Community Health Needs Assessment Report

RML Specialty Hospital

Hinsdale Campus

May 2016

(Updated November 2016)

Prepared by Illinois Public Health Institute and RML

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Executive Summary

RML Specialty Hospital conducted a Community Health Needs Assessment (CHNA) from January to May 2016 for its two hospital campuses – RML Specialty Hospital Hinsdale and RML Specialty Hospital Chicago – in accordance with IRS requirements for nonprofit hospitals. This is the second CHNA for RML Specialty Hospital; the first was completed in 2013.

Input and guidance were provided by a CHNA Advisory Council made up of leaders from a cross-section of RML departments across both campuses, former patients, and representatives from several key partner organizations that refer to and/or receive patients from RML. A list of the CHNA Advisory Council members is included in Appendix A.

Based on its specialized focus and understanding of the population it serves, RML defined its CHNA community as people, particularly elderly and low-income, who have suffered a severe, life-changing, debilitating illness and that require extensive psycho-social and health support services when they return home. Home, for patients admitted to RML Hinsdale, is largely Chicago, suburban Cook County, DuPage County and Will County. For patients at RML Chicago, home is mainly Chicago and suburban Cook County.

According to census data[1] from 2010-2014, 827,726 older adults age 65 and older live in Cook County, DuPage County and Will County; over a third of those older adults (292,962) are in the city of Chicago. Older adults living in poverty and living alone may have a more difficult time accessing the resources they need to adapt to home life with a severe, life-changing illness. In the service area, there are approximately 370,000 older adults living alone, and an estimated 140,000 older adults have independent living difficulty. Roughly 85,000 older adults in the service area are living in poverty.

As part of this CHNA, RML gathered community input through interviews with former patients and staff and focus groups with care coordinators, other RML staff and community service providers. Key topics that arose out of the community input were: chronic disease prevention and management, access to care and community services, support for caregivers and families of chronically critically ill (CCI), transportation, support for a growing older adult population, behavioral health (mental health and substance abuse), injury prevention and safety, poverty and low income as root causes of health disparities.

In April 2016, the CHNA Advisory Council reviewed the assessment data and engaged in a consensus-building prioritization process to identify priority health issues using the following criteria: prevalence and seriousness of the problem, disparities, importance to the community, available expertise, feasibility, and alignment with RML's mission.

[1] American Communities Survey 2010-2014

The priority issues that surfaced through the Advisory Council prioritization process included:

- coordination of care,
- health literacy,
- navigating insurance and the healthcare system,
- support services at home,
- behavioral and mental health,
- chronic disease prevention and management,
- support for caregivers, and
- transportation.

RML also joined two different collaboratives between 2015 and 2016 - the Health Impact Collaborative of Cook County and the Healthy Chicago Hospital Collaborative - to partner with other hospitals and health departments to address some of these larger community issues, particularly access to care and transportation. Participation on these collaboratives is expected to continue.

The Implementation Plan establishes coordination of care, chronic disease management, and transportation as RML's top priorities over the next three years.

The CHNA process also provides RML with opportunities to better understand the quality-of-life issues that are important to the community, engage with former patients to better understand daily struggles and hear ideas to overcome barriers and improve quality of life. In addition, the process provided an opportunity to build stronger relationships with other service providers for improved coordination and potential partnerships. RML looks forward to strengthening collaborative work to continue to address the priority needs of the community.

Introduction

Description of RML

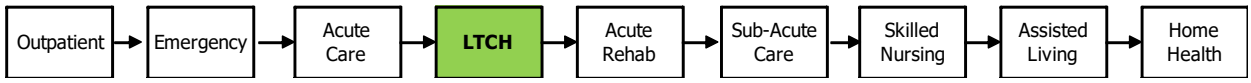
RML Specialty Hospital (RML) operates two campuses: a 115-bed hospital in Hinsdale (RML Specialty Hospital Hinsdale) and an 86-bed hospital on the near-west side of Chicago (RML Specialty Hospital Chicago).

RML is a long-term acute care hospital (LTCH). LTCHs are defined by Medicare as hospitals that have an average length-of-stay greater than 25 days.

LTCHs are very much like short-stay acute care hospitals (i.e., community hospitals and university hospitals) except for some unique characteristics. LTCHs typically admit only elective referrals from short-stay acute care hospitals and are treatment-based rather than diagnosis-based. LTCHs focus on a patient population that is recovering from critical illness; this population has a long length-of-stay, is largely older adults, and is very ill. Patients in an LTCH face intricate and delicate family issues, often involving end-of-life decisions. Also, they operate on a much smaller scale and have few, if any, outpatient services.

LTCHs provide a specialized role in the overall continuum of care. LTCHs are the first stop in what is known as "post-acute care". About 1% of the patients admitted to a short-stay acute care hospital are eventually referred to an LTCH. An LTCH's role in the continuum of care can be represented as follows:

Figure 1. LTCH's Role in Continuum of Care



The RML Specialty Hospitals in Hinsdale and Chicago admit patients from more than 65 hospitals across Northeast Illinois as well as from out-of-state. The overwhelming majority of RML's patients are admitted directly from the intensive care unit at the referring hospital and have been in the hospital for three weeks or longer.

RML specializes in the interdisciplinary physician-led treatment of patients with catastrophic or acute illnesses and injuries complicated by complex or multiple illnesses or conditions. RML has three major programs. About 65% of the patients come to RML to be weaned from a ventilator. These patients have failed to wean from the ventilator at the short-stay acute care hospitals in spite of repeated attempts following a major surgery or a severe illness.

About 20% of the patients are admitted to the medically complex program. These patients are critically ill and suffer from multiple debilitating conditions and are just starting to take very small steps toward their rehabilitation.

The remainder of patients come to RML with severe, possibly infected wounds, including pressure ulcers, surgical wounds, and burns. In fact, as all of the patients have been in the hospital for a long time, many of the patients in the other two programs are also suffering from pressure ulcers.

RML Specialty Hospital Hinsdale was started in 1987 as the Ventilator Support Center within Suburban Hospital. It began as a partnership between Rush University Medical Center, MacNeal Hospital, and Suburban Hospital. In 1997, Suburban Hospital ceased operations. At that time the Ventilator Support Center assumed operations of the entire facility and was recognized as an LTCH by CMS. Loyola University Medical Center replaced Suburban Hospital in the partnership in 1998 and the operation became known as RML. MacNeal Hospital left the Partnership in 2001. In 2010, RML Chicago (the former Advocate Bethany Hospital) was added and Advocate Health and Hospital System replaced Rush in the partnership. Loyola and Advocate are the current partners/owners of RML.

Over the past 25-plus years, RML has established a national reputation for high quality, positive outcomes. RML is the only LTCH recognized by *US News and World Reports* (2011) and is the only LTCH to participate in research funded by the National Institutes of Health (NIH).

Description of the CHNA process

Under the Patient Protection and Affordable Care Act of 2010, and the final rules for Section 501(r) published in 2014, nonprofit hospitals are required to conduct a Community Health Needs Assessment (CHNA) every three years in order to maintain nonprofit status. The CHNA must include a description of the community served by the hospital facilities, input from people who "represent broad interests of the community served", engagement of public health experts, public access to the CHNA results, and subsequent development of an implementation plan.

RML Specialty Hospital conducted its second Community Health Needs Assessment (CHNA) from January to May 2016 for both of its two hospital campuses – RML Specialty Hospital Hinsdale and RML Specialty Hospital Chicago.

RML's CHNA process was grounded in the organization's mission and values.

RML Mission

To provide quality, compassionate care to patients from our referring community who suffer from prolonged, severe illness.

RML Values

Integrity - We are ethical, fair, and honest in all our actions.

Service - We are committed to achieving service excellence in all that we do.

Respect - We respect the individual rights, dignity, and confidentiality of others.

Stewardship - We strive at all times to be good financial stewards of the resources entrusted to us.

Teamwork - We value each staff member's contribution to our Mission and believe that collaborative effort is essential to realizing our Vision.

Accountability - We hold ourselves accountable for our actions and for the achievement of results.

The CHNA process was co-led by RML's Chief Operating Officer and Director of Care Coordination. The Illinois Public Health Institute served as facilitator for the process and conducted data collection and analysis. RML formed a CHNA Advisory Council to review progress on 2013 CHNA implementation plan activities, review assessment data and provide input and guidance on the identification of priority issues for the 2016-2019 implementation plan.

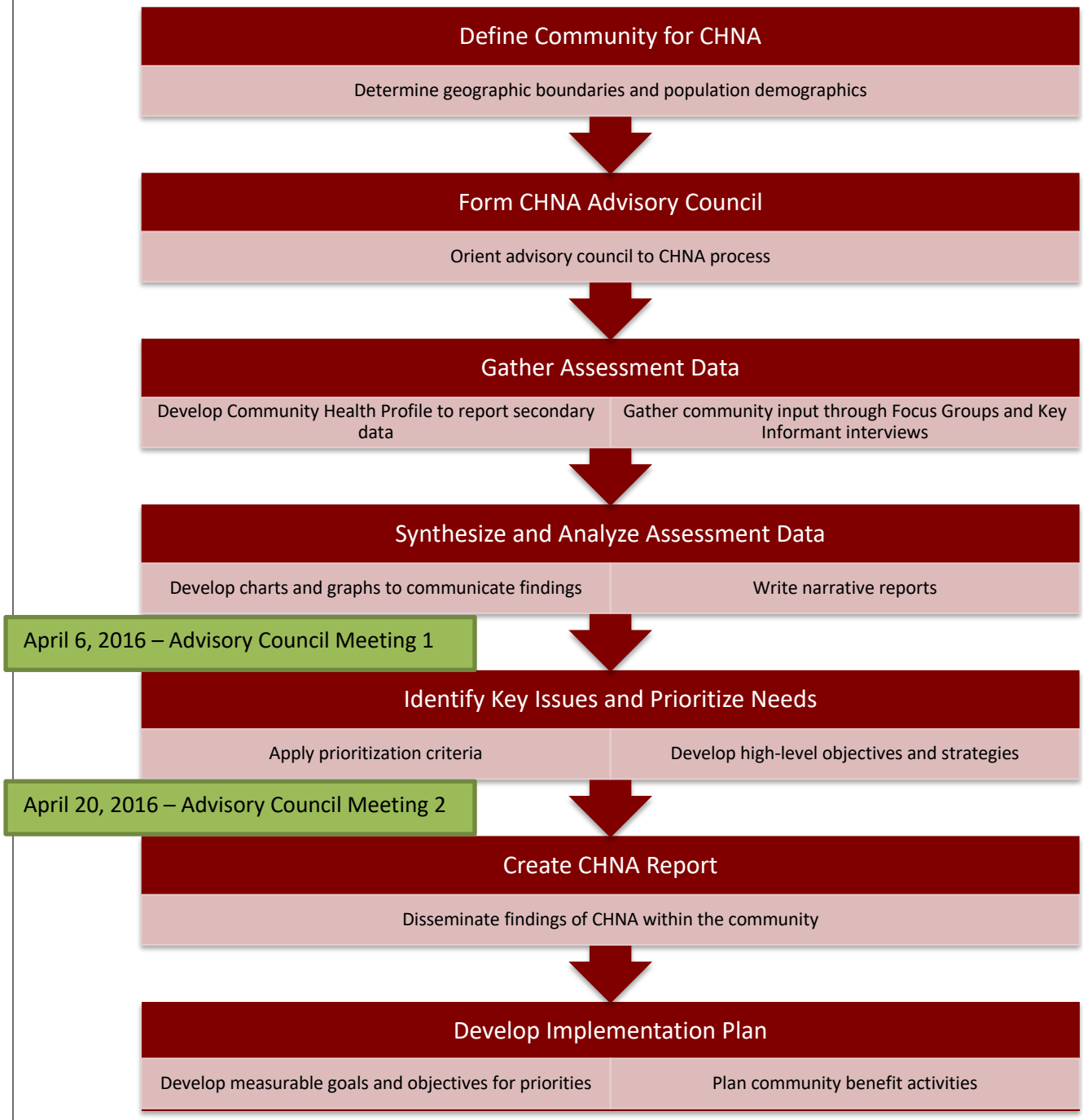
The CHNA Advisory Council was made up of leaders from a cross-section of RML departments across both facilities, former patients, and representatives from several key partner organizations that refer to and/or receive patients from RML. The council met two times.

In addition, throughout 2016 RML has participated as a member of the Health Impact Collaborative of Cook County, which includes 26 hospitals, 6 health departments and over 100 local stakeholders in Chicago and suburban Cook County. The members convened to conduct a collaborative CHNA and aligned implementation plans for collective impact. For the purpose of the assessment, Cook County was divided into 3 regions and RML hospitals are part of the Central region. RML staff participated in collaborative meetings with community stakeholders to review assessment data which included secondary data on demographics, social determinants, and health status in addition to primary data collected through 7 focus groups and through surveys with some of the most vulnerable population groups in the region.

RML has also been an active member of the Healthy Chicago Hospital Collaborative since 2015 to address shared implementation priorities from the 2013 CHNAs of Chicago

hospitals. The Healthy Chicago Hospital Collaborative has been working over the last year to develop plans to address transportation needs associated with accessing care, and RML has been highly involved in this planning effort. The Healthy Chicago Hospital Collaborative has also been discussing strategies to address mental health and chronic disease prevention and management.

Figure 2. RML's CHNA Process Diagram



Community Definition

Analysis of RML Specialty Hospital's FY2015 patient data shows that the vast majority of RML's patients come from the region that includes Chicago, suburban Cook County, DuPage County and Will County. The source of RML Chicago's patients is relatively concentrated with 82% living in Chicago and 13% in suburban Cook County. The source of RML Hinsdale's patients is more widely distributed: 14% live in Chicago, 39% live in suburban Cook County, 16% live in DuPage County, and 16% live in Will County.

Given RML's specialty in serving medically complex patients and patients with long term care needs, RML defined the CHNA communities in the following way:

RML Hinsdale's community**:** People in Chicago, suburban Cook County, DuPage County and Will County who have suffered a severe, life-changing, debilitating illness requiring extensive psycho-social and health support services when they return home. As the elderly and low-income are most unlikely to have the resources to adapt well to these circumstances, RML will focus on these populations.

RML Chicago's community**:** People in Chicago and suburban Cook County who have suffered a severe, life-changing, debilitating illness requiring extensive psycho-social and health support services when they return home. As the elderly and low-income are most unlikely to have the resources to adapt well to these circumstances, RML will focus on these populations.

Figure 3: IRS Guidance on CHNA Definition of Community

U.S. Internal Revenue Service (IRS) guidance (notice 2011-52) explains: "Generally, Treasury and the IRS expect that a hospital facility's community will be defined by geographic location (e.g., a particular city, county, or metropolitan region). However, in some cases, the definition of a hospital facility's community may also take into account target populations served (e.g., children, women, or the aged) and/or the hospital facility's principal functions (e.g., focus on a particular specialty area or targeted disease). Notwithstanding the foregoing, a community may not be defined in a manner that circumvents the requirement to assess the health needs of (or consult with persons who represent the broad interests of) the community served by a hospital facility by excluding, for example, medically underserved populations, low-income persons, minority groups, or those

Data Collection Approaches/Methods

This assessment includes two main data components: (1) a Community Health Profile including RML data and secondary data from a variety of community health data sources and (2) community input data that was collected through focus groups and interviews. Data was collected and analyzed both for Chicago and for suburban Cook County, DuPage County and Will County to coincide with the geographic service areas identified for RML Hinsdale and RML Chicago.

Community Health Profile - Secondary Data Analysis

For the Community Health Profile, IPHI worked with RML to collect data from a range of secondary sources. IPHI accessed data from local health departments (Chicago, Cook County, DuPage County, Will County) for many demographic and health status indicators. Other sources include:

- United States Decennial Census
- American Communities Survey (ACS)
- Centers for Disease Control and Prevention (CDC)
- Illinois Department of Public Health (IDPH)
- Illinois Department of Healthcare and Family Services (HFS)
- Heartland Alliance Social Impact Research Center
- Dartmouth Atlas of Health Care
- Henry J. Kaiser Family Foundation
- Health Indicators Warehouse
- City of Chicago Data Portal
- Impact DuPage
- RML Internal Records

Community Input – Primary Data Analysis

The community input data for the RML CHNA was collected between February and April 2016. IPHI worked with RML to apply two methods for collecting community input data: focus groups and key informant interviews. In addition, as part of the Health Impact Collaborative of Cook County, RML was able to access survey data collected through the collaborative CHNA process as another important insight into community perceptions and input.

Three focus groups were conducted with RML staff, care coordinators, and community partners. The RML staff focus group had representation from both RML campuses, and included a variety of disciplines including nutrition/dietetics, physical therapy, wound care, pharmacy, nursing, respiratory care, speech rehabilitation, patient/family relations, and performance management. The care coordinators focus group also had representation from both campuses. The community partner focus group had representatives from a skilled nursing facility, rehabilitation facility, and home health

care organization that work with many RML patients after discharge. The focus groups were conducted by IPHI following a semi-structured format, and RML and IPHI tailored questions for each focus group. (Questions are listed in Appendix C.)

Community Input - Key Informant Interviews

IPHI also conducted three key informant interviews to gather input and expertise on issues faced by the community that RML serves. One interview included 2 team members from an RML post-discharge follow-up project initiated in January 2016. A second staff interview was conducted with a physician from the RML Chicago campus. A final interview was conducted with two previous RML patients. Several attempts were made to secure additional patient and caregiver interviews that failed to come to fruition due to the daily challenges patients and caregivers experience. All interviews followed a semi-structured format and questions were personalized for each interviewee based on their area of expertise.

Findings from Community Health Profile

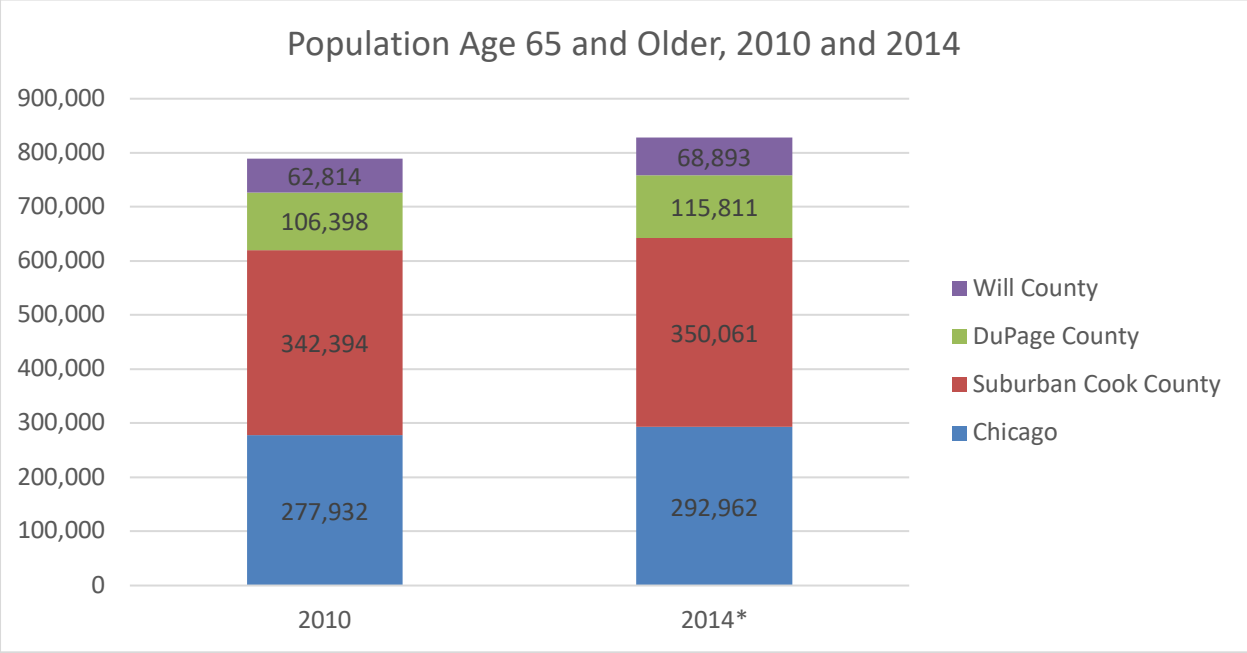
Target Community for this CHNA

As detailed in the Community Definitions section on page 9, RML's CHNA community of focus includes individuals that have suffered a severe, life-changing, debilitating illness requiring extensive psycho-social and health support services when they return home. The United States Library of Medicine (part of the National Institutes of Health), states "approximately 80% of the patients admitted into intensive care units survive the acute event, and most remain in this unit briefly. However, a subgroup does not recover sufficiently quickly to become independent and from then they recover slowly. These patients are called chronically critically ill (CCI) patients and, comprise 5 to 10% of the patients admitted into intensive care units." It is these CCI patients that are the vast majority of RML's patient community.

The Community Health Profiles for the two campuses (Appendix B) summarize the conclusions gathered from the data collected on demographic, socioeconomic, and health indicators for RML's community. As described on page 9, the geographic community covered by RML Hinsdale is Chicago, suburban Cook County, DuPage County and Will County. The geographic community covered by RML Chicago is Chicago and suburban Cook County. Citywide data is presented for Chicago and county data is presented for Cook County, DuPage County and Will County. State and federal comparison data are presented where available.

The total regional population, as of the 2010 Census, is 6,789,159 (approximately 2.7 million in the city of Chicago, 2.5 million in suburban Cook County, 915,000 in DuPage County, and 675,000 in Will County). As of 2014, the total population of older adults age 65 and older is 827,726, with 643,023 of those older adults living in Chicago and suburban Cook County. The population of older adults increased by approximately 5% between 2010 and 2014.

Figure 4. Population Age 65 and Older, 2010 and 2014



Source: 2010 U.S. Decennial Census and 2010-2014 American Community Survey
* Data is a 5-year estimate for 2010-2014

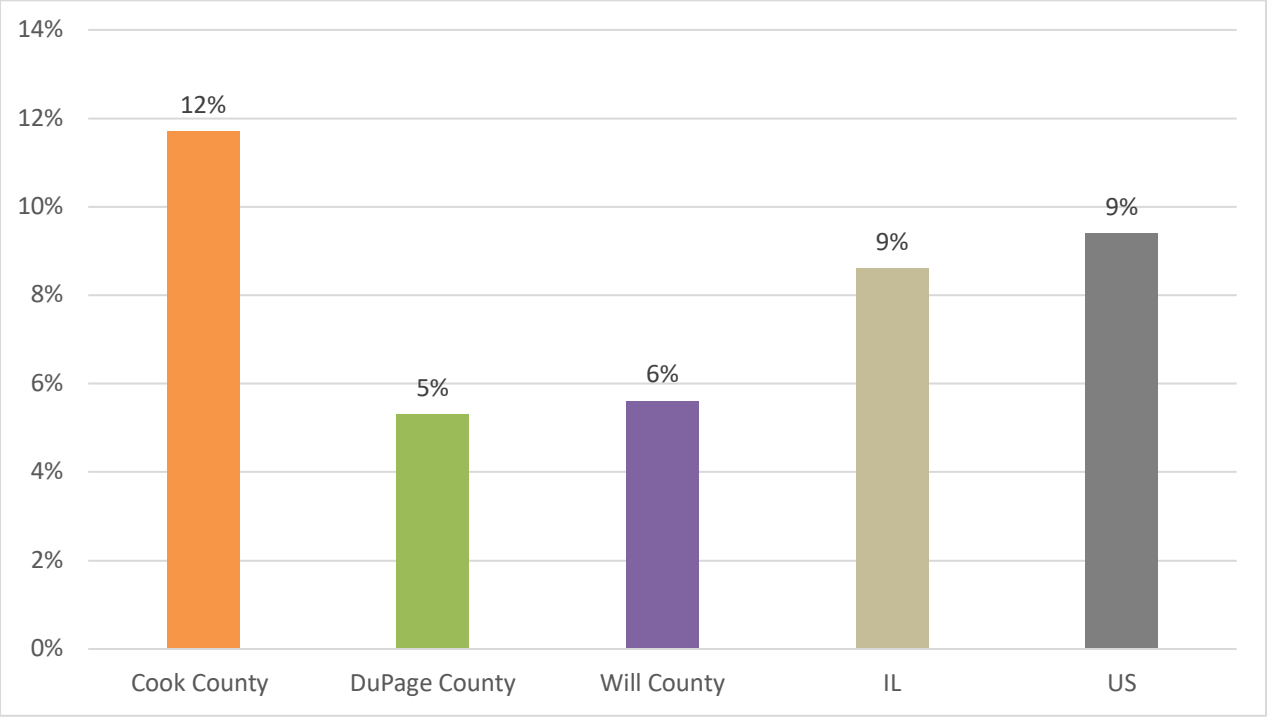
Poverty Among the Older Adult Population (65+)

A large number of older adults are living in poverty in the community areas served by RML Hinsdale and RML Chicago. Overall, approximately 10% or about 85,000 older adults are living below the federal poverty level in the area. For 2014, the federal poverty level is defined as an annual income less than $11,670 for a one-person household or less than $15,730 for a two-person household.[2]

Data are not specifically available about older adults living below 200% poverty (annual income less than $23,340 for a one person household or less than $31,460 for a two person household). However, as older adult poverty rates are very similar to poverty rates of the general population, we can assume that the number of older adults living between 100% and 200% of the poverty level is about twice as many (or about 170,000 people) as the number living under 100% of the poverty level. This means that one-third or more of the older adults in RML Chicago's community likely live under 200% of the federal poverty level.

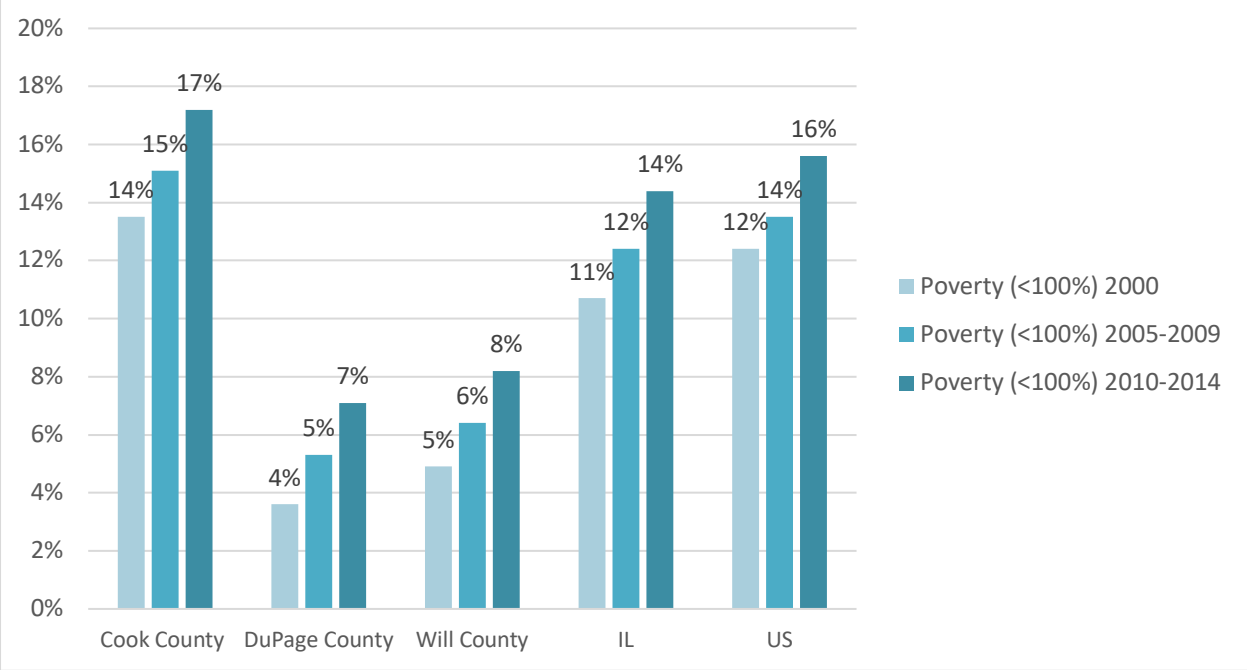
[2] https://www.federalregister.gov

Figure 5. Percent of Adults Age 65+ Living Below 100% Poverty Level, 2010-2014



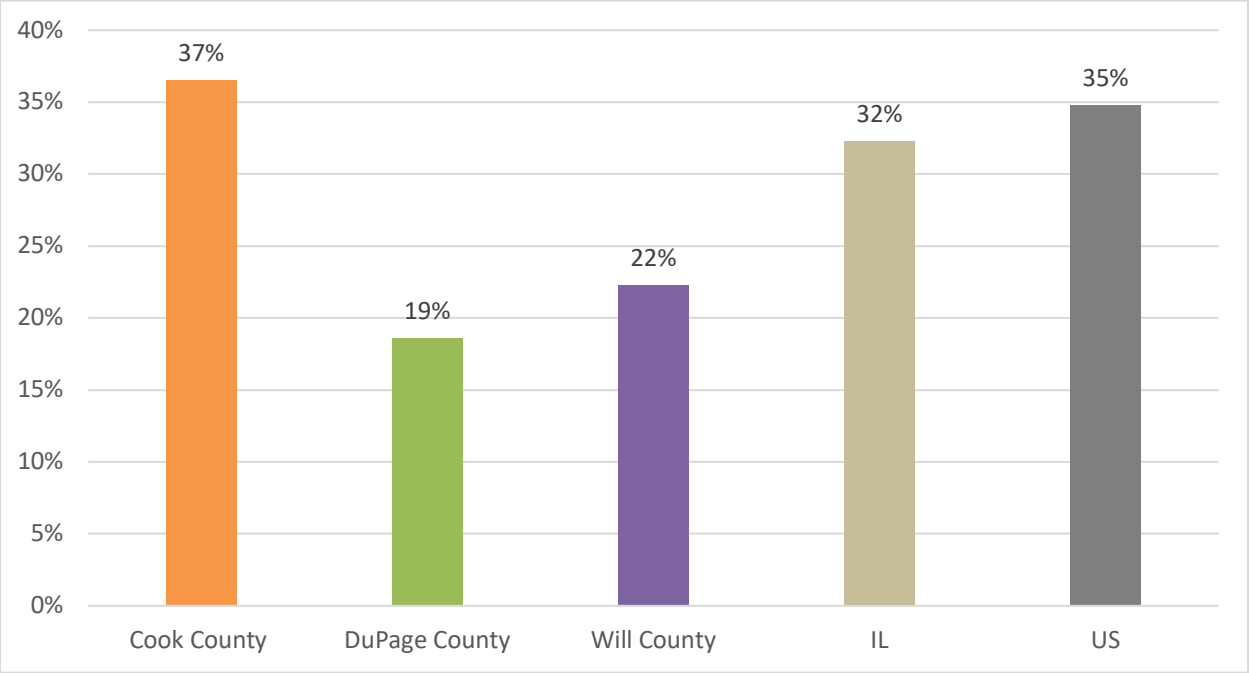
Source: American Community Survey, 2010-2014

Figure 6. Percent of Population Living Below 100% Poverty Level, 2000-2014



Source: 2000 U.S. Decennial Census; American Community Survey 2005-2009 and 2010-2014

Figure 7. Percent of Population Living Below 200% Poverty Level, 2013

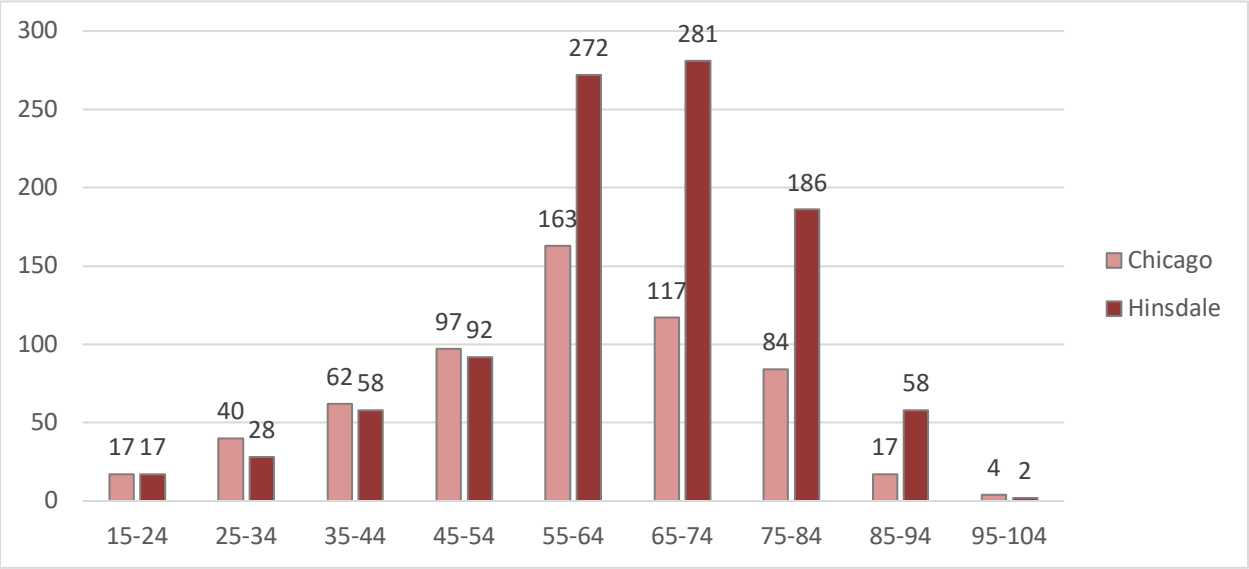


Source: Social Impact Research Center, *Poor By Comparison: Report on Illinois Poverty*. January 2015.

RML Patient Data

The majority of RML's patients are older adults. In 2015, 64% of patients at RML Chicago were 55 and older, including 37% over 65. 80% of patients at RML Hinsdale were 55 and older, including 53% over 65.

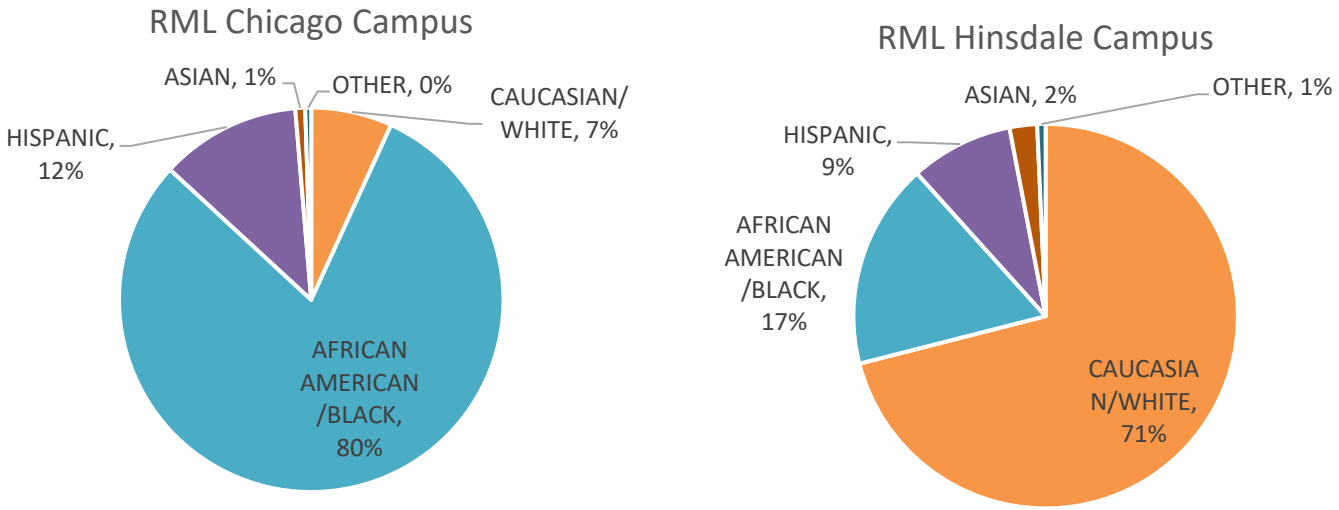
Figure 8. Age Distribution of RML Patients by Campus, 2015



Source: RML FY 2015 Data

The racial and ethnic makeup at the two RML campuses is very different. Over 90% of the patients at RML Chicago are non-white while 71% of the patients at RML Hinsdale are white, which indicates that important cultural differences likely exist that should be considered during implementation planning.

