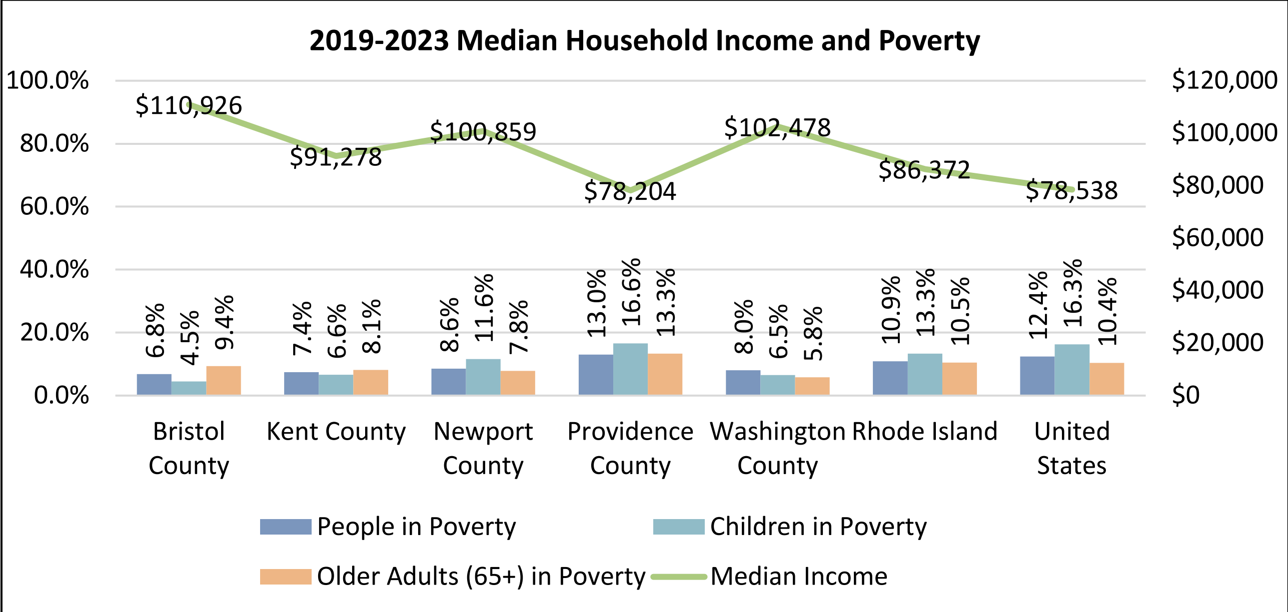
Source: Centers for Disease Control and Prevention

The Social Drivers of Health framework shows that at least 50% of a person's health profile is influenced by the socioeconomic and environmental factors that they experience. Understanding the impacts and addressing the conditions in the places where people live is essential to improving health outcomes and advancing fair access, support, and opportunities for all. Rhode Island's overall higher life expectancy reflects strong SDoH factors, including a diverse economy, highly educated workforce, rich health and social services, civic engagement, and robust recreational and green spaces.

Resident Insights:

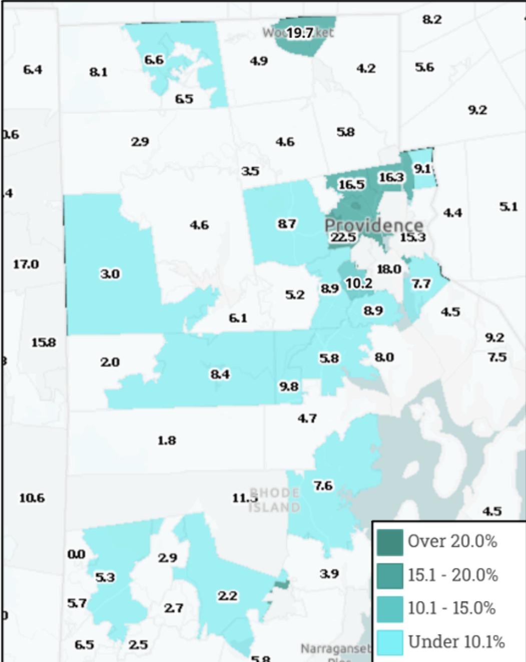
> *"[There are] grassroots efforts to ensure community members could participate in voting and have access to education. [There are] people wanting to make sure their communities are empowered."*
>
> *"In general, Rhode Island is a civic-minded state and promotes diverse thinking."*
>
> *"[We have] strong community values and leadership in protecting the special places and scenic areas of our state, including beaches, forests, ponds, parks, etc."*

However, not all people across Rhode Island share these positive outcomes. Within Rhode Island, there is a more than 3-year difference in life expectancy between counties with the highest and lowest averages, reflecting the impact of SDoH and historical disparities. As a whole, Rhode Island residents have higher median incomes and fewer experiences of poverty than their peers nationwide. But, looking more closely at neighborhoods and populations, clear disparities are present.

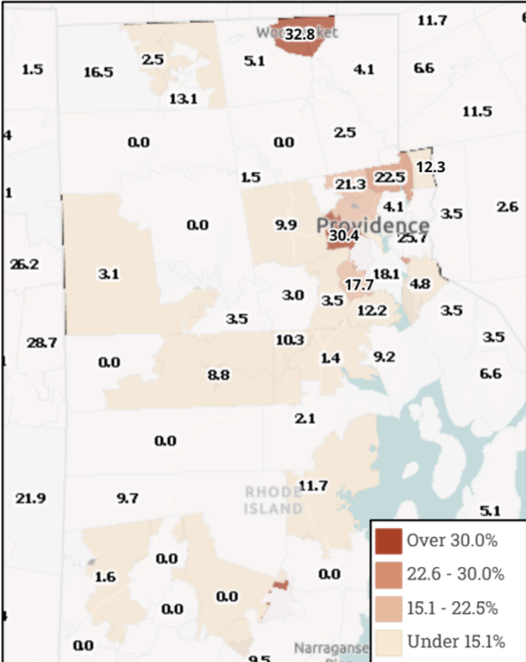


Source: US Census Bureau, American Community Survey

2019-2023 Population in Poverty by Zip Code



2019-2023 Children in Poverty by Zip Code



Source: US Census Bureau, American Community Survey

The Health Resources and Services Administration Unmet Need Score (UNS) helps in allocation of resources—including primary and preventive healthcare services—across communities with higher unmet need based on social, economic, and health status. The UNS evaluates zip codes using a weighted sum of 28 health and social measures with values ranging from 0 (least need) to 100 (greatest need).

Among the zip codes of origin for ESH patients, there is 59-point difference between zip codes with the highest and lowest UNS value, demonstrating community-level health and social disparities.

Eleanor Slater Hospital Patient Zip Codes of Origin by Unmet Need Score and Select Social Drivers of Health Indicators (Years 2019-2023) ^

Zip Code	Total Population in Poverty	Children in Poverty	Families with Low Income*	No High School Diploma	No Health Insurance	Unmet Need Score
02909, Providence	22.5%	30.4%	33.4%	20.2%	8.4%	62.59
02895, Woonsocket	19.7%	32.8%	31.0%	18.1%	6.5%	59.43
02860, Pawtucket	16.3%	22.5%	26.9%	20.1%	4.5%	59.03
02903, Providence	20.9%	4.0%	18.8%	11.2%	2.7%	54.19
02908, Providence	16.1%	18.0%	24.4%	16.3%	9.2%	52.50
02904, Providence	16.5%	21.3%	25.1%	12.5%	5.4%	47.16
02861, Pawtucket	9.1%	12.3%	15.6%	13.4%	4.4%	39.20
02920, Cranston	8.9%	3.5%	15.2%	11.5%	6.6%	35.72
02910, Cranston	10.2%	17.7%	17.9%	9.6%	4.7%	32.62
02893, West Warwick	9.8%	10.3%	18.6%	9.9%	4.3%	31.67
02919, Johnston	8.7%	9.9%	16.3%	9.1%	3.0%	27.51
02915, Riverside	7.7%	4.8%	13.2%	8.2%	2.0%	24.68
02886, Warwick	5.8%	1.4%	10.2%	6.7%	2.2%	24.13
02888, Warwick	8.9%	12.2%	10.9%	4.4%	6.1%	23.09
02816, Coventry	8.4%	8.8%	13.3%	13.3%	2.2%	16.21
02830, Harrisville	6.6%	2.5%	12.0%	9.3%	1.4%	15.45
02825, Foster	3.0%	3.1%	4.0%	5.6%	2.0%	8.09
02852, North Kingstown	7.6%	11.7%	9.6%	3.6%	2.2%	5.86
02832, Hope Valley	5.3%	1.6%	10.9%	9.2%	1.1%	3.42
Rhode Island	10.9%	13.3%	15.9%	10.5%	4.3%	NA

Source: Health Resources & Services Administration (HRSA) & US Census Bureau, American Community Survey
^Select SDoH indicators are presented to illustrate measures that influence the calculation of the Unmet Need Score.
*Families with incomes at or below 185% of the Federal Poverty Level (FPL). In 2024, a family of four people at 185% of the FPL had an income of $57,720.

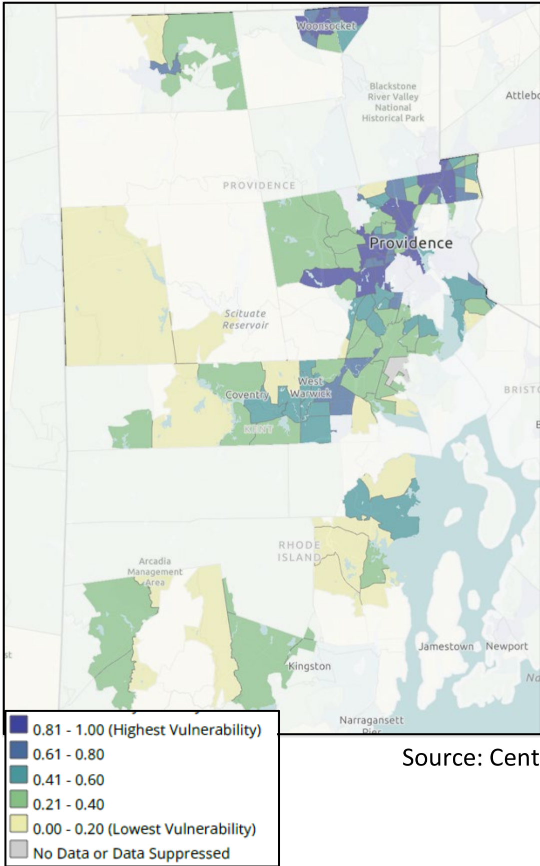
The Social Vulnerability Index (SVI) goes a level deeper than the UNS to demonstrate vulnerability to health disparities at a census tract-level.

Census tracts are small geographic regions defined for the purpose of taking a census, designed to be relatively homogeneous in terms of population characteristics, economic status, and living conditions. Census tracts cover the entire United States and typically contain between 1,500 and 8,000 people.

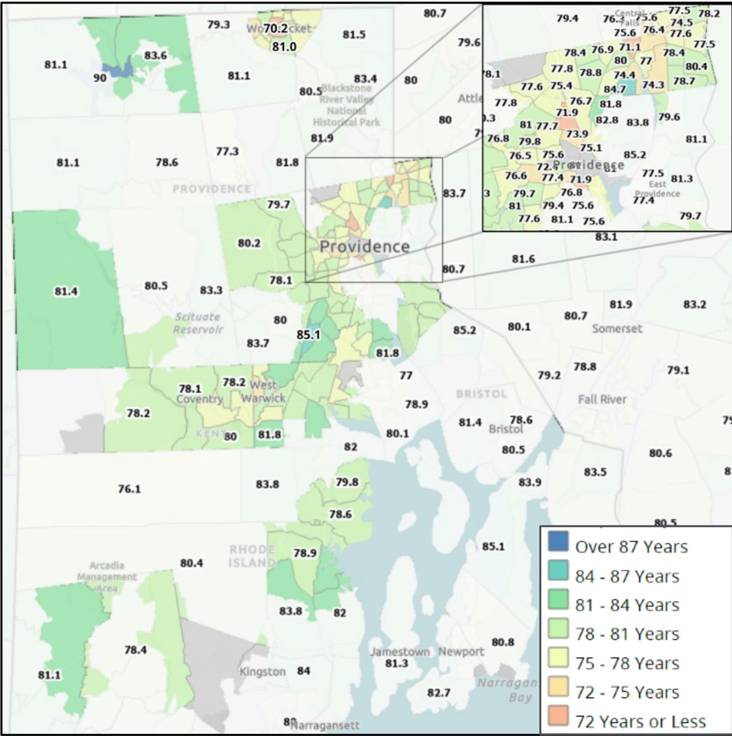
The SVI scores census tracts on a scale from 0.0 (lowest) to 1.0 (highest) vulnerability based on factors like poverty, lack of transportation, and overcrowded housing.

Examining the SVI in conjunction with average life expectancy demonstrates how SDoH impact health outcomes. Within areas of residence for patients served by ESH in 2023 and 2024, historical data indicates potential for a nearly 15-year difference in average life expectancy between communities with the lowest and highest averages. Affected areas, including Rhode Island's core cities, also have SVI values of 0.81 or higher, with some tracts valued at 0.98 and 0.99 out of a maximum score of 1.0, reported as recently as 2022.

2022 Social Vulnerability Index by Census Tract



2010-2015 Life Expectancy by Census Tract



Source: Centers for Disease Control and Prevention

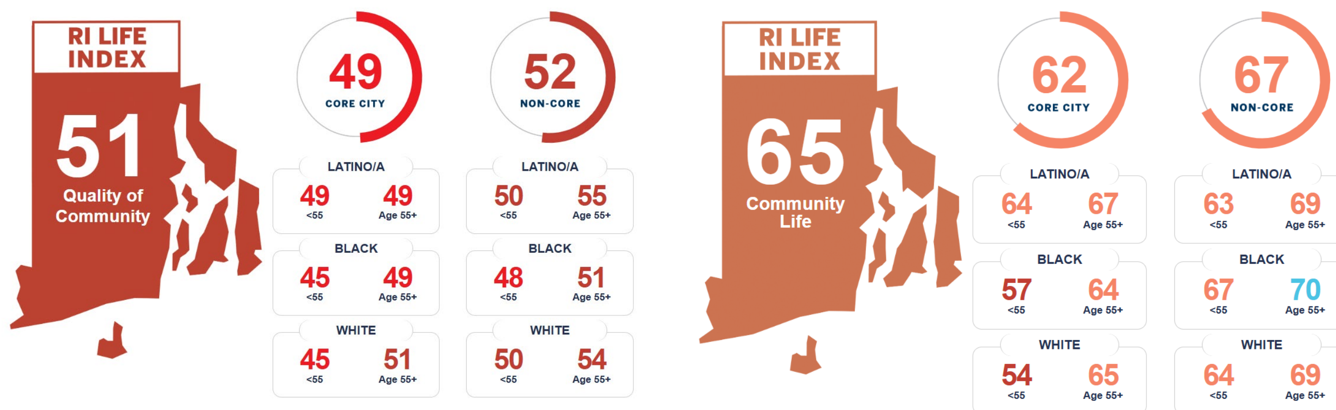
Blue Cross & Blue Shield of Rhode Island (BCBSRI) and the Brown University School of Public Health have produced the RI Life Index each year since 2019 to capture Rhode Islanders' perceptions of SDoH and wellbeing, including quality of community and quality of life. Scores are presented in aggregate (max score of 100) and broken down by respondent's residence (core city vs. non-core areas), race, ethnicity, and age. The Rhode Island core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Quality of Community scoring represents a summary of how residents rate social and economic aspects of their community, including the following topics:

- Access to childcare
- Activities for youth
- Employment
- Access to affordable food
- Cost of living
- Availability and quality of services and programs for seniors

Community Life scoring represents a summary of how residents perceive the lived experiences of typical individuals in their community, in the following areas:

- Employment
- Education
- Convenient locations for nutritious food
- Access to affordable housing
- Access to healthcare
- Feeling safe at home



The RI Life Index saw improved scores in 2024 in the *core cities* related to perceptions about community life, programs and services for children, and healthcare access, with particular improvement in perceptions about healthcare access among Black and Latino/a residents.

Overall perceptions of quality of community and community life for the state continued to decline from prior surveys, including declines in perceptions of affordable housing, cost of living, job opportunities, access to nutritious food, and experiences with food security. CHNA secondary data findings and resident feedback reinforced these key areas of need.

Community Health Needs

The CHNA was a comprehensive study of health and socioeconomic indicators for Rhode Island residents. The following section highlights key health, and wellbeing needs as determined by secondary data statistics and community stakeholder feedback.

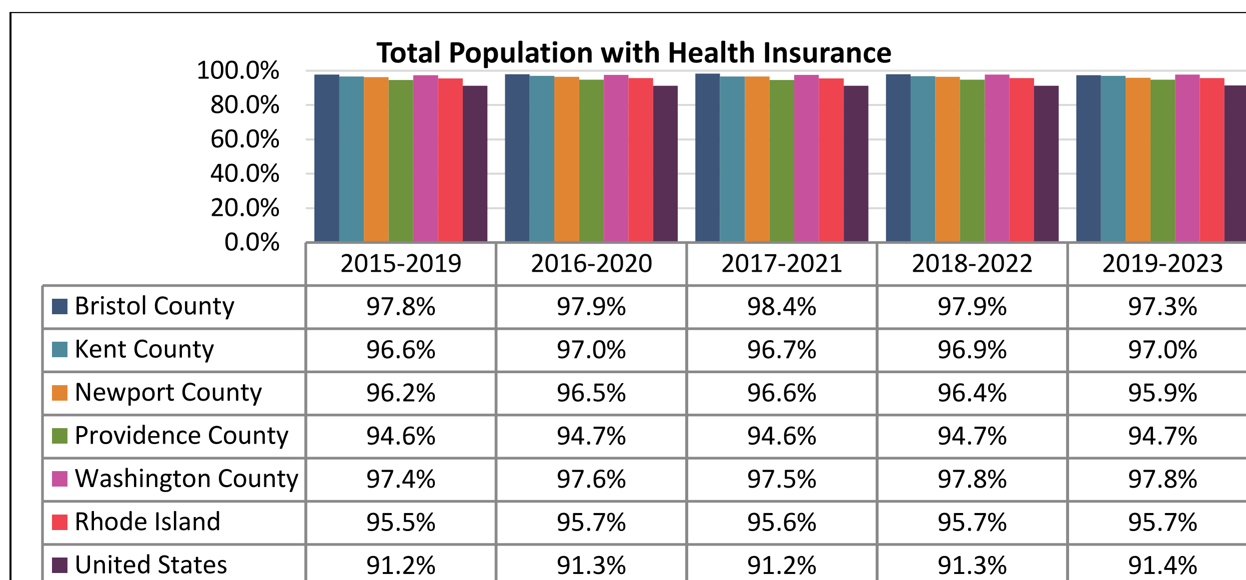
A full summary of secondary data findings is also provided on Eleanor Slater Hospital's website and available to our community partners as a resource to support their many programs and services.

