2025 Community Health Needs Assessment

Implementation Strategy

RML SPECIALTY HOSPITAL
CHICAGO - HINSDALE

Chicago

Approved By: RML Board of Directors

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RML Specialty Hospital's Mission

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

Purpose of RML's Implementation Strategy

The purpose of this implementation strategy is to outline how RML Specialty Hospital will address the significant community health needs identified in the 2025 Community Health Needs Assessment (CHNA). This strategy serves as a roadmap for deploying targeted initiatives, allocating resources, and establishing partnerships to improve health outcomes for the communities we serve. It demonstrates RML's accountability, transparency, and commitment to continuous health improvement.

About the Hospital

RML Specialty Hospital is a Long-Term Acute Care Hospital (LTCH) offering nationally recognized expertise in critical care for patients who need an extended hospital stay.

Founded in 1987, RML is the largest ventilator-weaning hospital in the United States. Dedicated to individualized patient care and committed to improving patient outcomes through research, RML is also a recognized leader in best practices for wound care and medically complex patient rehabilitation, receiving patient referrals from across the country. Additional information about RML Specialty Hospital is available at **rmlspecialtyhospital.org**.

Community Definition

Analysis of RML Specialty Hospital's FY2024 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 75% living in Chicago and 16% in suburban Cook County. The source of RML Hinsdale's patients is more widely distributed: 17% live in Chicago, 30% live in suburban Cook County, 14% live in DuPage County, and 23% 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:

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.

Community Health Needs Identified

RML Specialty Hospital is committed to improving the health and well-being of the communities we serve. As part of our 2025 Community Health Needs Assessment (CHNA), we identified eight key community health priorities.

- Access to Services (Financial Support and Supportive Services)
- Enhance Transitional Care
- Health Literacy
- Mental and Emotional Health Support
- Specialized Post-Acute and Long-Term Care
- Preventative Care Awareness
- Social and Community Support
- Affordability of Medications

This implementation plan outlines RML's strategic response to the most pressing community health needs over a multi-year period. It details the actions we will take, the focus areas they align with, and the timeline for execution.

As part of RML Specialty Hospital's 2025 Community Health Needs Assessment (CHNA) process, internal stakeholders were asked to rank the eight identified community health needs on a scale of 1 to 8, with 1 representing the lowest priority and 8 representing the highest priority for implementation.

The rankings were compiled across multiple departments and leadership roles, and the total score for each topic was calculated to determine group consensus. This method ensures that higher cumulative scores reflect greater shared urgency and importance among staff.

Based on the total scores, CHNA topics were grouped into three priority levels to guide implementation planning:

High Priority (highest scores indicating strongest agreement on urgent need for action)

1. Discharge & Transitional Care
2. Health Literacy & Education
3. Access to Specialized and Long-Term Care
4. Mental Health & Emotional Support

Intermediate Priority (moderate priority to be pursued based on feasibility and alignment with strategic resources)

5. Preventative Care Promotion
6. Caregiver & Family Support

Low Priority (important, yet may be addressed through future planning cycles or resource-light initiatives)

7. Staffing & Multidisciplinary Coordination
8. Financial Support & Insurance Navigation

To begin the process of building an implementation plan the CHNA committee discussed several initiatives that correlate directly to the eight key needs.

High Priority Focus Areas

The following initiatives address CHNA areas identified as highest priority, including Discharge & Transitional Care, Health Literacy & Education, Mental Health & Emotional Support, and Access to Specialized and Long-Term Care.

Follow-up Call Program	This initiative will provide structured follow-up calls to recently discharged patients to ensure continuity of care, identify challenges early, and reduce preventable readmissions. **Anticipated Impact:** Improves continuity of care and reduces preventable readmissions by identifying patient issues early. **Resources Committed:** Staff time for calls, training materials, phone systems, data tracking tools. **Potential Collaboration:** Partnerships with home health agencies and providers for escalated follow-up.
Know Before You Go Checklist	A practical tool given to patients prior to discharge, this checklist helps ensure that individuals and their caregivers are aware of critical next steps, appointments, and services. **Anticipated Impact:** Enhances patient preparedness for discharge, reducing confusion and increasing adherence to care plans. **Resources Committed:** Design and printing of checklists, nursing staff training. **Potential Collaboration:** Collaboration with care coordinators and case management teams.
Social Media Myth-Busting Series	A digital education campaign that addresses common misconceptions around chronic illness, post-acute recovery, and health literacy topics. **Anticipated Impact:** Improves public health knowledge by dispelling common misconceptions. **Resources Committed:** Marketing team time, graphic design tools, social media management platforms. **Potential Collaboration:** External partnerships with public health educators or influencers.