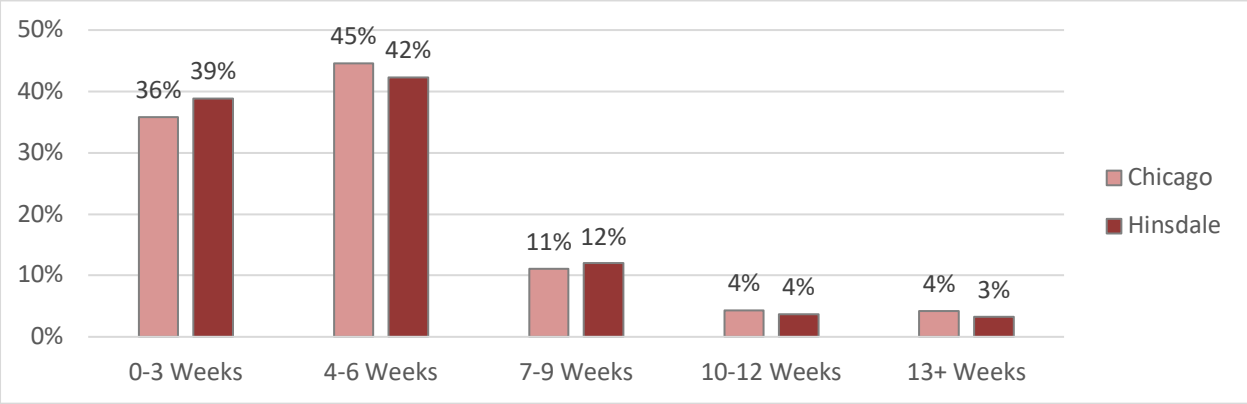
Figure 9. Race/Ethnicity of RML Patients, 2015



Source: RML FY 2015 Data

Over 60% of RML patients stay at RML for over three weeks. As most patients come to RML after three plus weeks in a short-stay hospital as well, the total length of stay in a hospital is usually six weeks or longer, not including the time spent in a rehabilitation or skilled nursing facility after discharge from RML. This emphasizes the severity of the patients' conditions and is indicative of the challenges they will face when returning home.

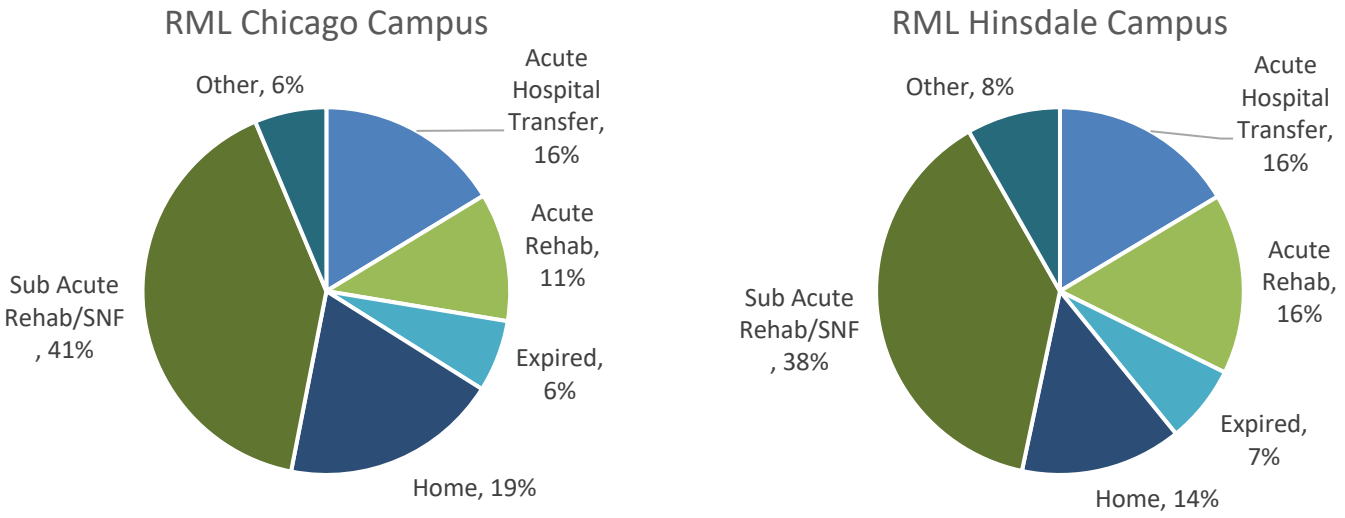
Figure 10. Length of Stay of RML Patients, 2015



Source: RML FY 2015 Data

In 2015, discharge profiles were similar for RML's Chicago and Hinsdale facilities. At both RML Chicago and RML Hinsdale, approximately 16% of the patients were transferred to acute hospitals. A slightly higher proportion of Chicago patients were discharged to Sub-Acute Rehabilitation or Skilled Nursing Facilities (41%) and to home (19%) compared to RML Hinsdale. RML Hinsdale had a higher proportion of patients discharged to Acute Rehabilitation (16%). Nearly three-quarters of RML patients have at least one intermediate stop before going home, which makes it challenging for RML to follow and assist patients at home.

Figure 11. Discharge Destination for RML Patients, 2015

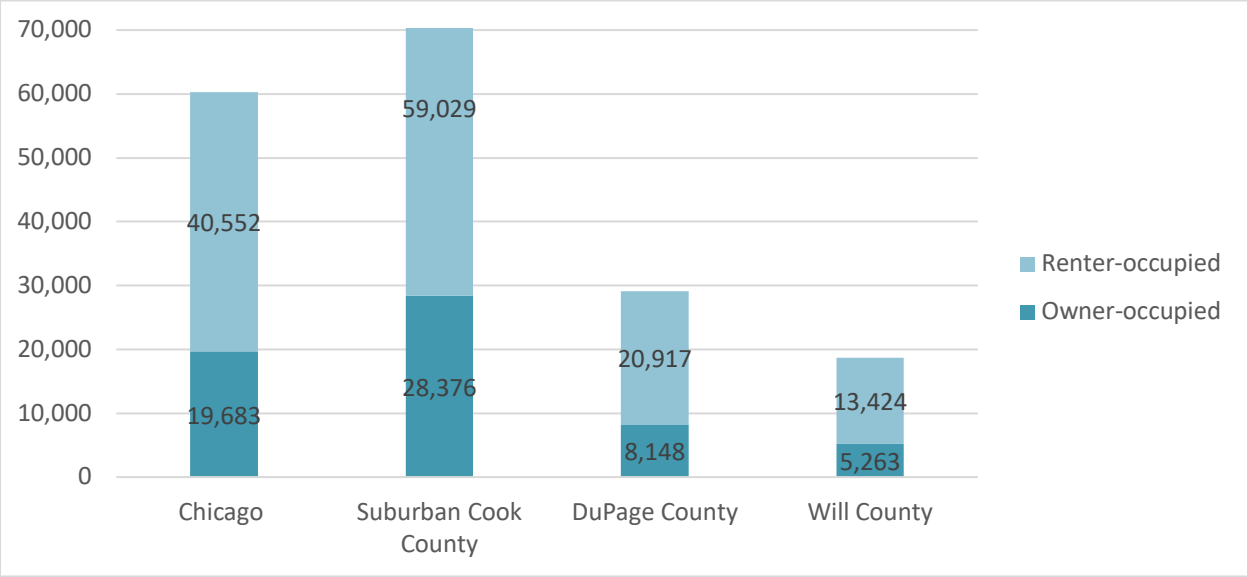


Source: RML FY 2015 Data

Home Support for Older Adults

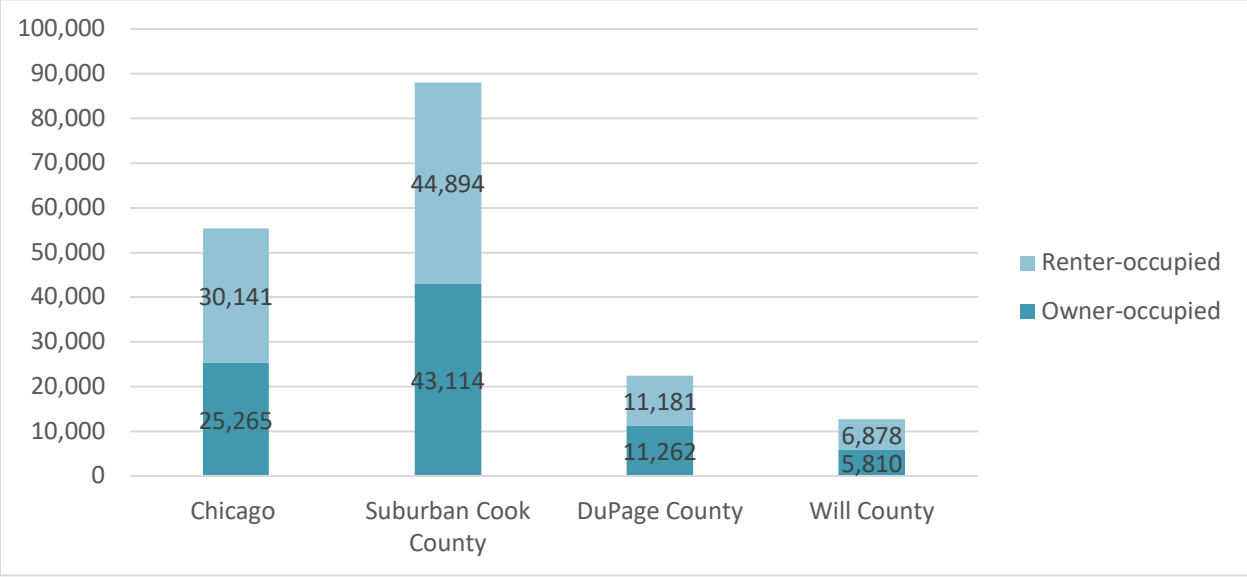
The number of older adults living alone, and the number of adults with independent living difficulty or self-care difficulty highlights the great need for support for this population from the community. As shown in Figures 11a and 11b, there were approximately 374,000 older adults living alone in the RML service area in 2014.

Figure 12a. Adults Age 65-74 with a 1-Person Household, 2010-2014



Source: American Community Survey, 2010-2014

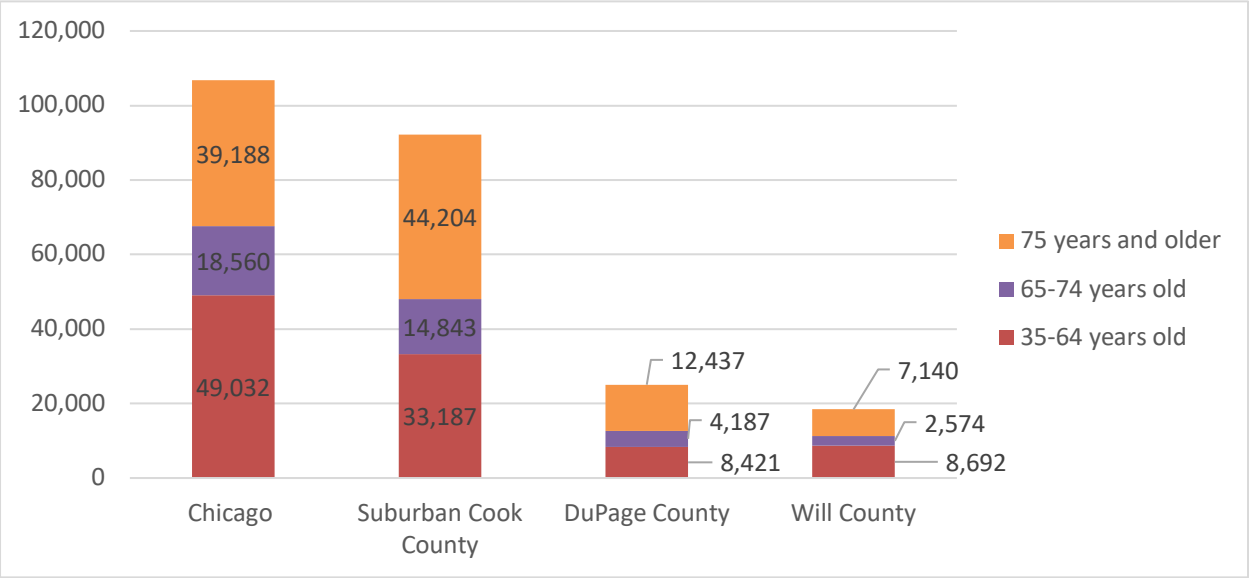
Figure 12b. Adults Age 75+ with a 1-Person Household, 2010-2014



Source: American Community Survey, 2010-2014

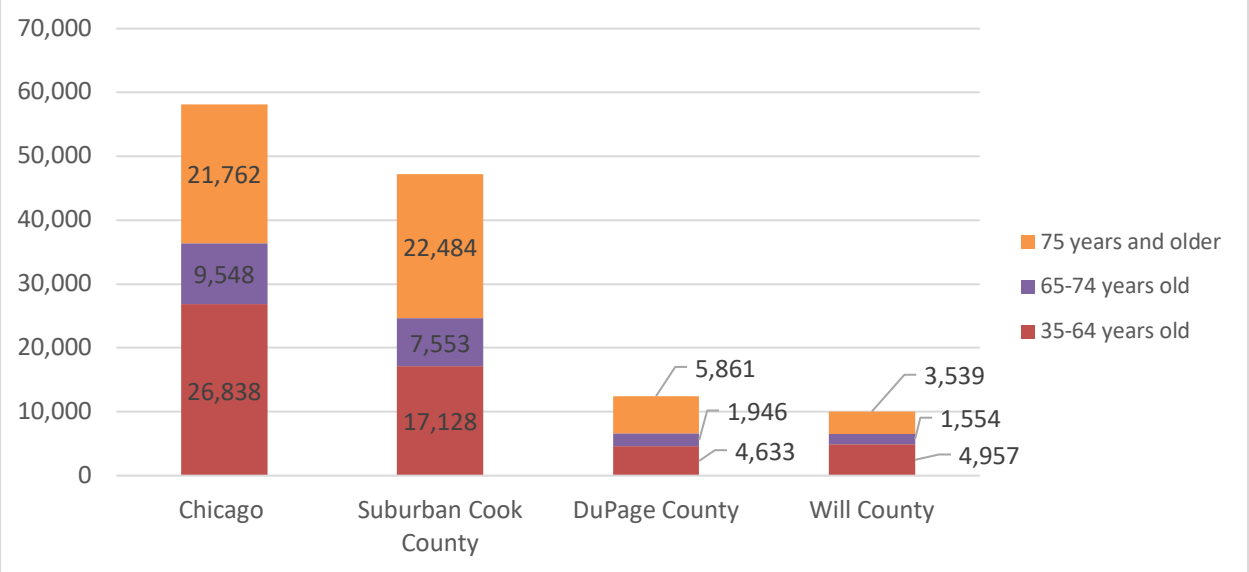
It is often not possible for patients returning home after a long-term illness to live independently. There were approximately 143,000 older adults with independent living difficulty and 75,000 older adults with self-care difficulty in the RML service area in 2013.

Figure 13. Adults with Independent Living Difficulty, 2011-2013



Source: American Community Survey, 2011-2013

Figure 14. Adults with Self-Care Difficulty, 2011-2013



Source: American Community Survey, 2011-2013

Medicare and Medicaid for Older Adults

Older adults are nearly universally covered by Medicare [3] and some older adults also qualify for Medicaid[4] coverage to assist with payment of deductibles and co-payments. Overall, in Illinois, 12% of older adults are "dual eligible" for Medicare and Medicaid. With one quarter of older adults qualifying as dual eligible, the City of Chicago has twice the rate of dual eligible older adults compared to the State. Older adults are particularly affected by all aspects of what services are covered by Medicare and Medicaid, especially home-based services.

Figure 15. Medicare Enrollment, 2015

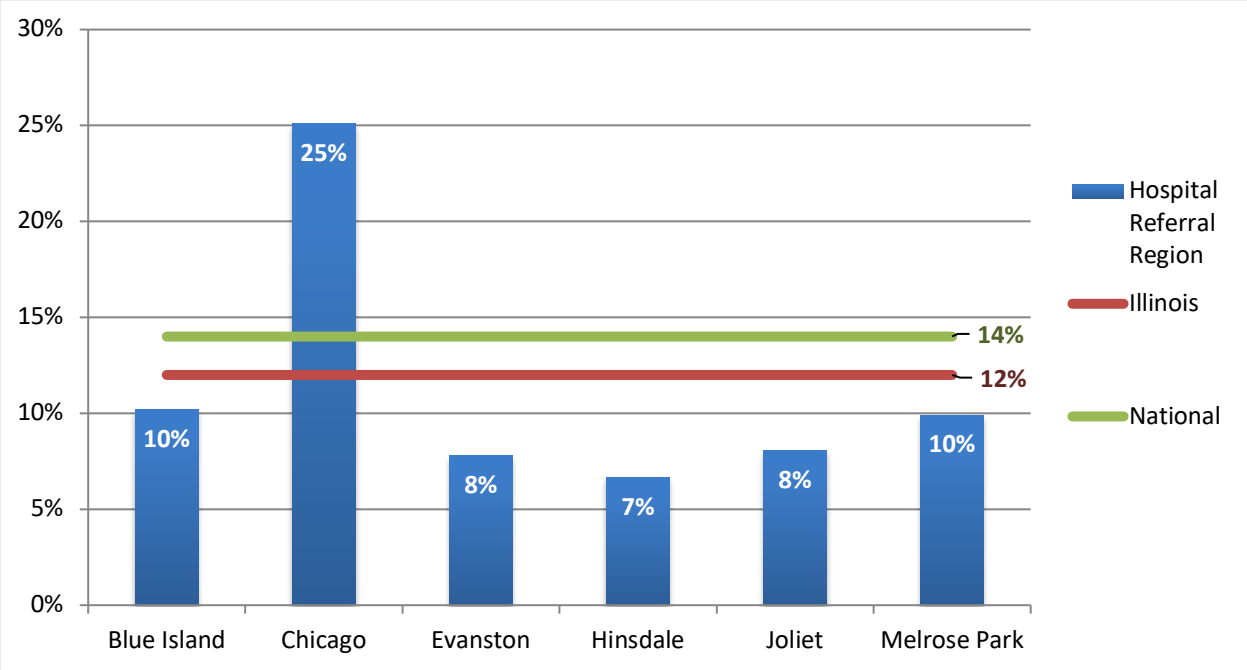
	Cook County	DuPage County	Will County
Total 65 and Older Population (2014)	643,023	115,811	68,893
Population Enrolled in Medicare Advantage Plans	132,940 (17%)	20,205 (15%)	14,152 (16%)
Medicare Part D Enrollment	87,541	9,812	7,467

Source: Henry J. Kaiser Family Foundation and ACS 2010-2014

[3] Medicare is available for people age 65 or older, younger people with disabilities and people with End Stage Renal Disease. To be eligible for Medicare, one must be a U.S. citizen living in the U.S. or a foreign national who has applied for legal residency and has lived in the U.S. for a minimum of five years. Source: U.S. Department of Health and Human Services.

[4] In all states, Medicaid provides health coverage for some low-income people, families and children, pregnant women, the elderly, and people with disabilities. In some states the program covers all low-income adults below a certain income level. Source: U.S. Department of Health and Human Services.

Figure 16. Dual Eligible Medicare/Medicaid Age 65+, 2013[5]



Source: Health Indicators Warehouse, 2013

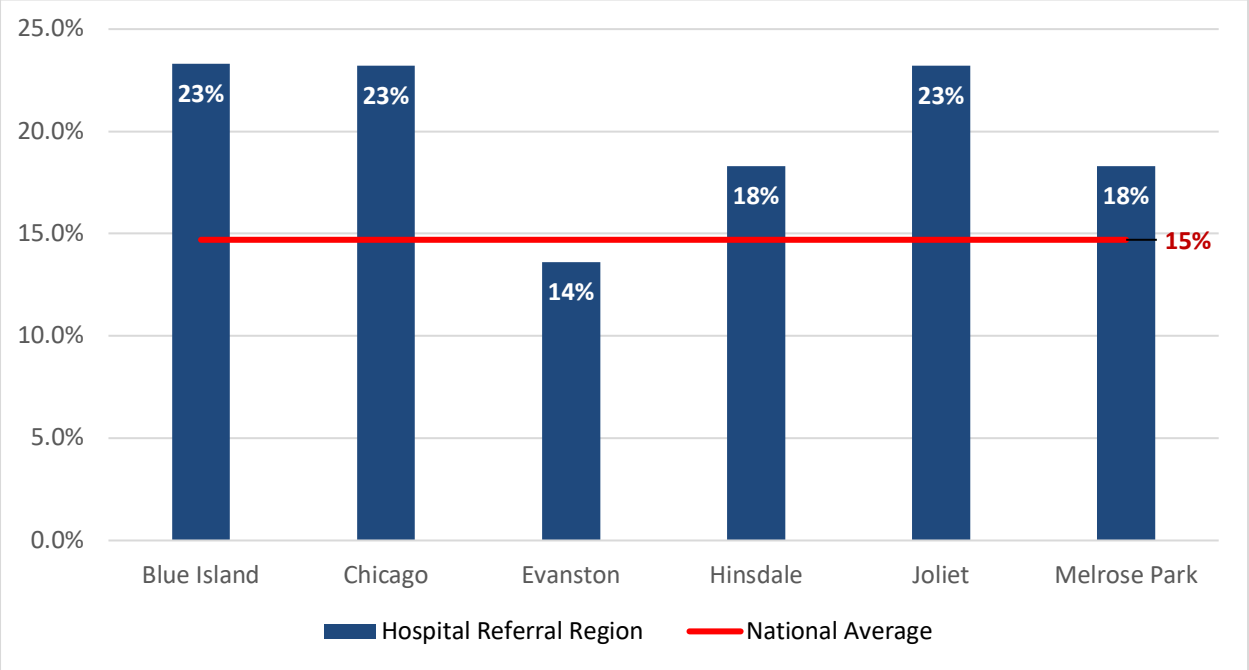
Chronically Critically Ill (CCI) Population

Long-term Acute Care Hospitals (LTCHs) have a high proportion of chronically critically ill (CCI) patients. The definition of CCI varies, but the general characteristics include: extended intensive care unit (ICU) stays, presence of sepsis, prolonged mechanical ventilation, and/or multiple organ failures.[6] Data from the Dartmouth Atlas of Health Care suggests that the RML service area has a high proportion of CCI patients compared to the national average.

[5] Hospital referral regions (HRRs) represent regional health care markets for tertiary medical care. Each HRR contains at least one hospital that performs major cardiovascular procedures and neurosurgery. Source: Dartmouth Atlas of Health Care.

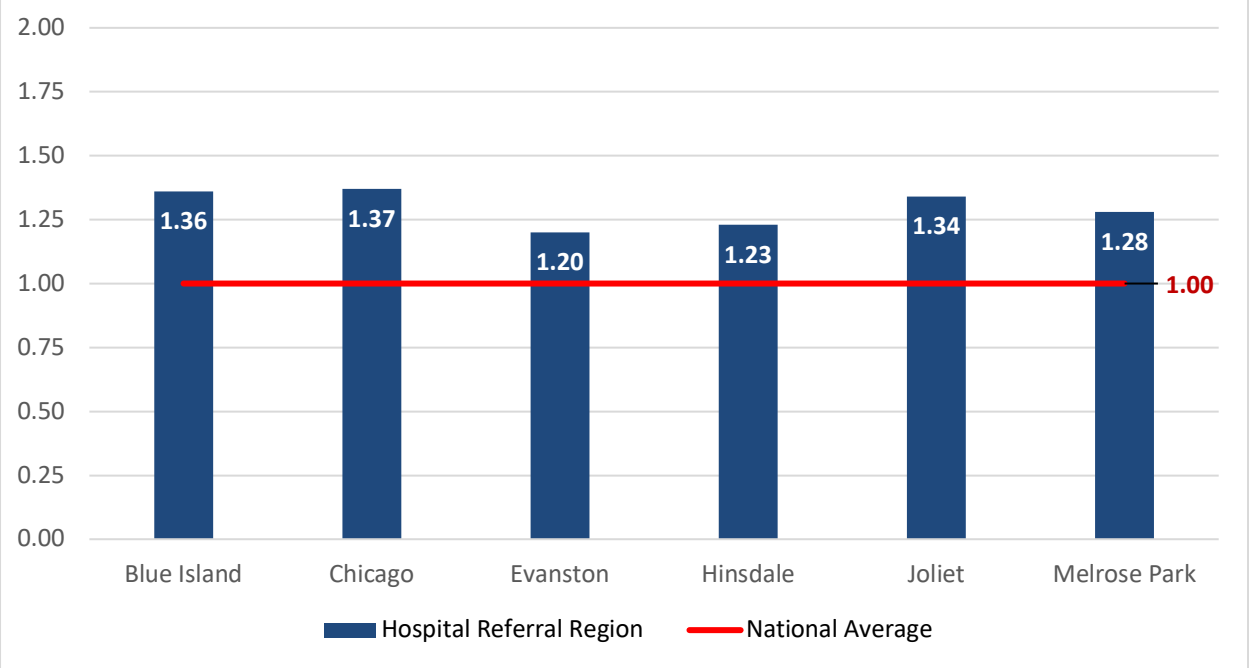
[6] RTI International, *Chronically Critically Ill Population Payment Recommendations Report*. March 2014.

Figure 17. Percent of Decedents Spending 7 or More Days in ICU/CCU during the Last Six Months of Life, 2012



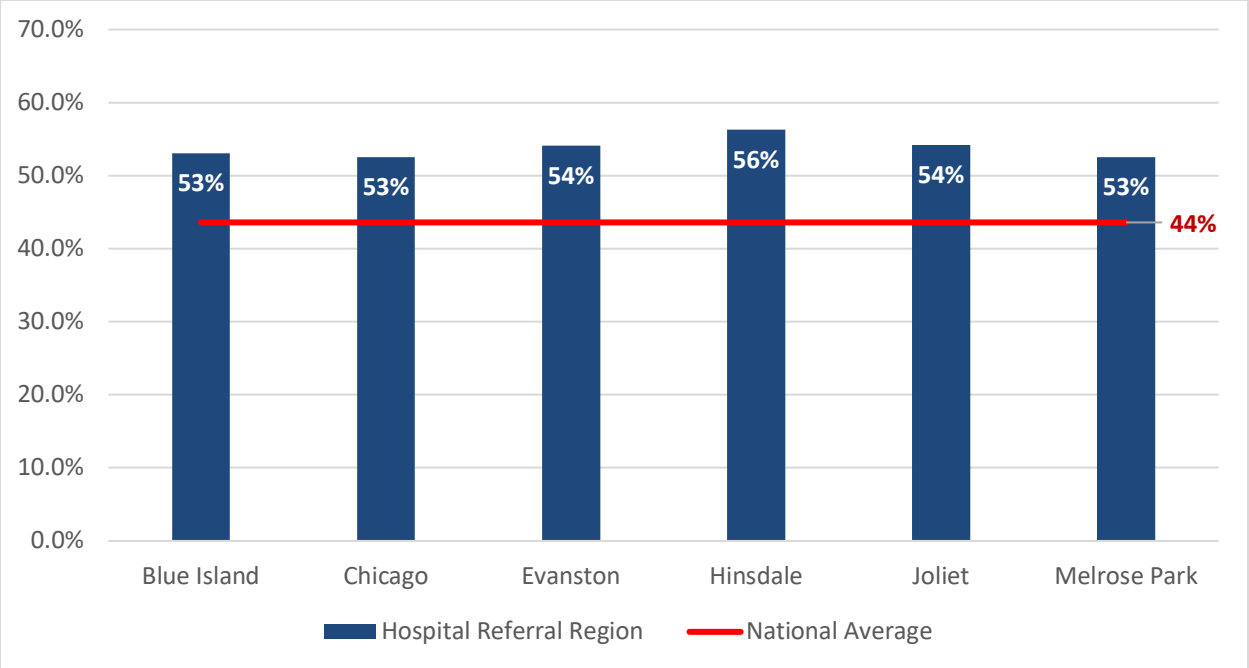
Source: Dartmouth Atlas of Health Care, 2012

Figure 18. Hospital Care Intensity Index, Last Two Years of Life, 2012



Source: Dartmouth Atlas of Health Care, 2012

Figure 19. Percent of Decedents Seeing 10 or More Different Physicians during the Last Six Months of Life (2012)



Source: Dartmouth Atlas of Health Care, 2012

Leading Causes of Death

In the RML service area, the 5 leading causes of death for all ages are heart disease, cancer, stroke/cerebrovascular diseases, chronic lower respiratory diease, and accidents. This is in line with the leading causes of death in Illinois and in the United States overall.

The leading causes of premature death vary more across the RML service area. They include cancer, accidents, heart disease, homicide, firearm-related, stroke/ cerebrovascular diseases, influenza and pneumonia, perinatal period and congenital malformations. This is similar to Illinois and the United States overall, except the 4th leading cause of premature death nationwide is suicide, which did not appear in the Cook, DuPage or Will County lists.

There was little recent data available on the leading causes of death for individuals 65 and older, however, DuPage County data is comparable to Illinois and the United States overall. The overall RML service area likely reflects these trends.

Figure 20a. 5 Leading Causes of Death, All Ages

Chicago (2012)	Cook County (2012)	DuPage County (2012)	Will County (2012)	Illinois (2014)	United States (2014)
Heart Disease	Heart Disease	Cancer	Cancer	Heart Disease	Heart Disease
Cancer	Cancer	Heart Disease	Heart Disease	Cancer	Cancer
Stroke/ Cerebrovascular Diseases	Stroke/ Cerebrovascular Diseases	Stroke/ Cerebrovascular Diseases	Stroke/ Cerebrovascular Diseases	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease
Chronic Lower Respiratory Disease	Chronic Lower Respiratory Diseases	Chronic Lower Respiratory Disease	Accidents	Stroke/ Cerebrovascular Diseases	Accidents
Accidents	Accidents	Accidents	Chronic Lower Respiratory Disease	Accidents	Stroke/ Cerebrovascular Diseases

Source: Chicago, Cook, DuPage, and Will County – Illinois Department of Public Health IQuery website
Illinois and USA – CDC WISQARS

Figure 20b. 5 Leading Causes of Premature Death

Chicago (2006-2010)	DuPage County (2012)	Will County (2006)	Illinois (2014)	United States (2014)
Cancer	Cancer	Heart Disease	Accidents	Accidents
Accidents	Accidents	Accidents	Cancer	Cancer
Heart Disease	Heart Disease	Perinatal Period	Heart Disease	Heart Disease
Assault (Homicide)	Stroke/ Cerebrovascular Diseases	Heart Disease	Perinatal Period	Suicide
Firearm-related	Influenza & Pneumonia	Congenital Malformations	Homicide	Perinatal Period

Source: Chicago – Chicago Data Portal
Will County – 2010 Will County Community Health Status Report
DuPage County – Impact DuPage
Illinois and USA – CDC WISQARS

Figure 20c. 5 Leading Causes of Death Age 65 and Older

DuPage County (2011)	Illinois (2014)	United States (2014)
Heart Disease	Heart Disease	Heart Disease
Cancer	Cancer	Cancer
Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease
Stroke/ Cerebrovascular Diseases	Stroke/ Cerebrovascular Diseases	Stroke/ Cerebrovascular Diseases
Alzheimer's Disease	Alzheimer's Disease	Alzheimer's Disease

Source: DuPage County – Impact DuPage: County Assessment Community Profile, 2015
Illinois and USA – CDC WISQARS

Findings from Community Input

The Community Input Reports (Appendix C) analyze all community data collected during the RML CHNA process. As described in the Data Collection Methods on page 10, the Community Input consisted of three focus groups (RML staff, RML care coordinators, and community partners), and three key informant interviews with RML staff and patients. In addition, two Advisory Council meetings were held.

Figure 21.

Partner Organizations Participating in Focus Groups or Advisory Council
Better Care Home Health
Glen Health & Home Management
Health & Disability Advocates
Loyola University Health System
Rehabilitation Institute of Chicago (RIC)

Summary of Cross Cutting Themes

The focus groups and interviews revealed a number of cross-cutting themes related to the needs of patients during and after their stay at RML, including some of the challenges accessing resources and care once they are back in the community.

Figure 22.

Themes from Community Input	
Access to Care and Community Services	Behavioral Health
Coordination of Care	Chronic Disease Prevention & Management
Hospice and Palliative Care	Injury Prevention/Safety
Cultural and Linguistic Competency	Low Income/Poverty
Health Literacy	Support for Caregivers/Families of CCI Patients
The Need for Patients to have a Primary Care Medical Home	Support for Growing Older Adult Population
Navigating Insurance and Healthcare System	Transportation
Support Services at Home	

Care Coordinators Focus Group – February 11, 2016

Care Coordinators discussed the system barriers for patients and the relationship to the complicated and ever-changing **insurance** plans. Care Coordinators also shared other barriers or challenges faced by patients and their families which included **stress** about being ill and coping with the loss of independent lifestyle; difficulty placing patients with criminal history, **substance use** history, or attempted suicide in skilled nursing facilities; and **financial stress** if the patient is the main income earner for the family. The group described supportive services that are most challenging to access after leaving RML, such as **medical services** (rehabilitation, psychiatry), **in-home services** (Meals on Wheels, home health physicians), equipment and supplies (fewer equipment closets at senior centers), and **transportation**. Care Coordinators shared ideas for improving the quality of life for RML patients and their families through **increasing education and prevention efforts** so medical issues can be addressed before the patient gets to the ICU or LTCH; providing critical medications early to manage a **chronic condition** and improving access to healthy food were two ways to do this. The group thought it was important that RML work with hospitals, SNFs, and other providers to educate them about **the role of RML** (and LTCHs in general) and to help **manage family expectations** related to prognosis throughout the continuum of care. Care coordinators stated that patients and families benefit from **honest, open, and consistent communication** from RML regarding the health of the patient, end of life issues and on-going challenges and needs.

Staff Focus Group – February 25, 2016

RML staff members discussed some of the barriers and challenges faced by patients and their families including **anxiety** about leaving RML and **fear of inadequate care** at skilled nursing facilities (SNFs) or at home, feeling **overwhelmed about taking their loved one home**, or feeling resistant about their loved one going to a SNF because of **fear about losing income** from the patient. Staff also discussed supportive services that are the most challenging to access after leaving RML including **medical services** (outpatient dialysis, nutrition), **in-home services** (24-hour home health care, ventilators, wound care), and **equipment/supplies** (bandages, inadequate space for equipment). RML staff participants expressed the need for RML staff to have consistent, standard language to talk about **end of life** issues with families. Staff participants also indicated that families need to have communication about **chronic disease progression**, proper care for the patient at home, proper **self-care**, and the role of LTCHs. Participants also discussed the best ways to improve the quality of life for patients and their families including performing **home needs assessments** before discharge, **communicating with insurance** companies about what services need to be reimbursable, support services for **self-efficacy**, more discussion and preparation for **end of life decisions** for the general population, and increasing access to **mental health services**. The group noted that RML could develop more relationships with other hospitals and community-based organizations to link patients and family members to **support groups** in the community.

Community Partner Focus Group – March 15, 2016

Community partners discussed some of the most challenging aspects of transitioning from RML to another facility or to home and mentioned the following challenges: **obtaining approval** from Centers for Medicare and Medicaid Services (CMS), Medicare-Medicaid Alignment Initiative (MMAI), or Medicare funded programs; obtaining **proper equipment** in the home; lack of a **primary care physician** to take over long term management of care; and fewer resources for younger patients who hit their insurance policy max. Group members noted that **respite for caregivers** is particularly important - caregiving is physically and mentally demanding, requires good training, and often causes burnout without proper self-care. Resources are needed to ensure respite care is available to all caregivers. Community partner participants discussed several common issues that patients encounter when they get home including: a realization that they have **lost mobility/independence**; calling the ER for care instead of the facility they were discharged from; and problems obtaining follow-up care which can lead to **non-compliance**. The community partners said they facilitate the patient's transition back into the community by providing **transportation assistance**, **case management**, and working with families and patients to take on management of care. Care Coordinators stated that the most important prevention needs to address in the community include **educating** on **chronic conditions** affecting the community (diabetes, hypertension, behavioral health, etc.); encouraging ownership of health; promoting **public safety** (safety helmets, seat belts, etc.); and understanding the demographics, economics, and cultures of the target population. The community partners also thought it was important to foster relationships with visiting physicians groups and vendors, and to **build alliances** with preferred providers to share best practices.

Patient Interviews – April 6, 2016

The two patients IPHI interviewed had a very positive experience at RML in Hinsdale. The former patients reported high quality care from the doctors and nurses; the **continuity of care** was well preserved between rotations and the patients believed the **high quality of care** made a big difference in their recovery. Patients noted that staff was always positive and willing to go above and beyond in the best interest of the patients. One patient said they appreciated the **structured rehabilitation program**, stating that staff were encouraging and helped the patient push themselves. Other helpful services at the hospital, as described by the patients, were **physical therapy**, **nutrition**, and **pastoral care**. One participant noted the **age of the Hinsdale facility** was a detriment, stating that the rooms were not large enough for occupational and physical therapy (for the patients who are able). One patient reported that RML staff came to his home to check on him periodically and showed him some tips for **wound care** that proved very valuable. In addition, patients described a "red book" provided by RML with information and contacts for therapy, medications, exercise, and supplies. The patient

described it as "an extremely helpful **roadmap**." Another patient said his **transition from RML to a rehab facility was seamless** because the doctor was on staff at both facilities.