Access to Care and Services

Rhode Island is home to high quality and comprehensive healthcare and social services. Residents benefit from programs that provide free and reduced cost healthcare for uninsured and underinsured people, and a wide array of human service agencies committed to helping residents. Agencies, providers, and advocates are active partners in community planning and coordinated service delivery.

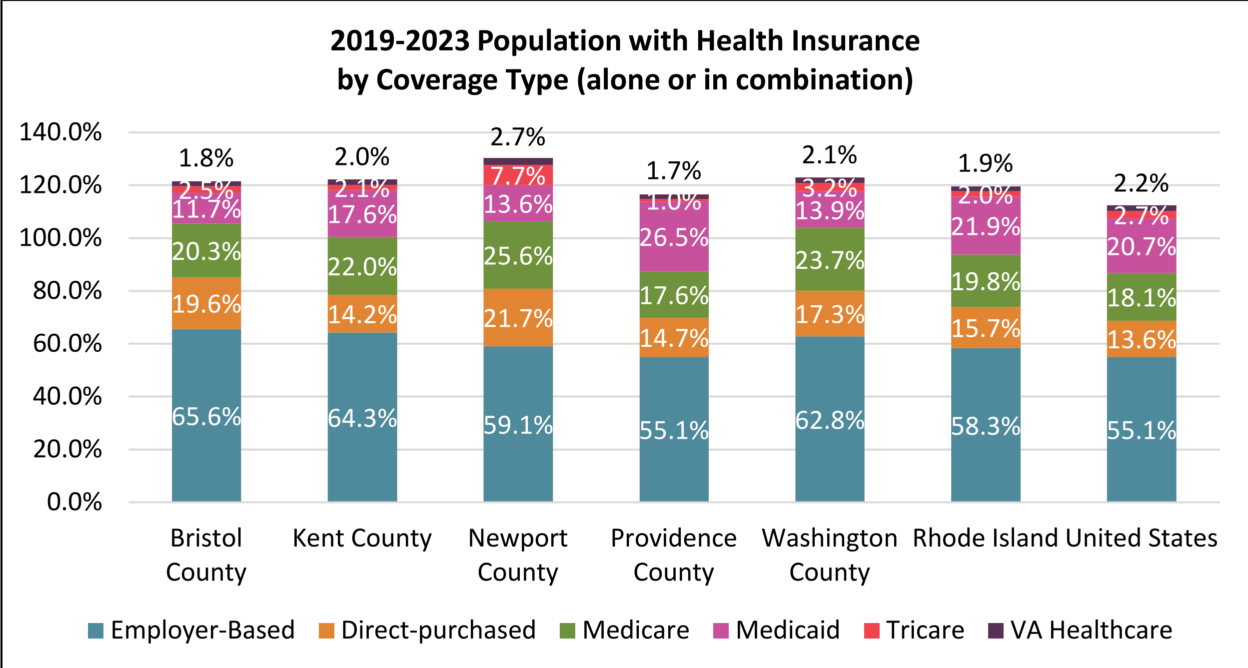
Health insurance coverage among Rhode Island residents has been consistently high with 95.7% of residents covered in 2023 compared to 91.4% of residents nationally. Statewide, a high proportion of insured residents obtain their insurance through an employer (58.3%), providing cost-sharing benefits and typically comprehensive coverage. Across Rhode Island counties, 81%-83% of adults received a routine primary care visit or checkup in 2022 compared to 74.2% of adults nationally.

The healthcare environment in Rhode Island has changed since the 2022 CHNA and there are distinct differences in healthcare access across counties. Across all counties, the proportion of residents with Medicare increased, a finding that is consistent with the state's aging population. Medicaid coverage increased in Newport and Washington counties. In Providence County, 1 in 4 residents receive Medicaid, with higher coverage among core city residents. The core cities are also primary care Health Professional Shortage Areas (HPSAs) for people with low income, indicating a shortage of healthcare providers for vulnerable residents.



	2015-2019	2016-2020	2017-2021	2018-2022	2019-2023
Bristol County	97.8%	97.9%	98.4%	97.9%	97.3%
Kent County	96.6%	97.0%	96.7%	96.9%	97.0%
Newport County	96.2%	96.5%	96.6%	96.4%	95.9%
Providence County	94.6%	94.7%	94.6%	94.7%	94.7%
Washington County	97.4%	97.6%	97.5%	97.8%	97.8%
Rhode Island	95.5%	95.7%	95.6%	95.7%	95.7%
United States	91.2%	91.3%	91.2%	91.3%	91.4%

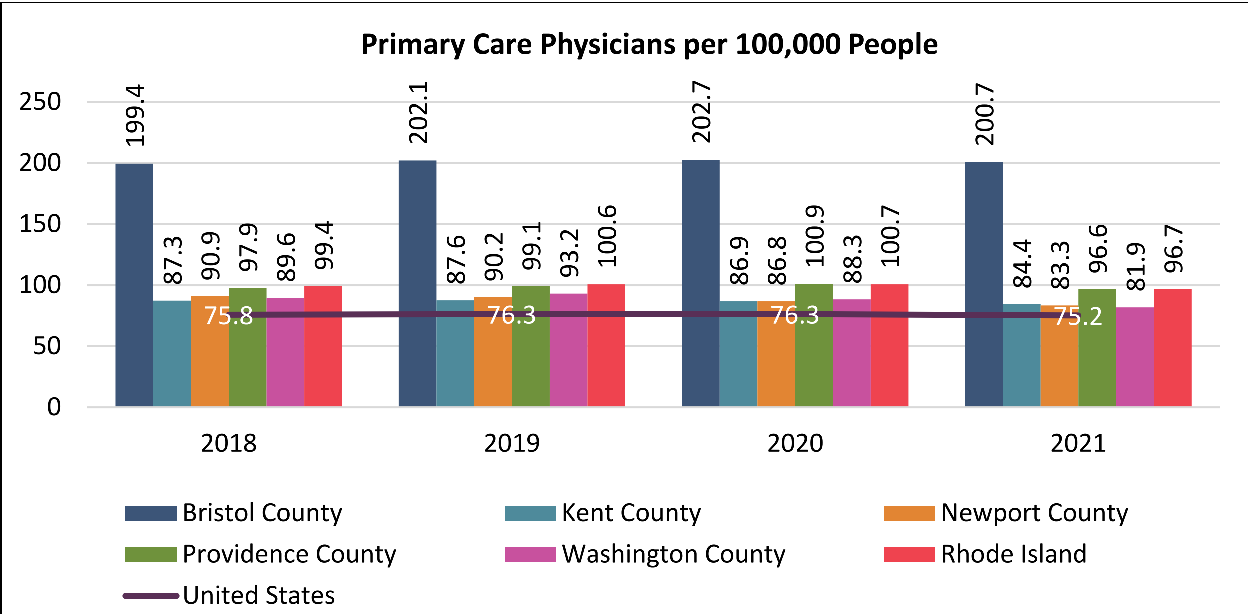
Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

Availability of primary care physicians in Rhode Island remains above national levels but declined in 2021. Feedback from healthcare leaders and recent reports from the Rhode Island Office of the Health Insurance Commissioner (OHIC) indicate that provider availability is a growing challenge with reported months long waits for primary care appointments and more limited access to preventive screenings.

> *"A renewed focus on attracting and retaining medical professionals (doctors, PAs, NPs) for primary care is at a crisis point. Finding ways to increase payments to providers without undue impact on the consumer would be a high priority."*



Source: Health Resources & Services Administration & Centers for Medicare and Medicaid Services

The Rhode Island OHIC published a report in December 2023, *"Primary Care in Rhode Island Current Status and Policy Recommendations,"* to evaluate primary care services in Rhode Island and inform future policy and regulation. Key findings from the report are highlighted below and continue to be primary focus areas for HARI member hospitals and others.

Primary Care Strengths and Challenges in Rhode Island (as reported by OHIC)

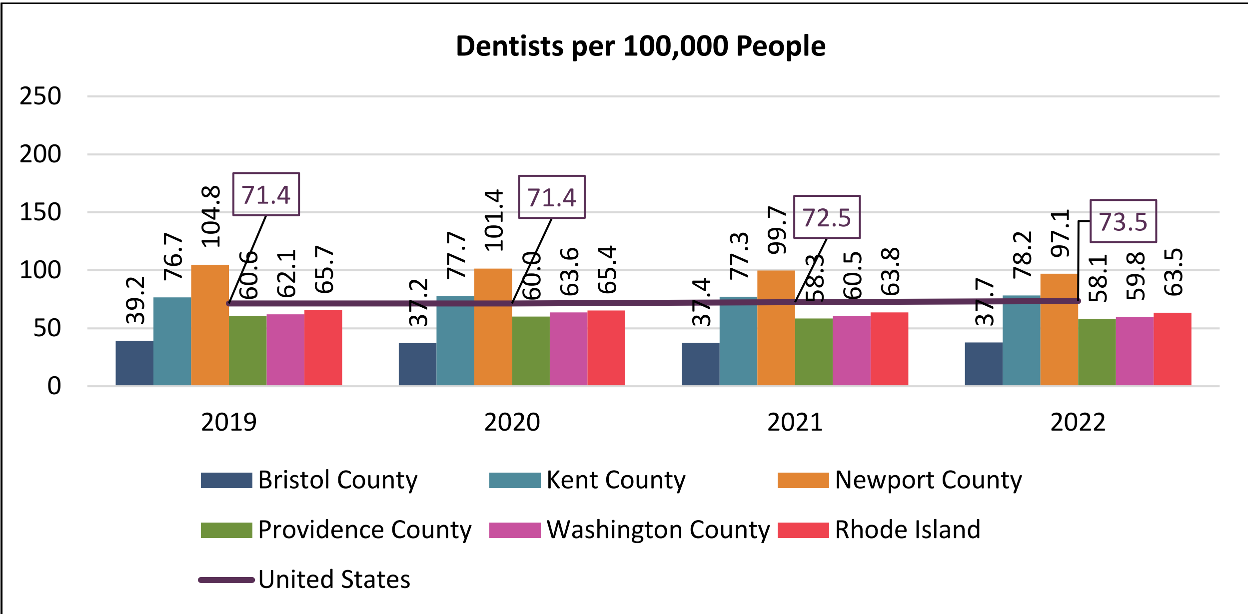
Primary Care Strengths

- Rhode Island has a higher number of primary care providers relative to population than most states.
- Rhode Island has a higher percentage of residents who report a usual source of care.
- Rhode Island's small size is an advantage because there are fewer barriers to collaboration among decisionmakers and interested parties.
- Rhode Island has a track record of policy innovation and multi-payer engagement in activities to improve primary care.

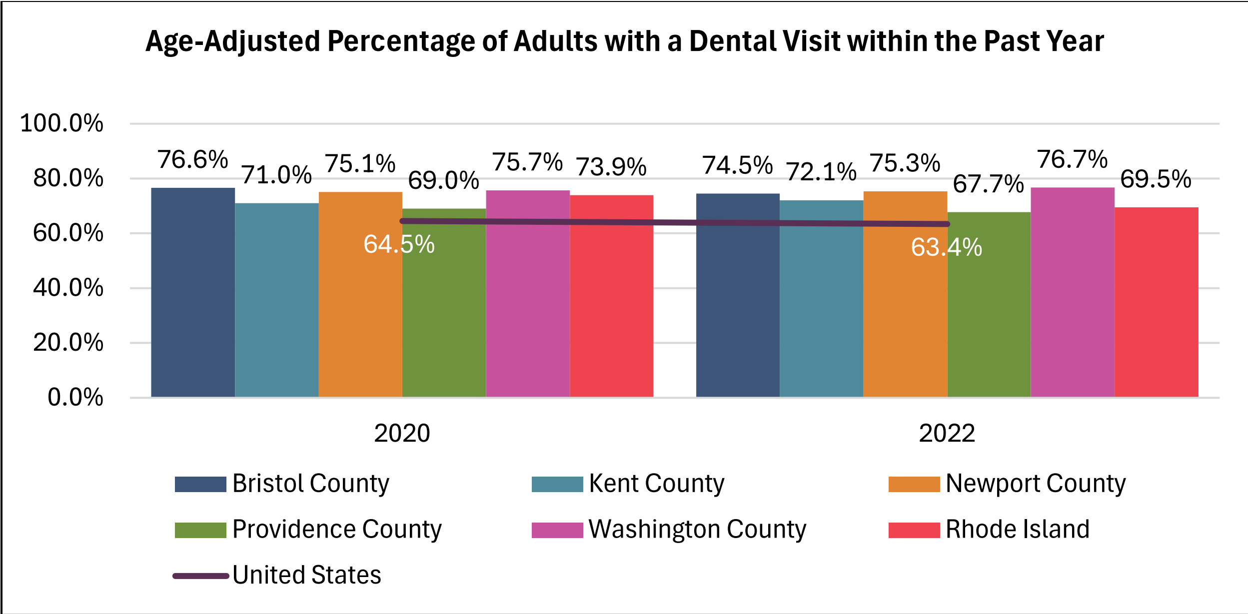
Primary Care Challenges

- The primary care workforce is aging, and many providers are contemplating retirement.
- Primary care is nationally reimbursed and compensated significantly less than most other medical specialties and there is evidence that primary care reimbursement in Rhode Island is not competitive with neighboring states.
- Nationally, fewer medical students are choosing primary care as a career path, in part due to salary differentials. Medical students who do choose primary care and are trained in Rhode Island are not necessarily staying in Rhode Island.
- Clinician burnout is a key concern and is driving primary care physicians and advanced practitioners to reduce or leave clinical practice.

Availability of dental care has also declined in Rhode Island and has historically been lower than national averages. Key stakeholders noted that access is especially limited for dental providers that accept Medicaid. Middletown and Newport in Newport County are HPSAs for professionals that serve Medicaid beneficiaries, and the core cities are HPSAs for people with low income. While all counties have a higher proportion of residents receiving annual routine dental care than the nation, there are stark differences between the counties which generally align with socioeconomic barriers.



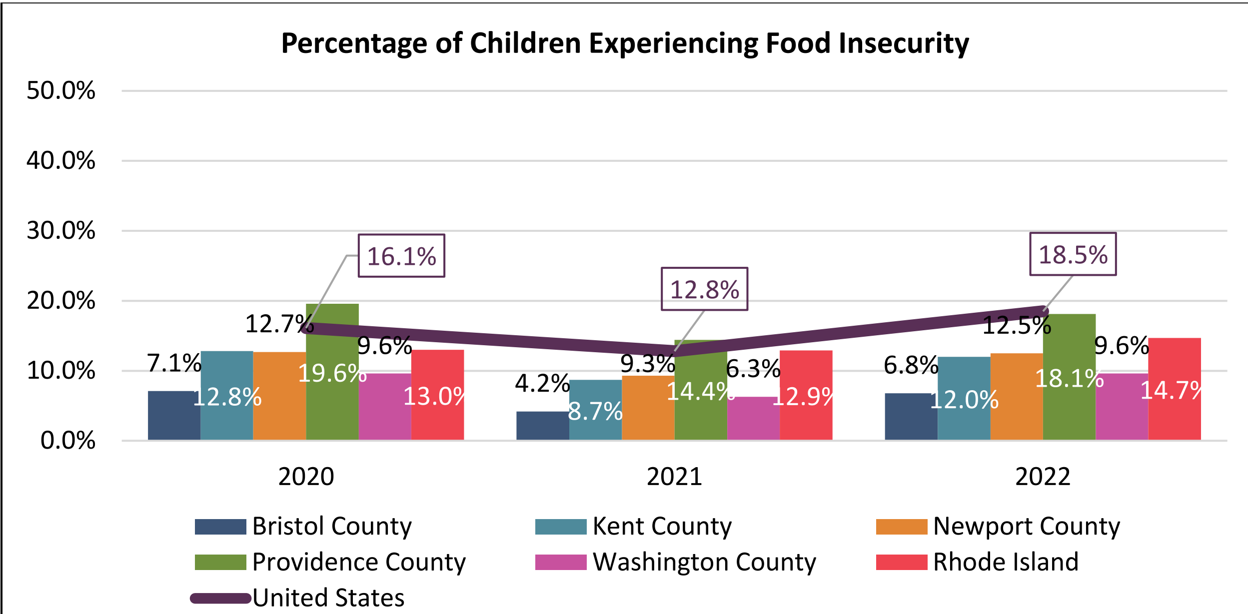
Source: Health Resources & Services Administration & Centers for Medicare and Medicaid Services



Source: Centers for Disease Control and Prevention

The rising cost of living has increased demand for social services and contributed to delays in accessing vital services. Statewide, the proportion of food insecure residents increased from 9.3% in 2021 to 10.9% in 2022, with an outsized impact on children. Statewide median home value rose 41% from 2019 to 2023; median rent rose 27%. The cost of childcare for a household with two children in Rhode Island, measured as a percentage of median household income, increased from 24.1% in 2021/2022 to 33.1% in 2022/2023.

Frontline social service providers described their work effort as being in "crisis mode," experiencing both organizational and personal stress in trying to meet increased resident needs.



Source: Feeding America

Childcare Availability and Affordability

	Number of childcare centers per 1,000 population under 5 years old	Childcare costs for a household with two children as a percentage of median household income
Bristol County	11.1	30.2%
Kent County	8.6	33.1%
Newport County	11.0	36.7%
Providence County	7.1	34.5%
Washington County	11.1	31.7%
Rhode Island	11.0	33.1%
United States	7.0	27.0%

Source: Homeland Infrastructure Foundation-Level Data, 2010-2022 & The Living Wage Calculator, Small Area Income and Poverty Estimates, 2023 & 2022

Key stakeholders also saw transportation as a key limiting factor for accessing community resources, noting that Rhode Island Public Transit Authority (RIPTA) offers limited services outside of urban areas. MTM Health, the state's non-emergency medical transportation manager, is helpful for people with Medicaid and/or eligible older adults but the service was reported to lack timeliness and coordination, contributing to missed appointments and stranded patients. Survey participants reported that Blue Cross Blue Shield's BlueCHiP Medicare coverage eliminated transportation and meal benefits.

Federal funding cuts planned for healthcare and social services are anticipated to further reduce access to community resources; cuts are expected to impact Medicaid, SNAP benefits, subsidized childcare, and low-income housing benefits. Stakeholders emphasized the need for elected leadership that respects and represents the lived experience of diverse populations in Rhode Island and the nation, and more opportunities for political leaders to intentionally engage with community members.