Caring Conversations Training	This program will train staff to engage in meaningful, empathetic dialogue with patients and families, particularly around sensitive or emotional issues. **Anticipated Impact:** Strengthens staff communication skills, improving patient satisfaction and emotional support. **Resources Committed:** Training modules, facilitator time, printed materials. **Potential Collaboration:** Internal collaboration across clinical departments and patient experience teams.
Resource Guide & Warm Handoff Process	This guide and referral system helps connect patients and families with appropriate post-discharge resources and support services through personalized handoffs. **Anticipated Impact:** Improves connection to community support, reducing gaps in care post-discharge. **Resources Committed:** Social work support, guide creation, referral tracking systems. **Potential Collaboration:** Community-based organizations and nonprofits for service referrals
Micro-Education Campaigns	A series of quick, focused learning opportunities for patients and caregivers around managing conditions, navigating care, and understanding hospital services. **Anticipated Impact:** Boosts patient and caregiver knowledge in short, digestible formats. **Resources Committed:** Education department staff, print or video content creation. **Potential Collaboration:** Partnering with disease-specific advocacy groups for content validation.
Video for Families Choosing Next Level of Care	A short video designed to educate families on care levels following discharge, helping them make informed decisions that align with patient needs. **Anticipated Impact:** Helps families make informed decisions, reducing stress and delays. **Resources Committed:** Video production team, script writers, patient educators. **Potential Collaboration:** Hospital discharge planners and local skilled nursing facilities.

Partnerships with Community Organizations	We will build relationships with local agencies that support patients post-discharge, including those addressing mental health, transportation, and home care. **Anticipated Impact:** Expands support network and access to services beyond hospital walls. **Resources Committed:** Staff for outreach coordination, meeting facilitation tools. **Potential Collaboration:** Formal MOUs with community partners like mental health and housing services.
Plain-Language Redesign of Patient Materials	All key patient-facing materials will be reviewed and rewritten in clear, plain language to increase comprehension and reduce confusion. **Anticipated Impact:** Improves comprehension and health literacy among diverse patient populations. **Resources Committed:** Patient education specialists, review teams, design software. **Potential Collaboration:** Feedback from patient and family advisory councils
Telehealth Information Sessions	This initiative introduces virtual sessions to educate patients and families on telehealth options and how to access care remotely. **Anticipated Impact:** Increases access to remote care and reduces no-show rates. **Resources Committed:** Telehealth platform access, IT support, education materials. **Potential Collaboration:** Vendor collaboration for telehealth solutions.

Intermediate Priority Focus Areas

The following initiatives address CHNA areas categorized as intermediate priority, including Preventative Care Promotion and Caregiver & Family Support. These initiatives provide meaningful value and will be implemented as resources allow.

Caregiver Tips Sheet	A concise, practical resource offering strategies and information for caregivers who are supporting patients through recovery or chronic conditions. **Anticipated Impact:** Empowers caregivers with practical tools and emotional readiness. **Resources Committed:** Educational design staff, printing, clinical review. **Potential Collaboration:** physicians, caregivers, elder care specialists and family councils.
Peer Support Referral List	A curated list of peer support networks and community-based programs to help patients and caregivers access emotional and experiential support. **Anticipated Impact:** Connects patients with lived-experience support, reducing isolation. **Resources Committed:** Social work input, database of groups, referral processes. **Potential Collaboration:** National peer networks, mental health advocacy groups, and local wellness groups.
Community Health Outreach Partnerships	Collaborations with external organizations to host outreach events, wellness checks, and preventative screenings within the community. **Anticipated Impact:** Promotes early detection and builds community trust. **Resources Committed:** Mobile equipment, event coordination staff, health educators. **Potential Collaboration:** Public health departments, faith-based organizations, community-based organizations and schools.
Caregiver Café	A drop-in support and education series designed to reduce caregiver burnout and increase resilience through community, resources, and conversation. **Anticipated Impact:** Reduces caregiver stress and enhances coping strategies. **Resources Committed:** Space, facilitators, light refreshments, promotional materials. **Potential Collaboration:** Alzheimer's Association or caregiver advocacy groups.

Low Priority Focus Areas

These initiatives are tied to CHNA topics categorized as lower priority, including Staffing & Multidisciplinary Coordination and Financial Support & Insurance Navigation. While still valuable, these efforts may be explored in future cycles or scaled gradually depending on organizational capacity.