Key Informant Interviews – March 3 + 4, 2016

The key informant interviews with RML staff echoed many of the key issues that were identified in the staff focus group and the care coordinators focus group. One interview included team members from an RML post-discharge follow-up project initiated in January 2016; and a second interview was conducted with a physician from the RML Chicago campus. The participants said that they are most effective at their jobs when there is **communication** between departments; they pointed to the staff "huddle" as an example, when all disciplines gather before a shift to discuss the patients for five minutes. When asked about challenges and barriers for RML staff, interviewees described fragmented **electronic medical records**, which can result in duplication of services; family or patient **resistance to recommendations** regarding treatment; and shortage of staff for care coordination. Staff described the greatest challenges for patients and families as they transition out of RML as **managing expectations** (quality of life, quality of care) and the **financial burden** of long-term care. The participants were asked to identify some population-based strategies to reduce the need for hospitalization. The areas they identified were: **education and health literacy**; holding **insurance companies** accountable; and addressing **root causes** of poor health (such as poverty and lack of access to healthy foods). The interviewees noted that **support systems** (community, family, and friends) and **end of life planning and care** are the two greatest ways to improve quality of life for RML patients and their families. Staff discussed important partners and relationships for RML such as: increasing communication between providers; developing a **SNF network**; developing **patient advocacy groups** more specific to Chronically Critically Ill (CCI) and respiratory patients; and doing more **outreach at community-based organizations** and businesses.

Health Impact Collaborative of Cook County - Central Survey Results

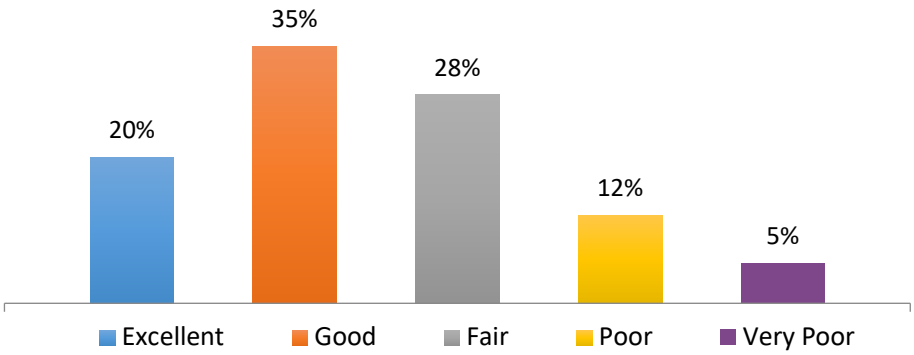
As described earlier, RML has joined the Health Impact Collaborative of Cook County (HIC-CC) to partner with other hospitals and health departments to identify and address priority health issues in Cook County.

The HIC-CC gathered community input through various means, including a community resident survey. By leveraging the networks of the Collaborative partners, approximately 5,200 resident surveys were collected through targeted outreach to the most vulnerable communities across the city and county, including 1,200 in the Central Cook County region.

The survey responses paralleled many of the themes that emerged from the RML focus groups and interviews. Overall, respondents rated their communities as "good" or "fair" places to grow old. Transportation, in terms of cost, convenience, and reliability, was rated fair to good. Some Central Cook communities are dealing with low wages, high unemployment, and community violence. The number one stressor in day to day life was "financial situation," followed by "health of family members" and "time pressures." Almost 30% of survey respondents from the Central region indicated that they or a family member put off or did not seek medical care because of cost. The survey results point to some of the reasons Central Cook residents may have trouble accessing care and how caring for family members' health is a source of stress for many individuals.

Detailed results are in Appendix C.

Figure 23. How would you rate your community ... as a place to grow old? (n=987)



Seventeen percent of respondents rated their communities as poor or very poor places to grow old, while 28% felt their communities were fair places for aging.

Other Planning Efforts Related to Public Health, Older Adults, and CCI Patients

There are other organizations and collaborations in the RML service area that are working on health planning and programming related to older adults and CCI patients. The following provides a brief overview of plans and programs that have emerged to assist the aging population. More details are provided in Appendix C.

Figure 24a.

Age Options (Suburban Cook County Agency for Aging) Fiscal Years 2016-2018 Area Plan on Aging	
2016 Needs Assessment	**Initiatives**
Transportation	Aging and Disability Resource Center
Affordable Housing	Advocacy
Mental Health Needs	Caring Together, Living Better
Basic Needs	Diabetes Self Management
Home Services	Economic Security Initiative
Taxes	Hospital Transitions
Walkability of Communities	Long-Term Support Choices
Managed Care	Make Medicare Work Coalition
	Re-Imagining Aging for 2030
	Suburban Elder Justice Coalition
	Senior Health Assistance Program (SHAP)
	Senior Health Insurance Program (SHIP)
	Senior Medicare Patrol (SMP)
	Take Charge of Your Health
	Targeting Linguistically & Culturally Isolated Individuals
	Veterans Independence Program

Figure 24b.

Chicago Area Agency on Aging Services	
Program	**Description**
Assisted Living Information	A comparison of different living arrangements for Seniors in the City of Chicago
Benefits and Services	Links Chicago residents age 60 and better to more than 70 city, state and federal benefits to which they may be entitled.
Caregiving Assistance	Offers a variety of programs and services for families who are caring for their older loved ones.

Insurance Counseling for Seniors	Volunteer counselors with Senior Health Insurance Program (SHIP) offer free, one-on-one insurance counseling at our Regional Senior Centers.
Regional Senior Center	Each Regional Center reflects the cultural diversity of the City of Chicago.
Satellite Senior Centers	Keep Chicago's neighborhoods active, accessible and affordable for Chicago's senior population, and provide services, programs and activities closer to seniors on the neighborhood level.
Senior Related Literature	Individuals can place a request for an older person or caregiver to receive information about the services offered by the Chicago Department of Family & Support Services.
Seniors Services Information and Assessment Assistance	Access information on all the programs Family and Support Services has to offer for Senior Information and Assistance.
Senior Well Being Check	This service request is used to identify seniors whose health, safety or general well being are in question.

Figure 24c.

Priority Issues for Local Hospital Collaboratives	
Healthy Chicago Hospital Collaborative	**Health Impact Collaborative of Cook County**
Access to Care (Transportation)	Social and Structural Determinants of Health
Mental Health	Access to Care and Services
Obesity	Behavioral Health/Mental Health
	Chronic Disease

Continuing to work in partnership, building new partnerships with other community stakeholders and actively participating in the existing local hospital collaboratives will provide RML with opportunities to make an impact on the priority issues selected based on the CHNA. Further, gathering additional community input during planning and implementation will also help RML to design activities that meet community-specific needs, address barriers and leverage existing community assets in order to effectively address priority issues and improve health for the community that RML serves.

Priority Issues

Following data collection and presentation of key findings, the CHNA Advisory Council discussed the results and identified emerging priority health issues for the communities RML serves.

The following issues were identified based on a review of all data:

A. Access to Care and Community Services
- Coordination of care
- Hospice and Palliative Care
- Cultural and Linguistic Competency
- Health Literacy
- Ensure patients have a Medical Home
- Navigating Insurance and Healthcare System
- Support Services at Home

B. Behavioral Health/Mental Health

C. Chronic Disease Prevention and Management

D. Injury Prevention/ Safety

E. Low Income/Poverty

F. Support for Caregivers/Families of Chronically Critically Ill Patients

G. Support for Growing Older Adult Population

H. Transportation

During the second Advisory Council meeting, the list of issues was presented and discussion was solicited by IPHI to further solidify the understanding of the issues and provide an opportunity for any additional issues. No additional issues were identified. IPHI also provided the Advisory Council with a set of prioritization criteria based on criteria used during the previous RML CHNA process (see Figure 25 on page 33). IPHI facilitated a consensus building workshop for identifying top issues by breaking Advisory Council members into small groups to prioritize the issues using these criteria.

Figure 25. Prioritization Criteria

Population Characteristics

Prevalence of the problem: Is this a common occurrence in our communities?
Seriousness of the problem: What is the severity of the impact on individual, family and community?
Disparities: Is one or more population disproportionately affected, particularly the low income and most vulnerable members of the community?
Important to the community: Is there evidence that the issue is important to diverse community stakeholders?

Internal and External Resources

Available expertise: Can we make an important contribution?
Feasibility: Do we have the internal resources, including money, people, and expertise? Alternatively, are there potential external resources that we can partner with? What time constraints do we need to be aware of?
Alignment with RML mission and strategic priorities: Is this consistent with our mission and who we are as an organization?

The prioritization exercise yielded the following top strategic issues:

- Coordination of Care
- Health Literacy
- Navigating Insurance and Healthcare System
- Support Services at Home
- Behavioral and Mental Health
- Chronic Disease Prevention and Management[7]
- Support for Caregivers
- Transportation

Following the discussion and prioritization exercise, the Advisory Council continued working in small groups and brainstormed potential approaches to address these issues. For each priority issue, Council members considered the following:

- What are potential strategies to address the issue?
- Who are important partners in this work?

RML will take the Advisory Council suggestions into consideration as the implementation plan is developed. Listed below are the potential strategies shared by the Advisory Council members.

[7] While RML Specialty Hospital is primarily engaged in chronic disease management, it supports the local hospital collaboratives' work around chronic disease prevention.

Figure 26. Potential Strategies

Coordination of Care

1. Develop a Chronically Critically Ill Action (CCIA) Team: Bring together hospitals, home health, SNFs, and community groups to share best practices, look at issues, and collaborate to implement ideas.
2. Facilitate a warm hand off with patients, physician to physician, to improve continuity of care.
3. Create a portal to facilitate better communication between levels of care; something like the Illinois Health Information Exchange (IHIE)
    a. Barrier: There is no funding for IHIE.
    b. Barrier: Metropolitan Chicago Healthcare Council started an HIE but the technology partner has pulled out due to financial problems.
4. Share information and use the same language to communicate with patients at all levels of care.

Health Literacy

1. Standardize education materials used by RML and partners provided to patients to improve health literacy.
2. Ensure consistent messaging from admission to discharge.
3. Provide more access to free community forums on hot button health issues (diabetes, heart, etc.) at senior centers, SNFs, etc. Make events open to the public.
    a. Present information at an understandable level.
4. RML could speak at some senior centers and other community gatherings about common health issues for the community.

Navigating Insurance and Healthcare System

1. Develop relationships with insurance companies (MCOs)
2. All MCO's and MMAI have a budget for education. Create a "train the trainer" program. RML staff can guide patients through the nuances of insurance.
    a. Prevent frustration for patients.
    b. Improve compliance and follow-up.
3. Increase efficiency within the navigation of the system.
4. Develop more patient education tools, similar to the "red book" from RML. Translate insurance company guides since they are not easily understood. Create a "roadmap" for patients.

Support Services at Home

1. Create patient portals connecting medical records from beginning to end. All providers could be connected and all information could be in one place so that the patient could access portal from home.
2. Provide more respite care and more affordable care services at home.

3. Provide more access to equipment by creating lending closets, recycling old equipment, and reaching out to former patients/families for used equipment.
    a. Helps families get rid of equipment they are not using.
    b. Helps families get equipment that is deemed a "luxury item" by insurance companies.
4. Look into policy changes to reduce waste of medications.

Behavioral and Mental Health

1. We should clarify what behavioral health information can be shared between levels of care to better treat psychiatric needs. Different levels of care have psychiatric care but it is segmented. Information is not passed on to the next level of care.
2. Impact policies related to mental health. Join collaboratives working on this issue.
3. Research available Behavioral Health and Mental Health Services and share what is available and how to access.

Chronic Disease Prevention and Management[8]

1. Utilizing the existing structure in the community, create tutorials and develop, train, and educate church leaders, senior groups, and other community groups on the importance of diligent disease management.

Support for Caregivers

1. Improve caregiver health literacy.
2. Create hospital support groups targeted toward health literacy.
    a. Previous RML sponsored support groups were not well attended.
    b. Combine health education with information about respite care; invite caregivers to meet home health agencies, etc.
3. Ensure community gets better access to what is already available.

Transportation

1. Map all support that is available for transportation (insurance, PACE, community organizations, etc.)
2. Connect Medicaid transportation to ridesharing opportunities.

[8] While RML Specialty Hospital is primarily engaged in chronic disease management, it supports the local hospital collaboratives' work around chronic disease prevention.

Implementation Plan

An internal work group examined the top priorities and potential initiatives identified by RML's CHNA Advisory Council. In developing the 2016 CHNA Implementation Plan, the work group had three main considerations:

1. Build upon the progress and effectiveness of initiatives contained in the 2013 CHNA Implementation Plan (see update later in this section).
2. Include strategies that would benefit the entire community rather than just RML patients.
3. Focus on strategies RML could implement as a small organization with limited resources that would be most effective in improving the health of RML's community.

From the potential priorities identified by the CHNA Advisory Council, the internal work group settled on three areas – Coordination of Care, Chronic Disease Management, and Transportation – that would be the focus of RML's implementation efforts. The other areas would be pursued as opportunities arise.

Figure 27 summarizes the initiatives that will be pursued by RML:

Figure 27. Priorities and Initiatives

Top Priorities	Initiatives
1. Coordination of Care	1a. Develop a Chronically Critically Ill Action Team. 1b. Create a portal to facilitate better communication between levels of care.
2. Chronic Disease Management	2. Continue efforts to study and better manage disease progression of CCI patients.
3. Transportation	3. Continue participation with Healthy Chicago Hospital Collaborative to develop transportation options for patients and families to attend physician visits.

Other Potential Areas of Focus	
Health Literacy Navigating Insurance and Healthcare System Support Services at Home Support for Caregivers Behavioral and Mental Health	4a. Standardize educational materials used by RML and partners. 4b. Continue participation with Healthy Chicago Hospital Collaborative to partner with United Way to educate patients and families about insurance options. 4c. Participate in regional Health Information Exchange (HIE) and/or create patient portals for access to medical records. 4d. Participate in Health Impact Collaborative of Cook County initiative to increase access to care and community resources. 4e. Create "lending closet" to increase patient access to equipment.

RML's Administrative Council approved the CHNA Implementation Plan on November 9, 2016. RML's Board of Directors approved the CHNA Implementation Plan by unanimous vote on November 15, 2016.

Update on 2013 Implementation Plan

RML's 2013 CHNA Implementation Plan was approved by the RML Board of Directors on September 11, 2013. The following is a summary of the progress made against the initiatives contained in the 2013 CHNA Implementation Plan since that time. Details can be found in Appendix D.

Priority #1: Patient / Family Knowledge of Disease Process

Initiative 1A - Develop quality educational materials.
Significant Progress

Initiative 1B - Provide support and information after discharge.
Significant Progress

Priority #2: Palliative Care and Hospice

Initiative 2A - Build awareness of palliative care and hospice services.
Some Progress

Initiative 2B - Participate in Project PREP / CPC - Palliative Care and Hospice.
Completed

Priority #3: Communication around Transitions and Handoffs

Initiative 3A - Participate in Project PREP / BOOST - Patient Discharges.
Completed

Initiative 3B - Apply for CMS Innovation Grant.
Completed

Initiative 3C - Identify high-quality discharge locations.
Significant Progress

Initiative 3D - Build community connections.
Moderate Progress

Initiative 3E - Work closely with patients' primary care physicians.
Significant Progress

Initiative 3F - Provide assistance with transitional care and respite care.
No Progress

Priority #4: Cost of Accessing Medications and Supplies

Initiative 4A - Work with Senior Service Centers
No Progress

Priority #5: Caregiver Stress

See Initiatives 1A, 1B, 3D, 3F

Reflections on CHNA

The Community Health Needs Assessment (CHNA) process provides a unique opportunity to engage a cross-section of RML departments and community partner agencies in looking at the community and discussing collaborative ways to improve the health and quality of life for the community.

RML continues to learn about the needs of the communities it serves through the process. RML's Chief Operating Officer and the Director of Care Coordination worked diligently to put together a committed Advisory Council. The Advisory Council provided a chance for people working in different RML departments to think collaboratively with representatives of the community, including partner agencies and former patients, about the needs of the community served by RML. These community representatives brought invaluable insights and ideas to the Advisory Council's discussions.

RML identified several keys to the successful completion of its CHNA that can be of use for other LTCHs and post-acute providers:

- Define a community that makes sense for the LTCH;
- Put together a committed Advisory Council;
- Establish clear roles and reasonable expectations for the Advisory Council and internal stakeholders in the CHNA process;
- Ensure that meetings are well-planned and professionally facilitated in a focused and interactive manner for maximum effectiveness as the stakeholders gathered often have limited time to contribute to such a process; and
- Be flexible in designing community input processes from a community that is dealing with severe medical conditions and extremely limited in its ability to participate.

A few lessons learned in compiling the **Community Health Profile**:

- The local health departments and Area Agencies on Aging are good partners for accessing data.
- Data on the Chronically Critically Ill (CCI) population is currently limited but there may be more data for this population in the near future.
- Advisory Council members are important resources in identifying relevant health indicators and data sources.
- RML recognizes that the Community Health Profile will be of interest and utility for many community groups, and the report was designed to be accessible to a public audience.

A few lessons learned in gathering **Community Input**:

- There is minimal existing secondary data for RML's community which makes community input data crucial for identifying needs and assets and arriving at priority issues.
- Gathering community input from former LTCH patients and family members is challenging, making flexibility in designing the methods for gathering community input essential.

The CHNA process and the community input data that was gathered reinforced the struggles faced by the patient population and community served by RML. Of particular note are the challenges with coordinating follow-up need and thriving at home after a prolonged, debilitating illness. It is apparent that the community resources available to support patients and families are disjointed, not well publicized, and not universally available due to budget cuts, cost, coverage and geographic constraints.

Engaging in this comprehensive CHNA process has led RML to develop partnerships to address the needs faced by the communities served. RML looks forward to continuing this work and expanding engagement with the community.

Approval

The RML Board of Directors approved the Community Health Needs Assessment by unanimous vote at its meeting on May 23, 2016. The Board approved the Implementation Plan on November 15, 2016.

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Appendix A: List of Advisory Council Members

Name	Affiliation
Armand Andreoni	Loyola University Health System, Strategic Analytics & Community Benefit
Cheryl Anderson	RML, Post Acute Project
Collins Fitzpatrick	RML, Physician
Cres Morta	RML Chicago, Rehabilitation Services
Dale Hengesbach	RML, Post Acute Project
Erica Salem	Health & Disability Advocates, Strategic Health Initiatives
Joseph Copeland	Former RML Patient
Karen Finerty	RML, Quality
Karen Reaume	RML, Patient Care Services
Kathleen Mikrut	RML, Pharmacy
Ken Pawola	RML, Operations
Linda Sassone	Rehabilitation Institute of Chicago, Case Management Lead
Martin Sliva	Former RML Patient
Marvin Javellana	Better Care Home Health, CEO
Mary O'Connor	RML, Care Coordination
Menai Edwards	RML, Retention & Recruitment
Michelle Mertens	Rehabilitation Institute of Chicago, Liaison
Michelle Stuercke	Glens SNF, Chief Nursing Officer
Pat O'Dea-Evans	Advocate Health Care, Post-Acute Network SNF Program
Peter Buttitta	RML Chicago, Chaplain
Scott Barron	RML Hinsdale, Chaplain
Sharon DeShazer	RML, Quality Improvement
Stacy Lindahl	RML, Case Management

Appendix B: Community Health Profile

Community Health Profile

RML Hinsdale

Chicago, Suburban Cook County, DuPage County, and Will County

Prepared by the Illinois Public Health Institute and

RML Specialty Hospital

Community Health Profile – RML Hinsdale

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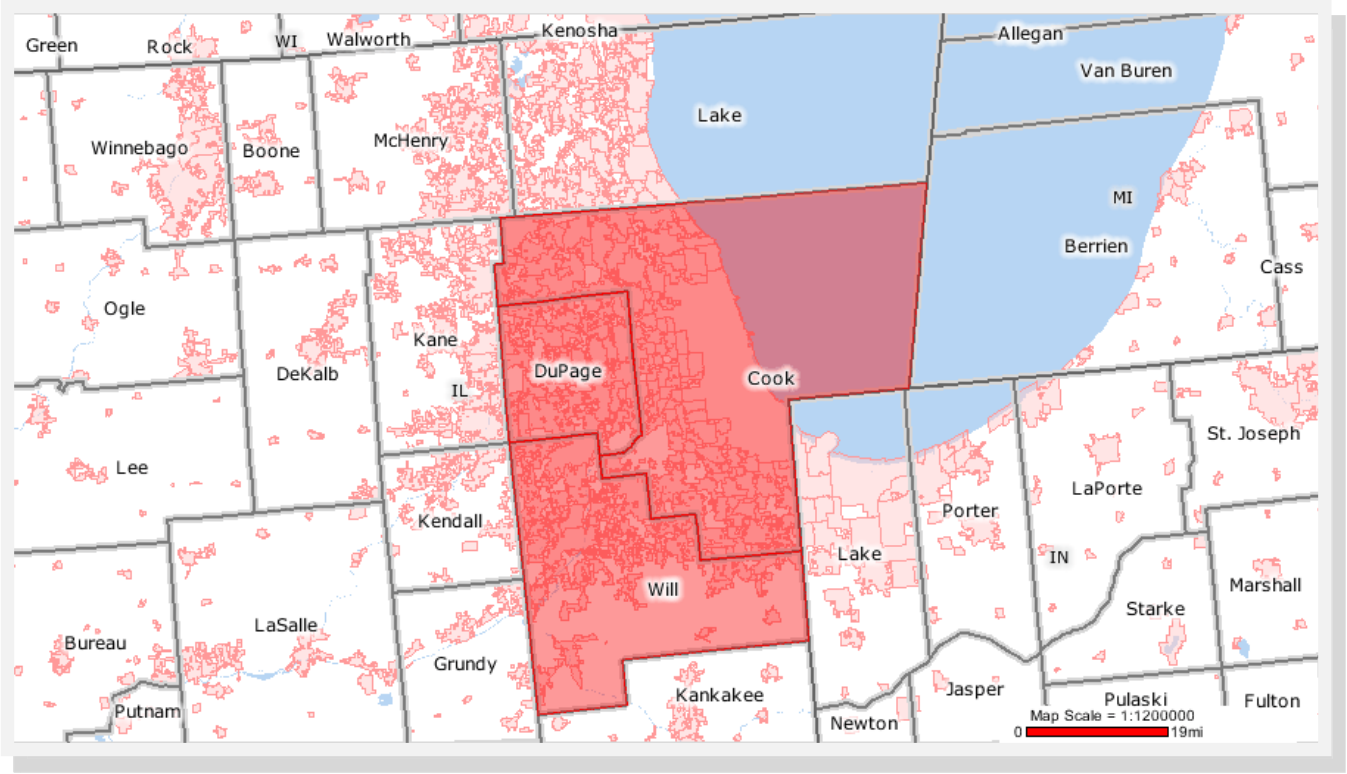
RML Hinsdale CHNA Community

RML Hinsdale's community: People in Chicago, Suburban Cook County, DuPage County and Will County who have suffered a severe, life-changing, debilitating illness requiring extensive psycho-social and health support services when they return home. As the elderly and low-income are most unlikely to have the resources to adapt well to these circumstances, we will focus on these populations.



Methods & Data

For the Community Health Profile, RML collected data from a range of secondary sources. The Illinois Public Health Institute helped in identifying the data sources and collecting, analyzing and presenting the data. RML was fortunate to be able to access data from local health departments (Chicago, Cook County, DuPage County, Will County) for many demographic and health status indicators. Other sources include:

- United States Decennial Census
- American Communities Survey (ACS)
- Centers for Disease Control and Prevention (CDC)
- Illinois Department of Public Health (IDPH)
- Illinois Department of Healthcare and Family Services (HFS)
- Heartland Alliance Social Impact Research Center
- Dartmouth Atlas of Health Care
- Henry J. Kaiser Family Foundation
- Health Indicators Warehouse
- City of Chicago Data Portal
- Impact DuPage
- RML Internal Records

Notes on data:

- While the Decennial Census is taken every 10 years, the American Community Survey (ACS) is a more detailed instrument given by the Census Bureau every year to a smaller sample of the population. In order to provide more accurate population data from a smaller sample, ACS data is averaged over a period of years. In this community health profile, we report data from the 2009-2013 and 2010-2014 ACS.

- To the greatest extent possible, all data for a given indicator are presented for the same time period. However, in some cases data at the local, county and national level are not reported for the same time period. In cases where the time periods on a graph do not match up exactly, a notation is included to identify the different years. These variations should be considered when making comparisons.

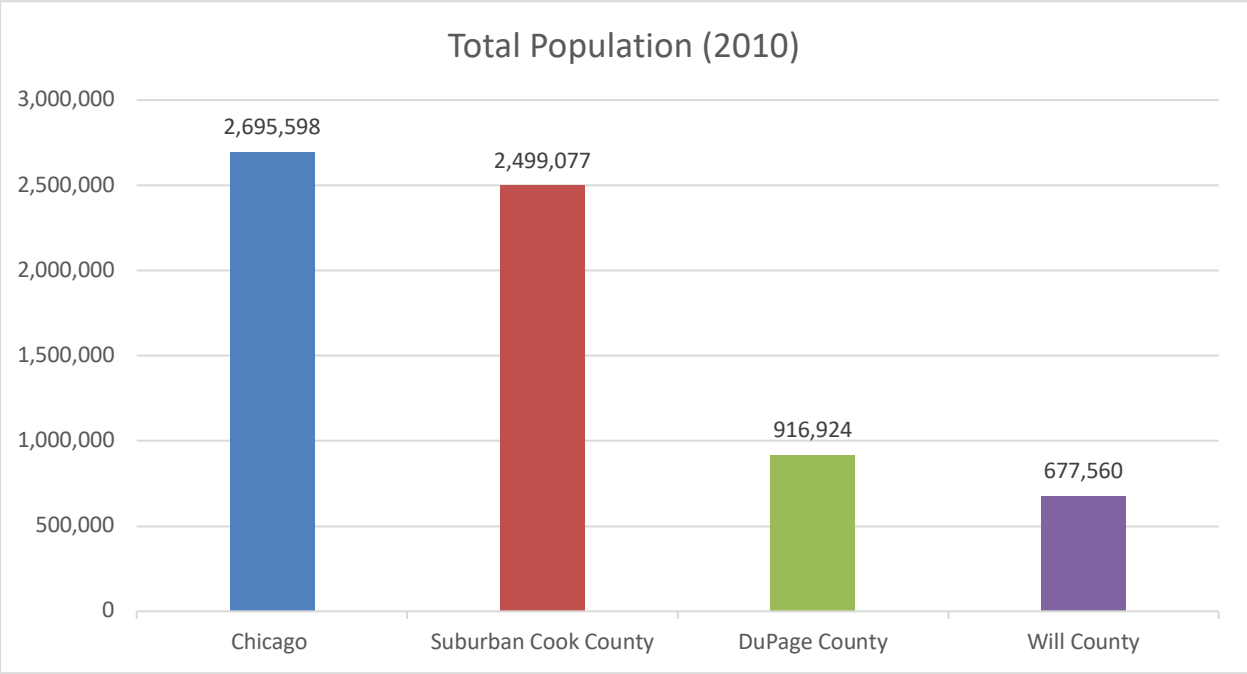
- The focus of the data indicators is on RML Hinsdale's community, defined as: People in Chicago, Suburban Cook County, DuPage County and Will County who have suffered a severe, life-changing, debilitating illness requiring extensive psycho-social and health support services when they return home. As the elderly and low-income are most unlikely to have the resources to adapt well to these circumstances, we will focus on these populations.

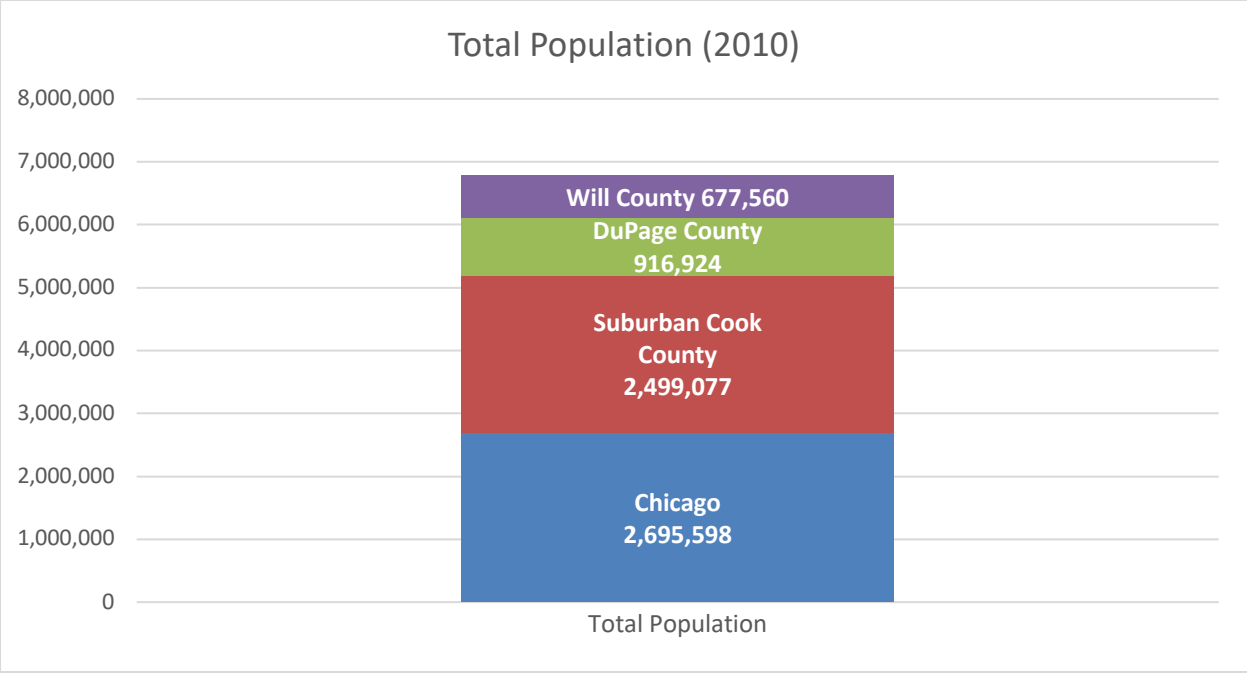
- There is limited data available for chronically critically ill (CCI) patients. The Dartmouth Atlas of Healthcare has some CCI indicators at the Hospital Referral Region (HRR) level, which we report in the community health profile.

Demographic Indicators

Total Population

As of 2010, the total population of the communities outlined in the Community Health Needs Assessment is 6,789,159. The most populous county served is Cook County (5,194,675), which includes the city of Chicago (2,695,598) and many other Suburban Cook communities (2,499,077). DuPage County has a population of 916,924 and Will County has a population of 677,560.





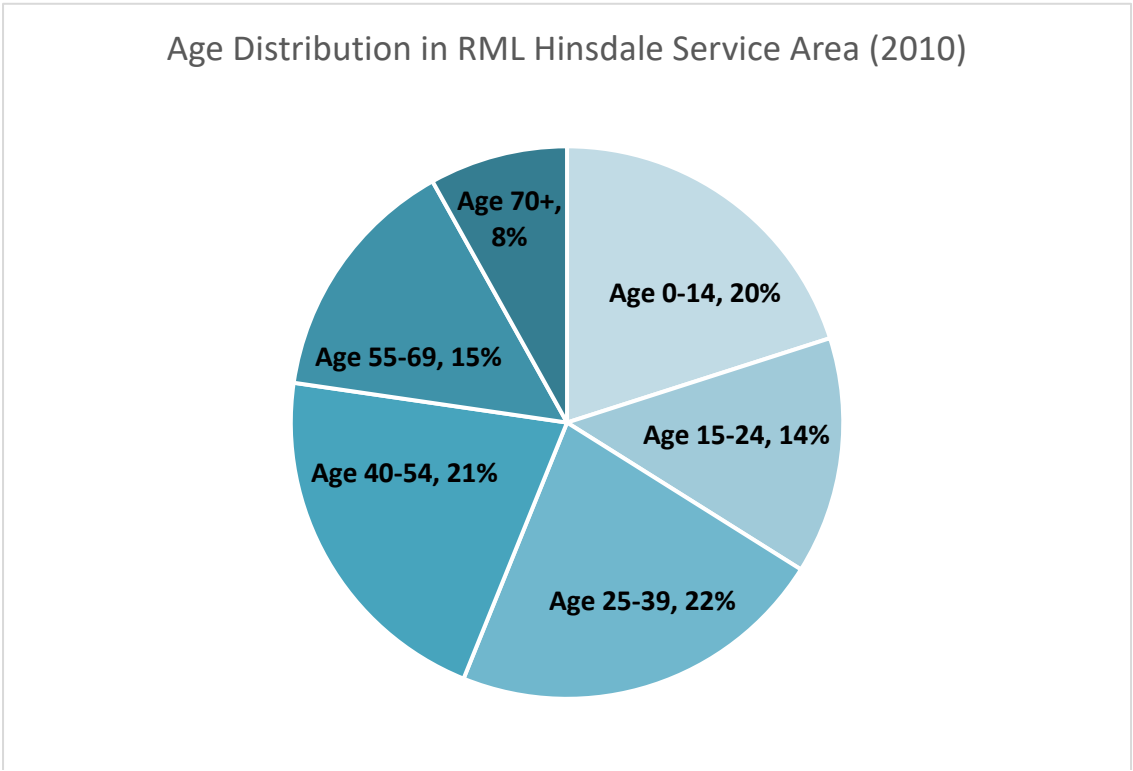
Source: U.S. Decennial Census 2010, DP-1

Age Distribution

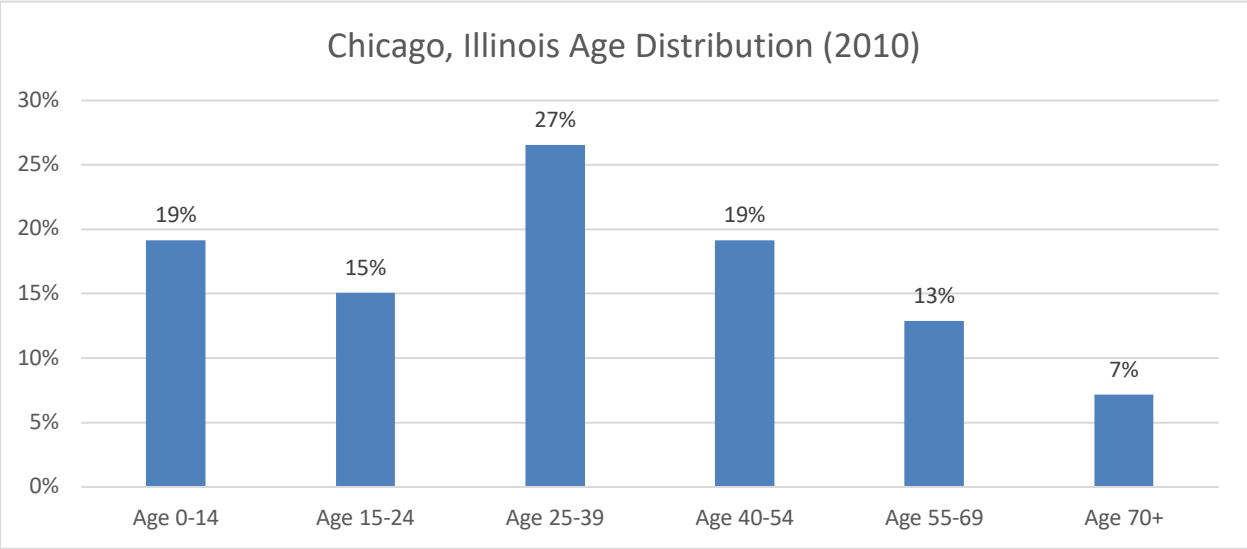
Approximately 23% of the total population in the RML Hinsdale service area is 55+.

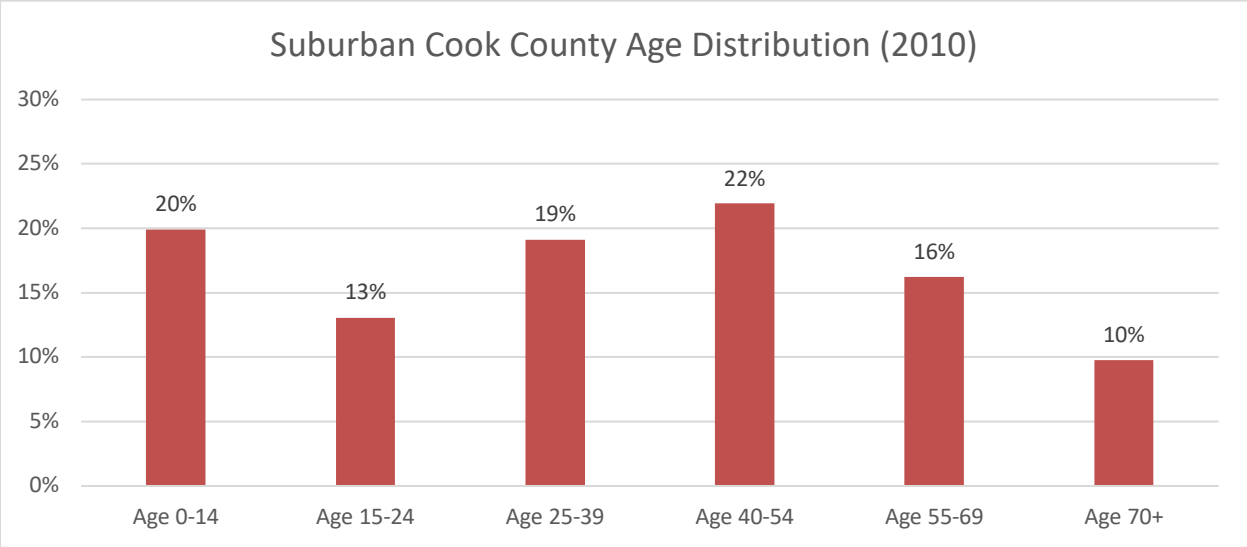
Suburban Cook County and DuPage County have the highest proportion of older adults. 26% of Suburban Cook and 24% of the DuPage County population is 55+. Chicago has the bulk of young adults; 27% of the population is 25-39. Will County has the highest proportion of school age children and youth; 37% of the population is under the age of 25.