> *"Often decision makers are removed from those who are patients or are community-facing, leaving major gaps in how the solutions are implemented. We need those with lived experience at the table to influence and make the decisions, as well."*
>
> *"Where do we catch our decision-makers to address these issues?"*

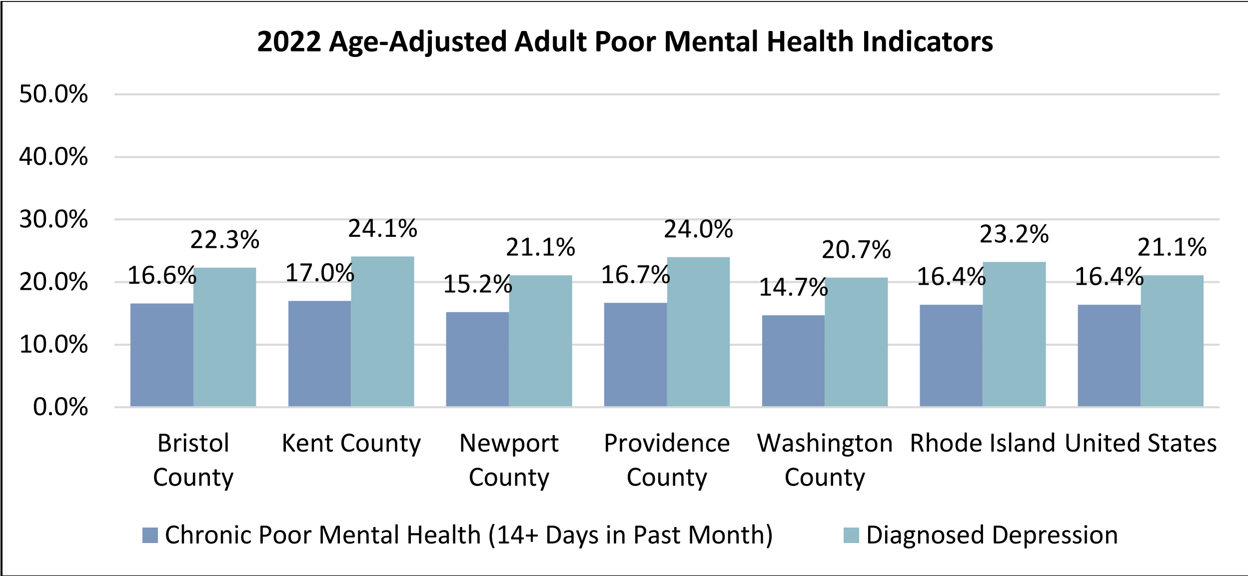
Key stakeholders recognized that groups who have been historically marginalized were more likely to experience health disparities. These underserved communities—including those that identify as people of color and/or people with disabilities—are more likely to face economic insecurity and have cultural and language barriers.

Stakeholders underscored the importance of staff and provider training in cultural competency and humility and increased health education materials that reflect the language and culture of communities. They also advocated for the inclusion of people with lived experience in developing community solutions.

> *"[They] keep cancelling appointments due to not enough interpreters available, or the doctor office didn't call until last minute."*
>
> *"The top health concerns for the Deaf community include limited access to healthcare services that are linguistically and culturally competent, with providers fluent in ASL or supported by qualified interpreters."*
>
> *"There are system and structural barriers that prevent certain populations from accessing the care they need and resources to live a comfortable life. We need to work together to identify these barriers and make changes."*

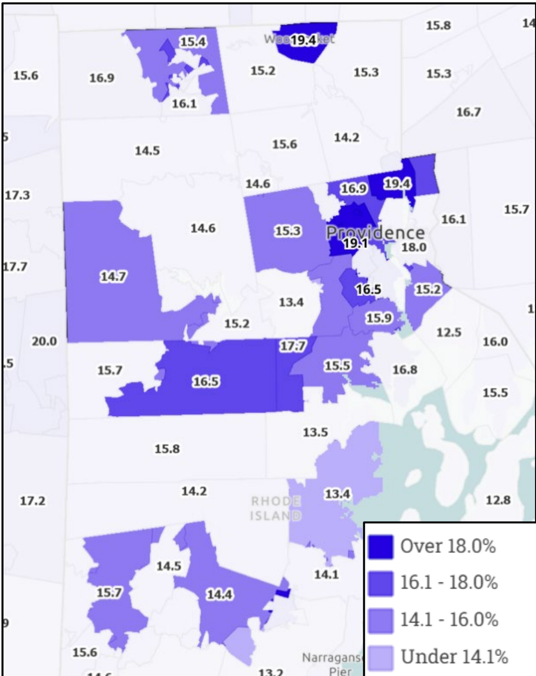
Behavioral Health

Experiences of mental distress have increased statewide and nationally. In 2022, approximately 16% of Rhode Island adults reported having chronic poor mental health (14 or more days in the past month) compared to 14% in 2020. Approximately 23% of adults reported being diagnosed with a depression disorder. Within the zip codes of origin for patients served by ESH in 2023 and 2024, experiences of mental distress are prevalent across communities, and more prevalent in communities experiencing socioeconomic barriers.



Source: Centers for Disease Control and Prevention

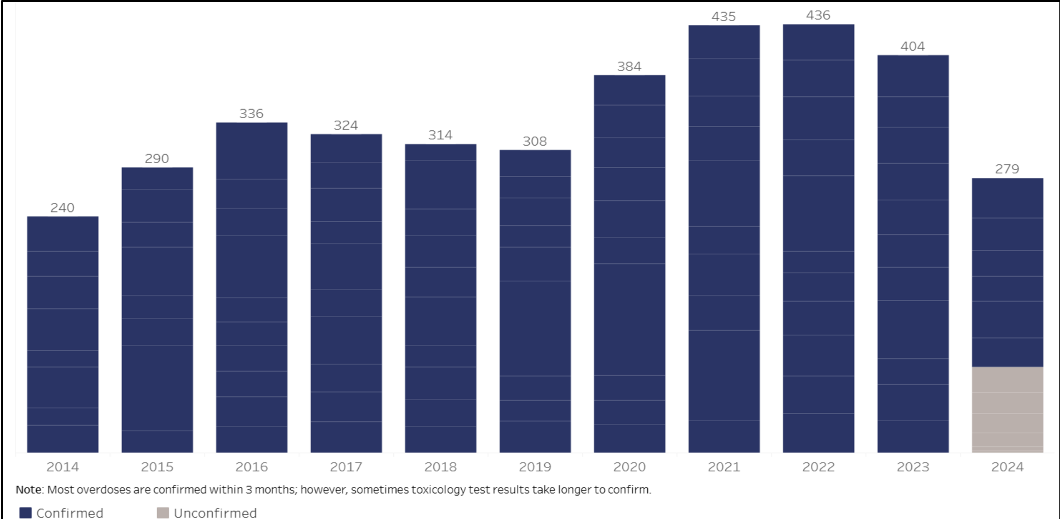
2022 Adults with Chronic Poor Mental Health by Zip Code



Source: Centers for Disease Control and Prevention

Fatal overdoses in Rhode Island have been on the rise since 2014 and peaked in 2021 and 2022, likely due in part to the COVID-19 pandemic which caused delays in care, social isolation, and unemployment. Data for 2024 suggest that overdose deaths are down, but professionals warn that the rise of new street drugs like medetomidine (a highly fatal additive to fentanyl) may reverse this trend. Ongoing training to prepare first responders is needed.

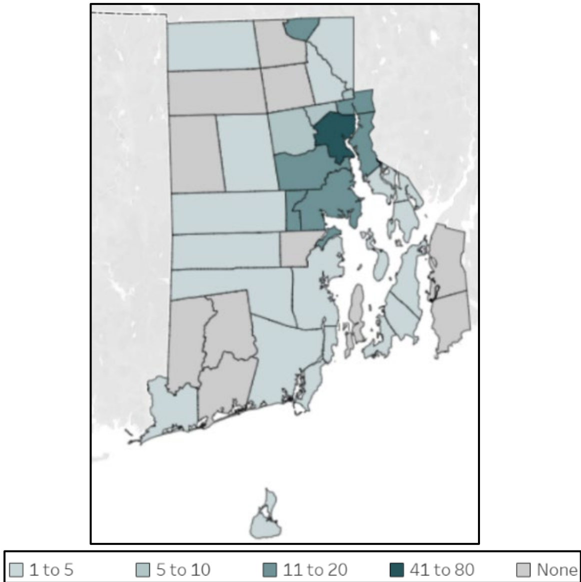
Rhode Island State Number of Drug Overdose-Related Deaths, 2014-2024



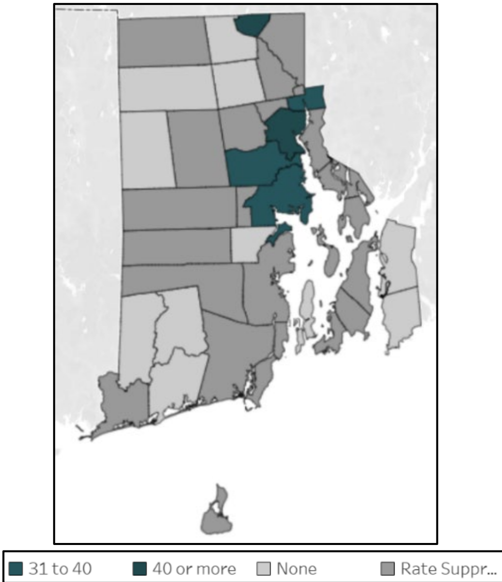
Source: Prevent Overdose RI

There has been an overdose in every Rhode Island town. The following maps use information from the Rhode Island Medical Examiner's Office to show overdose occurrences in 2024. Fatal overdoses were more prevalent in areas historically placed at risk, including core cities and areas in and around Warwick.

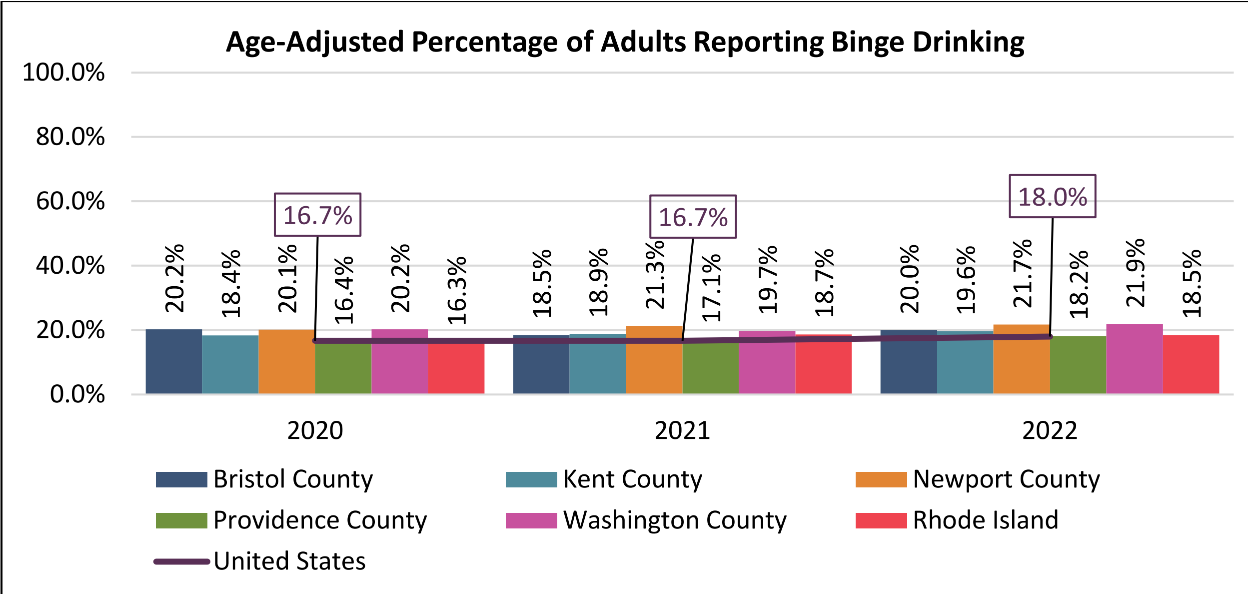
2024 Overdose Deaths by City/Town (counts)



2024 Overdose Deaths by City/Town (rate per 100,000)

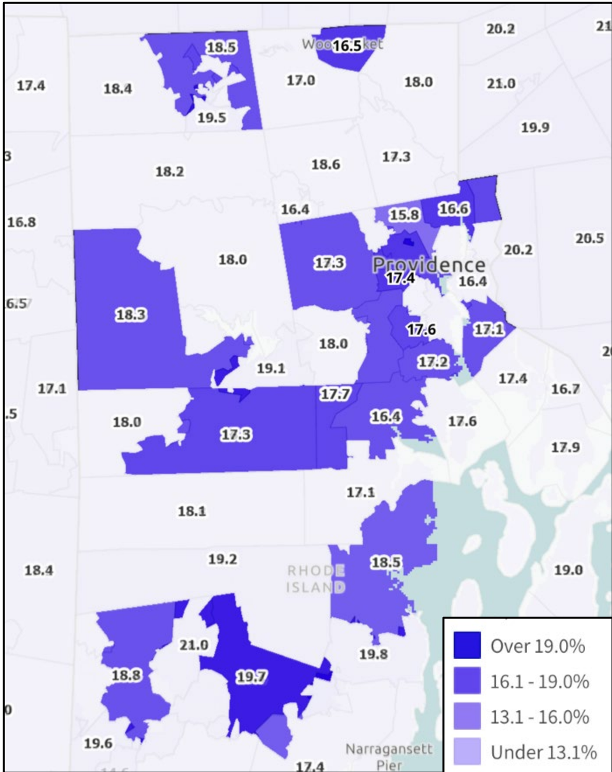


Alcohol use disorder is a growing concern nationally and for Rhode Island residents. Nearly 1 in 5 Rhode Island adults reported excessive alcohol use, with recent increases in all counties except Bristol. Zip code-level analysis shows that excessive alcohol use is prevalent across communities.



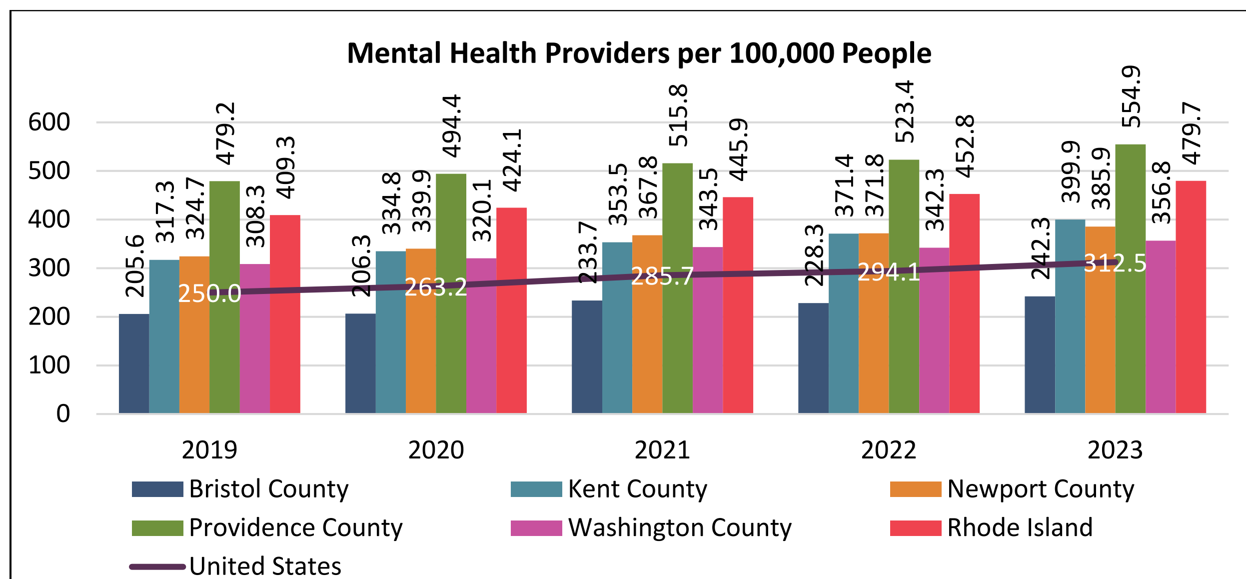
Source: Centers for Disease Control and Prevention

2022 Adults who Self-Report Binge Drinking by Zip Code



Source: Centers for Disease Control and Prevention

Rhode Island has a consistently higher rate of behavioral health providers compared to the national average, and the rate is increasing. Despite these trends, gaps in access to care and services persist. Newport and Washington counties are HPSAs for all people, and Providence County is a HPSA for people with low income.



Source: Centers for Medicare and Medicaid Services
*Mental health providers include those specializing in psychiatry, psychology, mental health, addiction or substance use disorders, or counselling.

Health and human service professionals reported an increase in patients presenting to acute hospital settings due to lack of outpatient resources (e.g., detox programs, psychiatrists, support groups), as well as lack of placement options post-discharge. Finding appropriate housing for discharge of patients with comorbidities or complex medical needs was especially challenging.

> *"[There is an] increase in patients seeking emergency room care [and] inadequate residential placement options for patients seeking treatment with skilled health care needs (i.e., with DME [durable medical equipment], IV abx [intravenous antibiotics] needs."*

> *"Patients with chronic behavioral health issues that cannot be placed at SNFs [skilled nursing] due to said behaviors and sit in acute care beds for weeks/months thus lessening available acute care beds."*

> *"Those suffering with substance use disorder who end up having complex medical needs for 30-45 days, who then have no housing or shelter - there are limited safe discharge options."*

Despite having an increasing number of behavioral health providers across the state, behavioral health care is not readily available for all that need it. Providers cited low reimbursement rates as one reason for limited providers, particularly those that participate with Medicaid. Low reimbursement rates have prompted some providers to move to private practice, opting to accept only self-pay clients. Stigma also continues to be a barrier to seeking treatment, particularly for people with substance use disorder.

> *"The community's concern is that they will be stigmatized because of use, they will not be supported in safe use, or that they will not be supported in the 50th attempt to cut down."*

> *"[There is] stigma surrounding alcoholism and dependence - social expectation in the area is to drink, not abstain."*

Health and human service professionals noted an increase in mental health and substance use concerns among youth, often rooted in adverse childhood experiences (ACEs) like living in poverty and exposure to violence. Isolation and developmental delays from the COVID-19 pandemic also have had lingering impact on youth.