Financial Resource One-Pager	A simple and accessible handout that outlines available financial aid resources and guidance for navigating insurance coverage and hospital billing. **Anticipated Impact:** Increases patient awareness of financial assistance, reducing financial stress. **Resources Committed:** Billing department input, graphic design, printing. **Potential Collaboration:** Financial services and social services. Note: While Financial Support & Insurance Navigation was categorized as a lower-priority health need based on CHNA scoring, the Financial Resource One-Pager emerged as an immediate win initiative due to its high feasibility, broad reach, and potential to positively impact patients across discharge and care transitions.
Team Huddles for High-Risk Patients	Structured, interdisciplinary team meetings focused on proactive care planning and coordination for patients with complex health needs. This currently happens however the priority would be for review and potential revision of the process. **Anticipated Impact:** Improves interdisciplinary care coordination and proactive planning. **Resources Committed:** Meeting time, coordination tools, facilitator roles. **Potential Collaboration:** Physicians, care coordination, therapy, patient care services, and any patient care stakeholders
Insurance Literacy Workshops	Workshops offered to patients and caregivers to increase understanding of insurance policies, terms, and processes related to coverage and appeals. **Anticipated Impact:** Empowers patients and families to navigate complex insurance systems. **Resources Committed:** Workshop materials, facilitators, conference space. **Potential Collaboration:** Health insurance representatives and advocacy agencies.

Scoring Approach for CHNA Implementation Ideas

To prioritize implementation ideas from the Community Health Needs Assessment (CHNA), each initiative was evaluated using a simple, three-part scoring model based on:

1. **Impact (1–5)**
    - How significantly the initiative addresses a key community health need.
    - Higher scores reflect broader health outcomes or alignment with priority CHNA areas.

2. **Feasibility (1–5)**
    - The practicality of implementing the idea with available staff, time, and resources.
    - Higher scores indicate minimal barriers or use of existing infrastructure.

3. **Reach (1–5)**
    - The extent to which the initiative benefits a large portion of the community or patient population.
    - Higher scores reflect wider access or applicability.

Each initiative received a **Total Score (maximum = 15)** by summing the three dimensions.

Priority Groupings Based on Total Score

Category	Score Range	Description
Immediate Wins	13–15	High-impact, feasible initiatives with broad reach. Ready for quick launch.
Medium-Term Projects	10–12	Valuable ideas that may require modest planning, partnerships, or setup.
Future Aspirational	<10	High-potential initiatives with current feasibility or resource limitations.

The following table shows the scoring and total score (in descending order) for each initiative:

Initiative	Impact (1-5)	Feasibility (1-5)	Reach (1-5)	Total
Financial Resource One-Pager	5	4	5	14
Follow-up Call Program	5	4	4	13
Know Before You Go Checklist	5	5	2.5	12.5
Team Huddles for High-Risk Patients	4	4	4	12
Social Media Myth-Busting Series (Instagram/TikTok/)	4.5	3	4	11.5
Caregiver Tips Sheet	3	5	3.5	11.5
Peer Support Referral List	3	5	3	11
Caring Conversations Training	4	4	3	11
Resource Guide & Warm Handoff Process	3	3	4	10
Micro-Education Campaigns	3	4	3	10
Community Health Outreach Partnerships	3.5	3	3.5	10
Development of video to assist families in choosing the next level of care after RML	5	2	3	10
Development of relationships with community-based organizations that provide support to patients	5	2	3	10
Plain-Language Redesign of Patient Materials	2	4	3	9
Caregiver Café	3	3	2.5	8.5
Telehealth Information Sessions	3	1	3	7
Insurance Literacy Workshops	2	1	4	7

- High Priority - Immediate

- Medium Term

- Future Aspirational

Note: Some initiatives may be implemented ahead of others based on practical factors such as ease of deployment and organizational readiness, even if the broader category ranks lower in priority.

Implementation Timeline

RML's CHNA Implementation Plan is structured in two phases:

December 1, 2025 – November 30, 2026:
During this initial phase, RML will focus on launching immediate win initiatives aligned with the highest-priority needs. These initiatives are considered high-impact, highly feasible, and capable of reaching a broad segment of the community. Leads will be assigned to each initiative, and progress will be tracked through quarterly updates to internal stakeholders and leadership.

December 1, 2026 – May 31, 2028:
In the second phase, RML will begin implementing medium-priority projects, which may require additional planning, partnerships, or resources. We will also assess feasibility for long-term initiatives and integrate any progress into our next CHNA planning cycle.

Next Steps

RML will finalize initiative leads and workgroup assignments for each focus area. Implementation teams will be tasked with integrating each initiative into the hospital's broader strategic and operational plans. All initiatives will be monitored and reviewed quarterly for progress, alignment, and impact. A summary of progress will be published annually and shared with stakeholders, community partners, and the public.

Significant Health Needs Not Addressed

RML Specialty Hospital reviewed all eight identified health needs from the 2025 Community Health Needs Assessment. At this time, we confirm that all significant health needs identified in the CHNA are being addressed in the implementation plan. This ensures full alignment with IRS requirements and reflects our commitment to comprehensive community health improvement.