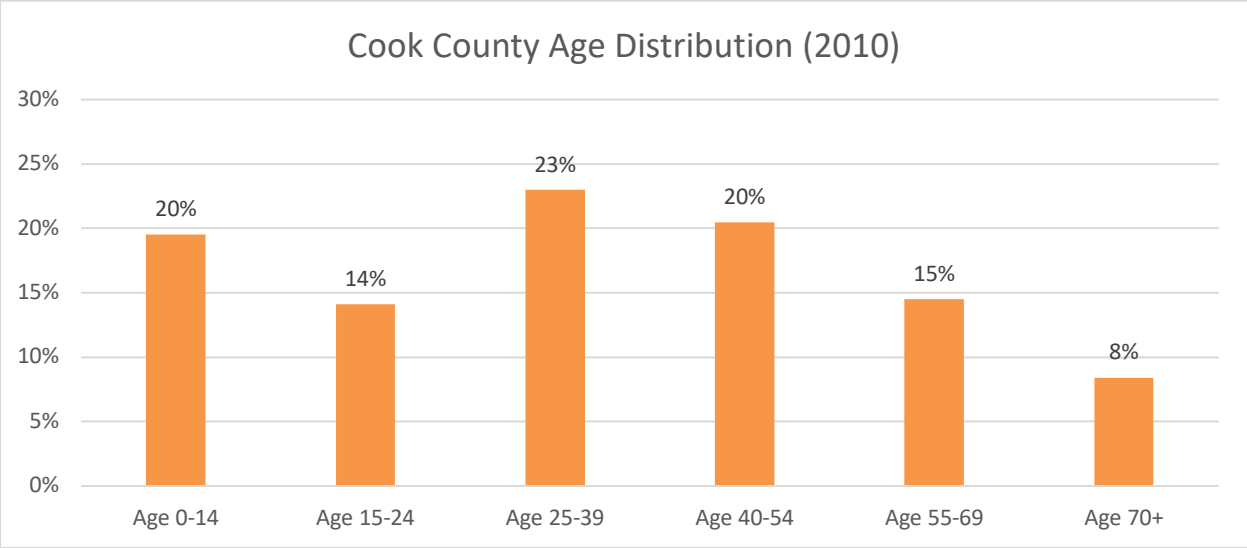
Age Distribution in RML Hinsdale Service Area (2010)				
	Chicago	**Suburban Cook County**	**DuPage County**	**Will County**
Age 0-14	19%	20%	20%	24%
Age 15-24	15%	13%	13%	13%
Age 25-39	27%	19%	19%	20%
Age 40-54	19%	22%	23%	23%
Age 55-69	13%	16%	16%	13%
Age 70+	7%	10%	8%	6%



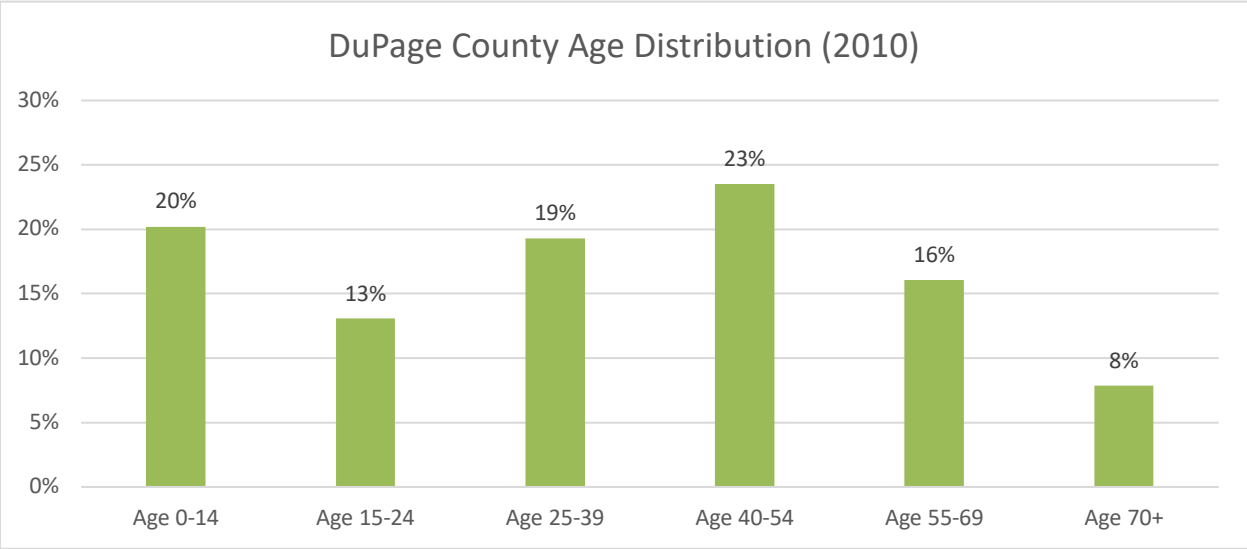
Source: U.S. Decennial Census 2010, DP-1

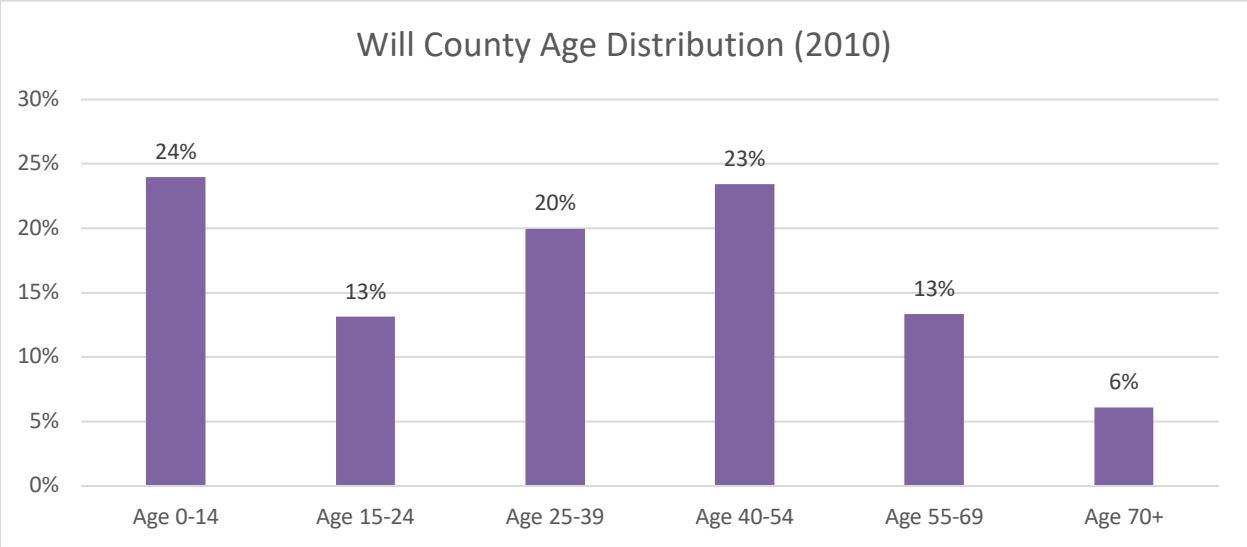


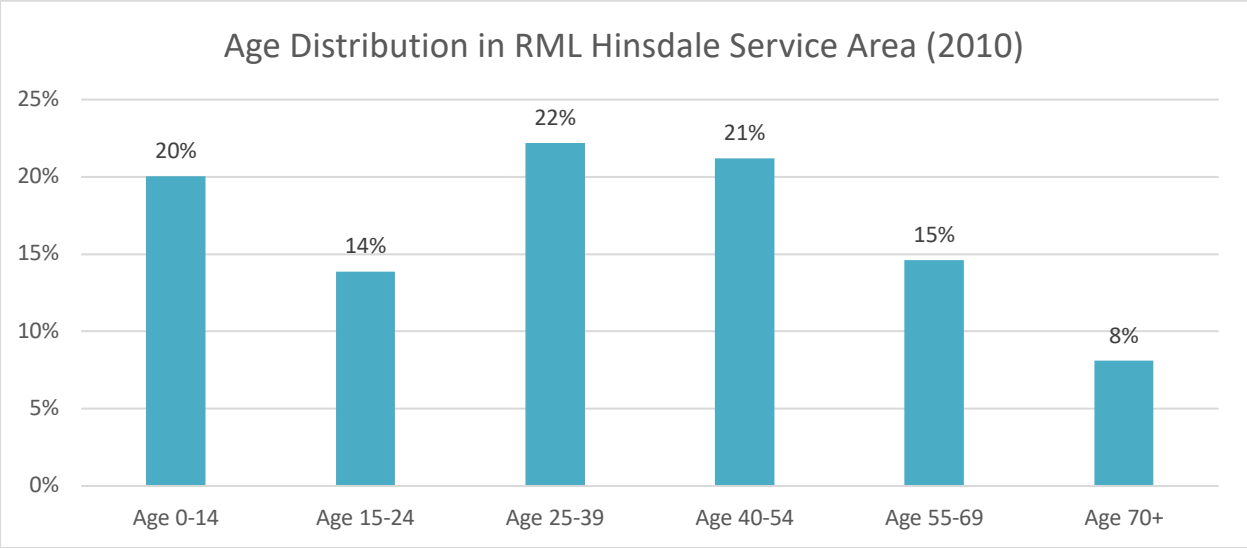




Source: U.S. Decennial Census 2010, DP-1



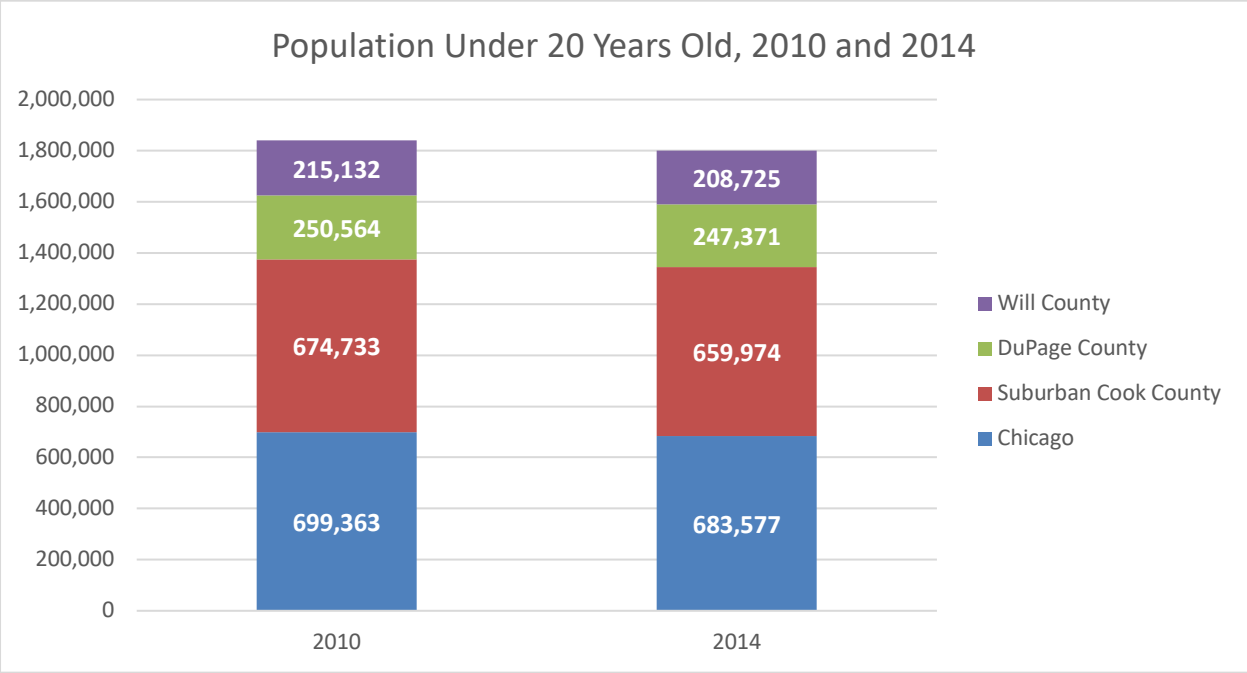


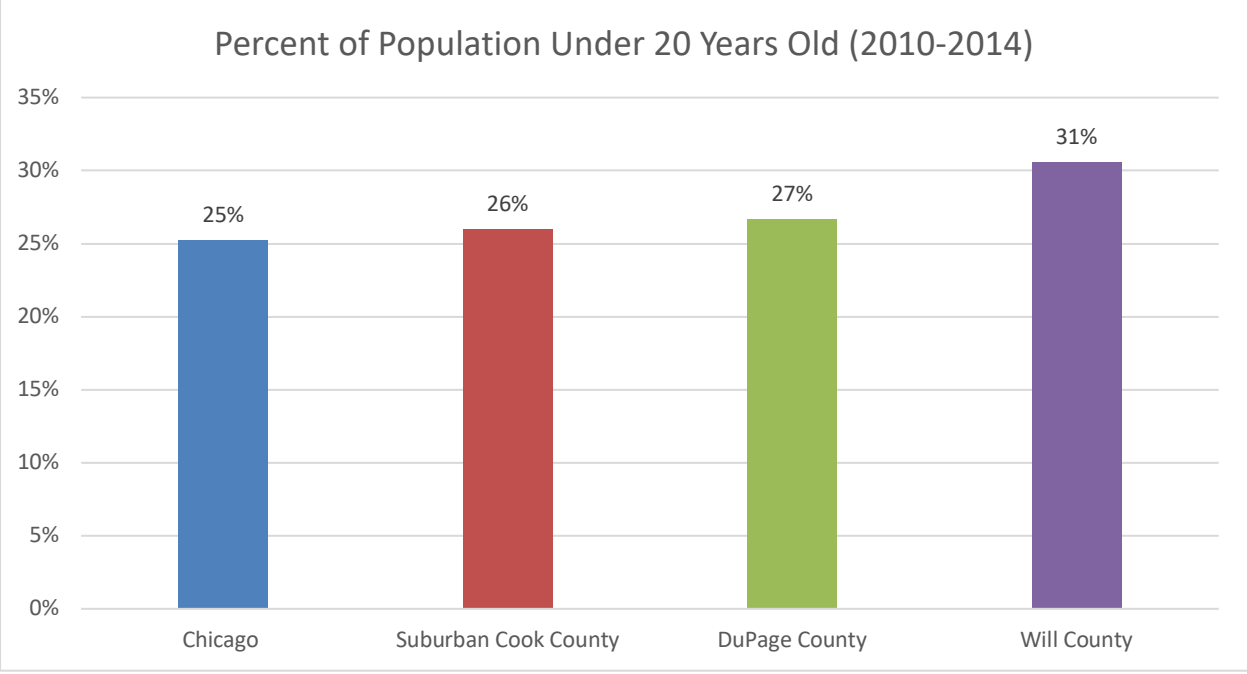


Source: U.S. Decennial Census 2010, DP-1

Population Under 20

The total number of people under 20 in the RML Hinsdale service area is 1,799,648. Individuals under the age of 20 account for 25-31% of the population, with Chicago having the lowest proportion and Will County having the highest proportion of people under 20 years old.

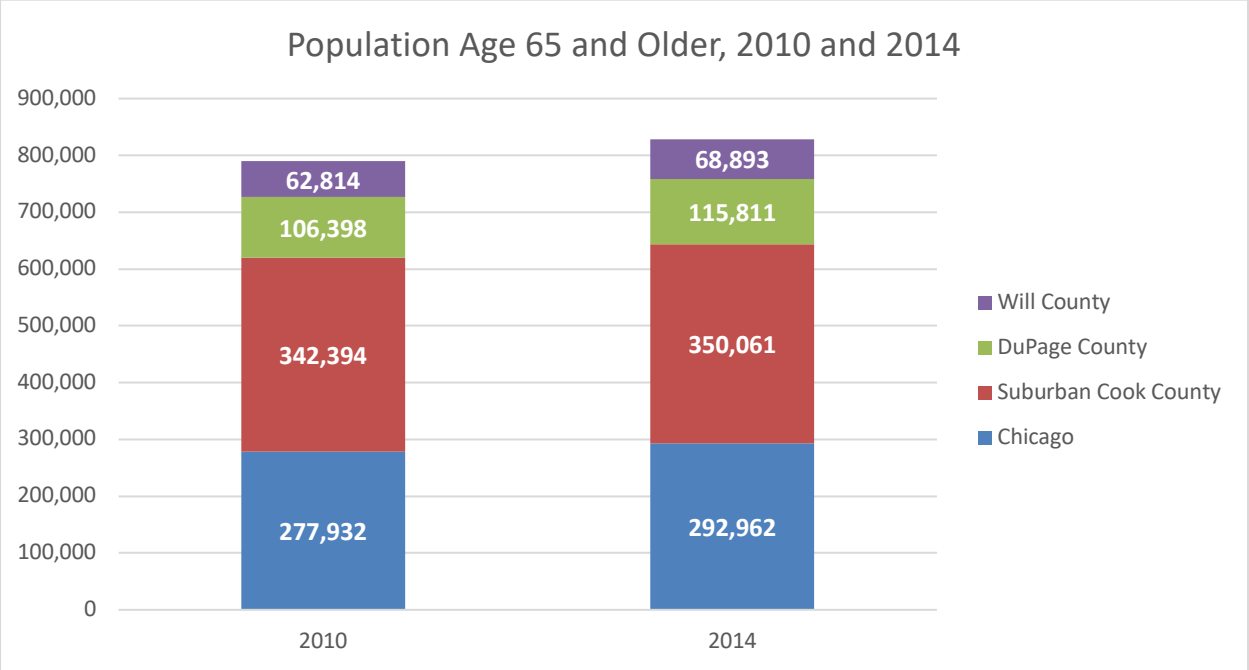


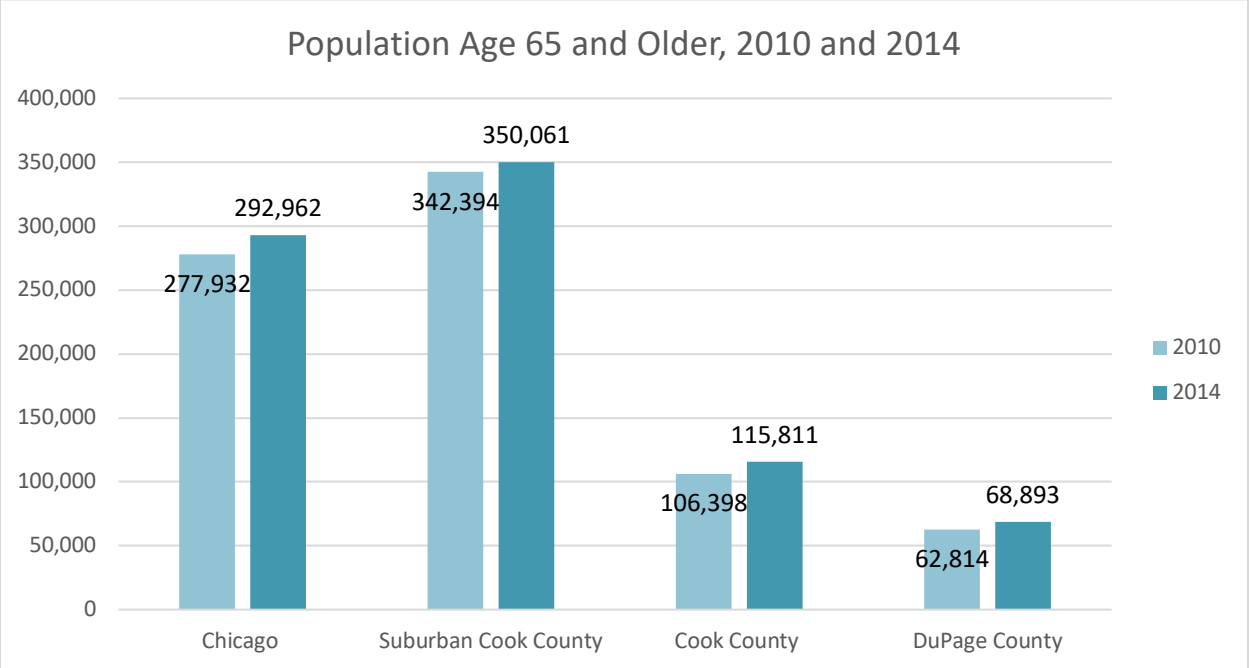


Source: U.S. Decennial Census 2010, DP-1 and ACS 2010-2014, S0101

Population 65 and Older

As of 2014, the total population of seniors age 65 and older in the RML Hinsdale service area is 827,726, with 643,023 (78%) of those seniors living in Chicago and Suburban Cook County. The population of seniors increased by approximately 5% between 2010 and 2014.





Source: U.S. Decennial Census 2010, DP-1 and American Community Survey 2010-2014, S0101

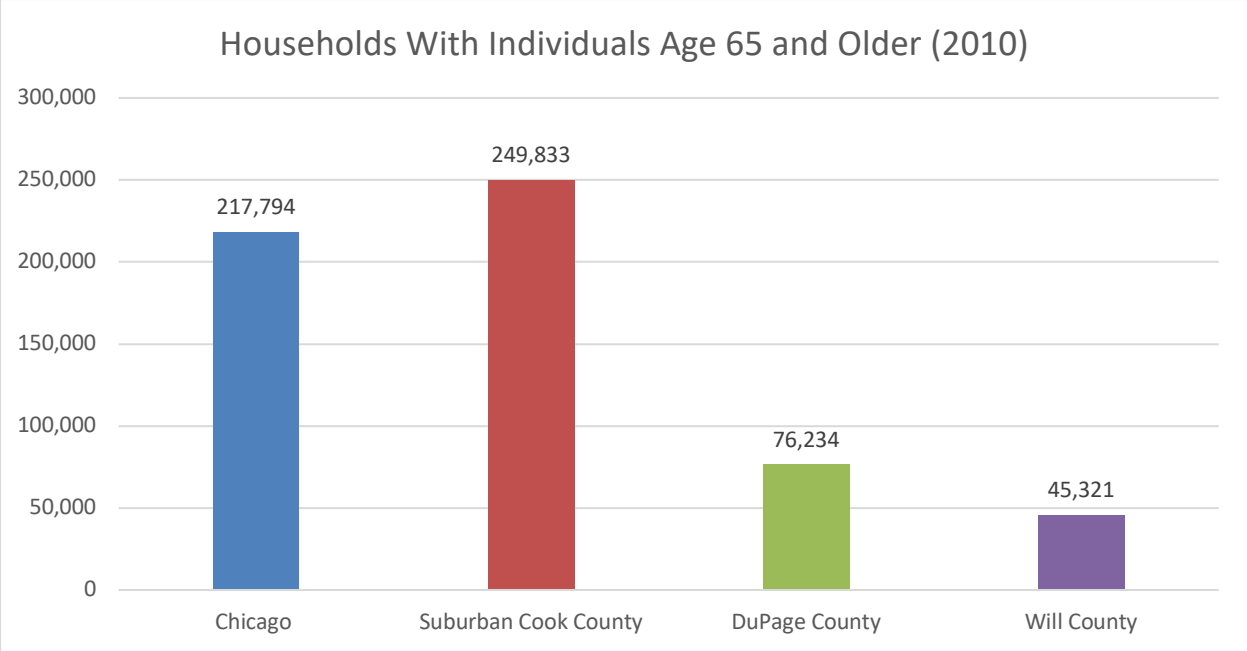
The region has seen a significant increase in the senior population, both in real numbers and as a proportion of the total population. In the RML Hinsdale service area, Will County and Lake County have seen the greatest proportional increase in the senior population from 2009 to 2014 (1.8% and 1.7% respectively). Suburban Cook County has increased its proportion of seniors by .9% and Chicago has increased its proportion of seniors by .4% over the same time period. Suburban Cook County and Chicago have the greatest number of households with seniors (about 470,000).

Proportion of residents age 65 and over, by county

REGION	2000	2005 - 2009	2010 - 2014
Cook County	11.7%	11.7%	12.4%
City of Chicago	10.3%	10.3%	10.7%
Cook County suburbs	13.4%	13.3%	14.2%
DuPage County	9.8%	10.8%	12.5%
Kane County	8.4%	8.6%	10.7%
Kendall County	8.5%	7.4%	7.7%
Lake County	8.5%	9.6%	11.3%
McHenry County	8.0%	9.9%	11.1%
Will County	8.3%	8.4%	10.2%
***CMAP Region**	**10.7%**	**10.9%**	**11.9%**

*CMAP region total also includes Aux Sable, Sandwich, and Somonauk townships.

Source: Chicago Metropolitan Agency for Planning analysis of U.S. Decennial Census data , 2000, and American Community Survey estimates, 2005-2009 and 2010-2014.

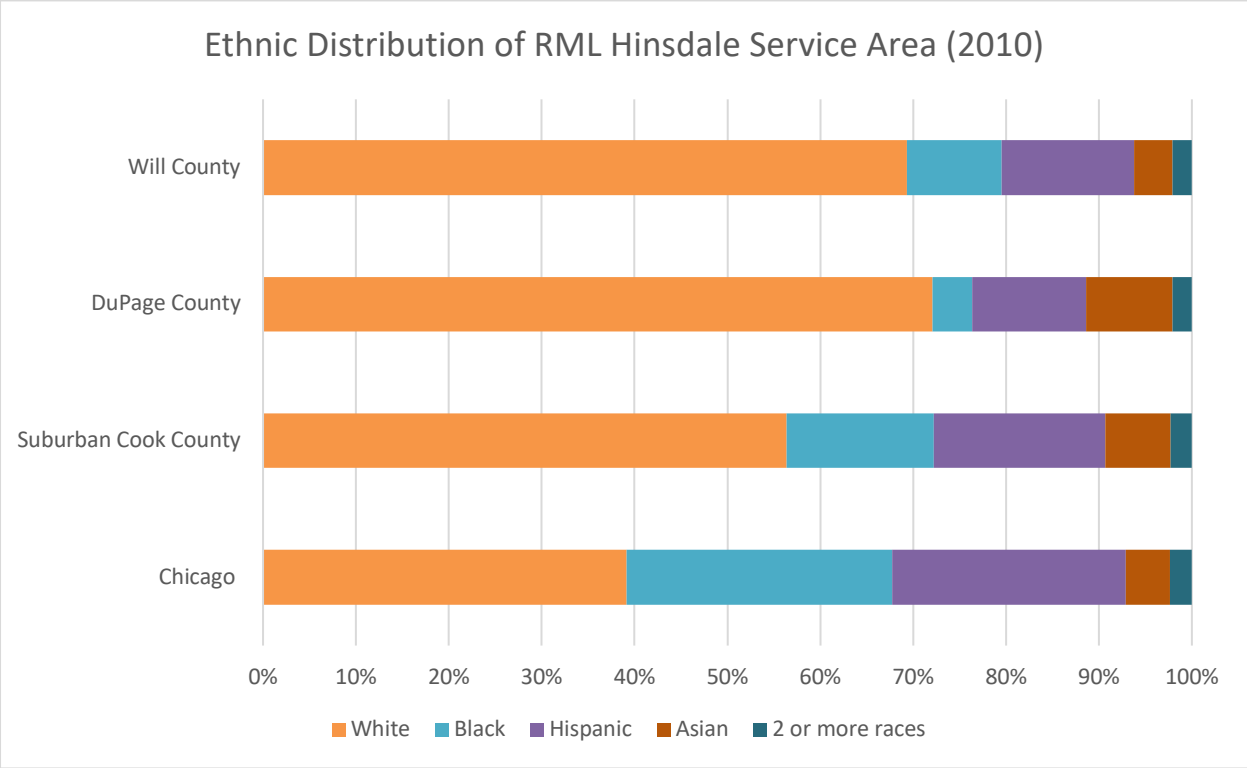


Source: U.S. Decennial Census 2010, DP-1

Race/Ethnicity

White or Caucasian individuals form the largest group in the RML Hinsdale service area. Chicago has a much higher proportion of African American and Hispanic or Latino individuals compared to other areas in the RML Hinsdale service area, and compared to Illinois and the United States overall. DuPage County has the highest proportion of Asian individuals compared to the other areas.

Race & Ethnicity in RML Hinsdale Service Area (2010)						
	Chicago	**Suburban Cook**	**DuPage County**	**Will County**	**IL**	**US**
White / Caucasian	39%	56%	72%	69%	66%	66%
African American	29%	16%	4%	10%	13%	12%
Hispanic / Latino	25%	18%	12%	14%	15%	15%
Asian	5%	7%	9%	4%	4%	4%
Other	2%	2%	2%	2%	2%	3%



Source: U.S. Decennial Census 2010, DP-1

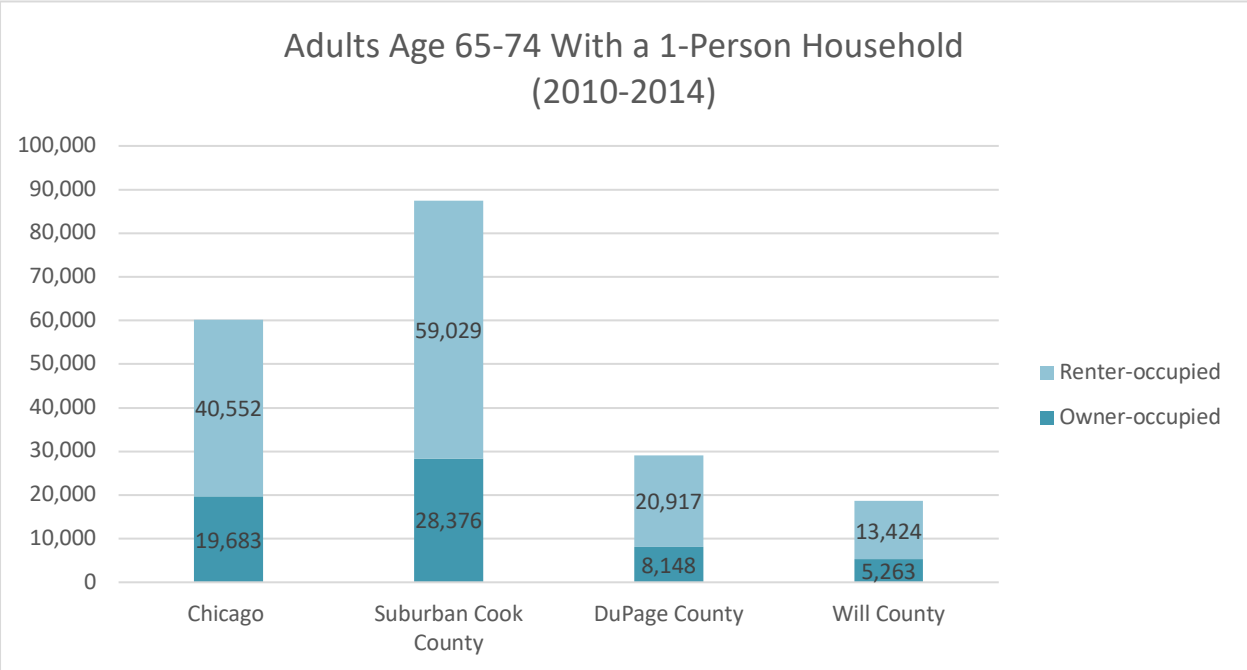
The biggest shift in terms of race/ethnicity in the RML Hinsdale service area was in the White and Hispanic population distribution. The suburban areas experienced a decrease in the proportion of White residents (between 7-10%) and an increase in the proportion of Hispanic residents (between 4-6%). The race/ethnic distribution did not shift as much in Chicago, though it did have a 4% decrease in the proportion of Black residents and a modest increase in the proportion of White, Hispanic, and Asian residents.

Proportional Change in Race/Ethnicity, 2000 to 2010						
	Chicago	**Suburban Cook**	**DuPage County**	**Will County**	**Illinois**	**United States**
White	2%	-10%	-7%	-9%	-3%	-4%
Black	-4%	2%	1%	0%	-1%	0%
Hispanic	2%	6%	4%	6%	3%	3%
Asian	1%	2%	2%	2%	1%	1%
2 or more races	0%	0%	0%	1%	0%	0%

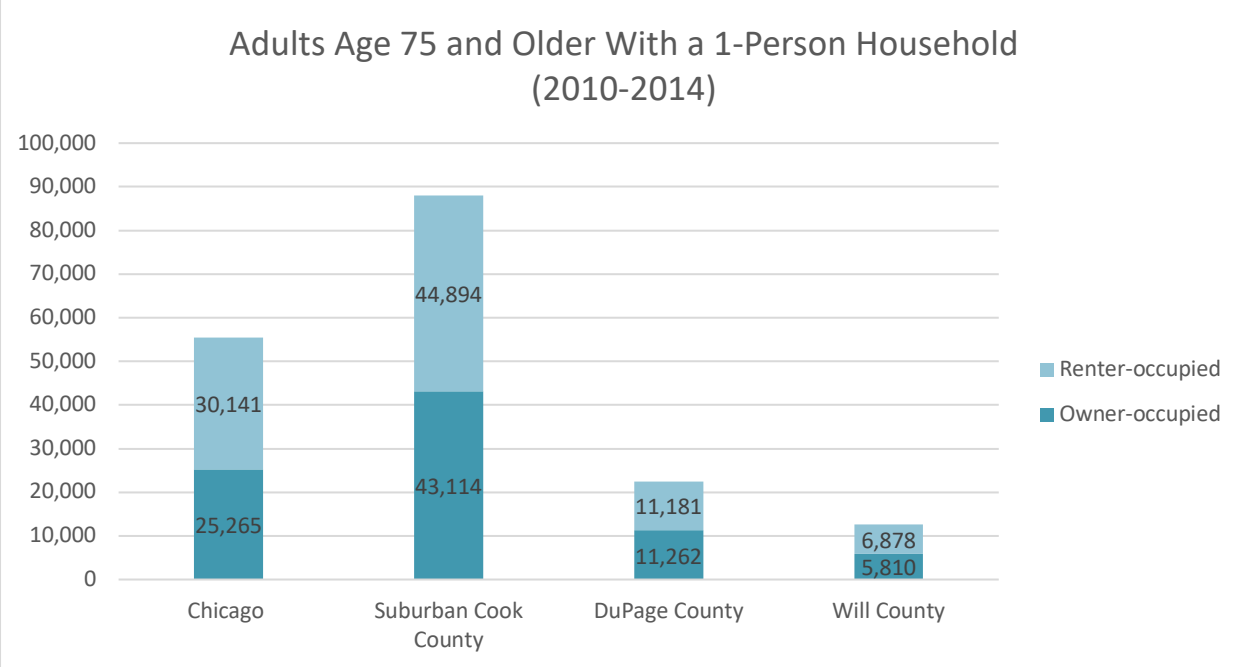
Source: U.S. Decennial Census 2010, DP-1

Ability to Live Independently

Suburban Cook County has the bulk of 1-person households age 65-74. In Chicago and Suburban Cook County, about 1/3 of these households are owner-occupied residences. This rate is lightly lower In DuPage and Will County, where about 28% of these households are owner-occupied.

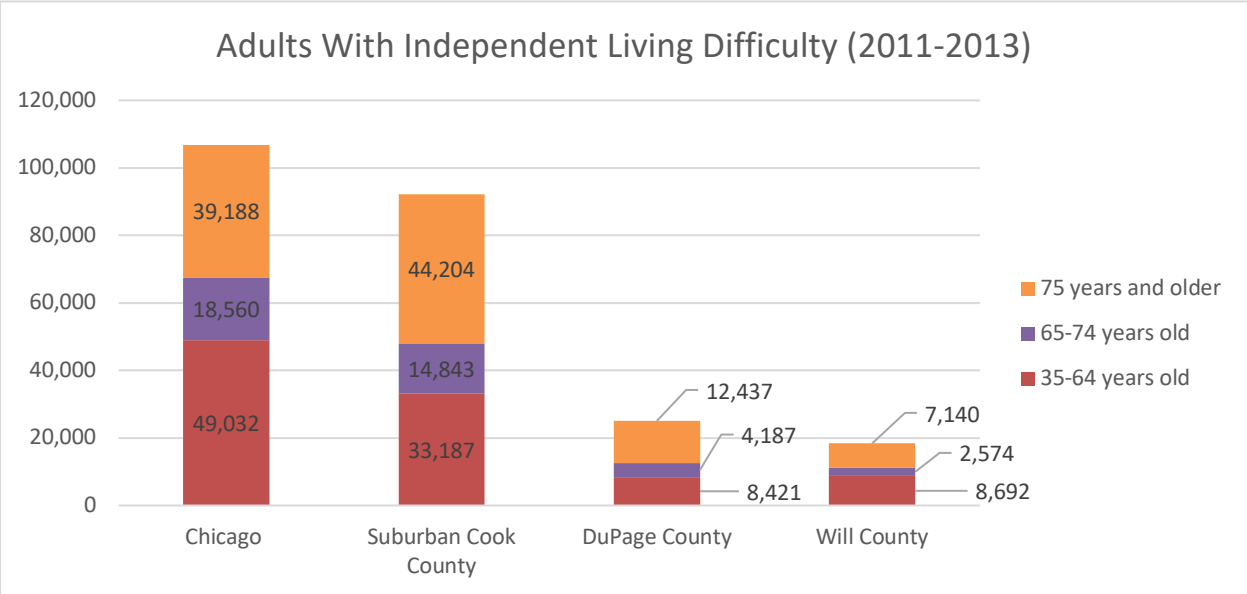


Suburban Cook County also has the bulk of 1-person households with adults 75 years or older. These household are about 50/50 owner-occupied versus renter-occupied.