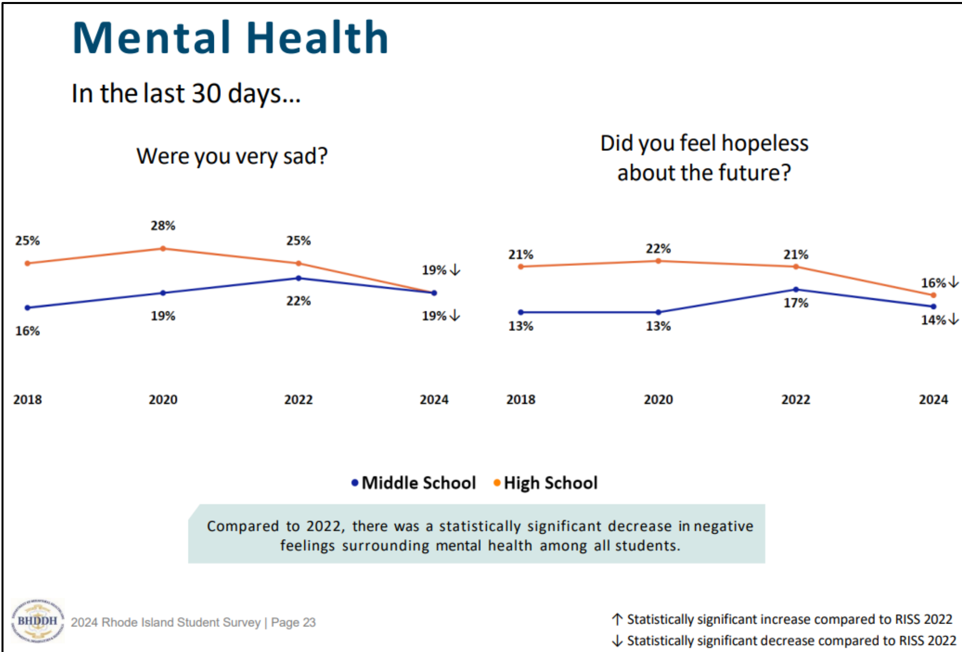
Professionals reported that there has been an increase in EMS calls to schools for mental health crises and suicide attempts, with trends among younger age groups than in past years. Youth professionals also held concerns that the legalization of cannabis (marijuana) and lack of regulation contributed to increased use among students and kids *"greening out in school."* Community representatives noted that funding for children's mobile crisis services is largely limited to children with Medicaid, creating a deficit in resources for other children in need of services. Partners recommended more investment in upstream interventions like engagement and mentorship activities and graduation support for at-risk students.

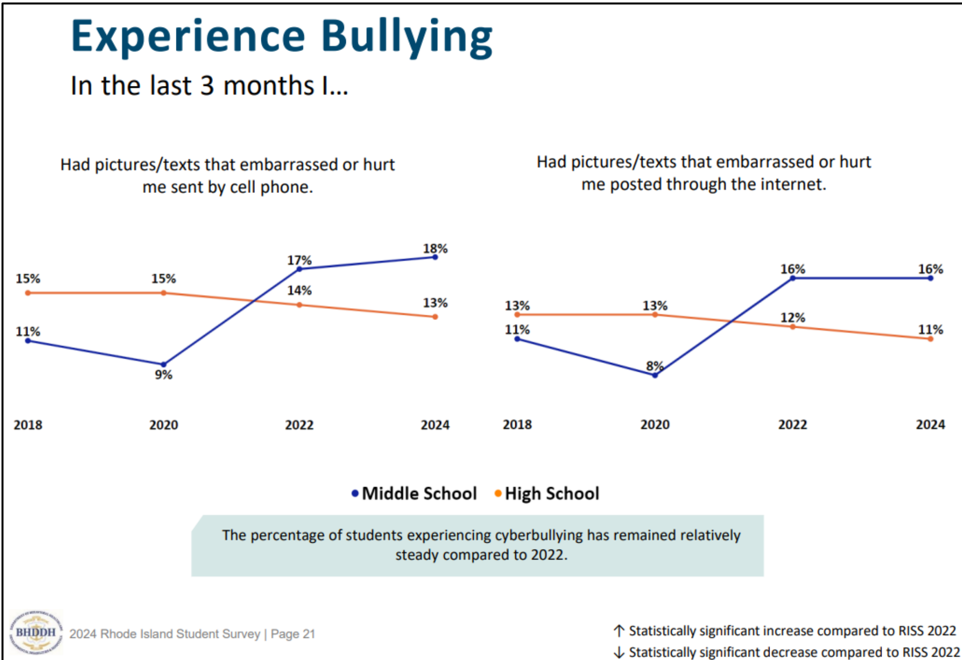
> *"The legalization of marijuana [during] COVID caused increases to an already growing problem that lacked resources. Specifically, we have many addicted students that need in-patient or intense treatment."*

> *"Treatment options for youth (12-18 y.o.) need to be identified and shored up. While the focus of many efforts has been on treatment, prevention is what needs to be differently funded to have a real impact."*

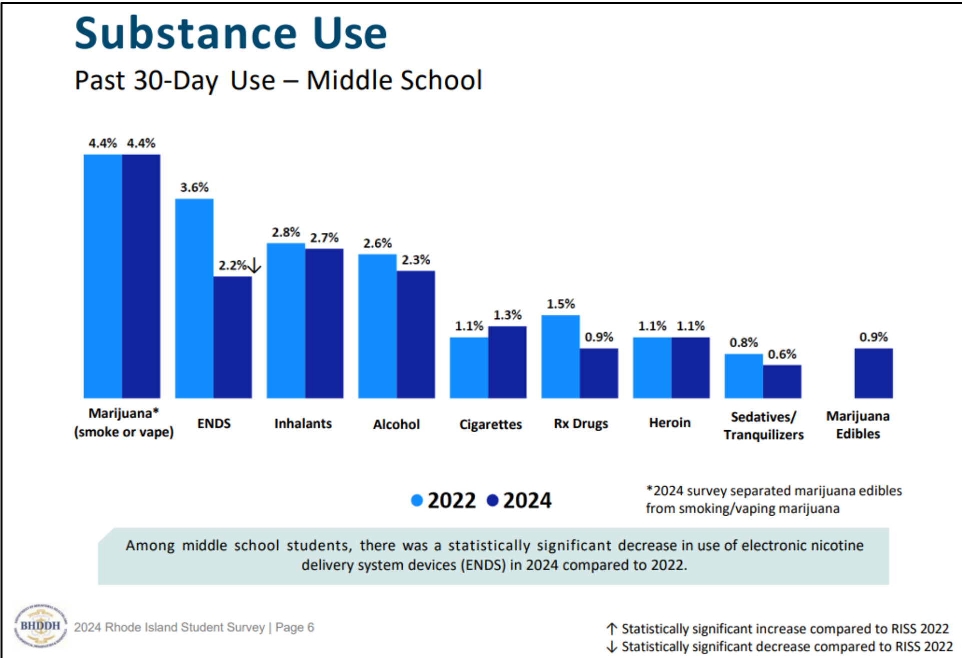
> *"Access to services is often limited due to long wait lists for therapy and psychiatry services for children and adolescents."*

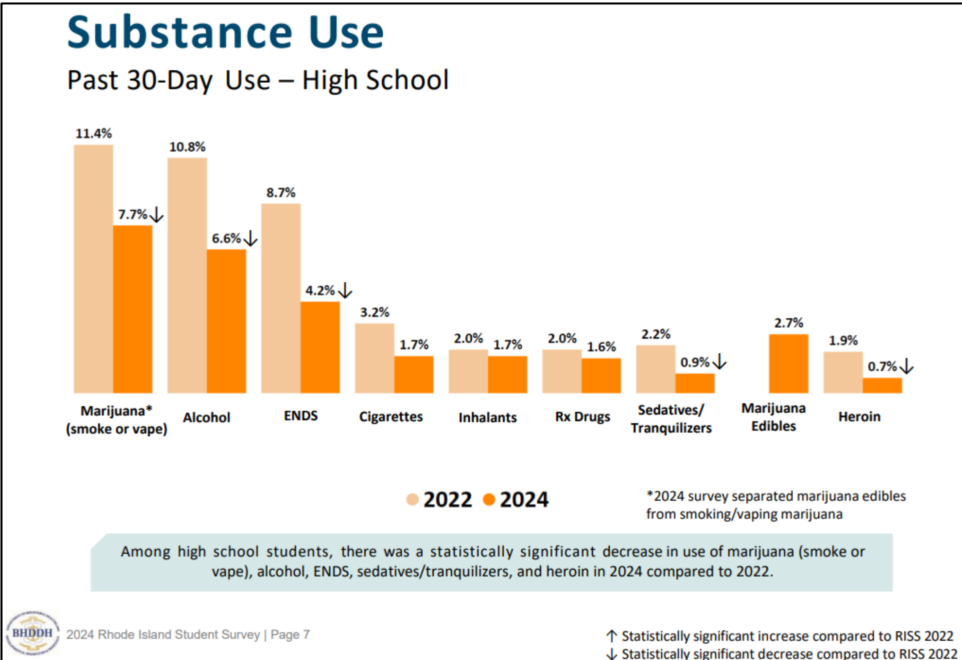
The Rhode Island Student Survey is a statewide survey administered every other year and examines the risk and prevalence of substance use, bullying, depression, suicide, and violence among Rhode Island youth in middle (MS) and high (HS) schools. The most recent survey administered in 2024 found significant improvement in mental health outcomes, but approximately 1 in 5 students still reported feeling very sad and/or hopeless about their future. Among students who considered attempting suicide, one-third or more attempted it. There were also significant increases in perpetrating bullying and cyberbullying among MS students, and experiences of bullying among both MS and HS students. Substance use declined significantly for students, except for a rise in cannabis use among MS students.





Source: Rhode Island Student Survey





Source: Rhode Island Student Survey

Health and human service professionals saw a need to better address behavioral health issues through a holistic care continuum, noting that the current system is “siloed” by individual needs or demographics. A holistic approach would include an open (immediate) access model and patient advocates to help navigate different levels of care and the healthcare system. Wraparound social services like housing were also seen as essential to help people be successful in their treatment.

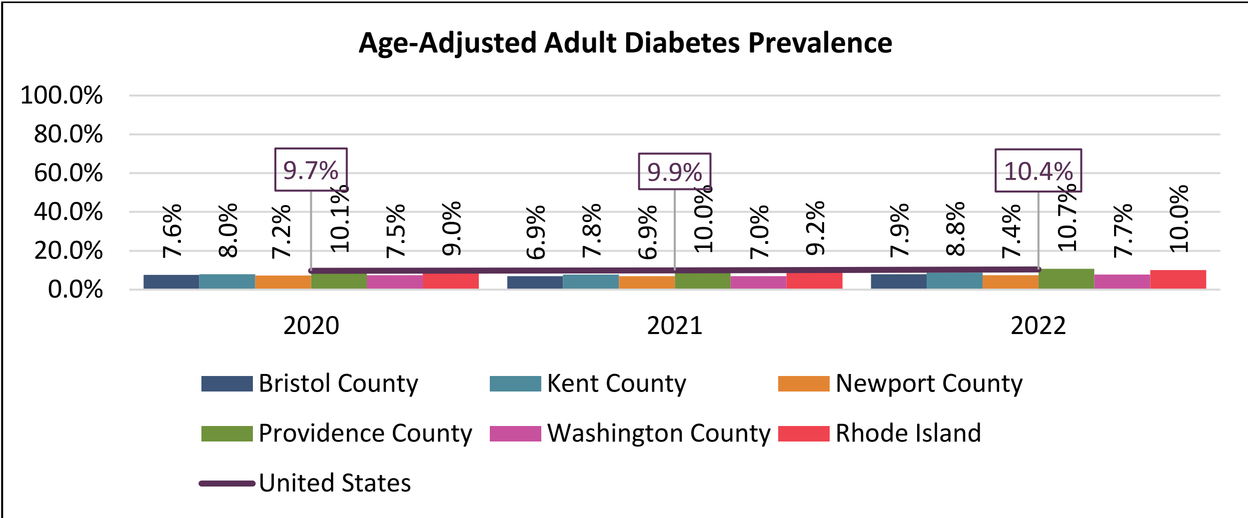
Concerted efforts to address increasing behavioral health needs have led to progress in improving community awareness and access to services. Health and human service professionals named the following successes within Rhode Island:

- Anchor ED and Anchor Peer Recovery Center
- Crisis Intervention Teams of Rhode Island (CIT-RI)
- Gateway Healthcare dedicated behavioral health services
- Hospital-initiated screening for behavioral health and SDoH
- Inclusion of people with lived experience as volunteers, staff, and advocates in developing programs (e.g., CIT-RI)
- Insurance reimbursement for peer recovery coaches
- Increased state and local funding for behavioral health programs and support

Chronic Diseases: Leading Causes of Death and Disease

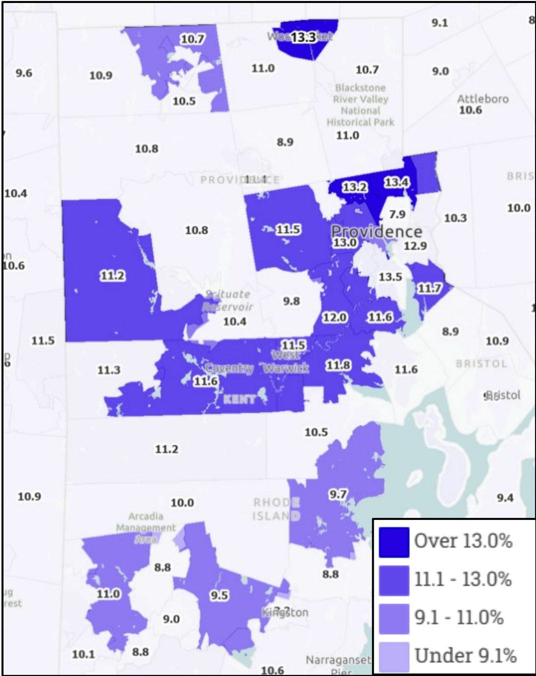
The following section focuses on the leading causes of disease burden and death, and the management and prevention efforts for these diseases.

Diabetes and heart disease are among the top causes of death for residents in Rhode Island. The proportion of adults in Rhode Island that are diagnosed with diabetes has increased since 2020 to approximately 1 in 10 adults. More than one-quarter of adults have high blood pressure and/or high cholesterol. Rates of disease outside of Providence County are historically lower than national averages.

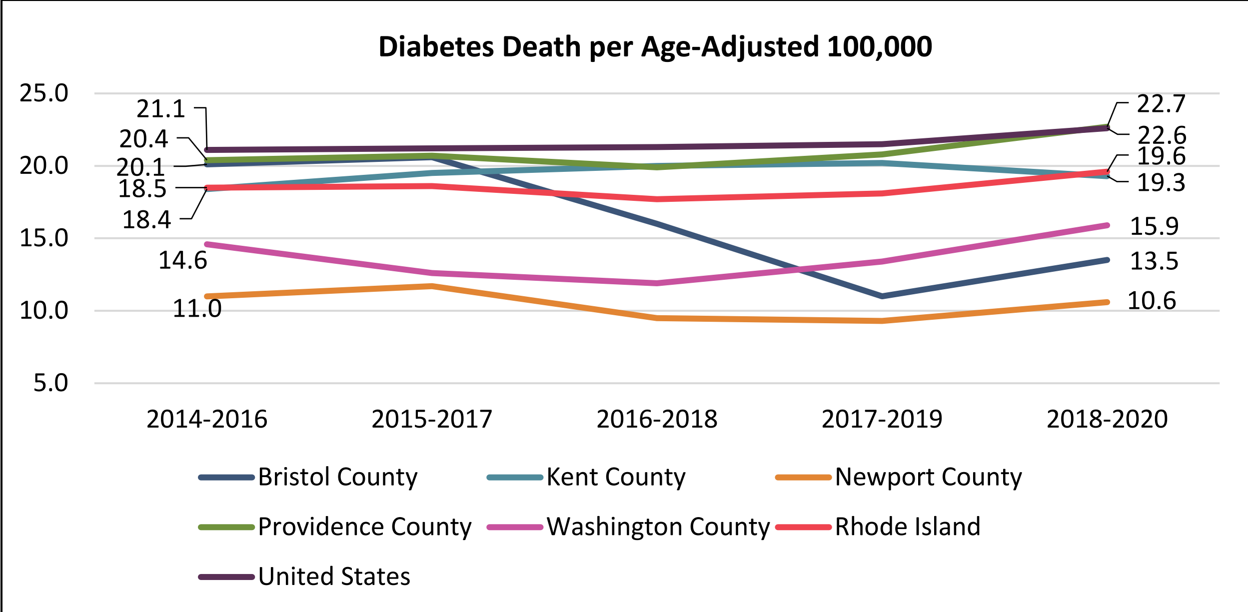


Source: Centers for Disease Control and Prevention

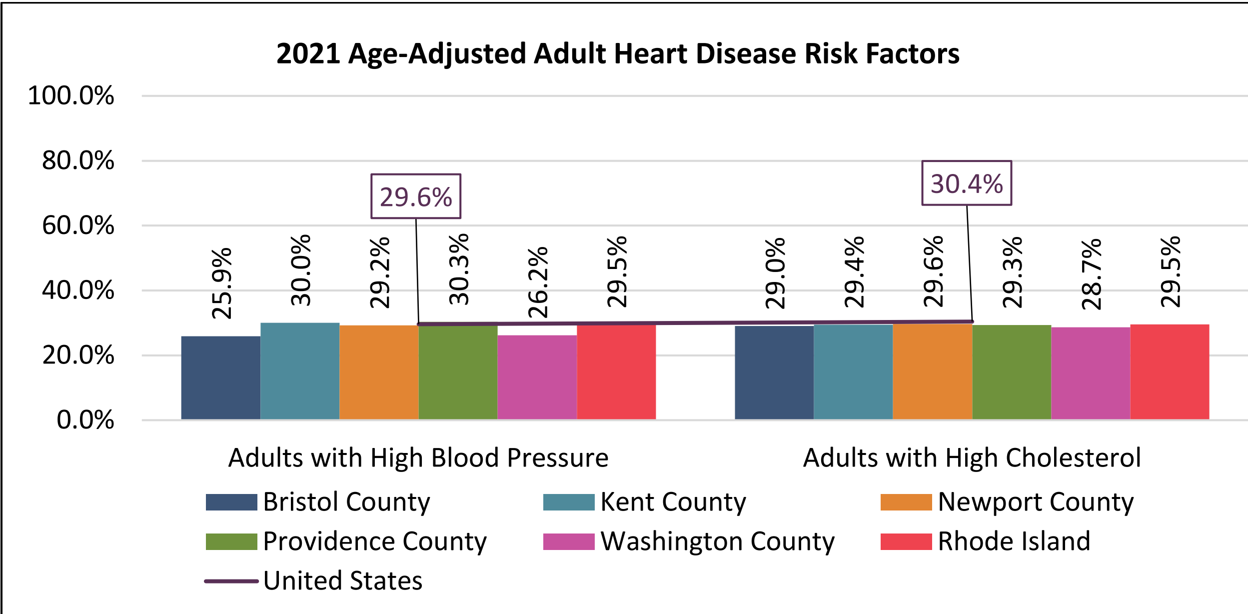
2022 Adults with Diabetes by Zip Code



Source: Centers for Disease Control and Prevention

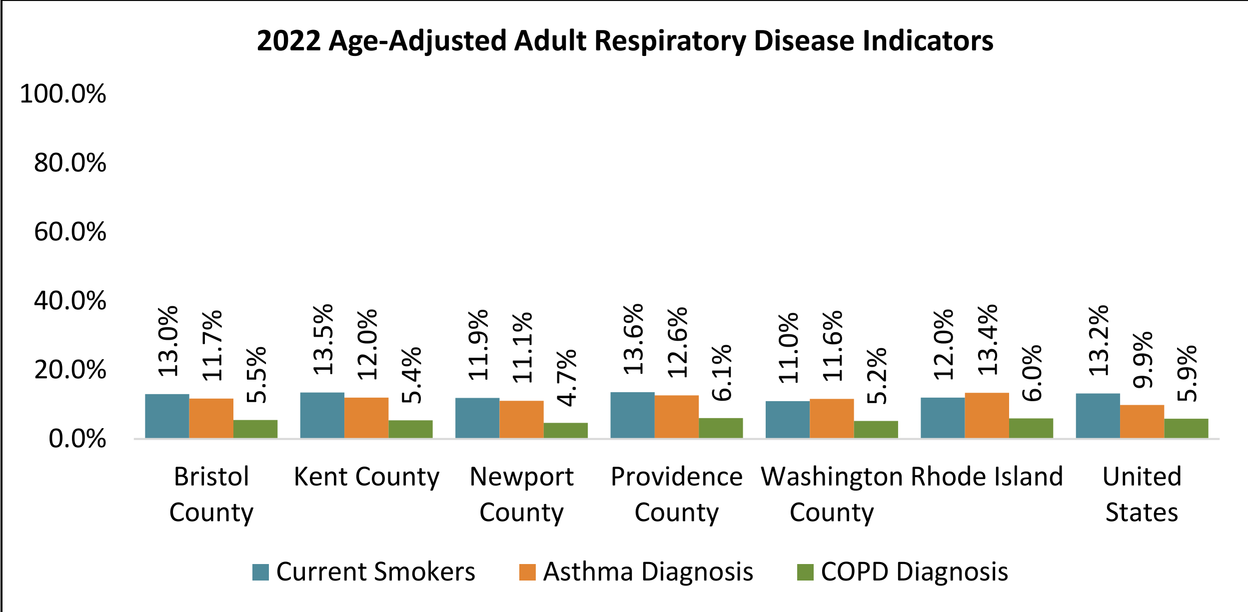


Source: Centers for Disease Control and Prevention



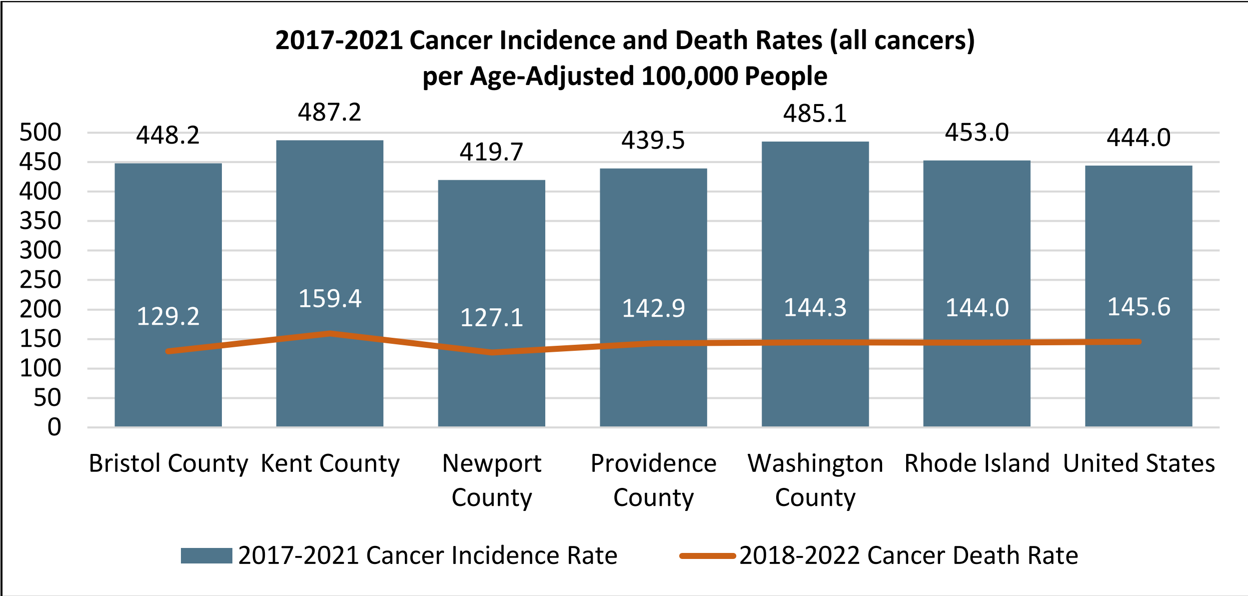
Source: Centers for Disease Control and Prevention

Traditional cigarette use (not including e-cigarettes, cigars, etc.) declined statewide and nationally over the last few decades. Rhode Island adults are less likely to smoke than their peers nationally, although prevalence is slightly higher in Kent and Providence counties compared to other communities. Chronic conditions like asthma and chronic obstructive pulmonary disorder (COPD) are strongly linked to cigarette use, as well as environmental factors like older housing stock. More Rhode Island residents have been diagnosed with asthma as compared to their peers nationally.



Source: Centers for Disease Control and Prevention

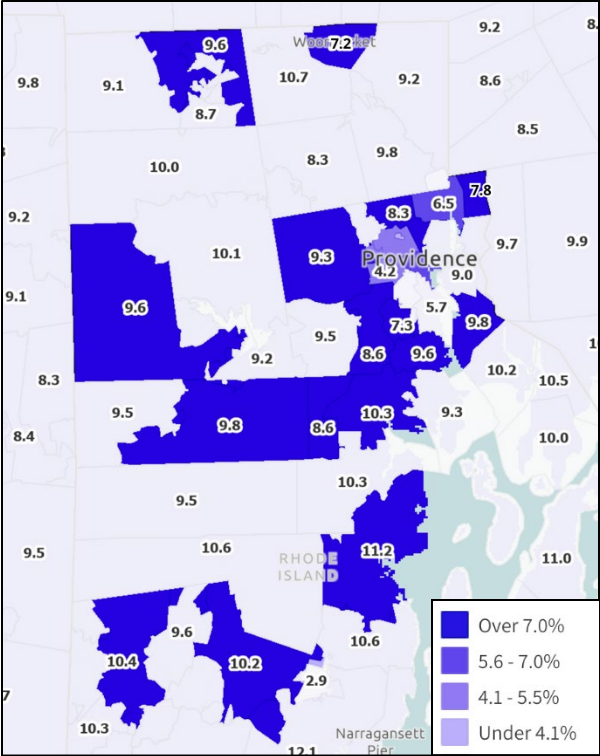
Rhode Island has similar incidence and death rates due to cancer as the nation, but experiences vary across the state with higher reported death rates in Kent and Providence counties. Across the zip codes of origin for patients served by ESH in 2023 and 2024, approximately 1 in 10 adults have been diagnosed with cancer.



Source: Centers for Disease Control and Prevention

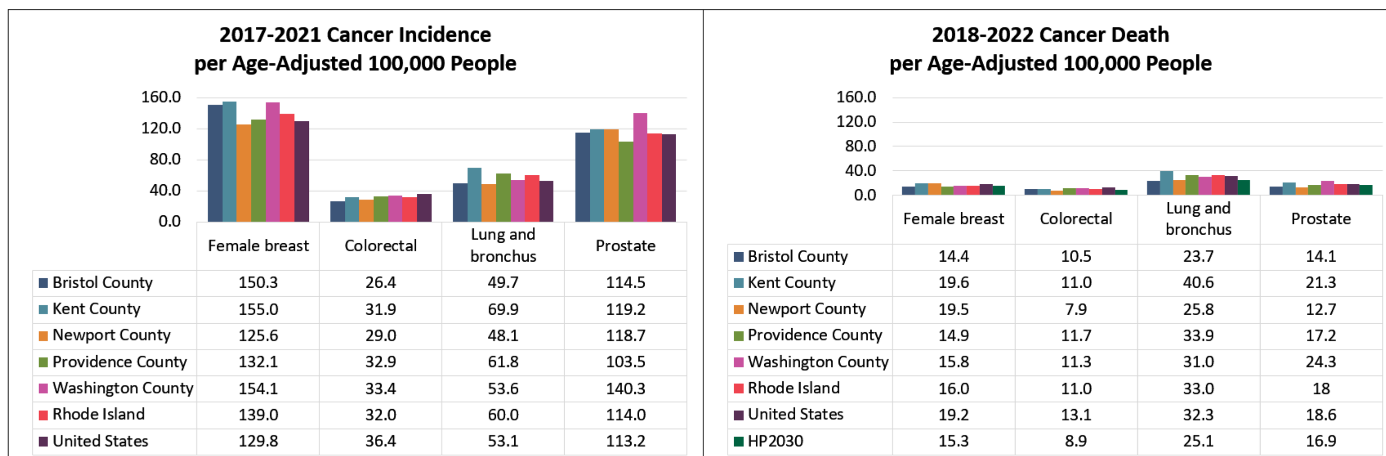
*Cancer incidence data lag and are reported for most recent years available.

2022 Adults with Cancer, (non-skin) or Melanoma, by Zip Code



Source: Centers for Disease Control and Prevention

The top four cancer types are female breast, colorectal, lung and bronchus, and prostate cancers. Statewide, residents have a higher incidence of female breast cancer, but a lower death rate due to female breast cancer, a trend that typically reflects better screening practices for early detection and treatment. Opportunity exists to address community-level disparities in cancer outcomes, including higher female breast cancer death in Kent and Newport counties, higher lung cancer incidence and death in Kent County, and higher prostate cancer death in Kent and Washington counties. Poorer health outcomes related to cancer in these areas may indicate the need for additional screenings and access to treatment as well as addressing social drivers that contribute to health disparities.



2017-2021 Cancer Incidence per Age-Adjusted 100,000 People

	Female breast	Colorectal	Lung and bronchus	Prostate
Bristol County	150.3	26.4	49.7	114.5
Kent County	155.0	31.9	69.9	119.2
Newport County	125.6	29.0	48.1	118.7
Providence County	132.1	32.9	61.8	103.5
Washington County	154.1	33.4	53.6	140.3
Rhode Island	139.0	32.0	60.0	114.0
United States	129.8	36.4	53.1	113.2

2018-2022 Cancer Death per Age-Adjusted 100,000 People

	Female breast	Colorectal	Lung and bronchus	Prostate
Bristol County	14.4	10.5	23.7	14.1
Kent County	19.6	11.0	40.6	21.3
Newport County	19.5	7.9	25.8	12.7
Providence County	14.9	11.7	33.9	17.2
Washington County	15.8	11.3	31.0	24.3
Rhode Island	16.0	11.0	33.0	18
United States	19.2	13.1	32.3	18.6
HP2030	15.3	8.9	25.1	16.9

Source: Centers for Disease Control and Prevention

Note: Years reported differ for incidence and death rate; data are reported for most recent years available.

Advocates working to reduce cancer in Rhode Island said that cost is a primary barrier for residents seeking preventive screenings and holistic cancer care. They noted that outside of the prevention schedule, insurance does not typically cover screenings (i.e., for lung cancer) at the patient's request. Out-of-pocket costs for nutrition and other holistic support are also not covered by insurance programs. Copays and other costs can keep people with limited resources from accessing primary care to increase early detection of disease. Primary care shortages in Rhode Island have also created a backlog for screenings and prompted some patients to travel to neighboring states where they perceive there is more comprehensive support.

Challenges and solutions as defined by health and human service professionals identified the following key drivers that impact effective chronic disease prevention and management:

- Declining access to primary care providers and specialized healthcare
- Health literacy among patients, including lack of understanding their insurance benefits
- “Silos” among health and social service providers, prompted by fear of losing resources or market share, which reduces effective collaboration and resource sharing
- Lack of transportation options to get to medical appointments
- Limited support for disease management (e.g., medication management and cost assistance)
- Need for more social workers to help patients and their families navigate the healthcare system and receive social supports

Recommendations to improve chronic disease healthcare and outcomes:

- More clinical sites and mobile options to provide local care and education (e.g., Blue Cross Blue Shield Blue Bus/Blue Store)
- Centralized public communication hub for community and health resource information
- Better reimbursements and incentives for doctors and other providers to stay in state
- Expanded use of Nurse Practitioners and other advanced practitioners to augment physicians
- Adoption of asynchronous visits using text messaging communications with patients
- Respite care and expanded support for caregivers
- More programs to address food security and nutrition like the *Food as Medicine* program

Housing

More than 70% of Key Stakeholder Survey participants rated housing affordability and availability as "poor." Participant feedback highlighted rising housing prices, a shortage of available and planned affordable housing across the state, and strong local NIMBY (not in my backyard) opponents to affordable housing development. Gentrification within communities and short-term and vacation rental properties were seen as contributing to affordability challenges. Housing has been treated as a commodity, a source of wealth accumulation and investment, harming residents and making it hard to advocate for housing needs.

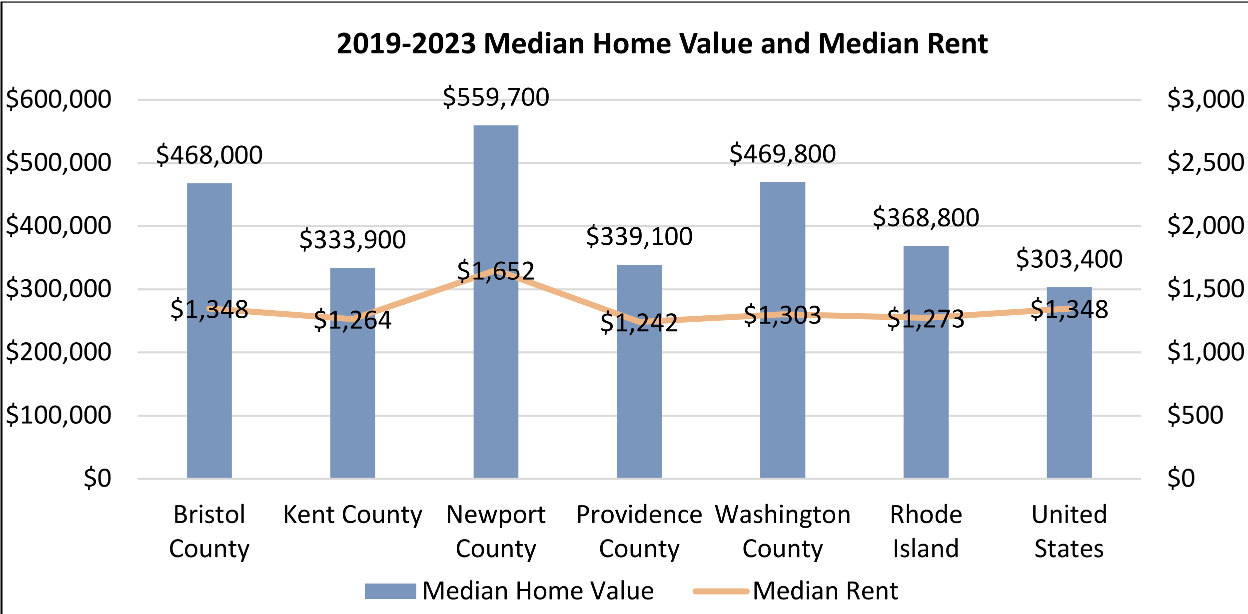
> *"The prevalence of economic disparity between those with much and those with not enough is growing greater every day. […] Ironically, some of the housing scarcity comes from the development of more arts and related businesses in the downtown area which has come at the expense of what used to be affordable housing apartments. Additionally, the over development of the short-term rental market has also removed housing stock from circulation even as it has contributed to summer over-crowding issues. Also, the political will of the NIMBY group here is quite tangible. Those who already have much are getting even more. Those without enough to live comfortably are being made more uncomfortable by the moment. The disparity is not sustainable."*

Health and human service professionals were concerned that while there has been more state-level support and funding for housing initiatives, programs are not implemented effectively at the local level. For some communities, housing insecurity is seen as an issue affecting "outsiders" and not neighbors and long-time residents. Professionals were frustrated by the overall lack of change in housing affordability, citing the need for a comprehensive statewide plan and long-term housing solutions.

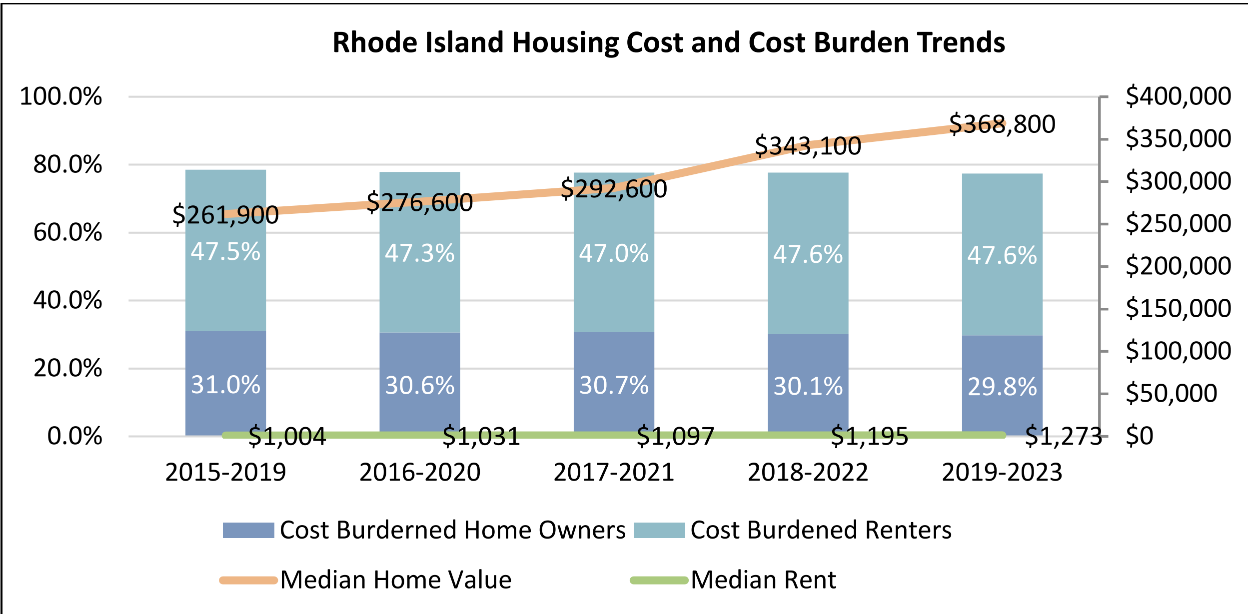
> *"They [affordable housing project opponents] don't think they're serving their own community."*
>
> *"What if we said, 'each town will build 250 units and 75% of them will be filled by people from the area?'"*
>
> *"We have been having these conversations for years now."*

Populations that are more likely to experience housing insecurity include people suffering unmanaged behavioral health conditions, justice-involved people, older adults, and survivors of domestic violence. Barriers to securing stable and appropriate housing are widespread and varied. There is a lack of assisted living beds for older adults, especially for those with cognitive disabilities. People seeking substance use recovery housing often need to leave their community to participate in programs, reducing their long-term stability. People with a criminal record or justice-involved are prohibited from some housing, which disproportionately affects people with substance use disorders. Housing residents report poor oversight and unsafe conditions in some shelters, especially for women and children.