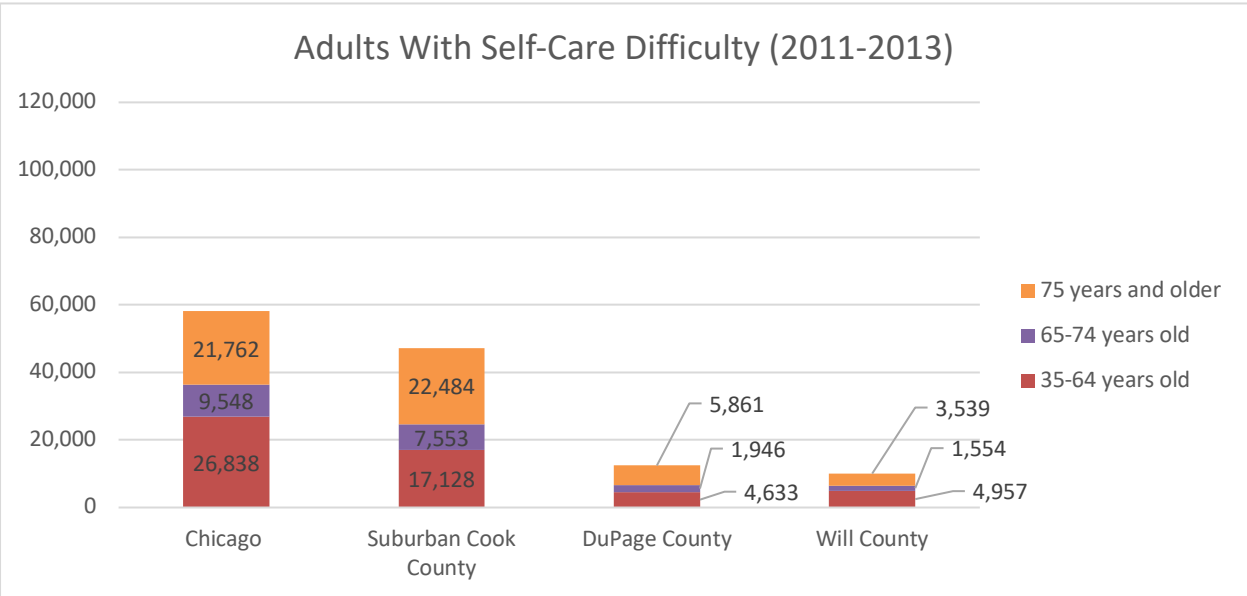
Source: American Community Survey 2010-2014, B25116

Chicago and Suburban Cook County have the most adults with independent living difficulty (a little over 200,000). Of this figure, approximately 143,000 are seniors age 65 and older. The proportion of each age group varies across the RML Hinsdale service area. Chicago and Will County have a higher proportion of adults age 35-64 with independent living difficulty, whereas Suburban Cook and DuPage County have a higher proportion of adults age 75 and older with independent living difficulty.



Source: American Community Survey 2011-2013, B18107

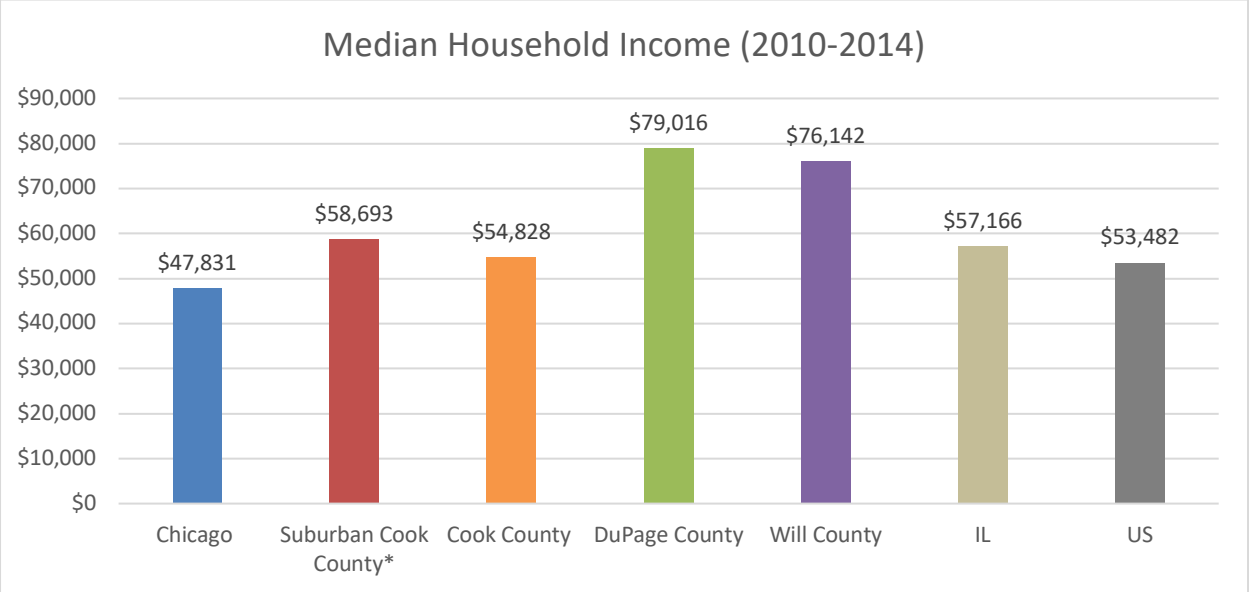
Chicago and Suburban Cook County have the most adults with self-care difficulty (a little over 100,000). Of this figure, approximately 75,000 are seniors age 65 and older. Again, the proportion of each age group varies across the RML Hinsdale service area. Chicago and Will County have a higher proportion of adults age 35-64 with self-care difficulty, whereas Suburban Cook and DuPage County have a higher proportion of adults age 75 and older with self-care difficulty.



Source: American Community Survey 2011-2013, B18106

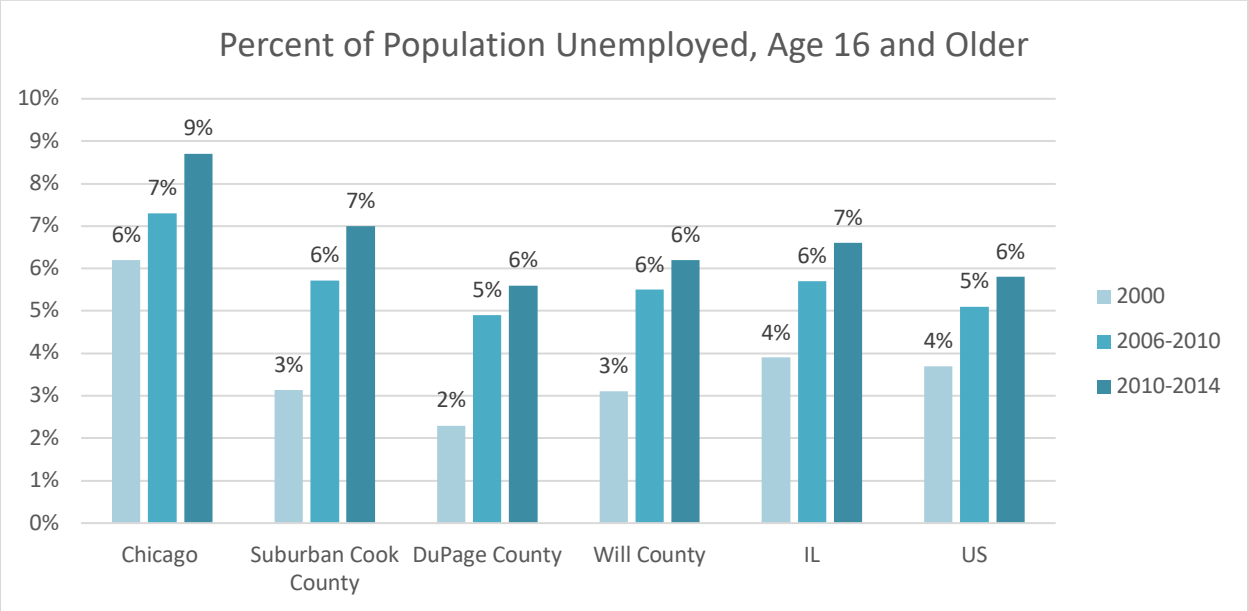
Socioeconomic Indicators

Overall, DuPage and Will County have the highest median household income, about 60-65% higher than Chicago median household income and about 42-47% higher than the national median household income. Suburban Cook County has the next highest median income, slightly above the median income for Illinois and the United States. Chicago has the lowest median income in the RML Hinsdale service area, lower than the median income for Illinois and the United States.



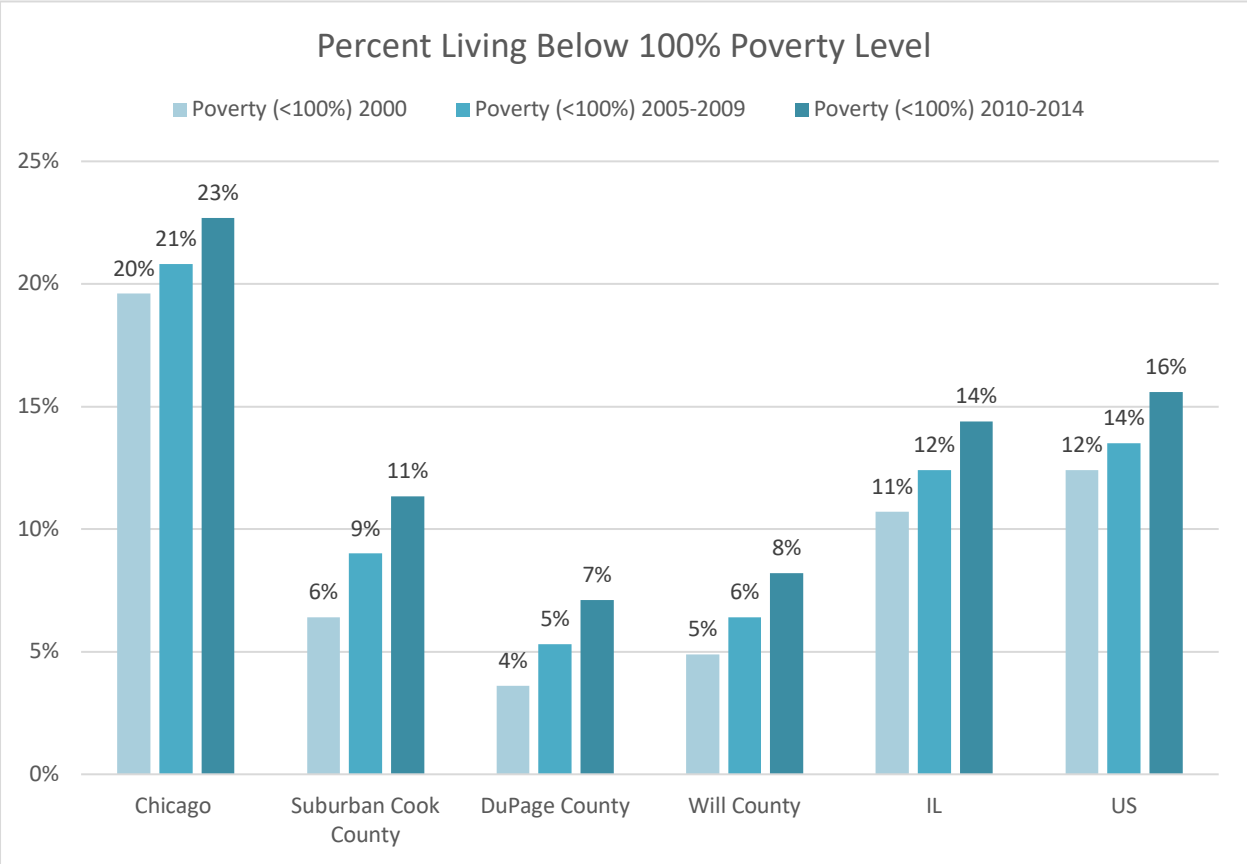
Source: U.S. Decennial Census 2010, DP-3 and *American Community Survey 2009-2013, DP-3

The unemployment rate has trended upward since 2000 in the RML Hinsdale service area. Chicago has the highest unemployment rate, at 9%, followed by Suburban Cook County at 7%.



Source: U.S. Decennial Census 2000, DP-3 and American Community Survey 2006-2010 and 2010-2014, DP-3

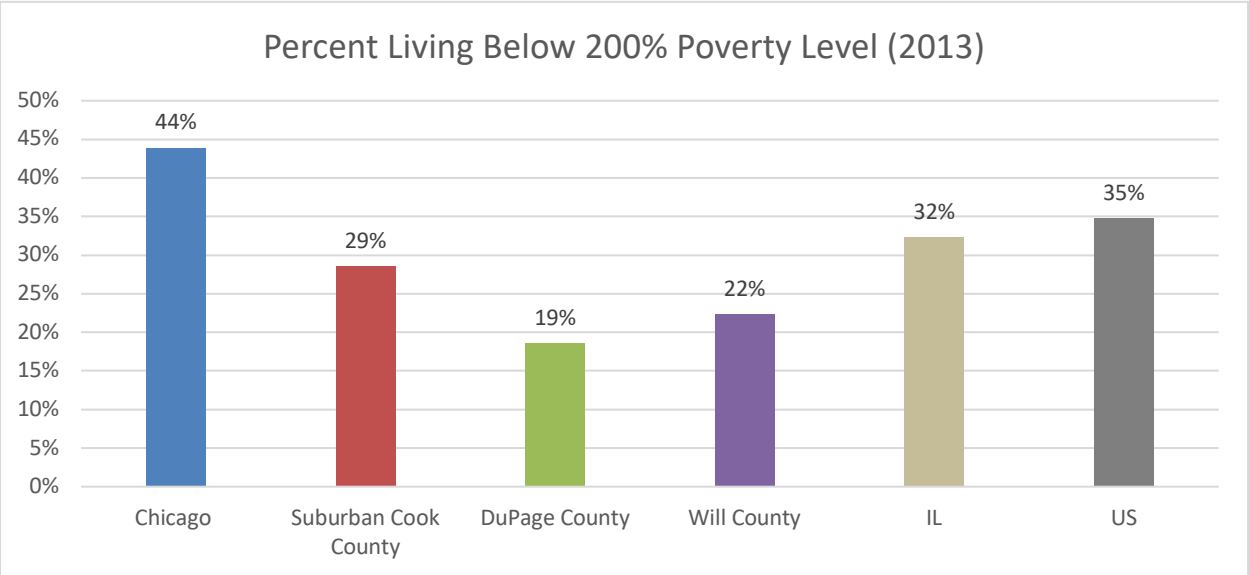
Like unemployment, poverty has also trended upward since 2000. The highest rate of poverty is found in Chicago (23%), which is double the rate in Suburban Cook County (11%) and three times the rate in DuPage (7%) and Will County (8%). The suburban areas of Chicago have lower poverty rates than Illinois and the United States overall. For 2014, the federal poverty level is defined as an annual income less than $11,670 for a one-person household or less than $15,730 for a two-person household.[1]



Source: U.S. Decennial Census 2000, DP-3 and American Community Survey 2006-2010 and 2010-2014, S1701

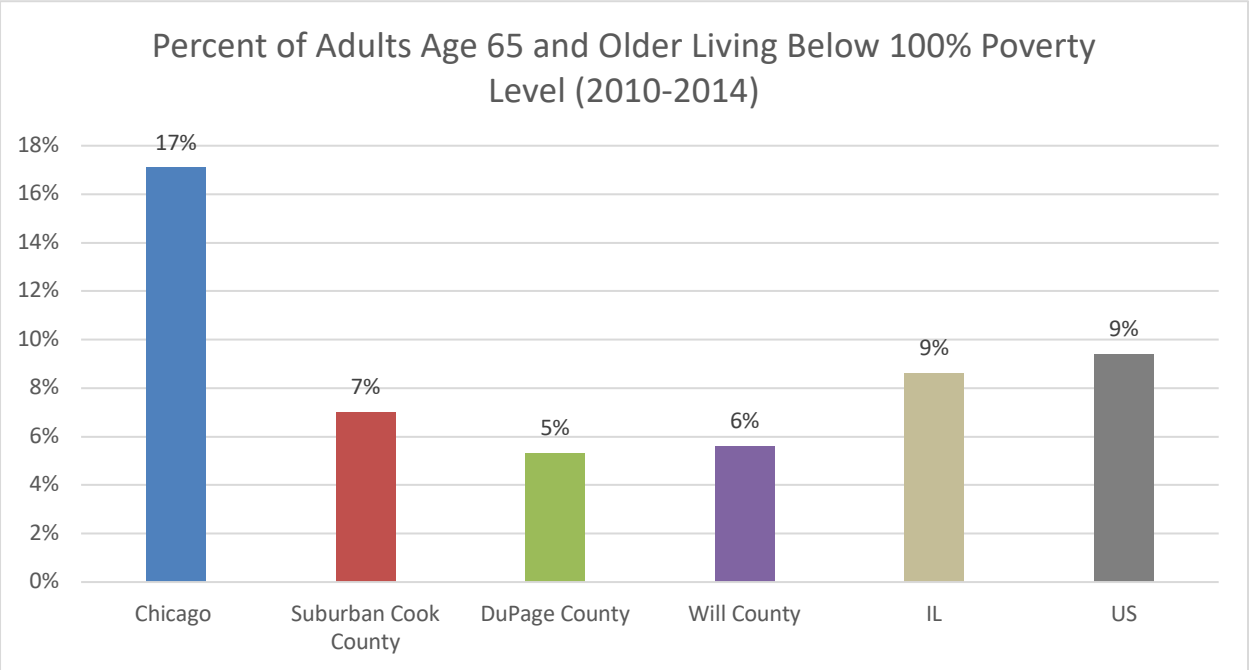
[1] https://www.federalregister.gov

Overall, residents of the city of Chicago also have a higher percent of the population living at or below 200% of the federal poverty level (an annual income less than $23,340 for a one-person household or less than $31,460 for a two-person household).



Source: Social Impact Research Center, *Poor By Comparison: Report on Illinois Poverty*. January 2015.

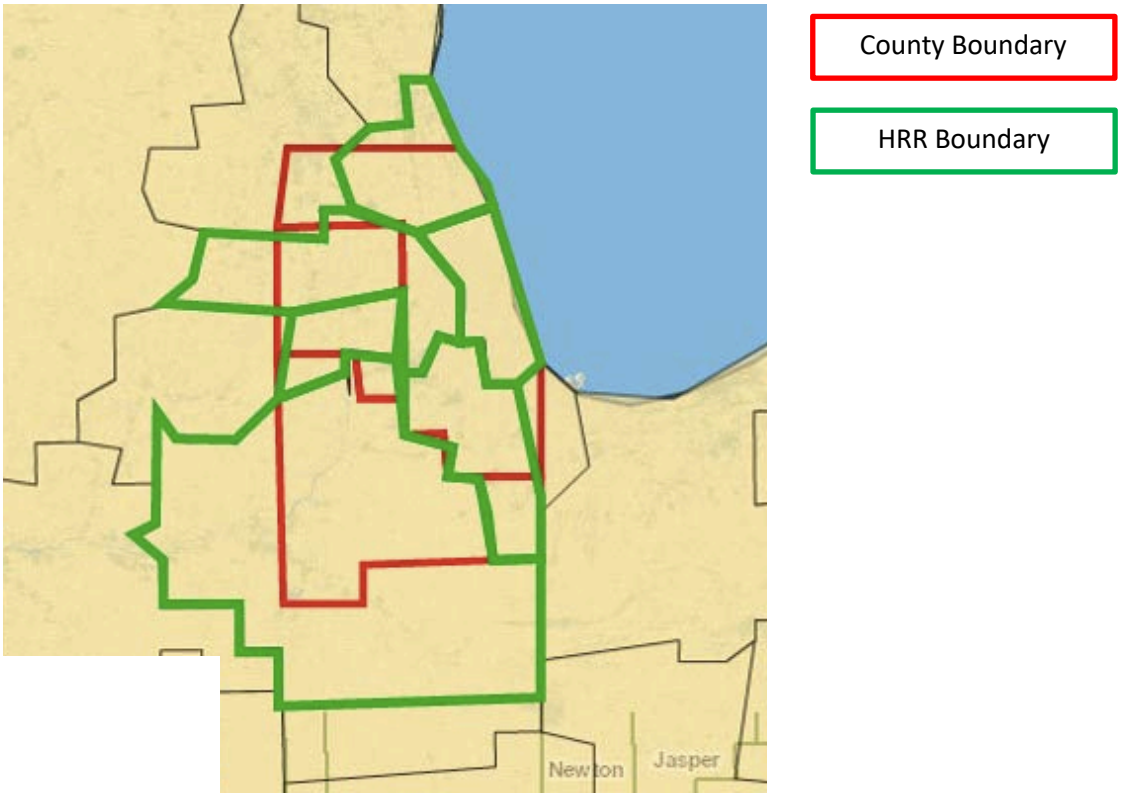
Chicago also has the highest rate of adults 65 and older living in poverty, two to three times the rate in Suburban Cook, DuPage, and Will County, and almost twice the rate of Illinois and the United States overall.



Source: American Community Survey 2010-2014, S1701

Health Indicators

Hospital Referral Region Definition and Map



Source: Dartmouth Atlas of Health Care

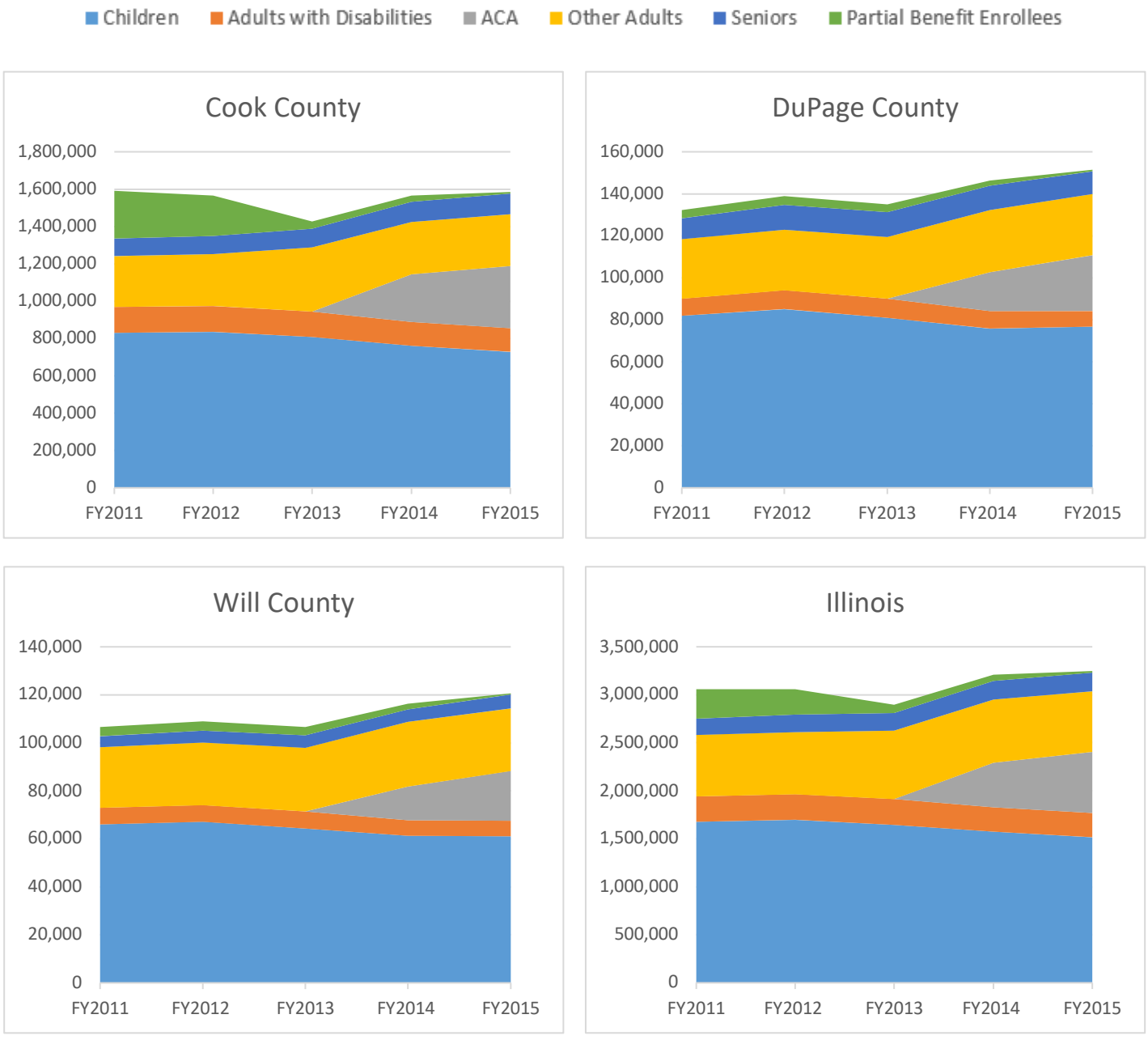
Hospital Referral Regions (HRRs) are regional market areas for tertiary medical care. Each HRR contains at least one hospital that performs major cardiovascular procedures and neurosurgery.

There are 6 HRRs in the RML Hinsdale service area:

- Blue Island
- Chicago
- Evanston
- Hinsdale
- Joliet
- Melrose Park

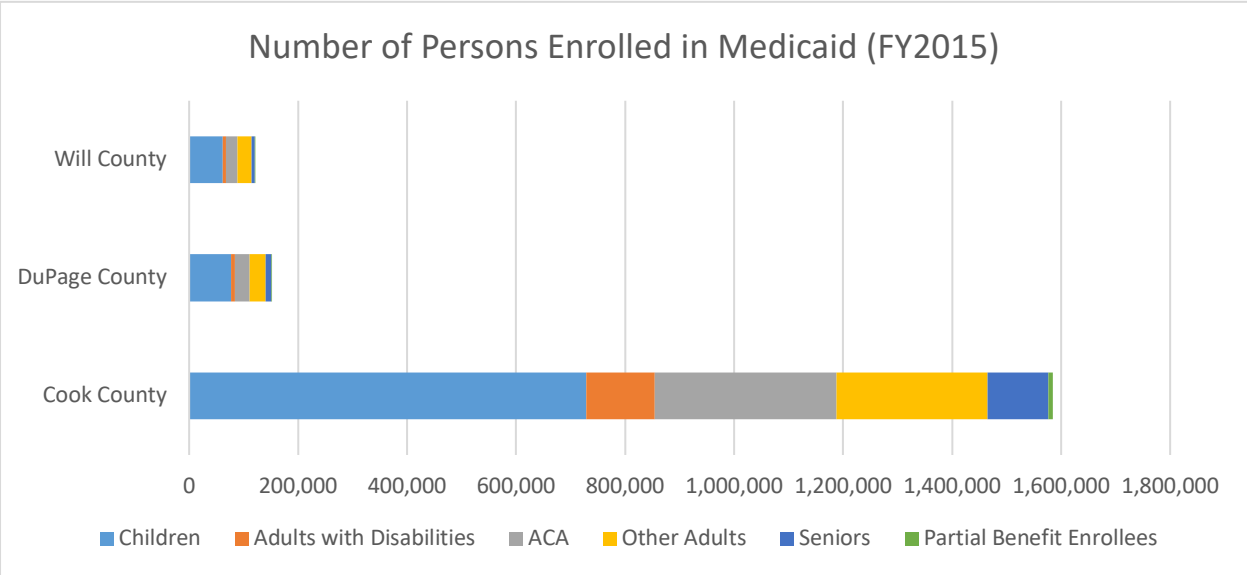
Medicaid and Medicaid Enrollment

Starting in 2013, there was a new enrollment category for the Affordable Care Act (ACA) indicated in grey in the figures below. The increase in the ACA category corresponds with a decline in partial benefit enrollees (green). The proportions for the other enrollment categories have stayed relatively the same.

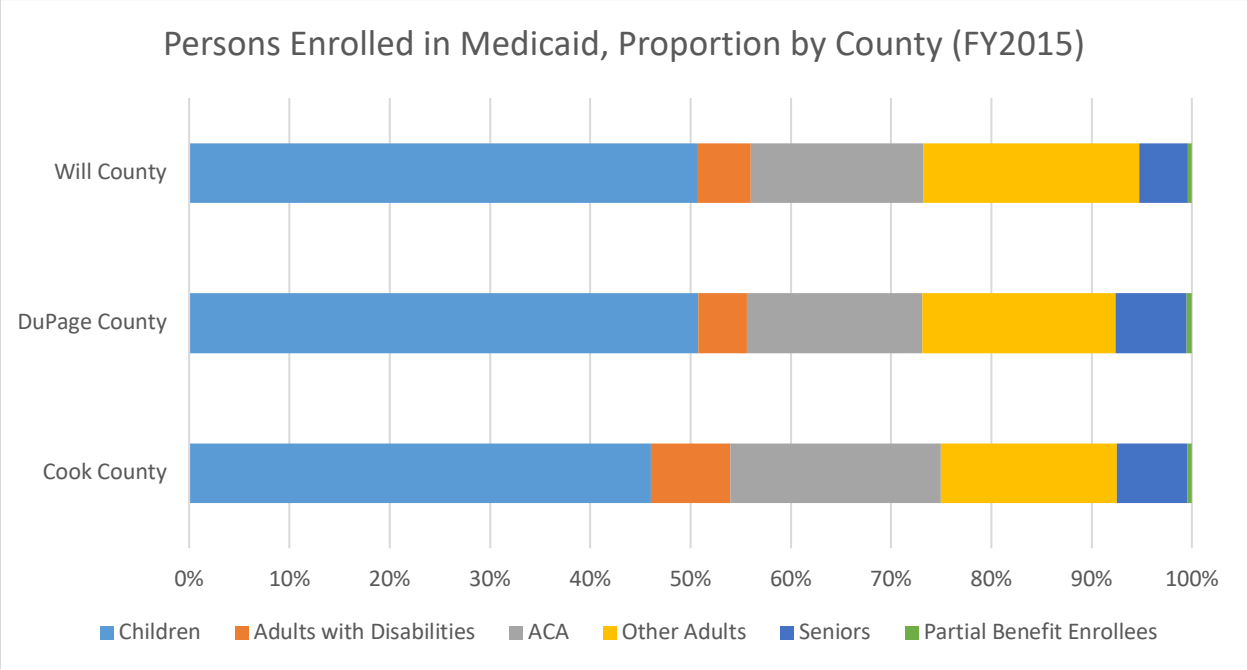


Source: Illinois Department of Healthcare and Family Services

As the most populous county in the RML Hinsdale service area, Cook County has a far greater number of people enrolled in Medicaid compared with the other counties. Cook County has nearly 1.6 million enrollees while DuPage and Will County have under 200,000 each.



Will, DuPage, and Cook County have a similar distribution across the different enrollment categories. Cook County has a slightly higher proportion of adults with disabilities enrolled while DuPage and Cook have a higher proportion of seniors enrolled in Medicaid.



Source: Illinois Department of Healthcare and Family Services

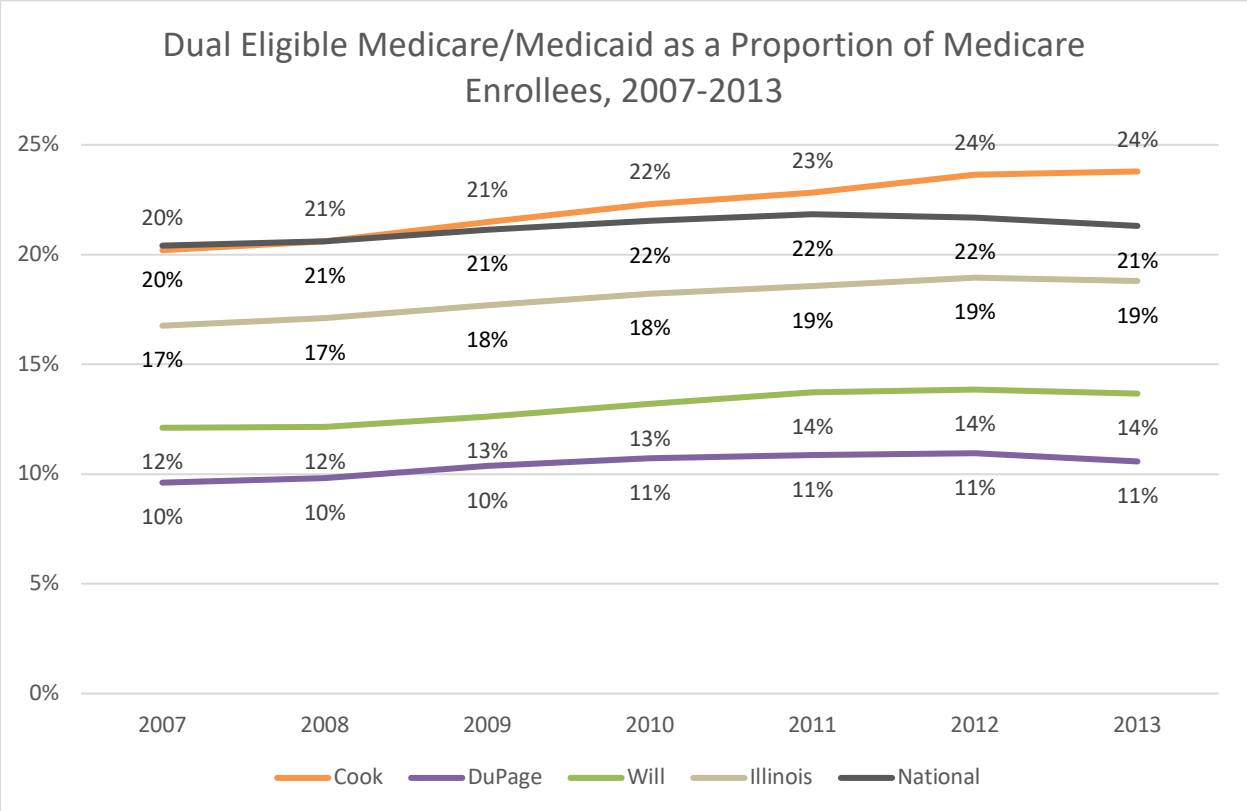
Medicare Advantage Enrollment in the RML Hinsdale service area ranges between 15-17% of the total Medicare Population. Medicare Part D Enrollment is highest in Cook County (87,541), followed by DuPage (9,812) and Will County (7,467).