The cost of housing increased nationally and across Rhode Island. From 2019 to 2023, the statewide median home value rose 41% and median rent rose 27%. The National Low Income Housing Coalition estimated that in 2023 the hourly wage a full-time worker needed to earn to afford a two-bedroom rental home at fair market rent in Rhode Island was $33.20. The state minimum wage is $14.00. Housing cost burdened is defined as spending 30% or more of household income on mortgage or rent expenses. Consistently across Rhode Island counties about 30% of homeowners and almost 50% of renters are considered cost burdened.



Source: US Census Bureau, American Community Survey

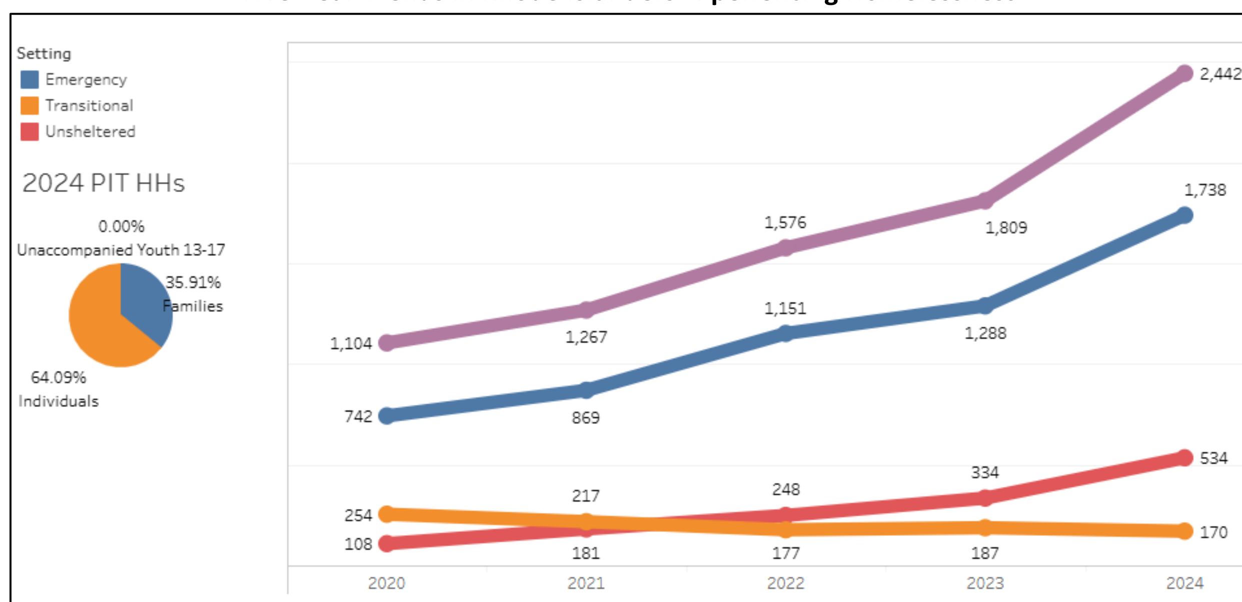


Source: US Census Bureau, American Community Survey

HousingWorks RI at Roger Williams University reports annually on housing affordability data for Rhode Island. In 2024, HousingWorks RI—for the first time—found no Rhode Island municipality where a household with an income under $100,000 could affordably buy. The lowest calculated income required to buy was in Woonsocket at $119,123. HousingWorks RI determined that Burrillville was the only municipality where the state's median renter household income of $45,560 was sufficient to affordably rent the average-priced two-bedroom apartment.

Rising housing costs have contributed to more people experiencing homelessness. The Point-in-Time (PIT) count is a nationwide count of sheltered and unsheltered people experiencing homelessness. The most recent count conducted in 2024 found that there were 2,442 unhoused Rhode Islanders, a 35% increase from 2023 and more than 120% increase from 2020.

Five-Year Trends in Rhode Islanders Experiencing Homelessness



Source: The Rhode Island Coalition to End Homelessness

Health and human service professionals identified the following recommendations to improve housing:

- Advocate for a comprehensive statewide housing plan with local level accountability
- Explore development of a medical shelter or other care continuum facility that can receive and care for chronically ill unhoused people upon hospital discharge
- Explore alternative approaches to affordable housing development, including acquiring/using abandoned housing
- Provide education like estate planning, financial literacy, etc. to help people pass housing to the next generation (e.g., RI Families-First Model)
- Provide more expungement services to help individuals with criminal records qualify for housing

Maternal and Child Health

Births have declined for most of the past decade, both nationally and in Rhode Island. National research suggests that the general decline in fertility is due to women delaying childbearing and having fewer total children. Rhode Island had the second lowest fertility rate among US states, and the number of babies born to mothers living in Rhode Island declined 18% between 2002 and 2022, from 12,375 to 10,115.

Rhode Island overall reports more positive pregnancy and birth outcomes than the nation. The statewide teen birth rate declined 58% between 2009-2013 and 2018-2022, from 21.0 births per 1,000 teen girls to 8.9 per 1,000. Across the state and all counties, people are more likely to receive early prenatal care, and fewer babies are born preterm and/or with low birth weight compared to national averages. However, significant differences in these outcomes are seen between counties population groups. Black people and babies continue to be placed at risk for many of these factors, with only slight improvements from the 2022 CHNA.

2018-2022 Maternal and Infant Health Indicators

	Teen Birth Rate (per 1,000 Ages 15-19)	First Trimester Prenatal Care	Preterm Births	Low Birth Weight Births	Breastfeeding at Time of Birth
Bristol County	NA	84.3%	8.1%	6.8%	83.0%
Kent County	NA	87.8%	8.6%	7.0%	79.0%
Newport County	NA	87.4%	7.5%	6.7%	85.0%
Providence County	NA	82.3%	9.6%	8.2%	73.0%
Washington County	NA	90.0%	8.3%	5.9%	81.0%
Rhode Island	8.9	84.2%	9.2%	7.7%	76.0%
Asian, non-Hispanic	3.3	83.7%	8.8%	8.9%	82.0%
Black or African American, Non-Hispanic	9.8	78.3%	11.4%	11.4%	69.0%
White, non-Hispanic	3.7	87.1%	8.4%	6.6%	79.0%
Hispanic or Latina (any race)	24.3	81.8%	10.2%	8.3%	70.0%
HP2030 Goal	NA	80.5%	9.4%	NA	NA

Source: Rhode Island KIDS COUNT Factbook

Pregnancy and birth disparities are evident in Providence County and largely experienced by people living in the core cities. While the teen birth rate for the core cities declined at a similar rate as the state overall, it remains more than three times higher than the remainder of the state. The proportion of people residing in the core cities and receiving early prenatal care improved from the 2022 CHNA (79.5% to 80.4%), but preterm and low birth weight births are persistently high. The core cities saw improvement in the proportion of people breastfeeding at time of birth from the 2022 CHNA (63% to 68%).

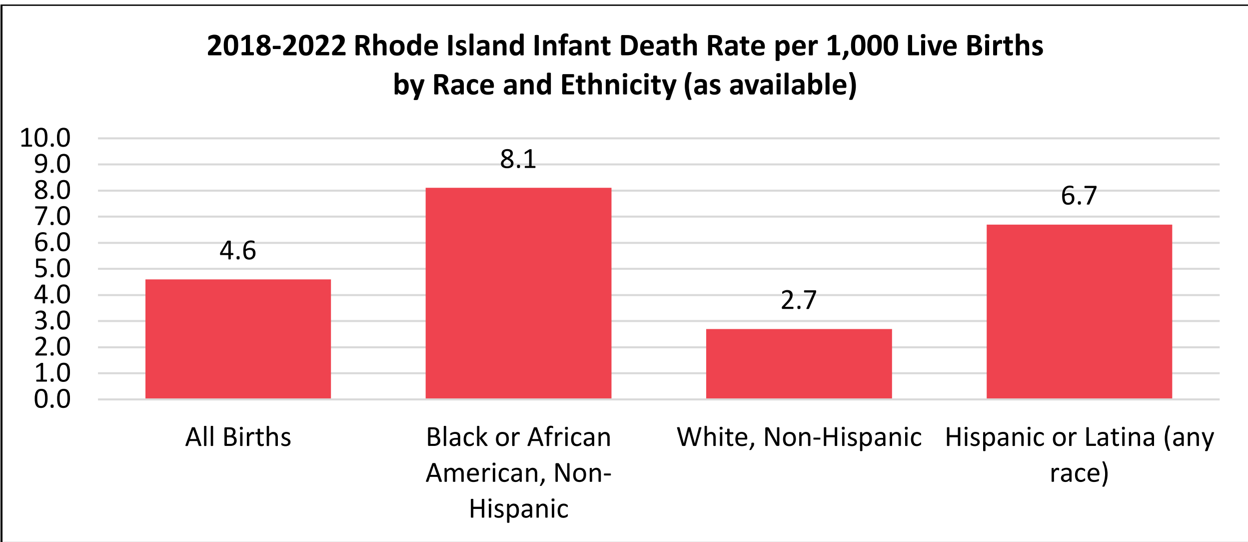
2018-2022 Maternal and Infant Health Indicators for Core Cities

	Teen Birth Rate (per 1,000 Ages 15-19)	First Trimester Prenatal Care	Preterm Births	Low Birth Weight Births	Breastfeeding at Time of Birth
Central Falls	21.3	77.9%	11.8%	8.3%	67.0%
Pawtucket	19.0	81.9%	9.9%	9.2%	70.0%
Providence	15.5	79.9%	10.1%	8.8%	68.0%
Woonsocket	25.5	81.9%	10.3%	8.8%	66.0%
Four Core Cities	17.3	80.4%	10.2%	8.8%	68.0%
Remainer of Rhode Island	4.5	86.5%	8.5%	7.0%	81.0%
Rhode Island (all)	8.9	84.2%	9.2%	7.7%	76.0%
HP2030 Goal	NA	80.5%	9.4%	NA	NA

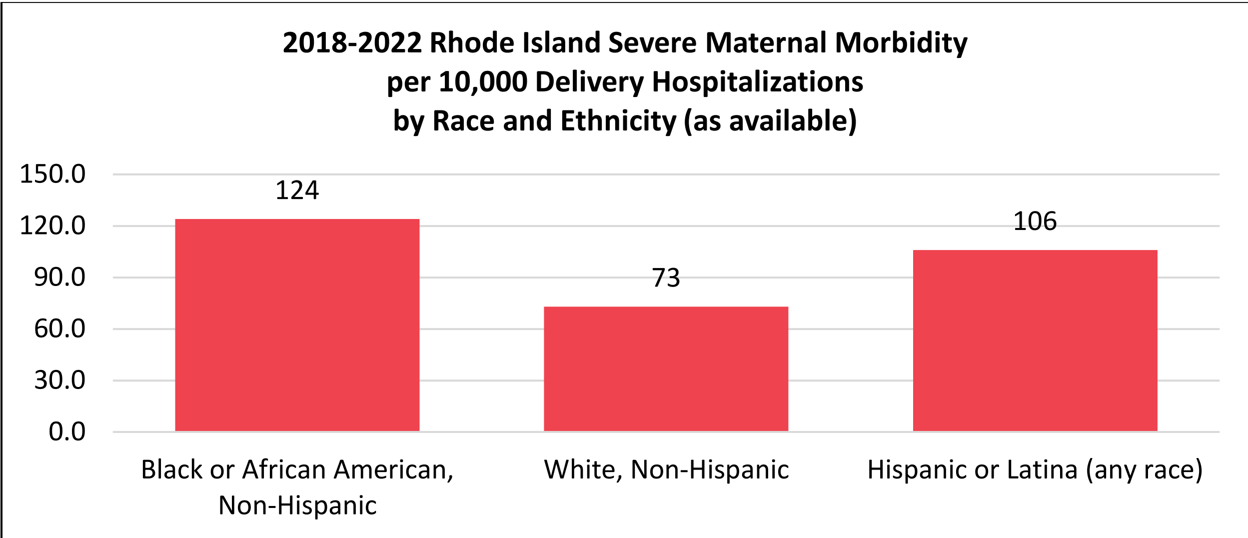
Source: Rhode Island KIDS COUNT Factbook

The infant death rate is widely used as a key indicator of community health because it reflects not only the health of infants but also the overall health and wellbeing of a population. It serves as an overall indication of factors like access to healthcare, socioeconomic conditions, and the quality of the environment.

The five-year aggregate (2018-2022) infant death rate for Rhode Island meets the Healthy People 2030 target of 5.0 per 1,000 live births, but disparities by race and ethnicity are indicative of the social and environmental stresses experienced by people of color. Across Rhode Island, the infant death rate for non-Hispanic Black and Hispanic and/or Latinx infants is 2.5-3 times higher than the death rate for white infants. Similarly, the prevalence of severe maternal morbidity, defined as unintended outcomes of labor and delivery that result in significant consequences to a woman’s health, is significantly higher for Black and Hispanic and/or Latina women.



Source: Rhode Island KIDS COUNT Factbook

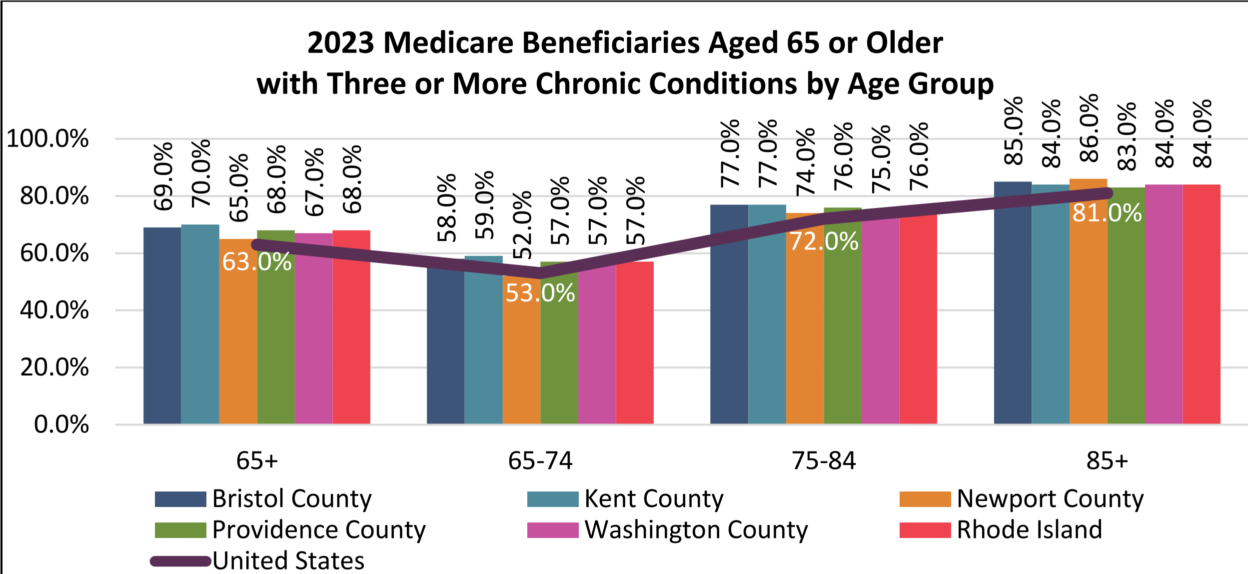


Source: Rhode Island KIDS COUNT Factbook

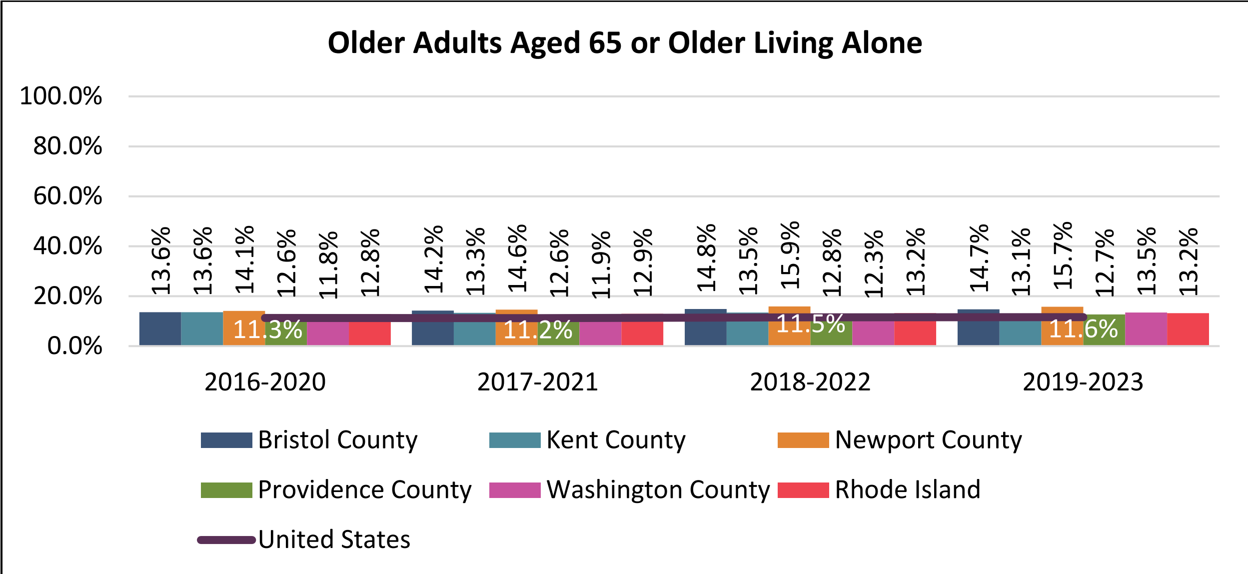
Older Adult Health and Wellbeing

Rhode Island's population is rapidly aging. From 2010 to 2023, the number of adult residents aged 65 or older grew 33.3% statewide and by as much as 50%-60% in Newport and Washington counties.

Older adults are more at risk for chronic disease, as well as factors that impede disease management, including economic insecurity, social isolation, and access barriers (e.g., transportation, digital literacy). In 2023, 68% of Rhode Island Medicare beneficiaries aged 65 or older managed three or more chronic conditions, most commonly high cholesterol (72%), high blood pressure (70%), rheumatoid arthritis (37%), diabetes (27%), and depression (21%). An increasing percentage of older adults live alone, estimated at 13% in 2023.



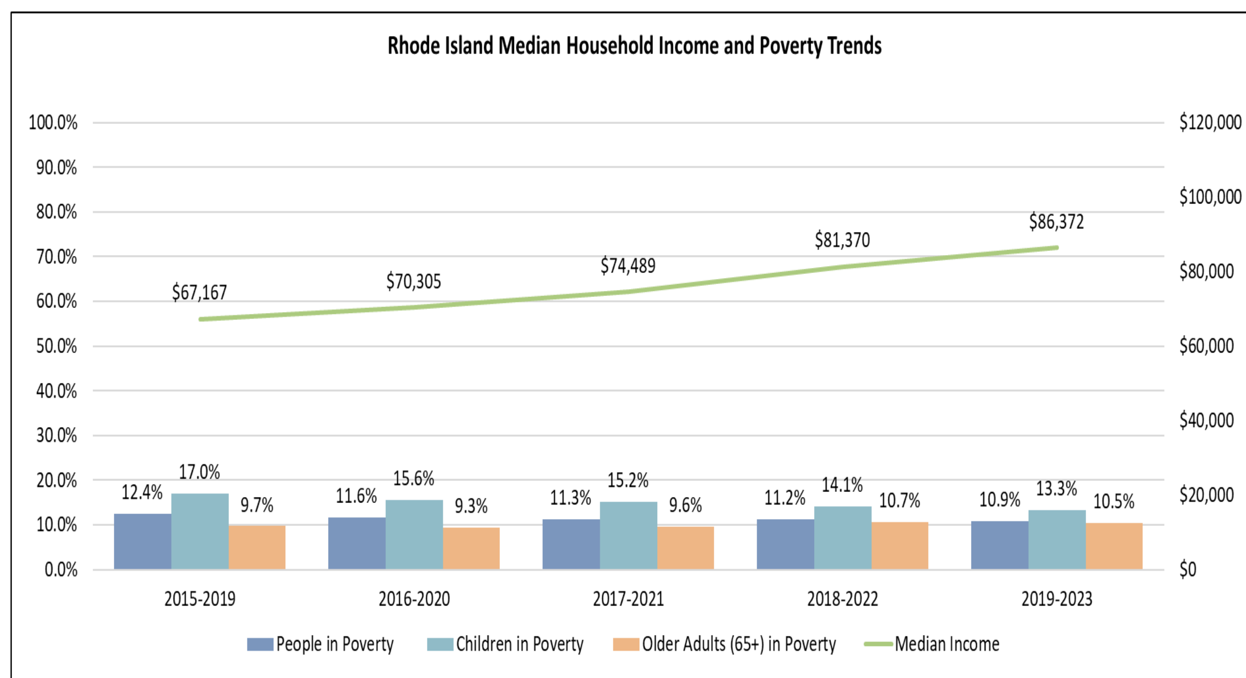
Source: Centers for Medicare and Medicaid Services



Source: US Census Bureau, American Community Survey

Health and human service professionals perceived that an increasing number of older adults experience mental health challenges, often rooted in loneliness and isolation. While socialization opportunities for older adults have improved (e.g., senior centers, volunteering, intergenerational college classes), more is needed to intentionally engage this population. Professionals recommended more direct communication, noting that older adults are increasingly opting in to text messages as a primary form of communication. They also recommended a centralized database for older adult events and information, leveraging organizations like Age Friendly Rhode Island to assist with implementation.

Older adults on a fixed income have been disproportionately affected by the rising cost of living. While the proportion of all Rhode Island residents and children living in poverty declined, the proportion of older adults living in poverty increased in recent years. More older adults were perceived to struggle with homelessness, food insecurity, and medication costs, among other concerns. Health and human service professionals noted that despite rising financial concerns, many older adults are either not aware of the services available to them or are uncomfortable asking for help.



Medicare insurance gaps and no coverage for caregiver support, impact older adults' ability to maintain their health and activities of daily living. Family caregivers are often overburdened by their responsibilities, with limited options for respite care and limited awareness of the available community resources. Medicare insurance gaps included high costs of supplemental insurance, lack of home care and home modification coverage, and a potential end to telehealth reimbursement.

> *"More seniors are homeless. Many can't afford their basic needs and may be too prideful to ask for help."*
>
> *"[Family]Caregivers don't know where to go. Trying to get information to them is hard. They don't come [to events]. They have children and parents to take care of."*

Community Health Improvement Plan: How ESH Will Respond to Community Needs

This action plan outlines strategic initiatives for Eleanor Slater Hospital (ESH) to address the critical community health needs identified in the comprehensive Community Health Needs Assessment (CHNA) for Rhode Island (2015-2025). ESH's unique role as a Long-Term Acute Care Hospital (LTACH) specializing in complex medical and psychiatric needs positions it to make significant contributions to the state's healthcare landscape. **Eleanor Slater Hospital is operated by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH).**

I. Overarching Goal

To strategically align Eleanor Slater Hospital's specialized services with identified community health needs, particularly in managing complex cases arising from severe medical, psychiatric, and social challenges, thereby enhancing patient outcomes, optimizing system-wide patient flow, and contributing to the overall health and well-being of Rhode Islanders. ESH will leverage its position within the state's continuum of care, recognizing its unique patient distribution across Rhode Island rather than a singular primary service area.

II. Key Priority Areas and Strategic Actions

Based on the CHNA findings and ESH's capabilities, the following priority areas and strategic actions are proposed:

Priority Area 1: Behavioral Health & Substance Use Disorders (Complex & Long-Term)

Community Need Addressed: High prevalence of behavioral health and substance use disorders, particularly for individuals with co-occurring complex medical conditions and those requiring long-term, high-acuity care beyond general psychiatric units or community settings.

ESH's Role: ESH provides comprehensive psychiatric services for patients with mental health conditions alongside acute and long-term medical illnesses.

Strategic Actions:

- **1.2 Strengthen Partnerships for Transition:**
    - **Action:** Formalize and strengthen collaborative agreements with community mental health centers, substance use disorder treatment providers, and other post-discharge support services to ensure smooth transitions of care for patients ready for lower levels of care.
    - **Metrics:** Increase in successful discharges to appropriate community-based behavioral health settings; decrease in length of stay for patients awaiting community placement.
    - **Timeline:** Within 6-12 months.
- **1.3 Address Workforce Development in Behavioral Health:**

- **Action:** Explore partnerships with academic institutions (e.g., nursing schools, medical schools, social work programs) to provide training opportunities and clinical rotations focused on complex behavioral health and co-occurring medical conditions, fostering a pipeline of specialists.
- **Metrics:** Number of students/residents completing rotations at ESH; increase in applications for behavioral health positions at ESH.
- **Timeline:** Within 12-24 months.

Priority Area 2: Chronic Disease Prevention & Management (High Acuity)

Community Need Addressed: Significant burden of chronic diseases, especially among an aging population, requiring high-acuity, long-term care, ventilator support, and complex wound management.

ESH's Role: ESH focuses on long-term acute care for patients with serious medical conditions requiring ongoing care, including specialized services like ventilator support, complex wound care, and infectious disease management.

Strategic Actions:

- **2.1 Optimize Long-Term Acute Care Pathways:**
  - **Action:** Continuously review and optimize clinical pathways for common high-acuity chronic conditions (e.g., ventilator weaning, complex wound healing, post-ICU recovery) to ensure best practices and efficient resource utilization.
  - **Metrics:** Improvement in patient outcomes for specific chronic conditions (e.g., ventilator weaning success rates, wound healing rates); reduction in preventable complications.
  - **Timeline:** Ongoing.
- **2.2 Enhance Patient and Family Education:**
  - **Action:** Develop comprehensive patient and family education programs focused on chronic disease self-management, medication adherence, and early warning signs of complications, tailored for long-term care needs.
  - **Metrics:** Increased patient/family understanding of care plans; reduction in emergency department visits for preventable chronic disease exacerbations post-discharge.
  - **Timeline:** Within 6-12 months.
- **2.3 Leverage Technology for Monitoring and Support:**
  - **Action:** Investigate and potentially implement telehealth or remote monitoring solutions for discharged patients with complex chronic conditions, providing ongoing support and reducing readmission risk.
  - **Metrics:** Pilot program success rates; patient engagement with remote monitoring tools.

  - **Timeline:** Within 18-36 months (exploratory phase).
- **2.4 Improve Health Literacy and Insurance Navigation:**
  - **Action:** Develop patient-friendly educational materials and provide dedicated support (e.g., patient navigators, social workers) to help patients and their families understand their chronic conditions, medication management, and insurance benefits, including coverage for preventive screenings and holistic support.
  - **Metrics:** Patient/family comprehension scores; number of patients receiving navigation support.
  - **Timeline:** Within 6-12 months.

Priority Area 3: Social Determinants of Health (SDoH) & Health Equity (Patient-Centered Discharge)

Community Need Addressed: Profound health inequities driven by underlying social determinants of health, particularly in core urban areas, affecting vulnerable populations.

ESH's Role: ESH likely serves a patient population heavily affected by SDoH due to the complexity of their needs and transfers from acute care.

Strategic Actions:

- **3.1 Comprehensive SDoH Screening and Referral:**
  - **Action:** Implement a standardized, comprehensive SDoH screening process for all ESH patients upon admission and throughout their stay, covering areas like housing, food security, transportation, and social support.
  - **Action:** Establish robust referral pathways to community-based organizations and social services that can address identified SDoH needs during hospitalization and for discharge planning.
  - **Metrics:** Percentage of patients screened for SDoH; number of referrals made to community resources; patient feedback on SDoH support.
  - **Timeline:** Within 24-36 months.
- **3.2 Enhance Culturally and Linguistically Competent Care:**
  - **Action:** Assess ESH's current linguistic and cultural competency resources and develop a plan to enhance training for staff and increase access to culturally sensitive materials and interpreters.
  - **Metrics:** Staff participation in cultural competency training; patient satisfaction scores from diverse populations.
  - **Timeline:** Within 12 months.
- **3.3 Strengthen Discharge Planning and Post-Acute Transitions:**

- **Action:** Develop interdisciplinary discharge planning teams that proactively involve patients, families, and community partners to ensure safe and successful transitions to appropriate post-acute care settings or home with adequate support. This directly addresses the "discharge bottleneck" identified in the CHNAs.
- **Metrics:** Reduction in avoidable readmissions; improved patient and family satisfaction with discharge planning; increased rate of successful transitions to lower levels of care.
- **Timeline:** Ongoing, with continuous improvement initiatives.

- **3.4 Address Transportation Barriers for Post-Discharge Care:**
  - **Action:** Work with RIPTA, MTM Health, and community transportation providers to advocate for improved timeliness, coordination, and expanded service areas for non-emergency medical transportation, especially for patients in rural areas or those reliant on public transit.
  - **Metrics:** Feedback from patients and partners on transportation access; advocacy outcomes.
  - **Timeline:** Within 12-24 months.
- **3.5 Support Statewide Housing Solutions & Medical Shelter Development:**
  - **Action:** Actively participate in state-level discussions and initiatives aimed at developing a comprehensive statewide housing plan. Explore the feasibility and advocate for the development of a "medical shelter" or other specialized care continuum facility for chronically ill unhoused individuals upon hospital discharge.
  - **Metrics:** Participation in housing initiatives; feasibility study completion; advocacy outcomes for new facilities.
  - **Timeline:** Ongoing advocacy and exploratory phase within 18-36 months.

Priority Area 4: Access to Care (Rehabilitation & Specialized Services)

Community Need Addressed: Systemic barriers limiting access to essential healthcare services, particularly specialized rehabilitation and post-acute care.

ESH's Role: ESH provides comprehensive physical, occupational, recreational, speech, and respiratory therapies, as well as acute brain injury care.

Strategic Actions:

- **4.1 Optimize Rehabilitation Service Delivery:**
  - **Action:** Review and enhance the efficiency and effectiveness of ESH's rehabilitation services, ensuring timely access to therapies and individualized treatment plans that maximize functional recovery.
  - **Metrics:** Improvement in patient functional independence measures; patient progress against rehabilitation goals.

  - **Timeline:** Ongoing.
- **4.2 Collaborate with Acute Care Hospitals for Streamlined Transfers:**
  - **Action:** Strengthen existing and forge new partnerships with acute care hospitals to streamline the transfer process for patients requiring ESH's specialized long-term acute and rehabilitation care, reducing bottlenecks in the broader system.
  - **Metrics:** Reduction in transfer delays from acute care to ESH; improved communication between transferring and receiving facilities.
  - **Timeline:** Within 24-36 months.
- **4.3 Community Outreach for Specialized Services:**
  - **Action:** Develop targeted outreach initiatives to educate referring hospitals, community providers, and the public about the unique capabilities and patient populations served by ESH's specialized rehabilitation and long-term acute care programs.
  - **Metrics:** Increase in appropriate referrals to ESH; improved community awareness of ESH's services.
  - **Timeline:** Within 12-18 months.
- **4.5 Strengthen Inter-Provider Collaboration to Reduce Silos:**
  - **Action:** Facilitate regular forums and communication channels with other health and social service providers to foster trust, reduce "silos," and improve resource sharing and coordinated care planning for complex patients.
  - **Metrics:** Number of collaborative meetings/initiatives; feedback from partner organizations on collaboration effectiveness.
  - **Timeline:** Within 6-12 months.

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III. Implementation and Evaluation

- **Leadership and Oversight:** Establish a dedicated CHNA Action Plan Committee within ESH, comprising representatives from clinical, administrative, and social work departments, to oversee implementation, monitor progress, and ensure accountability.
- **Resource Allocation:** Identify and allocate necessary financial, human, and technological resources to support the successful execution of the strategic actions.
- **Data Collection and Monitoring:** Implement robust data collection mechanisms to track progress on all defined metrics. Regularly review data to assess the effectiveness of interventions and make necessary adjustments.
- **Reporting and Communication:** Provide regular updates on the action plan's progress to ESH leadership, staff, and relevant external stakeholders (e.g., BHDDH, HARI).

- **Continuous Improvement:** This action plan is a living document. ESH will engage in continuous evaluation and adaptation based on new data, emerging community needs, and evolving best practices.

IV. Recommended Regulatory Considerations

Achieving the goals outlined in this action plan will be significantly aided by supportive regulatory frameworks and policy adjustments at the state and federal levels. As a state-operated hospital under BHDDH, ESH is uniquely positioned to advocate for and benefit from such changes.

General Regulatory Considerations:

- **Reimbursement Reform:** Advocate for reimbursement models that adequately compensate for the complex, long-term, and integrated care provided by LTACHs, particularly for patients with co-occurring medical and psychiatric conditions and those requiring extensive rehabilitation. This includes advocating for rates that support the high cost of specialized staffing and technology.
- **Data Sharing and Interoperability:** Support regulatory initiatives that promote seamless data exchange between acute care hospitals, LTACHs, community providers, and social service agencies. This would facilitate better care coordination, discharge planning, and SDoH referrals.
- **Workforce Development Incentives:** Encourage state and federal policies that provide incentives (e.g., loan forgiveness, scholarships, tax credits) for healthcare professionals to specialize in long-term acute care, complex psychiatric care, and rehabilitation, especially in underserved areas. This includes supporting initiatives to attract and retain linguistically and culturally competent providers.

Specific Regulatory Considerations by Priority Area:

- **Priority Area 1: Behavioral Health & Substance Use Disorders (Complex & Long-Term)**
  - **Telehealth Expansion:** Advocate for permanent and expanded telehealth reimbursement policies for behavioral health services, including those provided in long-term care settings, to improve access for patients with mobility limitations or geographic barriers.
  - **Integrated Care Reimbursement:** Support regulatory changes that specifically recognize and adequately reimburse for integrated physical and behavioral health services within LTACHs, acknowledging the higher complexity of these patients.
- **Priority Area 2: Chronic Disease Prevention & Management (High Acuity)**
  - **Long-Term Care Quality Metrics:** Collaborate with regulatory bodies to develop and implement quality metrics that accurately reflect the unique outcomes and complexities of long-term acute care, moving beyond acute care-centric measures.
  - **Remote Monitoring Policies:** Advocate for regulatory clarity and reimbursement for remote patient monitoring technologies for complex chronic disease management post-discharge, enabling ESH to extend care into the community.

- **Priority Area 3: Social Determinants of Health (SDoH) & Health Equity (Patient-Centered Discharge)**
    - **SDoH Screening Mandates/Incentives:** Support state-level mandates or incentives for healthcare providers, including LTACHs, to screen for SDoH and integrate social needs into care plans and discharge processes.
    - **Funding for Community-Based SDoH Partnerships:** Advocate for state funding or grant programs that support partnerships between healthcare institutions and community-based organizations addressing SDoH, facilitating robust referral networks.
- **Priority Area 4: Access to Care (Rehabilitation & Specialized Services)**
    - **Streamlined Transfer Protocols:** Work with state regulatory bodies (e.g., RIDOH, BHDDH) to establish standardized and efficient inter-facility transfer protocols between acute care hospitals and LTACHs, reducing administrative burdens and patient transfer delays.
    - **Specialty Rehabilitation Recognition:** Advocate for policies that clearly define and support the distinct role and reimbursement for specialized rehabilitation services provided in LTACH settings, differentiating them from general skilled nursing facility care.

V. Applicable Federal and State Funding Opportunities

Eleanor Slater Hospital can explore various federal and state funding opportunities to support the implementation of this action plan. As a state-operated facility under BHDDH, ESH may have direct access to or be eligible for specific grants and programs.

Federal Funding Opportunities:

- **Substance Abuse and Mental Health Services Administration (SAMHSA) Grants:**
    - **Community Mental Health Services Block Grant (MHBG):** Provides funds to states to provide comprehensive community mental health services, which ESH can leverage for its psychiatric services, especially for complex cases.
    - **Substance Abuse Prevention and Treatment Block Grant (SABG):** Offers funding to states for substance use prevention, treatment, and recovery services. ESH can align with state efforts to address co-occurring SUDs.
    - **Certified Community Behavioral Health Clinics (CCBHC) Expansion Grants:** While ESH is an LTACH, it could explore partnerships with CCBHCs or apply for funding if it can adapt its model to meet CCBHC requirements for integrated, comprehensive care.
    - **Assertive Community Treatment (ACT) Grant Program:** Supports the establishment or expansion of ACT programs, which could be relevant for ESH's complex behavioral health patients transitioning to community settings.
- **Health Resources and Services Administration (HRSA) Grants:**

  - **Health Workforce Grants:** HRSA offers various grants to organizations like hospitals and health departments for workforce development in areas like behavioral health, geriatrics, and nursing. This directly supports ESH's workforce development goals (Action 1.3).
  - **Telehealth Programs (Office for the Advancement of Telehealth - OAT):** HRSA provides funding for telehealth services, research, and technical assistance, including programs focused on direct services in primary care, behavioral health, and acute care (Action 2.3, Regulatory 1.1).
  - **Chronic Disease Self-Management Education (CDSME) Programs (Administration for Community Living - ACL):** While often targeting community-based organizations, ESH could partner with grantees or seek funding to integrate CDSME into its patient education for chronic disease management (Action 2.2).
- **Centers for Medicare & Medicaid Services (CMS) Initiatives:**
  - While CMS primarily focuses on reimbursement and quality reporting (e.g., LTCH Quality Reporting Program), ESH should monitor CMS Innovation Center initiatives that test new payment and service delivery models, particularly those focused on integrated care, care coordination, and SDoH, which could offer grant opportunities or new reimbursement pathways.