Medicare Enrollment, 2015

	Cook County	DuPage County	Will County
Total 65 and Older Population (2014)	643,023	115,811	68,893
Medicare Advantage: Total Enrollment	132,940	20,205	14,152
% of Medicare Population Enrolled in a Medicare Advantage Plan	17%	15%	16%
Medicare Part D Enrollment	87,541	9,812	7,467

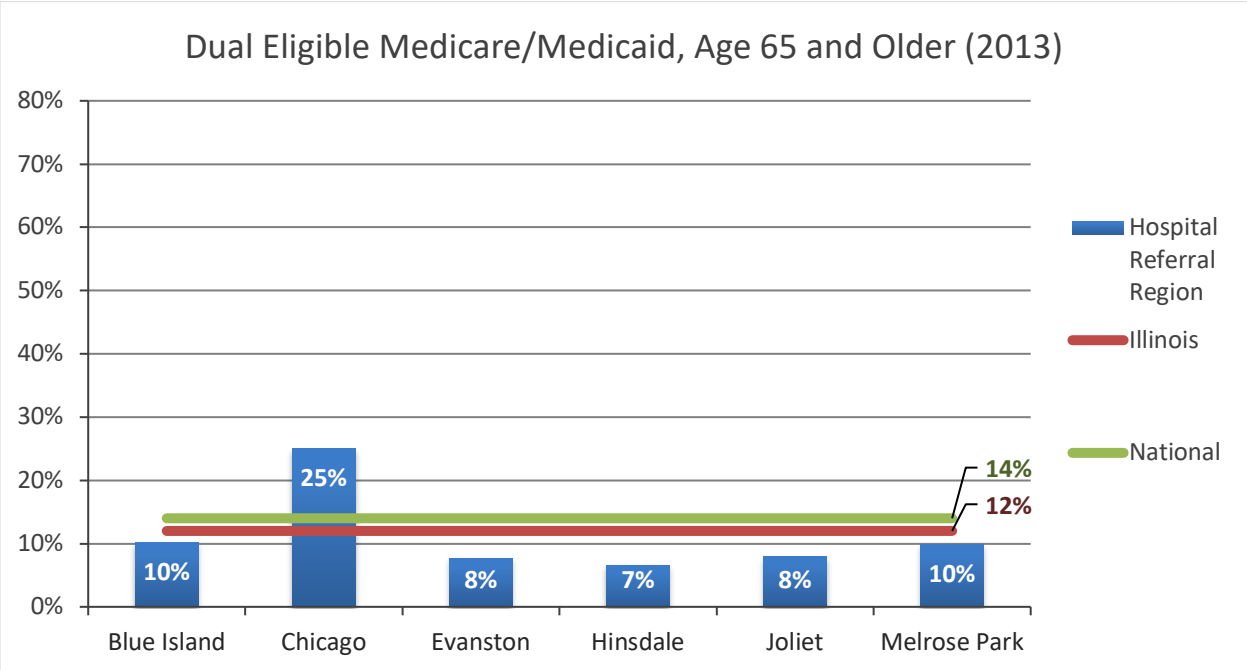
Source: Henry J. Kaiser Family Foundation and American Community Survey 2010-2014, S0101

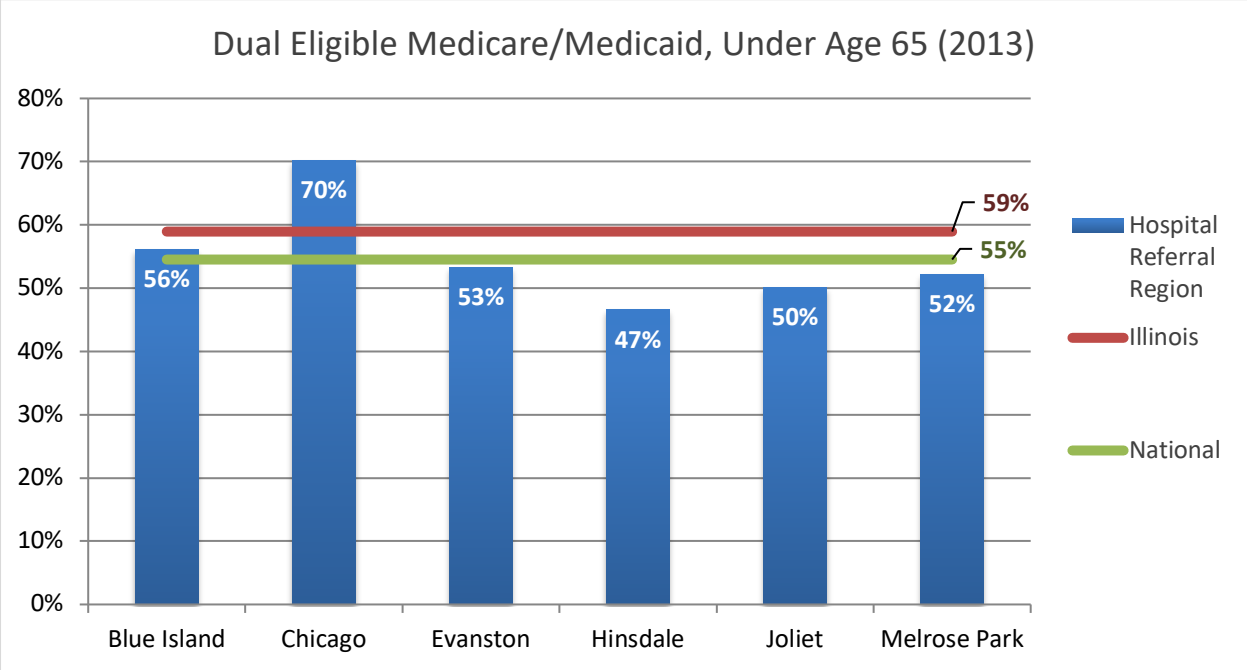
The proportion of dual eligible population (individuals eligible for both Medicare and Medicaid) has increased slightly since 2007 in the RML Hinsdale service area. Cook County has the highest proportion of dual eligibility, at 24%, while DuPage has the lowest, at 11%. Note these figures reflect all adults (not only seniors).



Source: Health Indicators Warehouse

There is a notable difference in the dual eligibility rates of Medicare enrollees under age 65. Though there are far fewer Medicare enrollees under the age of 65, a higher proportion of them are also eligible for Medicaid. Nearly 70% of the under 65 Medicare enrollees are dual eligible in Chicago. The national average is 55%.



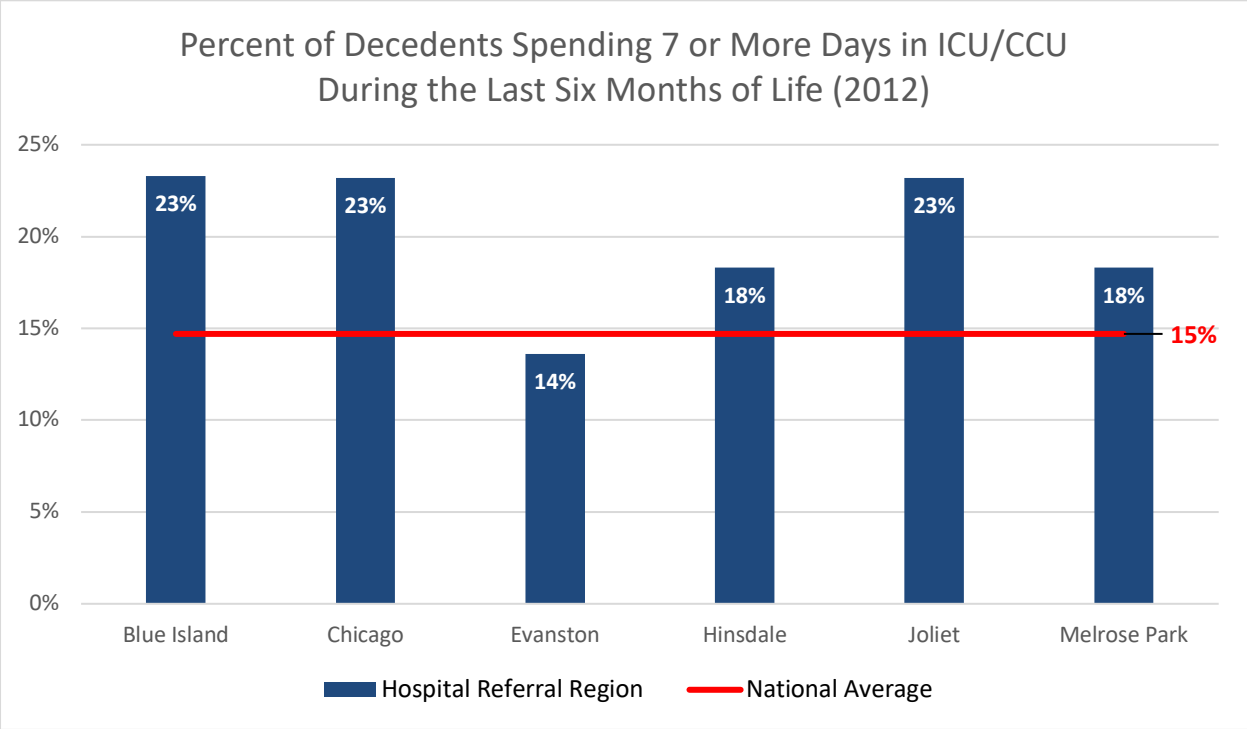


Source: Health Indicators Warehouse

Chronically Critically Ill (CCI) Population

Long-term Acute Care Hospitals (LTCHs) have a high proportion of chronically critically ill (CCI) patients. The definition of CCI varies, but the general characteristics include extended intensive care unit (ICU) stays, presence of sepsis, prolonged mechanical ventilation, and multiple organ failures.[2] Data from the Dartmouth Atlas of Health Care suggests that the RML Hinsdale service area has a high proportion of CCI patients compared to the national average.

The Hospital Referral Regions (HRRs) in the RML Hinsdale service area have a higher percentage of decedents spending 7 or more days in the ICU/CCU during the last sixth months of life compared to the national average, except for the Evanston HRR.



DENOMINATOR DEFINITION:
100% of Medicare enrollees age 65-99 who died during the measurement year with full Part A entitlement and no HMO enrollment during the measurement period. Age, gender, race, and eligibility are determined using the Denominator file.

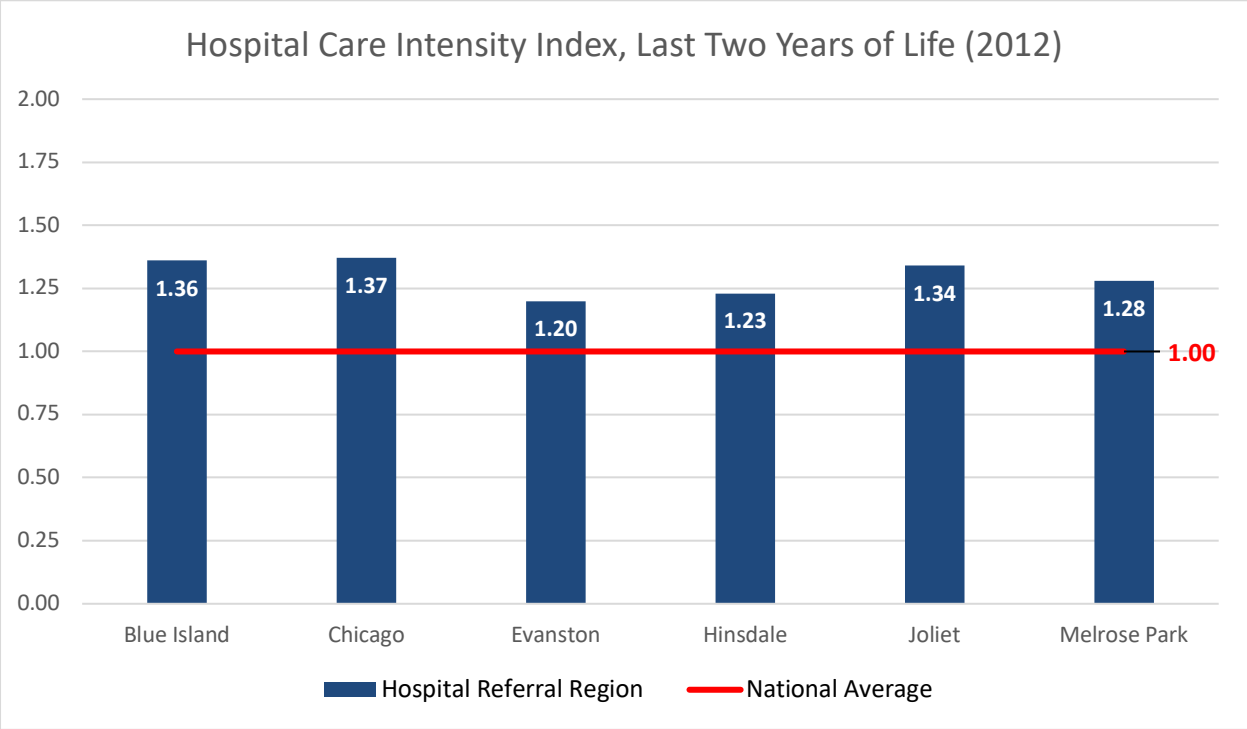
NUMERATOR DEFINITION:
Number of patients spending 7 or more days in ICU within six months of the death date in the MedPAR file. For stays that began prior to the six-month period before the death date, only the portion of the event that occurred within the six-month window is used. ICU days are determined by the following indicators in the MedPAR claim: ICARECNT (intensive care day count), CRNRYDAY (coronary care day count).

ADJUSTMENTS:
Rates are adjusted for age, sex and race using the indirect method, using the U.S. Medicare decedent population as the standard. Gender-specific rates are age and race adjusted; race-specific rates are age and sex adjusted.

Source: Dartmouth Atlas of Health Care

[2] RTI International, *Chronically Critically Ill Population Payment Recommendations Report*. March 2014.

The local HRRs have a higher Hospital Care Intensity Index than the national average, with the highest ratio in the Chicago HRR (1.37) and the lowest ratio in Evanston HRR (1.20).



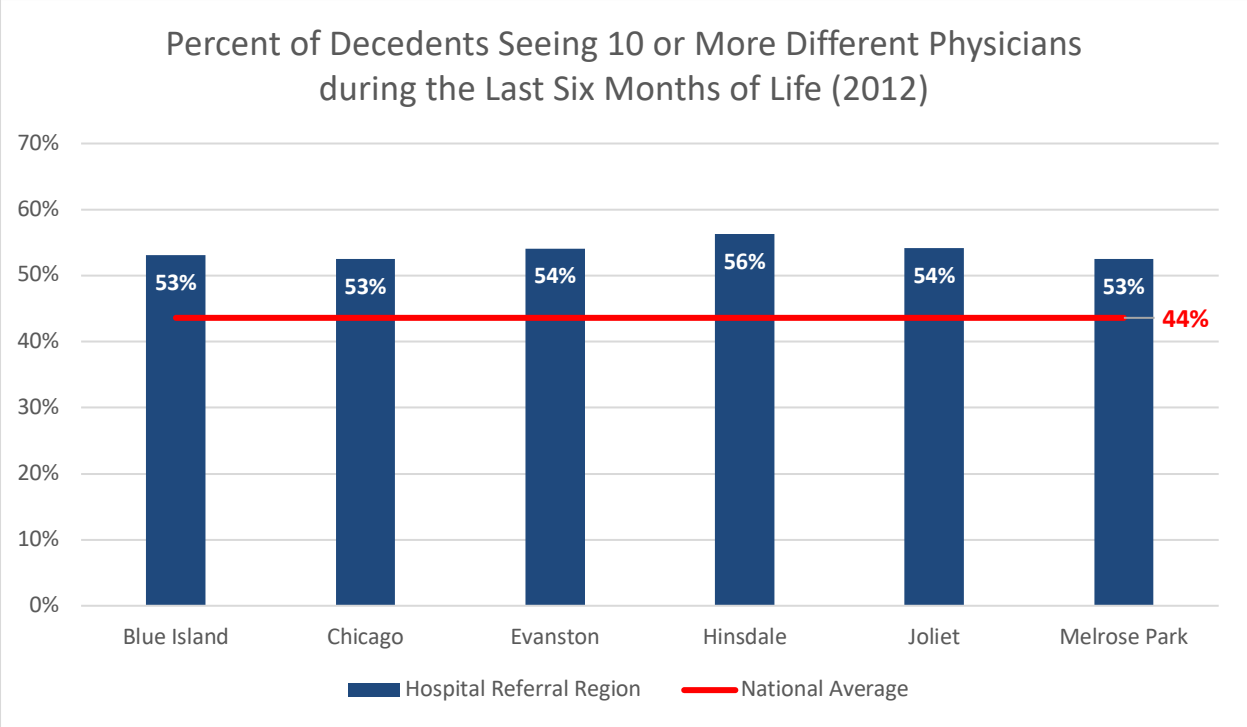
FOOTNOTES:
The HCI is based on two variables: the number of days patients spent in the hospital and the number of physician encounters (visits) they experienced as inpatients. It is computed as the age-sex-race-illness standardized ratio of patient days and visits. For each variable, the ratio of a given hospital's utilization rate to the national average was calculated, and these two ratios were averaged to create the index.

DENOMINATOR DEFINITION:
Click here to read about changes in methods between the 2001–05 and 2003–07 analyses. The study population includes beneficiaries with one of nine chronic conditions who were enrolled in traditional (fee-for-service) Medicare and died during the measurement period. To allow for two years of follow-back for all patients, the population is restricted to those whose age on the date of death was 67 to 99 years, and to those having full Part A and Part B entitlement throughout the last two years of life. Persons enrolled in managed care organizations were excluded from the analysis. For the hospital-specific analyses, patients had to be hospitalized for chronic illness at least once during their last two years of life to be included. For regional analyses, all patients diagnosed with a chronic illness were included.

ADJUSTMENTS:
Rates are adjusted for age, sex, race, primary chronic condition, and the presence of more than one chronic condition using ordinary least squares regression.

Source: Dartmouth Atlas of Health Care

The local HRRs have a higher percent of decedents (53-56%) seeing 10 or more different physicians during the last 6 months of life than the national average (44%).



DENOMINATOR DEFINITION:

Click here to read about changes in methods between the 2001–05 and 2003–07 analyses. The study population includes beneficiaries with one of nine chronic conditions who were enrolled in traditional (fee-for-service) Medicare and died during the measurement period. To allow for two years of follow-back for all patients, the population is restricted to those whose age on the date of death was 67 to 99 years, and to those having full Part A and Part B entitlement throughout the last two years of life. Persons enrolled in managed care organizations were excluded from the analysis. For the hospital-specific analyses, patients had to be hospitalized for chronic illness at least once during their last two years of life to be included. For regional analyses, all patients diagnosed with a chronic illness were included.

NUMERATOR DEFINITION:

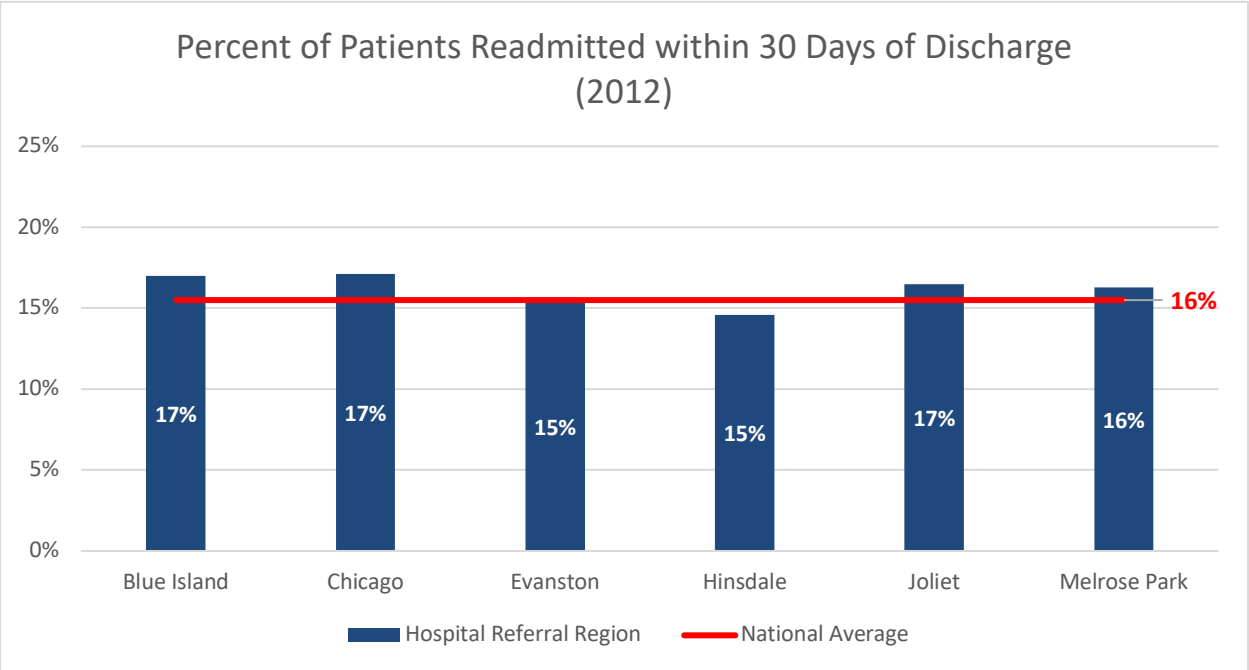
Number of patients that saw 10 or more different physicians during the last six months of life. The number of physicians seen in the last six months of life is computed based on the Unique Provider Identification Number (UPIN) on the Part B claim.

ADJUSTMENTS:

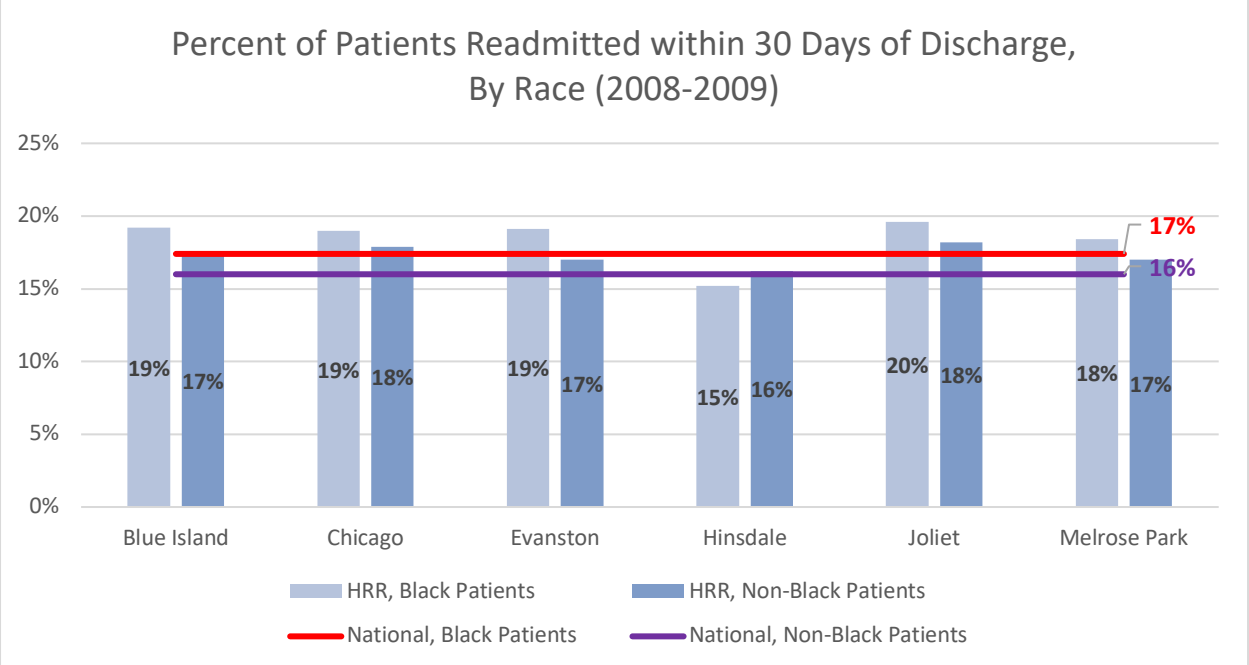
Rates are adjusted for age, sex, race, primary chronic condition, and the presence of more than one chronic condition using ordinary least squares regression.

Source: Dartmouth Atlas of Health Care

Three of the local HRRs (Blue Island, Chicago, and Joliet) were slightly above the national average of 16% of patients readmitted within 30 days of discharge, while three (Evanston, Hinsdale, and Melrose Park) were at or below the national average.



Overall re-admission rates have decreased in all HRRs since 2009. However, locally and nationally, a higher proportion of black patients are readmitted within 30 days compared to non-black patients. Hinsdale HRR is the exception.



Source: Dartmouth Atlas of Health Care

Leading Causes of Death

5 Leading Causes of Death, All Ages

Chicago (2012)	Cook County (2012)	DuPage County (2012)	Will County (2012)	Illinois (2014)	United States (2014)
Heart Disease	Heart Disease	Cancer	Cancer	Heart Disease	Heart Disease
Cancer	Cancer	Heart Disease	Heart Disease	Cancer	Cancer
Stroke/ Cerebrovascular Diseases	Stroke/ Cerebrovascular Diseases	Stroke/ Cerebrovascular Diseases	Stroke/ Cerebrovascular Diseases	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease
Chronic Lower Respiratory Disease	Chronic Lower Respiratory Diseases	Chronic Lower Respiratory Disease	Accidents	Stroke/ Cerebrovascular Diseases	Accidents
Accidents	Accidents	Accidents	Chronic Lower Respiratory Disease	Accidents	Stroke/ Cerebrovascular Diseases

Source: Chicago, Cook, DuPage, and Will County – Illinois Department of Public Health IQuery website
Illinois and USA – CDC WISQARS

5 Leading Causes of Premature Death[3]

Chicago (2006-2010)	DuPage County (2012)	Will County (2006)	Illinois (2014)	United States (2014)
Cancer	Cancer	Heart Disease	Accidents	Accidents
Accidents	Accidents	Accidents	Cancer	Cancer
Heart Disease	Heart Disease	Perinatal Period	Heart Disease	Heart Disease
Assault (Homicide)	Stroke/ Cerebrovascular Diseases	Heart Disease	Perinatal Period	Suicide
Firearm-related	Influenza & Pneumonia	Congenital Malformations	Homicide	Perinatal Period

Source: Chicago – Chicago Data Portal
Will County – 2010 Will County Community Health Status Report
DuPage County – Impact DuPage
Illinois and USA – CDC WISQARS

[3] Premature Death is the years of potential life lost before age 75 (YPLL-75). Every death occurring before the age of 75 contributes to the total number of years of potential life lost. For example, a person dying at age 25 contributes 50 years of life lost, whereas a person who dies at age 65 contributes 10 years of life lost. Source: County Health Rankings & Roadmaps website.

5 Leading Causes of Death Age 65 and Older

DuPage County (2011)	Illinois (2014)	United States (2014)
Heart Disease	Heart Disease	Heart Disease
Cancer	Cancer	Cancer
Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease
Stroke/ Cerebrovascular Diseases	Stroke/ Cerebrovascular Diseases	Stroke/ Cerebrovascular Diseases
Alzheimer's Disease	Alzheimer's Disease	Alzheimer's Disease

Source: DuPage County – Impact DuPage: County Assessment Community Profile, 2015
Illinois and USA – CDC WISQARS

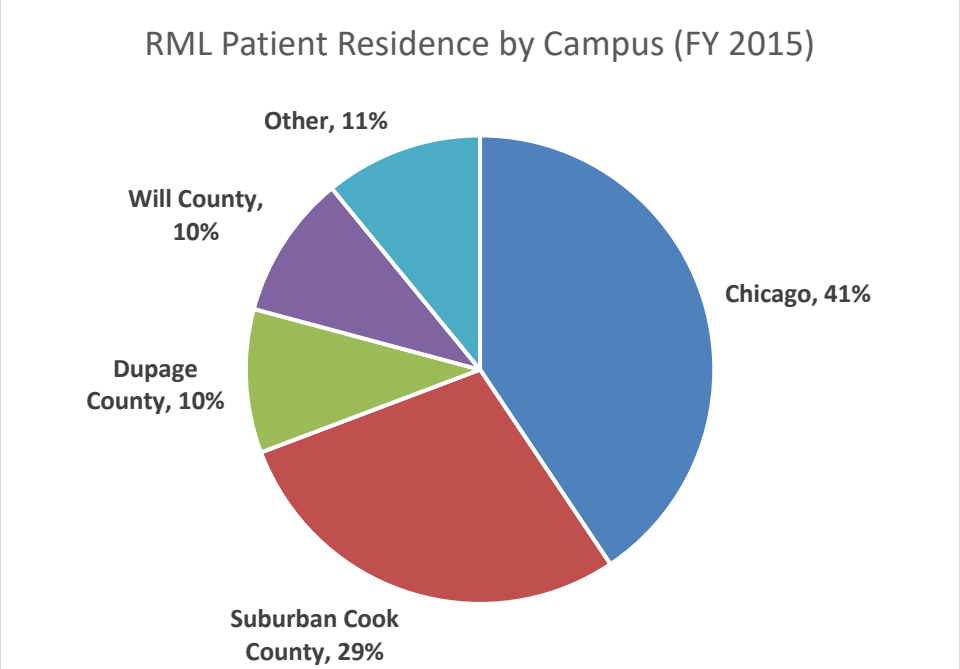
RML Patient Data

Patient Residence

Most of RML's patients reside in Cook County. RML Hinsdale patients are mostly from Suburban Cook County, while RML Chicago patients are mostly from the city of Chicago. About 11% of RML patients come from outside Cook, DuPage, or Will County.

RML Patient Residence by Campus (FY 2015)

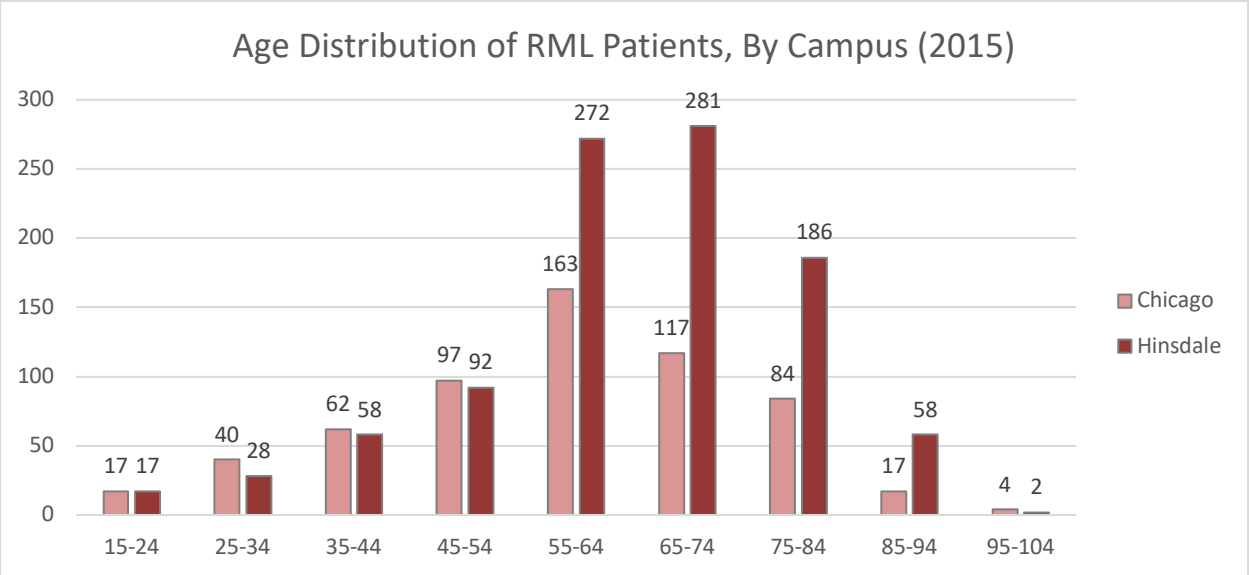
Residence	RML	RML Hinsdale	RML Chicago
Chicago	41%	14%	82%
Suburban Cook	29%	39%	13%
DuPage County	10%	16%	1%
Will County	10%	16%	1%
Other	11%	16%	3%



Source: RML patient data, FY 2015

Age Distribution

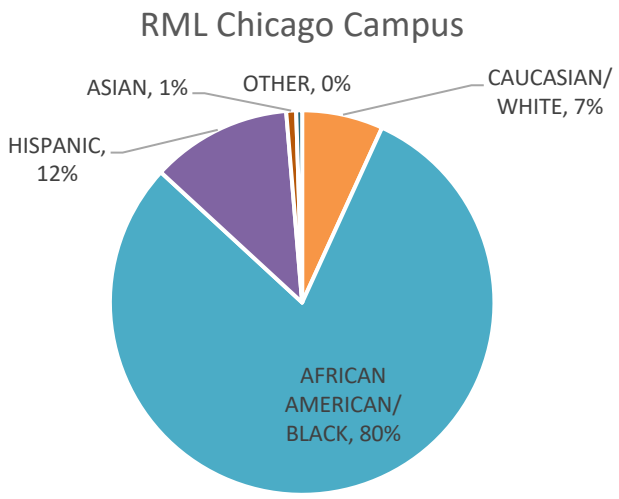
About 47% of all RML patients are age 65 or older. The Chicago Campus has a higher proportion of younger patients. About 36% of patients at the Chicago Campus are between 15-54 years old, compared to about 20% of Hinsdale patients. On the other hand, the Hinsdale Campus has a higher proportion of elderly patients. About 53% of patients at the Hinsdale Campus are between 65-104 years old, compared to about 37% of Chicago patients. The two campuses have roughly the same proportion of 55-64 year old patients.

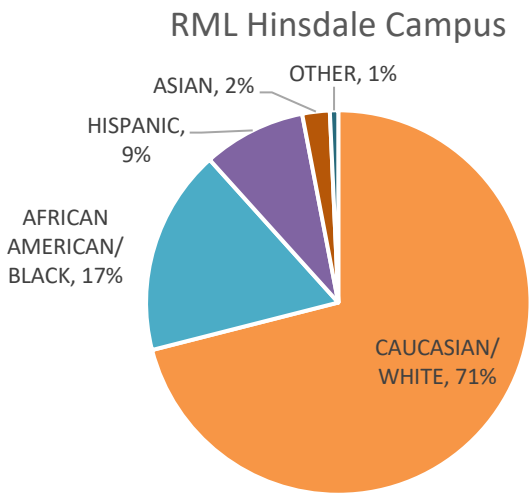


Source: RML patient data, FY 2015

Race/Ethnicity

The racial and ethnic makeup at the two RML campuses is very different. Over 90% of the patients at RML Chicago are non-white while 71% of the patients at RML Hinsdale are white.

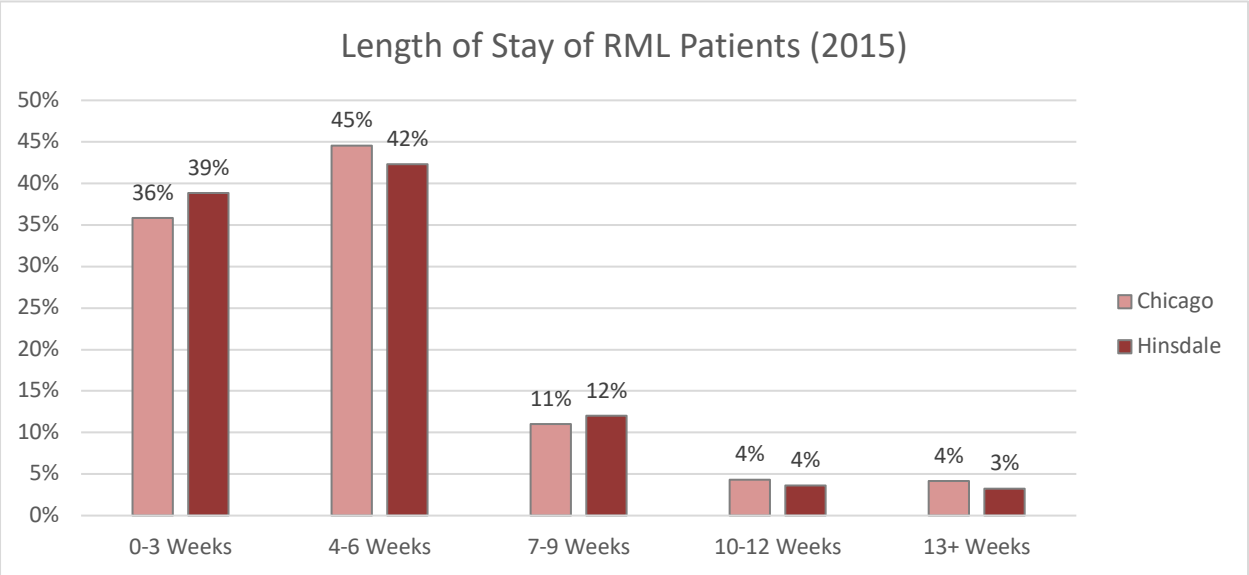




Source: RML patient data, FY 2015

Length of Stay

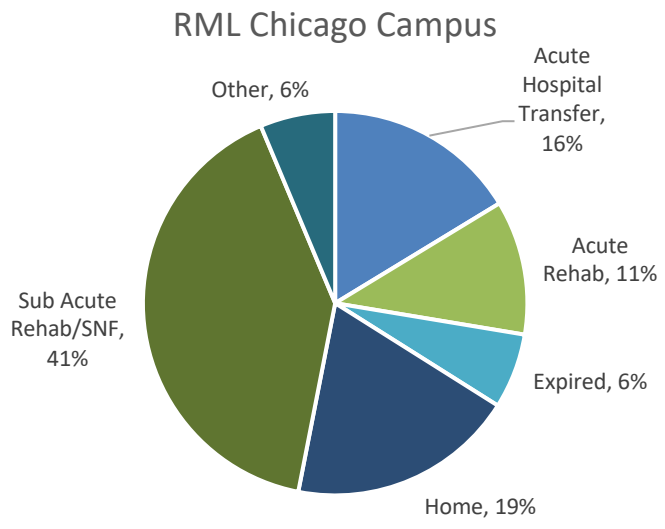
The length of stay for patients is roughly the same at each campus, with the Chicago Campus having a greater number of patients staying 4-6 weeks (45%) compared to the Hinsdale Campus (42%). Most patients (81%) stay at RML 6 weeks or less.