State Funding Opportunities (Rhode Island):

- **Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH):** As the operating agency for ESH, BHDDH is the primary conduit for state funding related to behavioral health, developmental disabilities, and hospital services. ESH should work closely with BHDDH to identify and secure direct state appropriations or grants managed by the department that align with the action plan's priorities.
- **Rhode Island Department of Health (RIDOH):** RIDOH often manages state and federal pass-through grants for public health initiatives, chronic disease prevention, and health equity. ESH should monitor RIDOH's funding announcements for programs related to chronic disease management, SDoH, and access to care (e.g., grants for health equity initiatives).
- **Rhode Island Executive Office of Health and Human Services (EOHHS):** EOHHS oversees the state's healthcare system and may have initiatives or grants related to integrated care, care coordination, and addressing SDoH, such as the Integrated Care Initiative (though its primary focus is on Medicare-Medicaid alignment, it signifies a state interest in integrated models).
- **Rhode Island Foundation:** This private philanthropic organization offers various grants, including "Capacity Building Grants," "Catalyst Grants," and "Community Priority Grants," which often support human services and healthcare, with a focus on community priorities. ESH could explore these for specific projects related to SDoH, health equity, or innovative care models.
- **GrantWatch (Rhode Island Specific):** Platforms like GrantWatch list health and medical grants for Rhode Island nonprofits, which may include opportunities for projects benefiting residents,

supporting health equity, and addressing chronic diseases. ESH should regularly review these listings.

Strategies for Securing Funding:

- **Align with Funder Priorities:** Clearly articulate how ESH's proposed actions align with the specific goals and priorities of each funding opportunity.
- **Demonstrate Need and Impact:** Provide compelling data (from the CHNA and ESH's internal data) to demonstrate the community need and the potential impact of ESH's interventions.
- **Highlight Collaboration:** Emphasize existing and planned partnerships with other healthcare providers, community organizations, and academic institutions, as many grants prioritize collaborative approaches.
- **Showcase Innovation and Evidence-Based Practices:** Highlight innovative approaches and the use of evidence-based practices in ESH's programs.
- **Develop Strong Grant Proposals:** Invest in developing well-written, data-driven, and compelling grant proposals that clearly outline objectives, activities, budgets, and evaluation plans.

VI. Additional Community-Based Programs, Services, and Supports

Successful implementation of this action plan will require robust collaboration with a wide array of community-based programs, services, and supports. These organizations can serve as vital partners in extending ESH's reach into the community, facilitating successful patient transitions, and addressing the holistic needs of its complex patient population.

General Community Health & Social Services:

- **Community Health Centers (CHCs):** CHCs provide primary care, dental, and behavioral health services, often serving underserved populations. Partnerships can facilitate seamless transitions for ESH patients needing ongoing primary and preventive care post-discharge.
- **Area Agencies on Aging (AAAs):** For ESH's older adult population, AAAs offer a range of services including information and referral, case management, nutrition programs, transportation, and caregiver support.
- **United Way of Rhode Island:** As a central hub for social services, United Way can connect ESH with a broad network of local non-profits addressing housing, food insecurity, financial assistance, and other SDoH.
- **Local Food Banks and Pantries:** Essential partners for addressing food insecurity among vulnerable patients, especially during discharge planning.
- **Housing Authorities and Homeless Shelters:** Critical for patients experiencing homelessness or housing instability, aiding in securing safe and appropriate housing post-discharge.
- **Transportation Services:** Partnerships with public transit, non-emergency medical transportation (NEMT) providers, or volunteer driver programs are crucial for ensuring patients can access follow-up appointments and community resources.

Behavioral Health & Substance Use Disorder Specific:

- **Community Mental Health Organizations (CMHOs):** Beyond formal partnerships for transition (Action 1.2), CMHOs offer outpatient therapy, case management, peer support, and crisis services that can provide ongoing support for ESH's behavioral health patients.
- **Substance Use Disorder (SUD) Treatment Centers:** Collaboration with outpatient and residential SUD treatment providers is essential for patients with co-occurring substance use disorders, facilitating access to medication-assisted treatment (MAT), counseling, and recovery support.
- **Peer Recovery Organizations:** These organizations provide invaluable support through lived experience, connecting patients with recovery coaches and support groups, which can significantly aid in long-term recovery and community reintegration.
- **Crisis Intervention Teams (CIT) / Mobile Crisis Units:** While ESH manages acute inpatient needs, partnerships with community-based mobile crisis teams can support patients in the community or during transitions, potentially preventing readmissions.

Chronic Disease & Rehabilitation Support:

- **Disease-Specific Support Groups:** Organizations focused on specific chronic conditions (e.g., American Lung Association, American Diabetes Association, American Heart Association) offer educational resources, support groups, and advocacy that can empower patients in self-management.
- **Home Health Agencies and Skilled Nursing Facilities (SNFs):** These are crucial partners for post-acute care, providing skilled nursing, therapy, and personal care services in the home or a less intensive institutional setting, facilitating step-down care from ESH.
- **Adult Day Health Centers:** Offer structured daytime programs for older adults and individuals with disabilities, providing medical monitoring, therapy, social activities, and caregiver respite.
- **Vocational Rehabilitation Services:** For patients recovering from brain injuries or other disabling conditions, these services assist with job training, placement, and support to help individuals return to work.

Workforce Development & Education:

- **Community Colleges and Vocational Schools:** Potential partners for developing training programs for healthcare support staff, certified nursing assistants (CNAs), and other roles critical to ESH's operations and the broader healthcare workforce.
- **Local Workforce Development Boards:** These boards can connect ESH with training funds, job placement services, and initiatives aimed at building a skilled healthcare workforce in Rhode Island.

VII. Additional Recommendations for Enhanced Impact

Based on a deeper analysis of the CHNA, the following additional recommendations are proposed to further strengthen the action plan and maximize ESH's impact:

- **7.1 Leverage Existing Community Strengths and Successes:**
  - **Recommendation:** Actively engage with and learn from successful existing community initiatives and assets identified in the CHNA, such as the Anchor ED and Anchor Peer Recovery Center models, Crisis Intervention Teams of Rhode Island (CIT-RI), and the inclusion of people with lived experience in program development. ESH should seek to integrate these proven models or collaborate with their implementers.
  - **Rationale:** The CHNA highlights several successful programs and community strengths (e.g., social cohesion, commitment to health equity). Building upon these existing foundations can accelerate progress and foster stronger partnerships.
- **7.2 Proactive Engagement with Political Leadership and Policy Makers:**
  - **Recommendation:** Beyond advocating for specific regulatory changes, ESH should establish regular, intentional engagement with state and local political leaders to educate them on the unique challenges and needs of ESH's patient population and the broader implications of SDoH. This includes inviting decision-makers to ESH and facilitating direct conversations with patients and staff.
  - **Rationale:** Stakeholder feedback in the CHNA emphasized the need for decision-makers to be more connected to lived experiences and for political will to address systemic issues like housing and transportation. As a state-operated hospital, ESH has a direct line to BHDDH and the state government.
- **7.3 Enhance Data Utilization for Targeted Interventions:**
  - **Recommendation:** Utilize the granular data presented in the CHNA (e.g., Unmet Need Score by zip code, Social Vulnerability Index by census tract, specific disparities by race/ethnicity) to further refine and target ESH's interventions and partnerships. This includes identifying specific high-need communities for concentrated efforts in discharge planning and SDoH referrals.
  - **Rationale:** The CHNA provides detailed geographic and demographic data on disparities, which can inform more precise and impactful resource allocation and partnership development.
- **7.4 Explore Innovative Housing Solutions for Complex Patients:**
  - **Recommendation:** Actively participate in pilot programs or advocate for the development of alternative housing models tailored for patients with complex medical and behavioral health needs who do not fit traditional shelter or skilled nursing criteria (e.g., "medical respite" or "recuperative care" housing). This aligns with the CHNA's recommendation for a "medical shelter."
  - **Rationale:** The CHNA highlights significant challenges in housing for patients with unmanaged behavioral health conditions, justice involvement, and complex medical needs, leading to prolonged hospital stays.
- **7.5 Support Caregivers of Complex and Older Adult Patients:**

- **Recommendation:** Develop and promote resources and support systems specifically for family caregivers of ESH patients, particularly older adults. This includes providing information on available community resources, advocating for respite care options, and addressing Medicare insurance gaps related to home care and caregiver support.
- **Rationale:** The CHNA explicitly mentions overburdened family caregivers, lack of respite care, and Medicare gaps for home care and caregiver support as significant challenges for older adult health and well-being.

By diligently implementing this action plan and actively engaging in advocacy for these recommended regulatory changes, Eleanor Slater Hospital will reinforce its indispensable role in the Rhode Island healthcare system, effectively addressing critical community health needs and improving outcomes for its unique patient population.

Next Steps and Board Approval

Thank you to our community partners that provided guidance, expertise, and ongoing collaboration to inform the 2025 CHNA and foster collective impact in improving the health and wellbeing of Rhode Island residents.

The CHNA was approved by the Eleanor Slater Hospital's Governing Board in September 2025. Following the Board's approval, the CHNA report was made widely available to the public via our website at https://bhddh.ri.gov/eleanor-slater-hospital.

A full summary of secondary data findings for Rhode Island and its counties is also provided on the website and available to our community partners to serve as a resource for grant making, advocacy, and to support their many programs and services.

We value your input on our CHNA and CHIP. To contact us, please visit our website or contact Hector Guerreiro at hector.guerreiro@bhddh.ri.gov.

Appendix A: Secondary Data References

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Appendix B: Key Stakeholder Survey Participants

The following is a list of represented community organizations and the participants' respective title, as provided.

Organization	Title/Role
Acoustic Neuroma Assoc Support Group - Southeast New England Chapter	Moderator
Alzheimer's Association RI Chapter	Executive Director
Big Brothers Big Sisters of RI	Director of Program Growth and Impact
Boys & Girls Clubs of Northern RI (BGCNRI)	Director of Family & Community Engagement
Bradley Hospital	Family Liaison Program Manager
Brown Health Medical Group Primary Care- formerly Coastal Medical	Chief of Primary Care
Brown University Health	Case Management
Brown University Health	Director of Discharge Planning
Brown University Health	VP, Care Coordination
Brown University Health Transitions Clinic	Americorp VISTA member
Brown University Health (RIH, TMH and NPH)	Director of Social Work
Butler Hospital / CNE	Butler Hospital / CNE
Care New England	Vice President and Chief Diversity Officer
Care New England	Director Revenue Finance
Care New England / The Warren Alpert Medical School	Primary Care Physician / Chief Health Equity Officer / Associate Dean
Comprehensive Community Action Plan	Education Coordinator
Chariho Regional School District	Director of Development and Sustainability
Charter Care/Roger Williams Medical Center	Manager of Case Management
CharterCARE health partners	CharterCARE health partners
Coastline EAP/RI Student Assistance Services	CEO
East Bay Community Action Plan	Community Health Worker, Transgender Whole Healthcare
Eleanor Slater Hospital	Chief Executive Officer
Eleanor Slater Hospital	Associate Director of LTACH Admissions/ Community Relations Liaison
Eleanor Slater Hospital BHDDH	Administration
Emma Pendleton Bradley Hospital	President
Family Service of Rhode Island	Chief of Behavioral Health
Hospital Association of RI/Health Care Coalition Rhode Island	Director
Harris House Apartments	Harris House Apartments
Healthcentric Advisors	CEO
HousingWorks RI	Executive Director
Juneteenth RI	President
Kent Hospital	Kent Hospital
Landmark Medical Center	Administration
Leadership RI	Fellow
LISC- Pawtucket Central Falls Health Equity Zones	Program Officer
Ministers Alliance of Rhode Island	Treasurer
National Alliance on Mental Illness Rhode Island	Executive Director
North Kingstown Fire Department	Assistant Fire Chief/EMS Chief

Organization	Title/Role
North Providence Fire Department	EMS Chief
Ocean Community YMCA - Westerly	Health & Wellness Director
Office of the Health Insurance Commission, Yale New Haven Health Systems	Suicide Prevention Coordinator
PACE-RI Elderly Services	Chief of External Affairs
Partnership to Reduce Cancer in Rhode Island	Coalition Coordinator
Partnership to Reduce Cancer in Rhode Island	Executive Director
Perspectives Corporation	Director
Portsmouth Middle School	School Counselor
Providence Public School District	Social worker
Pride in Aging RI	Volunteer
Prime Healthcare	Corporate Regional Director of Case Management
Providence Career and Technical Academy	Providence Career and Technical Academy
Providence Community Health Centers	AVP, Site Operations
Rhode Island Coalition to End Homelessness	Community Programs Manager
PACE-RI Elderly Services	Chief of External Affairs
Partnership to Reduce Cancer in Rhode Island	Coalition Coordinator
Partnership to Reduce Cancer in Rhode Island	Executive Director
Perspectives Corporation	Director
Portsmouth Middle School	School Counselor
Providence Public School District	Social worker
Pride in Aging RI	Volunteer
Prime Healthcare	Corporate Regional Director of Case Management
Providence Career and Technical Academy	Providence Career and Technical Academy
Providence Community Health Centers	AVP, Site Operations
Rhode Island Coalition to End Homelessness	Community Programs Manager
Rhode Island College	Interim Dean, Onanian School of Nursing
Rhode Island Commission on the Deaf and Hard of Hearing	Deaf community member
Rhode Island Community Food Bank	CEO
Rhode Island Health Care Association (RIHCA)	President & CEO
Rhode Island KIDS COUNT	Director of Early Childhood Policy and Strategy
RI Deaf Senior Citizens	President
RI Certified School Nurse Association	President
RI Coalition for Elder Justice	Healthcare EM Director
RI Legal Services	Social Worker, BSW
RI legislature	NA
RI Coalition Against Domestic Violence	Executive Director
RI Department of Health	Epidemiologist
RIPIN	Resource Coordinator Office of Special Needs (RIDOH)
RIPIN	Family Support Specialist
Saint Elizabeth Haven for Elder Justice	Elder Justice Advocate
South County Health	CMO
South County Health	South County Health
South County Health	Team Leader
South County Health	Manager
South County Health	Administrative Director of Nursing Operations
South County Health	Director of Revenue Cycle Management

Organization	Title/Role
South County Health	South County Health
South County Health	South County Health
South County Health	South County Health
South County Health	Case Manager
South County Health	VP Strategy
South County Health	Clinical Leader Respiratory Therapy, EKG, EEG
South County Health	AVP Community Health
South County Home Health, HCO-ID 65237 (Wakefield, RI)	Director
South County Hospital	Nurse
South County Hospital	Director Emergency Services
South County Hospital	South County Hospital
South County Hospital	South County Hospital
South County Hospital	nursing director
South County Hospital	Clinical Leader
South County hospital Case Manager Department	CM /RN
South County Hospital Health Care System	South County Hospital Health Care System
South County Hospital	Pharmacy Manager
St. Thomas	Pastor
The Miriam Hospital	Manager of Case Management
The Providence Center	The Providence Center
The Rhode Island Department of Elementary and Secondary Education	The Rhode Island Department of Elementary and Secondary Education
Town of Richmond	Human Services
Town of Westerly	Assistant Town Manager
Tri County Community Action Agency HEZ	Tri County Community Action Agency HEZ
United Congregational Church of Westerly, United Church of Christ	Pastor
United Way of Rhode Island	Chief Impact and Equity Officer
Washington County Coalition for Children	Director
West Elmwood Housing	02907 HEZ Program Director
West Elmwood Housing / 02907 Hez	Community Health Worker
West Warwick Police Department	Chief of Police

Appendix C: Partner Forum Participants

The following is a list of community representatives and their respective organization, as provided.

Warwick Partner Forum

Organization	Name
Boys and Girls Clubs of Warwick	Jo-Ann Schofield
Elizabeth Buffum Chace Center	Stefanie Curran
Kent Hospital	Emily Angelo
Kent Hospital	Jenny Laluz
Kent Hospital	Kayla Goncalves
Kent Hospital	Tiffany Belcher
Mothers Against Drunk Driving	Jenn O'Neil
Thrive BH	Brooke Myers
Thrive BH	Dawn Allen
Tides Family Services	Meredith Correia
Warwick HEZ	Deidre Jones
Warwick HEZ	Michael Fratus
WIC	Chantelle Dos Remedios

Washington County Partner Forum

Organization	Name
Alzheimer's Association - Rhode Island Chapter	Jennifer Finley
Brown Health - Gateway	Danielle Stewart
Chestnut Court Tenant Association	Charlene Fry
Gateway Healthcare	Susan Stevenson
Healthy Bodies Healthy Minds Washington County HEZ	Kristen Frady
Oakley Home Access	Justin Oakley
Ocean Community YMCA - Westerly	Janine Parkins
Society of Saint Vincent de Paul - Rhode Island Southern District	Joan Gradilone
South County Health	Lynne Driscoll
South County Health	Holly Fuscaldo
South County Home Health	Elaine Irby
South County Home Health	Kelly Pucino
South County Hospital	Alyssa Marciniak
South County Hospital	Nina Laing
South County Mobile Integrated Health	Kevin McEnery
South Kingstown Police Department	Matthew Moynihan
Town of Exeter	Jessica DeMartino
Wellbeing Collaborative	Dan Fitzgerald
Wood River Health	Christine King
Wood River Health	Frank Hopkins
Wood River Health	Kat Miller
Wood River Health	Sarah Channing
Yale New Haven Hospital	Shanthi Mogali
Yale New Haven Hospital	Rob Harrison, MD
Resident-at-Large	Maxine Mae Hutchins

Woonsocket Partner Forum

Organization	Name
Blackstone Valley Prevention Coalition	Lisa Carcifero
City of Woonsocket	Margaux Morisseau
Community Care Alliance	Bette Gallogly
Community Care Alliance	Mark Cote
Community Care Alliance	Christa Thomas-Sowers
Community Care Alliance	Jessica Jones
Connecting for Children & Families	Felix Colón
Connecting for Children & Families	Erin Spaulding
Crisis Intervention Teams of Rhode Island	Sarah Begin
Discovery House of Woonsocket Comprehensive Treatment Center	Kar Wilson
Eleanor Slater Hospital	Hector Guerreiro
Hospital Association of Rhode Island	Lisa Tomasso
Landmark Medical Center	Deb Hansen
Landmark Medical Center	Carolyn Kyle
Landmark Medical Center	Daniel Quinn
Providence Revolving Fund	Veronicka Vega
The Autism Project	Linda Brunetti
Tides Family Services	Meredith Correia
Woonsocket City Council	Kristina Contreras Fox
Woonsocket Comprehensive Treatment Center	Matthew Rogalski
Woonsocket Head Start Child Development Association	Jody Ragosta
Woonsocket Health Equity Zone	Ana Antonopoulos
Woonsocket Health Equity Zone	Kwang Baek
Woonsocket Health Equity Zone	Tara Cimini
Woonsocket Health Equity Zone	Shelly Hyson
Woonsocket Health Equity Zone	Boonie Piekarski