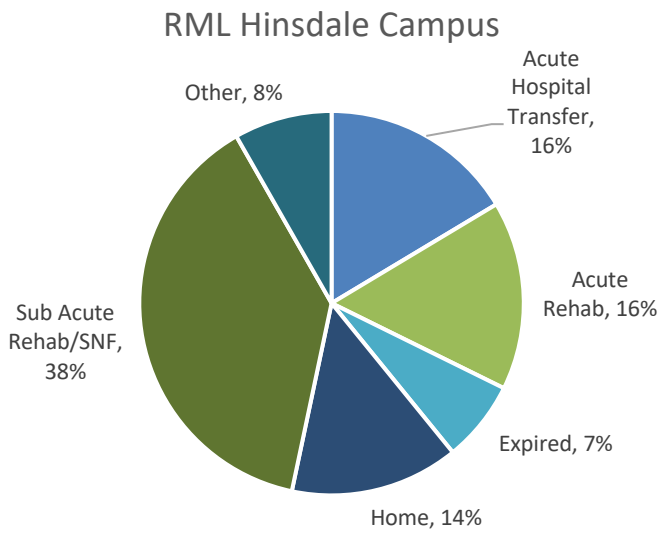


Source: RML patient data, FY 2015

Discharge Destination

In 2015, discharge profiles were similar for RML's Chicago and Hinsdale facilities. At both RML Chicago and RML Hinsdale approximately 16% of the patients were transferred to acute hospitals. A higher proportion of Chicago patients were discharged to Sub-Acute Rehabilitation or Skilled Nursing Facilities (41%) and to home (19%) compared to RML Hinsdale. RML Hinsdale had a higher proportion of patients discharged to Acute Rehabilitation (16%).





Source: RML patient data, FY 2015

Patient Diagnoses

RML specializes in the interdisciplinary physician-led treatment of patients with catastrophic or acute illnesses and injuries complicated by complex or multiple illnesses or conditions. RML has three major programs. About 65% of the patients come to RML to be weaned from a ventilator. These patients have failed to wean from the ventilator at the short-stay acute care hospitals in spite of repeated attempts following a major surgery or a severe illness. About 20% of the patients are admitted to the medically complex program. These patients are critically ill and suffer from multiple debilitating conditions and are just starting to take very small steps toward their rehabilitation. The remainder of patients (15%) come to RML with severe, possibly infected wounds, including pressure ulcers, surgical wounds, and burns. In fact, as all of the patients have been in the hospital for a long time, many of the patients in the other two programs are also suffering from pressure ulcers.

Ventilator Weaning
(65% of patients)

- Neurological dysfunction
- Chronic and acute lung disease
- Post-operative complications
- Coronary artery disease
- West Nile Virus & other infectious

Wound Management
(15% of patients)

- Complex pressure ulcers
- Surgical wounds
- Vascular ulcer
- Burns
- Osteomyelitis
- Fistula Management

Medically Complex
(20% of patients)

- Cerebrovascular accident (CVA)
- Head injury
- Pre-rehab
- Ortho
- Neuro
- Deconditioned
- Organ Transplant
- Ventricular Assist Devices

Appendix C: Community Input Report

Community Input Report

RML Hinsdale and RML Chicago

Prepared by the Illinois Public Health Institute and

RML Specialty Hospital

Community Input Report

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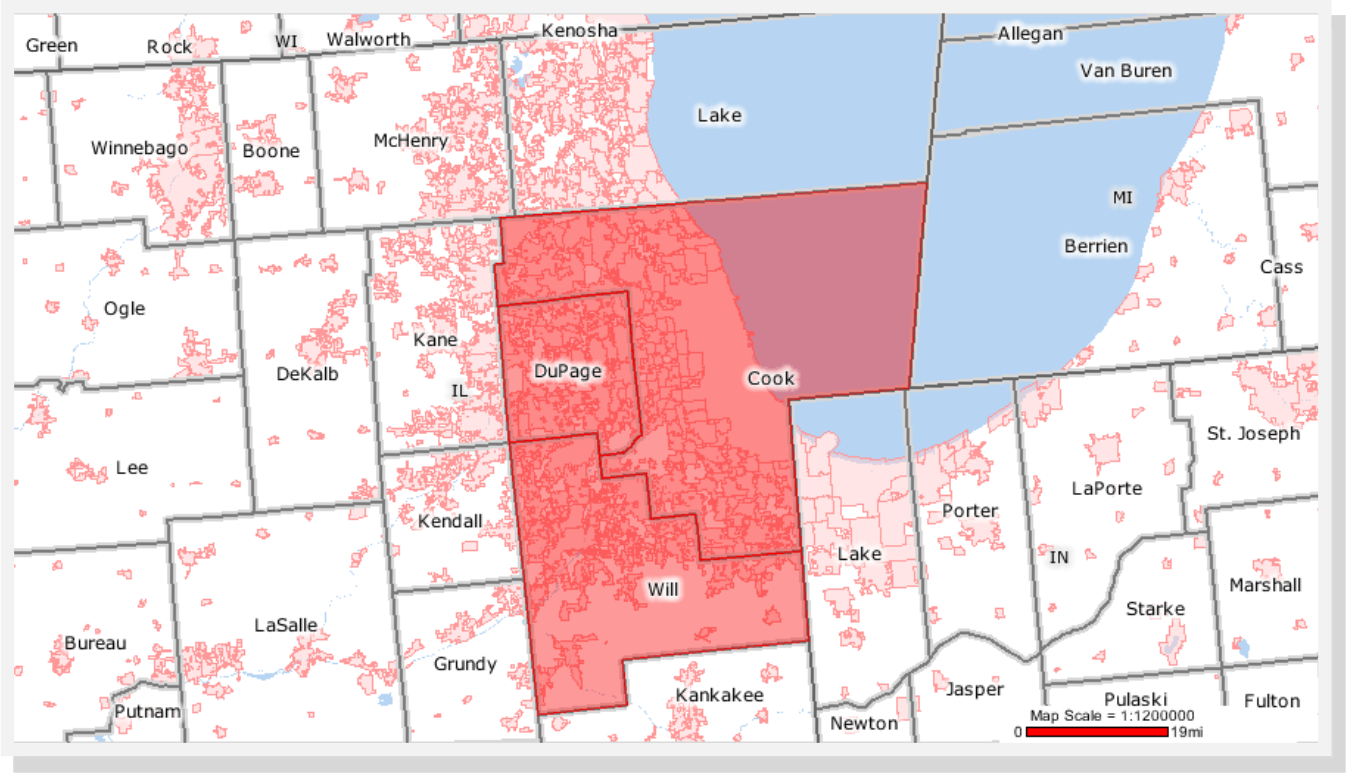
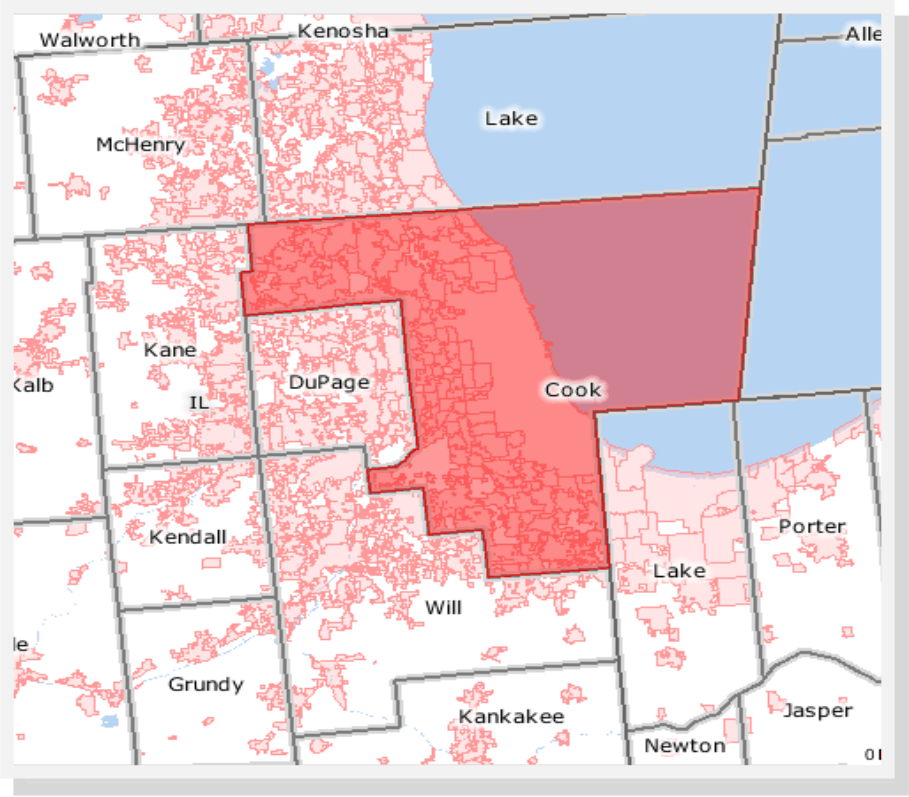
RML Hinsdale CHNA Community

RML Hinsdale's community: People in Chicago, Suburban Cook County, DuPage County and Will County who have suffered a severe, life-changing, debilitating illness requiring extensive psycho-social and health support services when they return home. As the elderly and low-income are most unlikely to have the resources to adapt well to these circumstances, we will focus on these populations.



RML Chicago CHNA Community

RML Chicago's community**:** People in Chicago and Suburban Cook County who have suffered a severe, life-changing, debilitating illness requiring extensive psycho-social and health support services when they return home. As the elderly and low-income are most unlikely to have the resources to adapt well to these circumstances, we will focus on these populations.



Methods

The community input data for the RML CHNA was collected between February and April 2016. IPHI worked with RML to apply two methods for collecting community input data: focus groups and key informant interviews. The focus groups and interviews were conducted by IPHI following a semi-structured format, and RML and IPHI tailored questions for each group. In addition, as part of the Health Impact Collaborative of Cook County, RML was able to access survey data collected through the collaborative CHNA process as another important insight into community perceptions and input.

Care Coordinator Focus Group

The care coordinator focus group was conducted at the Hinsdale campus on February 11, 2016 with Laurie Call as facilitator and Antonia Lalagos as note-taker. The group had 9 participants with representation from both RML campuses.

Staff Focus Group

The staff focus group was conducted at the Hinsdale campus on February 25, 2016 with Laurie Call as facilitator and Antonia Lalagos as note-taker. The group had 11 participants from a variety of disciplines including nutrition/dietetics, physical therapy, wound care, pharmacy, nursing, respiratory care, speech rehabilitation, patient/family relations, and performance management. Staff from both RML Campuses participated.

Community Partner Focus Group

The community partner focus group was conducted at the Hinsdale campus on March 15, 2016 with Laurie Call as facilitator and Antonia Lalagos as note-taker. The group had 4 participants and included representatives from a skilled nursing facility, home health care organization, and 2 representatives from a rehabilitation facility that work with many RML patients after discharge.

Patient Interviews

The patient interviews were conducted at the Hinsdale campus on April 6, 2016 with Laurie Call leading the interviews and Antonia Lalagos as note-taker. The two former patients had spent their time at the RML Hinsdale Campus. Additional interviews were attempted but the patients were unable to meet the scheduled sessions due to their illnesses.

Key Informant Interviews

Laurie Call and Antonia Lalagos conducted two phone interviews with key informants to gather their input and expertise on issues faced by the community that RML serves. The first interview, conducted on March 3, 2016, included 2 team members from an RML post-discharge follow-up project initiated in January 2016. The second interview was conducted on March 4, 2016 with a physician from the RML Chicago Campus.

HIC-CC Central Cook Survey Data

The HIC-CC gathered community input through various means, including a community resident survey. By leveraging the networks of the Collaborative partners, approximately 5,200 resident surveys were collected through targeted outreach to the most vulnerable communities across the city and county, including 1,200 in the Central Cook County region. The survey was disseminated in four languages – English, Spanish, Polish and Korean –and was available on paper and online. The majority of the responses were paper-based (about 75%) and about a quarter were submitted online. Surveys were collected between October 2015 and January 2016.

Care Coordinator Focus Group Results

The following includes the list of questions asked and a brief summary of the themed responses from participants.

What brings you greatest joy in your role? When things really go well…what's that look like? What's in place?

- Seeing progress in patients
- When patients are able to go home
- Forming good relationship with patients and families
- Ability to help families navigate health care system
- Helping families come to terms with end of life care

What are some of the greatest challenges and barriers you face with care coordination for patients and families?

<u>System barriers or challenges:</u>

- Complicated and ever-changing insurance plans
    - Difficult to find home health providers with Medicaid
    - No one-stop shops for services or supplies
    - No mechanism to keep staff informed about plan changes
- Time-consuming to find providers and get authorization
    - Staff spend a great deal of time making many phone calls for one patient
- Some providers stop accepting patients if they have not been reimbursed
- Delays in discharging patients reduces the number of open beds and backs up the workload of staff
- We are able to keep patients alive longer, but find it challenging to work with families to reach appropriate balance with impact on quality of life and expense

<u>Gaps in services or access:</u>

- RML doesn't have certain specialists on staff
    - Hinsdale: Gynecology, Dermatology, Orthopedic, Urology, Interventional Radiology
    - Chicago: Dental, Ophthalmology, Interventional Radiology
- Minimal support systems are available in community
- Quality of skilled nursing facilities is highly variable
- Difficult to find 24-hour in-home medical care
- Difficult to find home health providers accepting Medicaid
- Very challenging to place bariatric patients, especially those with co-morbidity
- Limited number of facilities available for medically complex patients (especially those on ventilation or dialysis)

Are there any other specific barriers or challenges for patients and their caregivers in managing their health and recovery as they transition out of RML?

- Some patients don't have family support
- Stressors about being ill and coping with loss of independent lifestyle
- Patients who have criminal history, substance use history, or have attempted suicide have more trouble being placed in care

- Facilities are not willing to expand Sub Part S funding for mental health and substance abuse treatment
- Age limitations at facilities
- Financial stress if patient is the main income earner for family

What seems to surprise patients and families most about the transition out of RML?

- Patients don't want to leave
- Patients don't understand the role of LTACs
    - Surprised when they learn they have to go to acute rehab before they go home; expected that they would be fully rehabilitated at LTAC
- Patients may not be able to wean completely from ventilator
- Patients sometimes have limited options for care despite having insurance
- Shock at quality of skilled nursing facilities

What supportive services are the most challenging for patients and their families to access after their hospital stay?

- Medical Services
    - Senior centers have cut back on regular well-being checks
    - Outpatient dialysis can be difficult to find
    - Rehabilitation services are not covered
    - Psychiatric conditions often overshadow other issues; need access to treatment
- In-Home Services
    - Funding has been cut for Meals on Wheels
    - Home health physicians, especially for trach or bed-bound
- Equipment/Supplies
    - Sharply decreased equipment closets at senior centers
    - Who can fix it equipment? Who can replace equipment that is destroyed, stolen, or broken?
- Transportation (to get to doctors, dialysis, pharmacy, etc.)
    - State budget cuts affected transit funding
    - Some seniors can't drive anymore

What would be the most effective ways to improve quality of life for the types of patients that RML sees?

- Increase education and prevention efforts so medical issues can be addressed before the patient gets to the ICU or LTAC
- Provide critical medications early to manage a chronic condition
- Increase the availability of community health care resources; healthcare in the neighborhood is essential
- Improve access to healthy food

Who are important partners and relationships for RML to develop in order to better support patient caregivers and family members to help them have the best quality of life possible back in the community?

- Work with hospitals, SNFs, and other providers to understand the role of RML (and LTACs in general) and manage family expectations related to prognosis
- Build relationships with payer sources and case managers to learn the best ways to expedite authorization
- Providers/insurance needs to be more consumer friendly for RML so we can coordinate care

- Long lists no one can read, outdated/inaccurate information

What do patients and their families need most from RML during their hospital stays to prepare them for life after RML?

- Honest, open, consistent communication
  - Balance between compassion and directness
  - Families need to know where they are in the recovery/care process, what an LTAC is, etc.
  - Manage expectations of patient and family related to level of care, prognosis of patient
  - Communicate with families, even if it's not what they want to hear

How can information be best communicated to patients, their family members, and key community stakeholders in caring for these patient populations?

- Important to build on relationships with liaisons from SNFs and home health
  - Face-to-face meetings with the family and patient before they are discharged is really helpful
  - Liaison asks questions about patient's needs and describes the facility's premises and services
- Educate families on choosing a SNF
  - RML has printed material on how to choose a SNF
  - Encourage families to tour facilities with a critical eye
  - Visit facilities without making an appointment
  - Go to medicare.gov to look at ratings for facilities
  - Know where the closest hospital is in relation to SNF, in case loved-one is taken to hospital
- Wish list
  - Reminders about follow-up appointments with physicians, surgeons, etc.
  - Portal for sharing patient information from their other caregivers, so we're not duplicating services

Staff Focus Group Results

What brings you greatest joy in your role? When things really go well…what's that look like?

- Adequate staffing levels
    - No one is overwhelmed
    - Allows time to work with other departments
    - Allows time to connect with families
    - Allows time to dig deeper (examine cost containment interventions, educate peers, etc.)
- When staff is working as a team, collaborating and communicating, procedures go smoothly
- When we get good feedback from patients about staff performance
- Seeing progress in patients

What are specific barriers or challenges for patients and their caregivers in managing their health and recovery as they transition out of RML?

- Patients are not ready to leave or don't want to leave
    - Fear of inadequate care at SNFs or at home
    - Anxiety about taking next steps
    - Some patients fight to stay (physical fights or petitions)
- Getting adequate reimbursement for wound care is difficult
- Families feel overwhelmed taking a patient home
    - Worried about continuity and quality of care
- Families are afraid of losing income from the patient, so they resist nursing homes

What seems to surprise patients and families most about the transition out of RML?

- Patients don't understand the role of LTACs
    - Patients think LTAC is a long-term stay or a nursing home
    - Patients think they will be fully recovered before they are discharged
    - Patients think after LTAC, the next step is to go home
- Families have trouble accepting that patient may not survive, or may not have the quality of life they had previously
- Families have difficulty making end of life choices if there is no directive from patient

How can information be best communicated to patients, their family members, and key community stakeholders in caring for these patient populations?

- Need consistent, standard language to talk about end of life, starting at the acute care hospital
- Educate families about:
    - Chronic disease progression
    - Proper care for patient (turning, wounds, nutrition, etc.)
    - Proper self-care
    - Role of LTAC
- Advocacy for positive outcomes, basic care items, and preventative treatments
- Intake liaisons educate hospitals and partners about LTAC role
- Improve planning and communication between disciplines

What supportive services are the most challenging for patients and their families to access after their hospital stay?

- Medical Services
    - Outpatient dialysis centers will not accept trach patients
    - Monitoring nutrition

        - No reimbursement for tube feeding if a patient passes a swallow test; but patients cannot jump immediately from tube feeding to eating 3 meals a day on their own
        - TPN is not reimbursable unless patient is only on TPN
- In-Home Services
    - Qualified home health care
    - Insurance will not cover 24-hour home health care
    - Ventilators
    - Wound care
- Equipment/Supplies
    - Sometimes cannot get optimal healing items (ex: bandages) because they do not qualify for a particular home health provider; the better alternative may be a nursing home
    - Sometimes living spaces are not large enough for equipment

What do you do to try to prevent patients from being readmitted to RML?

- Basic care needs adequately addressed
- Home health providers must monitor patients
- Educate patients on how to self-manage conditions
    - Some readmissions occur due to non-compliance (medication, wound care, etc.)
    - Difficult to change bad habits

What would be the most effective ways to improve quality of life for the types of patients that RML sees?

- Perform home needs assessments
- Tell MCOs and insurance companies what is not working, what services need to be reimbursable
- Support services for self-efficacy
- Encourage more discussion and preparation for end of life decisions for the general population
    - Tendency to hold on to people in acute care beyond having a good quality of life
    - Patient's desires are not always clear, which can make family choices difficult
    - Recognize the cultural and religious influences of these decisions
- Mental health services
    - Patients do not heal because of depression, denial, etc.
- Develop a community feeding setting within RML
- Reduce prevalence of ICU psychosis for elderly patients by getting them out of room if possible
- Connect with community organizations
    - Faith-based organizations for support groups
    - Helping patients with mobility, planning outings
    - Education on prevention, lifestyle choice coaching
- Oversight of finances so that elderly patients are not exploited; likely a social worker role

Who are important partners and relationships for RML to develop in order to better support patient caregivers and family members to help them have the best quality of life possible back in the community?

- Narrow our list of discharge destinations to the high quality providers
    - Communicate to SNFs our minimum criteria for quality of care
- Link patients to support groups
    - Acute care hospitals have many groups
    - Community-based organizations
    - Improve linkage along entire continuum of care

Community Partner Focus Group Results

What is the transition from RML to the rehab facility/SNF like?

- Liaison comes to RML and talks to case manager about patient needs
- Review clinical and financial background to see if patient can be managed in their setting
    - Some factors may prohibit patient acceptance at SNF: funding, criminal history, > 50% ventilator
    - Some factors may prohibit patient acceptance at rehab: undocumented, homelessness
- For home health care, liaison comes to RML to examine psycho-social factors; speaks with clinicians to match patients with services; speaks with family to set expectations

What needs to happen so that a patient can discharge to facility like yours? What medical stability is needed?

- SNF and Rehab
    - Labs at normal levels
    - Check vent settings and mode are appropriate for facility
    - Restraints acceptable
    - Consider wound care needs (can patient sit for 3 hours straight for rehab?)
    - Consider orthopedic restrictions (can patient bear weight?)
    - Consider neurological damage
    - Consider dialysis needs
- Home Health Care
    - Patient safety at home
    - Our ability to provide intermittent care
    - Training and support available at home
    - Appropriate space and power supply for equipment

What is the most challenging aspect of transition?

- CMS, MMAI or any Medicare funded program. A lot of paperwork required ahead of time. Companies will not bring anything out without face to face.
- Wheelchairs and walkers companies have cut services by 40% because they can't afford to deliver one piece of equipment. Or they won't deliver at all. Go to thrift stores to find used equipment.
- Wound care equipment takes a long time
- If proper equipment is not in the home, it delays patients going home
- If patient doesn't have primary care physician, it is unclear who will take over long term management of care

From your perspective, is there something more hospitals like RML could do to help caregivers and their families?

- RML does a good job on planning stage. Care Coordinators train the home care givers.
- RML and providers collaborate to procure equipment.
- Many physicians are on staff both at RML and at facilities, so there is some continuity of care.
- Our social workers find out who their PCP in the community is and link them to care.
- Need consistent messaging. Delivery of realistic expectation. Delicate balance of giving hope and being realistic.

What are the greatest challenges for patients and their caregivers during their time at your facility/receiving your services? And after leaving?

- Financial situation
- Family dynamics
- Age limits for nursing homes
- Caregivers
    - Physically and mentally demanding
        - Try to train backup caregiver; educate everyone in the family who is willing and able
        - Sometimes caregiver ends up in ER and patient has to be readmitted because they have no where else to go
    - Training required
        - Tap into town/county for support groups
        - Freeclinics.com
        - Refer people to the Cook County Health System
    - Burnout
        - Funding for respite care from senior services
        - If training for respite care is not provided, we provide it
- Lack of primary care physician

At follow-up after discharge, what are the most commonly identified issues?

- Once patient gets home they realize they aren't as independent
- Calling the ER instead of the facility; readmission within 30 days
- Ability to receive follow-up care (PCP, medications, etc.) can lead to non-compliance
    - "Feeling better"
    - No transportation
    - Finances
- Delayed equipment delivery
- Patient or family decides they don't want home health after they already agreed

How do you facilitate a patient's transition back into the community? Do most patients continue rehabilitation at one of your outpatient sites? Does case management continue after discharge from inpatient care?

- Comprehensive day rehab program, for half or full days.
    - Transportation provided
    - Outpatient services (PT, OT, speech)
    - Payer source authorization is challenging – some insurance companies don't recognize day rehab. But it is good for patients because the services are packaged together.
- Transportation assistance
    - Working with Uber
    - Some communities have help from PACE
    - Curbside pick-up for $12 round trip
    - Some insurance plans have transportation benefits
- Case management up to 30 days after discharge
    - You're depending on the person to pick up phone
    - Questions about how long they are allowed to communicate with patients after discharge
- Work with family and patient to take on management of care. Educate family on companies or organizations that will help.

- Working on getting reimbursable telemonitoring for home health. Important for us to be able to intervene before client health declines.

Can you talk a little more about what resources/ suggestions you share in the caregiver support group? Do you address resources that caregivers can utilize after their loved one leaves the facility?

- Senior services
- Link to support groups
- Respite care
- If caregiver can no longer work, state provides some income
- Few resources for younger patients who hit policy max
    - Want to do more education on insurance policies

In terms of preventing patients from ever reaching the point that they need to be at RML and in your care, what are the most important issues to address? How could communities prevent people from ending up needing the services at RML?

- Conditions affecting community
    - Diabetes
    - Hypertension
    - Smoking
    - COPD
    - Nutrition
    - Mental health
    - Substance abuse
- Ownership of health
    - Awareness
    - Proactive about seeing PCP regularly
- Public safety
    - Safety helmets
    - Seatbelts
    - Texting while driving
- Understand demographics, culture, economics of target population

What are some important relationships to maintain and develop?

- MCOs
    - Create and replicate process for getting reimbursements faster
    - Must prove your value proposition; “If I save you money, can you pay me more or faster?”
- Visiting physicians groups
- Senior services
- Vendors of all types
    - Equipment companies
    - Negative pressure therapy
- Utilize health information exchange to improve continuum of care
    - HIE in Illinois, but there is no funding in Chicagoland
    - HIPAA can be restrictive. People don’t understand what you can and can’t share because of HIPAA
- Build alliances or loose associations with preferred providers to hare best practices, reduce silos

Patient Interview Results

In thinking about the time you (as a patient and caregiver) were at RML, what did you need most from RML during the hospital stay?

- Appreciated the structured rehabilitation program; didn't see this structure in other hospitals
    - Knew who was coming to see me each day
    - Couldn't have done this kind of rehab on my own
    - Staff encourages you to push yourself
- Transition from RML to RIC was flawless because the same doctor was on staff at both facilities
- Phenomenal care from doctors and nurses
    - Continuity of care was well preserved for how many rotations they go through
    - High quality of care made a difference in my recovery
- Staff was willing to go above and beyond in the best interest of the patient
    - Gave patients "humanity"
    - Staff was always positive
- Nutrition support was important; the nurse explained why I needed to keep trying to eat even though I wasn't hungry; I would have panicked at home by myself.
- Room is small for occupational and physical therapists to do a lot of movement; maybe they need to get some funding to upgrade facility
-
- Able to insert feeding tube without going to endoscopic lab
- Able to do communion with pastor

What supportive services are most important for patients and their families after their hospital stay?

- RML came out and checked on me periodically, made sure I could navigate
- Patient followed recommendations from "red book" RML prepared
- RML taught me some tricks in wound care that really helped, you can't find that info elsewhere
    - Not sure if transfer of knowledge goes up to other institutions, I know it flows down to patients

Any community resources particularly important to you for your health?

- Didn't access them because I didn't think I needed them

What surprised you or were you unprepared for? How could RML have better prepared you?

- Pleasantly surprised that doctor was on staff at RML and RIC
- Prepared a little red book for me with Info on: therapy, medications, exercise, ostomy supplies
    - All disciplines signed off on red book
    - If I needed to follow up, I checked book for contact info
    - Extremely helpful roadmap

In terms of preventing the need to come to RML, is there anything you can think of that is important/necessary?

- If you leave hospital and you're not ready to, and you get sick again, it costs more money than if you did it right from the beginning
- Not sure if having a PCP mattered; went for colonoscopy at regular interval, was diagnosed with stage 4 cancer. I didn't have any symptoms. How do you catch it early?
- Health issues that were not being addressed early even though patient had annual physicals
    - PCP did not suggest early interventions or treatment for high triglycerides

Key Informant Interview Results

What brings you the greatest joy in your role? When things really go well…what's that look like? What's in place?

- Communication between departments
- Communication between patients and families
- Having a shared vision of what we want to accomplish makes implementation more effective
- Started doing "huddle" to improve communication
    - All disciplines gather before shift to discuss patients for 5 minutes
    - Prior shift collects info and communicates it to the next shift

What are some of the greatest challenges and barriers you face while caring for patients and families?

- Communication break down between disciplines
- One patient that is not doing well can get you behind
- Electronic medical records
    - Different modules for different departments don't always connect seamlessly
- *50% of time, families are unaware of the condition of patient before they are admitted; when they get diagnosis there is some denial*
- *Internal conflict in families*
- *Resistance to recommendation regarding treatment*
- *Short staffed on care coordination*
- *Having access to psychologist and pastoral care*
- *Computer system is not universal for doctors*
    - *We have EPIC, only connected to a few hospitals*
    - *Waste time repeating process on patient. MRI, lab tests, etc. Duplication costs money and time.*

Are there any other specific barriers or challenges for patients and their caregivers in managing their health and recovery as they transition out of RML?

- Managing expectation of level of health they will have when they leave RML
- Uncertainty about what next step will be
- Financial burden of long term care
- Level of care at another facility; they don't get same attentiveness
- Sometimes patients are not ready to leave RML, feel they are being rushed out
- Some didn't expect level of therapy they would get more intense; but it is positive because they feel they are getting pushed, that they are improving
- *Occasionally people don't have coverage; this is less common now due to ACA and County Care*
- *Think that RML is a long-term stay, like a nursing home; surprised that they have to leave*
- *Service is excellent; good location; parking; doctors and specialists come around every day; so they don't want to go somewhere else*

What supportive services are most important for patients and their families after their hospital stay?

- Equipment; hospital bed or trapeze
- Home health care geographic coverage, some agencies will not go to certain neighborhoods due to security concerns

Are there any population-based strategies you think would reduce the likelihood of patients ending up in RML or other acute care?

- Education and health literacy

    - On chronic disease and medications
    - Why it's important to monitor conditions
    - Tailored to different education levels, languages, etc.
    - *Health fairs are helpful. Insurance companies sometimes paid for these. Community centers, churches, doctors would do half day fairs to help community.*
- *Health insurance companies need to be held accountable*
    - *Need to contact their clients at certain intervals for check-ups on different conditions, give patients list of providers*
    - *They are responsible for certain number of lives, and they get money for this*
    - *They have gaps they need to cover, need to be more proactive*
    - *They can identify high risk clients.*
- *Lack of awareness leads to non-compliance*
    - *Children see parents not taking care of themselves, and they will follow the same path*
- *Lack of funds*
    - *Ability to buy cheaper [unhealthy] foods contributes to conditions*

What would be the most effective ways to improve quality of life for the types of patients that RML sees?

- Support system: community, family, friends
    - Helps keep patients positive. Emotional support can be more important than medical.
- *End of life care*
    - *Offer families resources to think about end of life choices, hospices*
    - *How to keep best quality of life while the patient is still alert*
    - *Discuss openly, but delicately*
    - *Some are afraid to take ill home because they are afraid of death*
    - *It would be good to have constant access to 2-3 beds in hospice*
    - *Comforting to family to know the same doctor is continuing with hospice care*

Who are important partners and relationships for RML to develop in order to better support patient caregivers and family members to help them have the best quality of life possible back in the community?

- Increasing communications between providers
    - Understand patient needs and make sure they can provide that level of care
- Develop SNF network
    - Patients can have very special needs; difficult to match all needs (geography, specialty)
    - Narrow SNF list and work more closely with them, add capabilities to serve patients
    - Identified 8 key capabilities for SNFs
- Develop patient advocacy groups more specific to CCI and respiratory patients
    - Understand conditions AND what is important to patients
- *Outreach nurse used to go to churches, YMCA, local grocery stores.*

How can information be best communicated to patients, their family members, and key community stakeholders in caring for these patient populations?

- Intake liaisons do a good job, but social workers may not know about expectations/role of RML
- Families feel they don't have enough time to communicate with physicians
    - Families should know the role of the CC and know they can communicate with CC to help answer questions or put you in touch with physician.
- *Care coordinators do a good just but are short staffed; they have a high load, high turnover, may need some support*

Health Impact Collaborative of Cook County (HIC-CC) Central Cook Survey Data

The Health Impact Collaborative of Cook County (HIC-CC) is a partnership between the Illinois Public Health Institute, hospitals, health departments and community organizations across Chicago and Cook County. This collaborative initiative is engaging these entities in conducting collaborative Community Health Needs Assessment (CHNA), action planning and implementation activities across three Cook County regions – South, Central and North. RML is a member of the collaborative and the Central Regional Leadership Team as both RML Campuses are located in the Central Region.

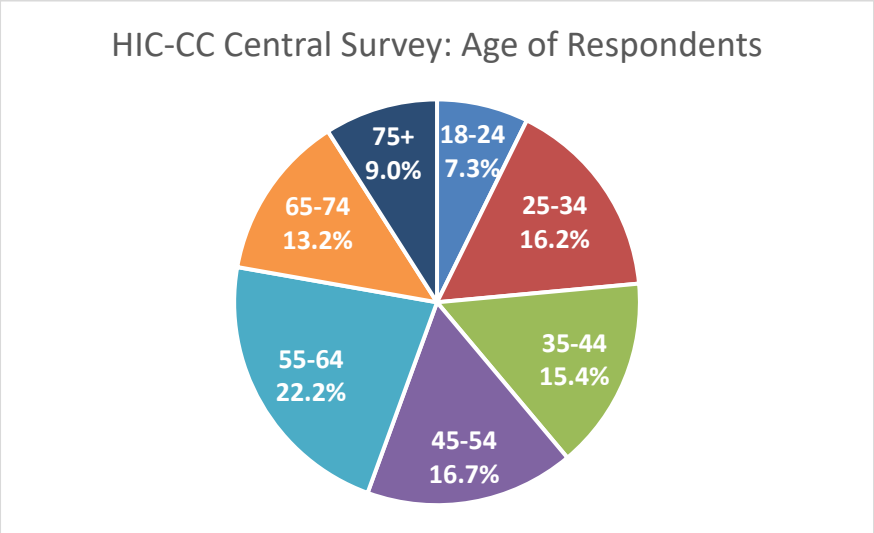
The HIC-CC gathered community input through various means, including a community resident survey. By leveraging the networks of the Collaborative partners, approximately 5,200 resident surveys were collected through targeted outreach to the most vulnerable communities across the city and county, including 1,200 in the Central Cook County region. The survey was disseminated in four languages – English, Spanish, Polish and Korean –and was available on paper and online. The majority of the responses were paper-based (about 75%) and about a quarter were submitted online. Surveys were collected between October 2015 and January 2016.

The following is a brief excerpt of the HIC-CC Central Survey Report on the survey data most applicable to the RML community.

Demographic Characteristics of Central Survey Respondents

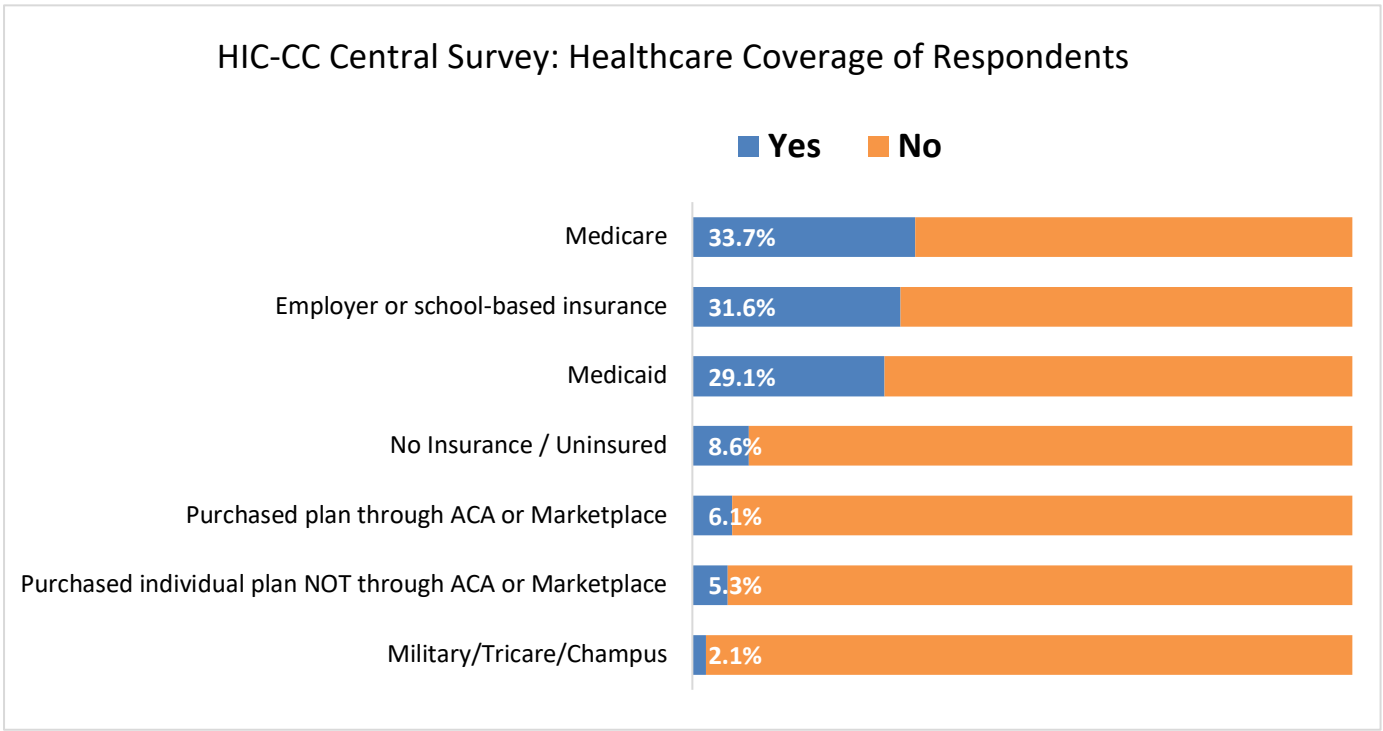
Age

Survey respondents represented a wide range of ages, with the largest group of respondents between ages 55-64 (22%). The least represented age groups were 18-24 (7%) and 75+ (9%).



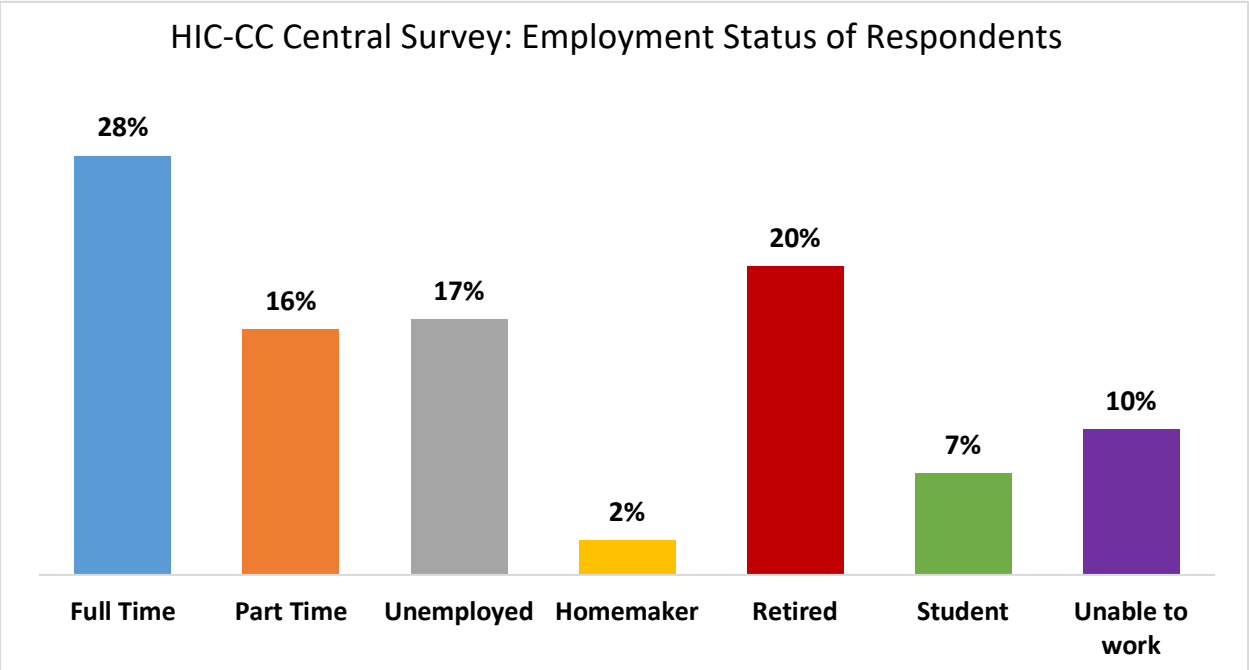
Healthcare Coverage

63% percent of respondents reported Medicare (34%) or Medicaid (29%) coverage. Approximately 1/3 reported employer or school-based insurance coverage (32%), while 11% of individuals reported purchasing an insurance plan. 9% of respondents reported being uninsured.



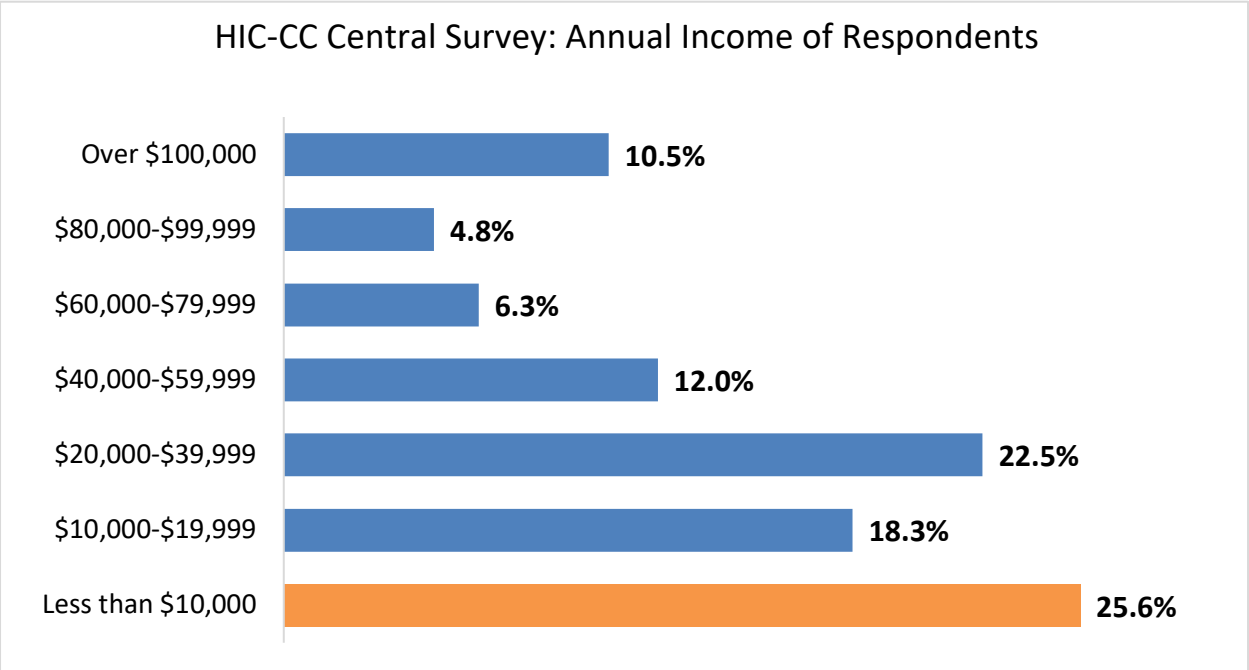
Employment Status

The largest groups of respondents were either employed full time (28%) or retired (20%). Those who were unemployed (17%) or unable to work (10%) represented over a quarter of survey respondents.



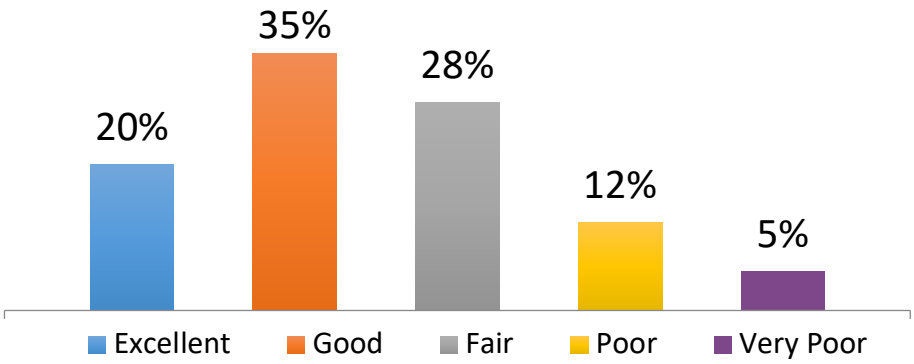
Annual Income

Over a quarter of respondents (26%) reported an annual household income of less than $10,000 and two-thirds or respondents (67%) reported an annual household income of less than $39,999. Twenty-two percent of respondents reported an income of over %60,000.



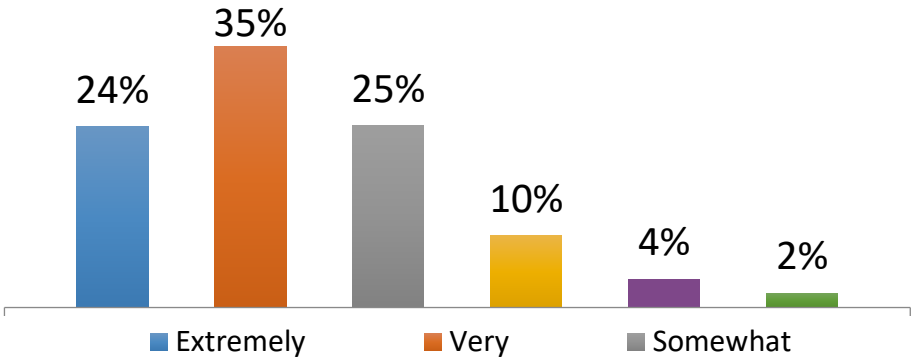
Quality of Life

How would you rate your community ... as a place to grow old? (n=987)



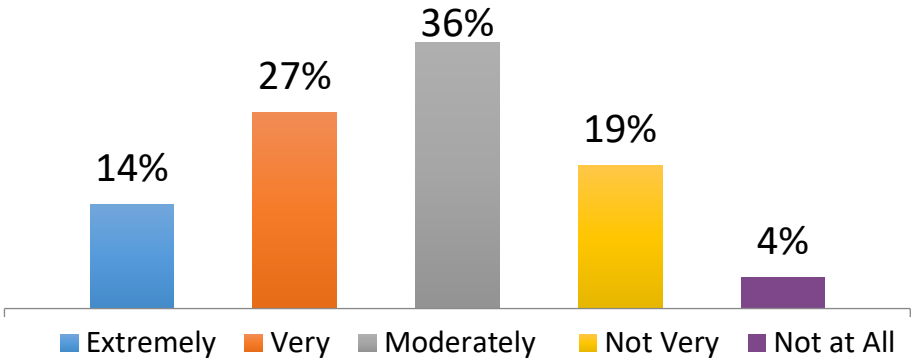
Seventeen percent of respondents rated their communities as poor or very poor places to grow old, while 28% felt their communities were fair places for aging.

How available are healthy foods, including fresh fruits and vegetables, in your community? (n=1012)



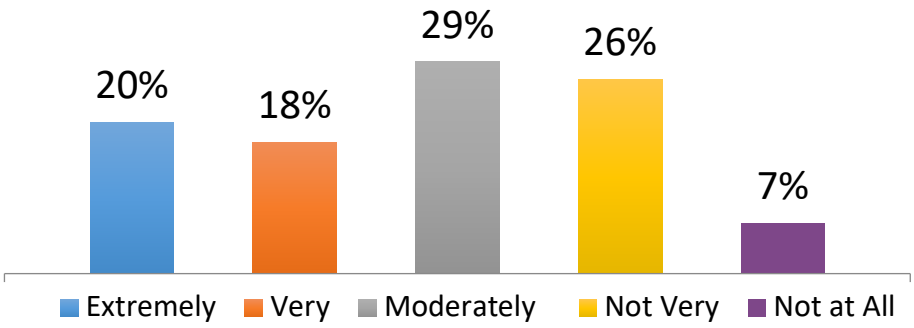
The majority of respondents (59%) found healthy foods to be extremely or very available. Fourteen percent or respondents felt healthy food options were not very or not at all available.

How common are low wages or unemployment in your community? (n=910)



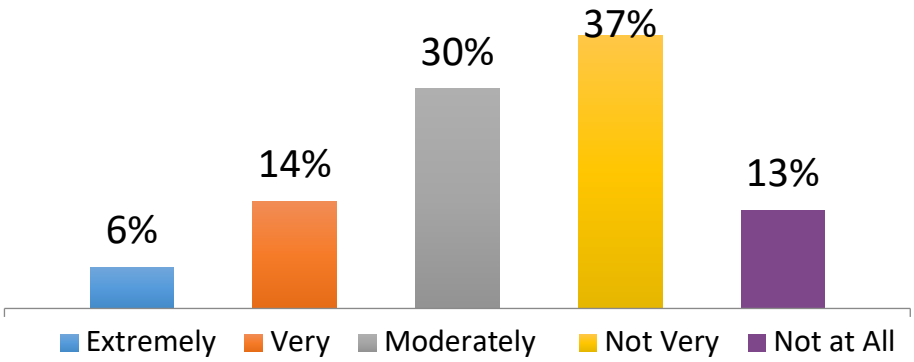
Low wages or unemployment were reported as extremely or very common by 40% of respondents and another 36% reported this as a moderately common issue.

How common is Community Violence (gang-related crime, gun violence, drug-related crime, etc.) in your community? (n=939)



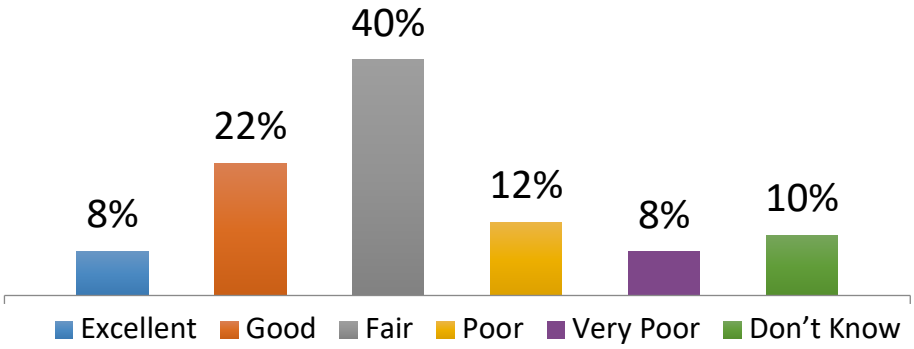
38% of respondents reported community violence as extremely or very common, while another 29% reported it was moderately common. A quarter of respondents (26%) felt that community violence was not very common.

How common is it for community members to be treated unfairly because of the way that they speak English? (n=919)



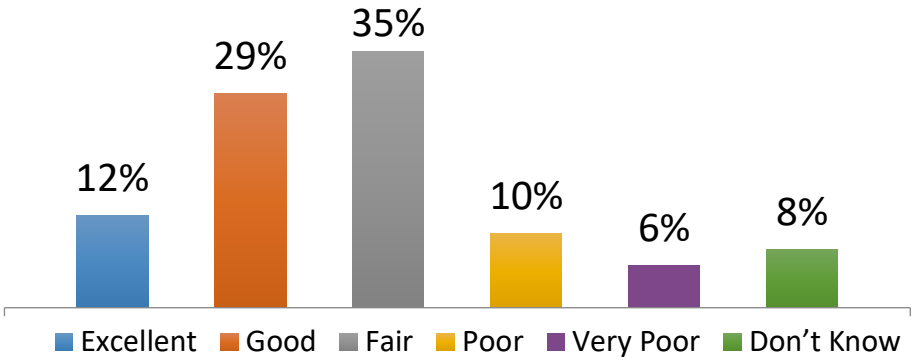
20% of respondents reported that unfair treatment because of the way they speak English was extremely or very common. Another 30% reported this as a moderate issue, while 50% reported this as uncommon or not a problem at all.

Cost of Fares (n=909)



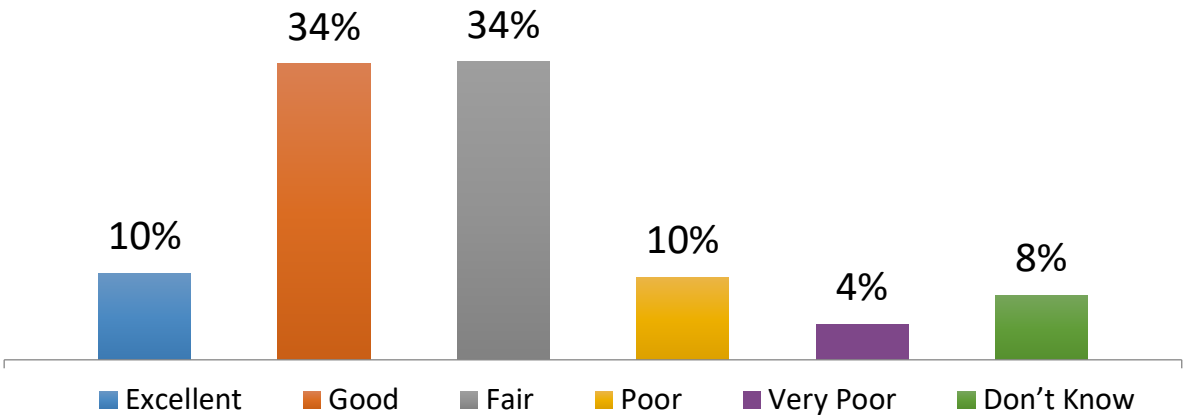
30% of respondents felt that the cost of fares was good or excellent. 40% of respondents reported that the cost of fares on public transit was fair, while nearly 20% found costs poor or very poor.

Convenience of stops/timing for public transportation (n=934)



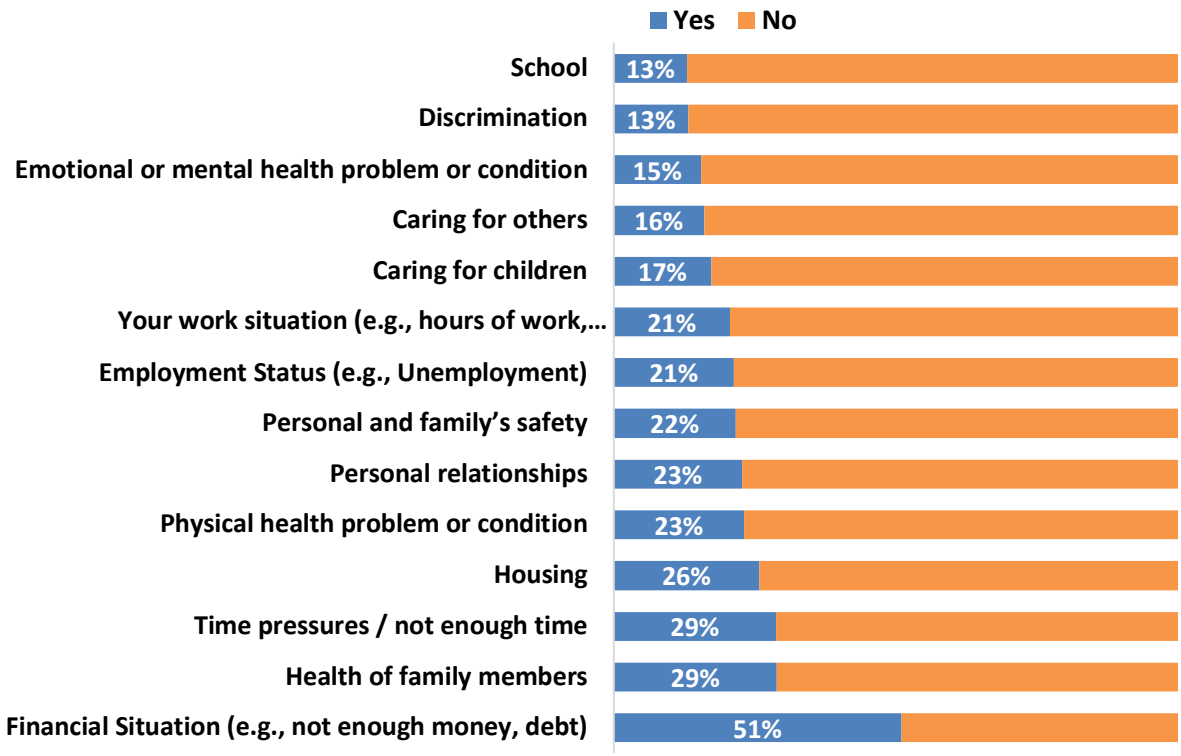
42%of respondents reported excellent or good ratings for conveniences of stops and timing on public transportation. Another 35% found convenience to be fair, while 16% found convenience to be poor or very poor.

Reliability of public transportation (n=941)



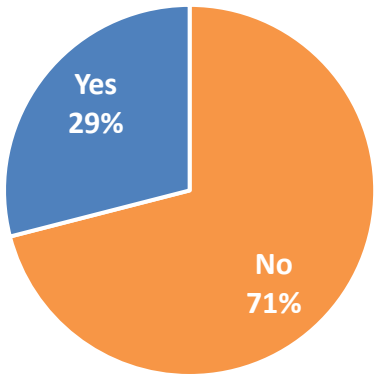
44% percent of respondents rated the reliability of public transportation to be excellent or good, while 35% found it fair and 14% found it to be poor or very poor.

Thinking about stress in your day-to-day life, which of these contribute the most to feelings of stress you may have? Check all that apply. (n=874)



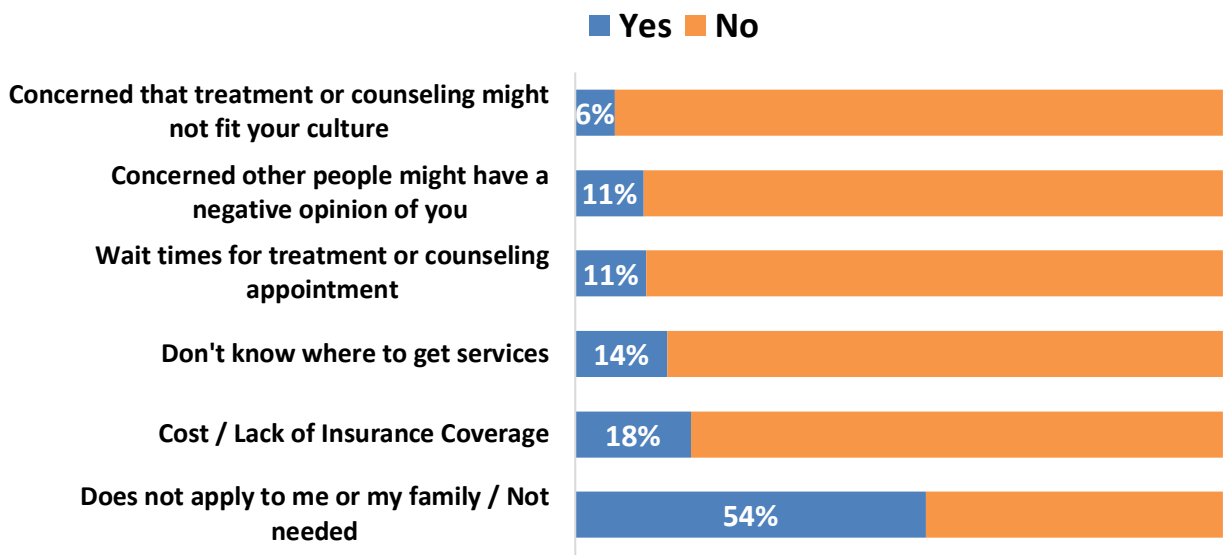
The majority of respondents in central Cook County report their financial situation as a contributor to stress (51%). Health of family members and time pressures were the next most frequent responses, with 29% of respondents citing these as daily stressors.

In the past 12 months, did you or a member of your family put off or not seek medical care because of cost? (n=876)



30% of survey respondents from the Central region indicated that they or a family member put off or did not seek medical care because of cost.

Please think about any time when you or a member of your family may have needed mental health treatment or counseling. If you did not get needed mental health care, which of these statements explain why you did not get it? <u>Select all that apply.</u> (n=801)



Respondents most often cited cost or lack of insurance coverage (18%), as well as not knowing where to get services (14%) as factors in not getting needed mental health treatment or counseling. Wait times for services and being perceived negatively by others were both factors cited by 11% of respondents.

Appendix D: Update on 2013 RML CHNA Implementation Plan

RML's CHNA Implementation Plan was approved by the RML Board of Directors on September 11, 2013. The following is a summary of the progress made against the initiatives contained in the CHNA Implementation Plan since that time.

Priority #1: Patient / Family Knowledge of Disease Process

Initiative 1A - Develop quality educational materials.

Significant Progress 

Most of the clinical departments have significantly upgraded their discharge materials. Respiratory Therapy has updated its materials and provides education on several aspects of ventilator-related care. Rehabilitation Therapy has developed individualized materials for each patient that include written and illustrated instructions. Food and Nutritional Services has made available a variety of information on the many diets patients need to follow. Nurses have been retrained to locate educational materials regarding medications and diseases from standard medical information sites available on the RML intranet (e.g., Micromedix).

Initiative 1B - Provide support and information after discharge.

Significant Progress 

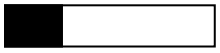
Care Coordinators call all patients discharged to home within 72 hours and Clinical Nursing Supervisors are calling nurses at skilled nursing facilities to check on the progress of recently discharged patients. The vast majority of the patients are being reached. Documentation of the calls has been made in the patients' progress notes and a new Meditech assessment has been created, which will provide better reporting information going forward.

In addition, Care Coordinators have always encouraged patients and families to call with any questions they may have after discharge.

Also, see response to Initiative 3A

Priority #2: Palliative Care and Hospice

Initiative 2A - Build awareness of palliative care and hospice services.

Some Progress 

Efforts have been made to find palliative care and hospice physicians to work with RML's patients. However, specialists with the time to devote to RML have not been identified. An internal medicine physician with board certification in palliative care has and joined the medical staff. This physician has consulted on a few cases but he is not used regularly.

Initiative 2B - Participate in Project PREP / CPC - Palliative Care and Hospice.

Completed [redacted]

CPC team members - including Dr. John Brofman (RML Medical Director), RML's Patient Family Resources Team (patient ambassadors, psychologists, chaplains), and RML's care coordinators - have completed the program sponsored by BlueCross BlueShield Illinois and Northwestern Memorial Hospital at the Kellogg School of Business at Northwestern University in how to approach having the delicate conversation about palliative care and hospice with patients and families.

CPC team members were trained in facilitating conversations on patient-centered goals-of-care (GOC). During interdisciplinary staffing meetings, patients are identified that are unlikely to recover from their illness and GOC conversations are held with these patients and/or families. Physicians are using "GOC conversations" in the day-to-day provision of care with the support of the core CPC team. An intervention with the electronic medical record was developed to document the date and outcome of the GOC conversations.

As a result, there has been a shift toward less aggressive, comfort-driven care for patients in the final stages of their illness, as indicated by an increase in patients choosing comfort care and hospice and changing to DNR status. There have been no negative reactions or complaints from any of the patients or their families, reflecting the appropriateness and timing of the discussions as well as the respect and professionalism of the team members leading the discussions. There has also been a 50% decrease in ethics consults since the program began.

Going forward, there will be a greater focus on the discussions resulting in no change in direction in the patient's care. Training will also be considered for RML physicians that were not part of the CPC project.

Priority #3: Communication around Transitions and Handoffs

Initiative 3A - Participate in Project PREP / BOOST - Patient Discharges.

Completed [redacted]

As a result of discussions with patients, families, and skilled nursing facilities, BOOST team members focused on improving the coordination and delivery of discharge education and providing sufficient information to the patient regarding their stay at RML and plan of care after discharge. A detailed process was developed to streamline and enhance the discharge education and preparation process starting several days prior to discharge. Binders containing detailed information of the patient's stay are sent with every patient discharged to a skilled nursing facility. In addition, follow-up calls to patients and SNFs have been made since the middle of the summer.

Feedback from patients and SNFs have been very supportive and positive of the team's efforts.

Initiative 3B - Apply for CMS Innovation Grant.

Completed 

Unfortunately, RML was not awarded a grant as part of CMMI's Health Care Innovation Awards Round Two (HCIA2). The selection process was highly competitive. CMS contracted with an external organization to manage the review process. Our application was reviewed and scored against criteria published in the "Funding Opportunity Announcement" (FOA). An independent review panel then reviewed our application and ranked it against other applications. Although RML's funding request was denied, we have used the data and analyses gathered to continue focusing on RML's market opportunity and patient population. We continue to request and study updated Medicare data sets on a regular basis to gain additional insight into market utilization patterns.

We continue to request managed care payer post-acute discharge information for the Chicago area, so that we can make comparisons between Medicare and managed care payers. We explored the possibility of applying for a Patient Centered Outcomes Research Institute (PCORI) grant, and consulted with post-acute care experts from both The Brookings Institute and the University of Pittsburgh School of Medicine regarding the merits of doing so, but concluded that it would be best to defer such efforts while pursuing several other initiatives already underway. For example, we are participating in research being conducted in the post acute arena by one of the researchers referenced above and recently submitted a Letter of Intent to apply for an Innovations in Care Program grant from the Hillman Foundation.

We have also recently begun following a systematically-selected sample of patients for up to one year after discharge to try to gain a better understanding of what happens to them after they leave RML. It is hoped this effort will provide insight into how RML can intervene to improve long-term outcomes and reduce the total cost of caring for chronically, critically ill patients.

Initiative 3C - Identify high-quality discharge locations.

Significant Progress 

Information on specific discharge sites has been collected for all patient discharges since the start of FY2013. The data shows that RML has discharged patients to well over 100 skilled nursing facilities, with the top twenty such facilities receiving more than half of all patients. We are now set to begin working with our higher volume skilled nursing facilities to obtain quality information and discuss ways to improve their outcomes and supplement their services.

Over the next six to nine months, RML plans to: develop and begin implementation of an ongoing patient and stakeholder post-acute care engagement plan; identify and pursue opportunities to fund the testing/validation of a new coordinated post-acute care service delivery model; identify and begin discussions with targeted strategic post-acute care partners; and continue efforts to further integrate our post-acute care strategic activities with those of the Advocate Post Acute Network (PAN).

Initiative 3D - Build community connections.

Moderate Progress 

The Executive Director of RML's Chicago location has been strengthening community ties by working closely with the local City Alderman. This relationship has resulted in job training opportunities as well as the Executive Director becoming involved in a local revitalization effort.

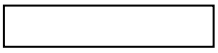
RML has also become involved in two local health care collaboratives: The Healthy Chicago Hospital Collaborative and the Health Impact Collaborative of Cook County. RML is participating with a focus on assisting with initiatives that can play a role in improving the health of its specially-defined community of chronically critically ill patients. For example, the Healthy Chicago Hospital Collaborative is looking to form partnerships with a ride sharing company to ensure transportation for patients to follow-up appointments after they are discharged to home.

Initiative 3E - Work closely with patients' primary care physicians.

Significant Progress 

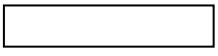
Clinical Coordinators have been making a concerted effort to link patients with their primary care physicians (PCP) prior to discharge. The Care Coordinators are finding that many patients either do not have a PCP or have a PCP who does not feel comfortable taking care of these sick patients at home. In response, the Care Coordinators are developing a list of physicians and physician agencies that are willing to accept and follow RML's patients after discharge. The list notes key physician demographics including location, diseases treated, and insurance accepted. As a result, almost all patients discharged to home have a PCP appointment set up for them when they leave. At this time, no decisions have been made regarding additional efforts centering on this initiative.

Initiative 3F - Provide assistance with transitional care and respite care.

No Progress 

Priority #4: Cost of Accessing Medications and Supplies

Initiative 4A - Work with Senior Service Centers

No Progress 

Priority #5: Caregiver Stress

See Initiatives 1A, 1B, 3D, 3F

Age Options

AgeOptions is a nonprofit community-based organization that partner's with other area nonprofit organizations that serve older adults and their caregivers. AgeOptions can help connect you, or a senior you love and care about with programs and services in your community such as:

- In-home care
- Adult day services
- Telephone assistance to answer questions and link callers to the resources they need
- Problem solving with information specialists concerning care needs
- Nutritious meals
- Intervention against fraud, abuse and neglect
- Advocacy to protect the rights of older adults
- Employment and volunteer opportunities

The following is an excerpt from the AgeOptions Fiscal Years 2016-2018 Area Plan on Aging Public Information Document. The document provides a summary of the AgeOptions Fiscal Year 2016 Needs Assessment.

> Summary of Fiscal Year 2016 Needs Assessment
>
> AgeOptions uses the results of our needs assessment and planning process to set funding priorities and refine standards for our Request for Proposals. We will continue to use the results of our needs assessment in the development of training and resources for the network, advocacy strategies, increased collaboration and coordination, and special initiatives. During our planning process the following themes emerged:
>
> 1. Transportation
>   a. There is a need for transportation to medical appointments.
>   b. Transportation must have wheelchair access.
>   c. Affordable transportation is an issue.
>   d. There is a need to coordinate transportation to cross county and township lines.
> 2. Affordable Housing
>   a. Builders should not be allowed to "buy out" of requirement for affordable housing in new buildings. There is a waiting list for affordable housing.
>   b. People want to age in place and need more Supportive Living Facilities (SLF) in their communities.
>   c. There is a need for more subsidized housing.
> 3. Mental Health Needs
>   a. There is need for more mental health services for home bound and other older adults.
>   b. There are limited resources to deal with these complex issues, and certainly little funding.
> 4. Basic Needs
>   a. People need help with prescription assistance and basic needs.
>   b. It is hard for people with lower incomes who do not qualify for SNAP, LIHEAP, and Medicaid etc.

5. Home Services
    a. There is a need for help with chores inside the home such as changing light bulbs.
    b. Some older adults need assistance with snow removal, cutting grass and home upkeep.
6. Taxes
    a. It is difficult to live on a fixed income in some communities due to the high taxes.
    b. Older adults are using tax deferral programs, but taxes are still too high.
7. Walkability of Communities
    a. It is difficult for older adults to get safely across the street. Drivers are impatient. They need disabled friendly intersections.
    b. Walking in some areas is dangerous because there are no sidewalks on major thoroughfares.
8. Managed Care
    a. There needs to be improved coordination between Managed Care Organizations, Care Coordination Units, Ombudsman, and Adult Protective Services.
    b. There is confusion regarding the Medicare Medicaid Alignment Initiative.

Chicago Area Agency on Aging

The Chicago Department of Family and Support Services hosts the Chicago Area Agency on Aging, which administrates a variety programs designed to address the diverse needs and interests of older Chicagoans, from those who are healthy and active, to those who are frail and homebound. The agency operates six Regional Senior Centers that act as community focal points for information and assessment, and provide senior services in health and fitness, education and recreation. It also partners with non-profit groups to operate ten satellite senior centers that offer information and assessments as well as opportunities for cultural enrichment, health and fitness, and education.

Services provided by the Chicago Area Agency on Aging include:

<u>Assisted Living Information</u>
A comparison of different living arrangements for Seniors in the City of Chicago

<u>Benefits and Services</u>
The Chicago Department of Family & Support Services links Chicago residents age 60 and better to more than 70 city, state and federal benefits to which they may be entitled

<u>Caregiving Assistance</u>
The Chicago Department of Senior Services offers a variety of programs and services for families who are caring for their older loved ones. We know that your goal as an informal caregiver is to help your loved one maintain as much control over their own lives as possible under the circumstances. Our goal is to help you do that.

<u>Insurance Counseling for Seniors</u>
Volunteer counselors with Senior Health Insurance Program (SHIP)offer free, one-on-one insurance counseling at our Regional Senior Centers.

<u>Regional Senior Center</u>
Each Regional Center reflects the cultural diversity of the City of Chicago.

Satellite Senior Centers
The satellite senior centers, part of the Mayor's vision to keep Chicago's neighborhoods active, accessible and affordable for Chicago's senior population, provide services, programs and activities closer to seniors on the neighborhood level.

Senior Related Literature
Information is the key element to accessing all programs and services for senior citizens. By placing a request an older person or caregiver receives information about the services offered by the Chicago Department of Family & Support Services.

Senior Services Information and Assessment Assistance
Accessing information on all the programs Family and Support Services has to offer for Senior Information and Assistance.

Senior Well Being Check
This service request is used to identify seniors whose health, safety or general well being are in question.

Additional Resources

- American Association of Retired Persons – website: www.aarp.org
  The AARP website contains articles about hiring a home care worker as well as other information about the different types of home-care providers available.

- AgeOptions – website: www.ageoptions.org
  AgeOptions core program focuses on Cook County and other collar counties and is funded by the Older Americans Act. There are 10 Caregiver Resource Centers located around suburban Cook County and includes opportunities for trainings, respite and adult daycare.

- Aging Care Connections – website: www.agingcareconnections.org
  Aging Care Connections meets with seniors at the hospital to assess needs and to inform them about services that are available in their community.

- Chicago Area Agency on Aging – website: www.cityofchicago.org/city/en/depts/fss/provdrs/senior.html
  The Chicago Department of Family and Support Services hosts the Chicago Area Agency on Aging, which administrates a variety programs designed to address the diverse needs and interests of older Chicagoans, from those who are healthy and active, to those who are frail and homebound.

- Illinois DHS Division of Rehabilitation Services – website: www.dhs.state.il.us
  The Illinois Department of Human Services' Division of Rehabilitation Services is the state's lead agency serving individuals with disabilities. DRS works in partnership with people with disabilities and their families to assist them in making informed choices to achieve full community participation through employment, education, and independent living opportunities.

- Medicaid – website: www.medicaid.gov

The official Medicaid website has details about what is covered by Medicaid and also the requirements needed to qualify.

- Medicare – website: www.medicare.gov
  The official Medicare website contains useful information, fact sheets and support for knowing about your own personal Medicare plan. There are also location services that can find the nearest doctors, health professionals, nursing homes, hospitals, home health services, medical equipment suppliers and also other specialty medical facilities. Information is also available to find out what is covered and how someone can qualify for Medicare.

- National Caregivers Library – website: www.caregiverslibrary.org
  The National Caregivers Library was developed by FamilyCare America, Inc. and contains a lot of useful information that caregivers can utilize in dealing with common occurrences as a caregiver. Examples of Available Tools:
    - Questionnaires
    - Checklists
    - FAQ Sheets
    - Articles
    - Important forms