2025 Community Health Needs Assessment

RML SPECIALTY HOSPITAL
CHICAGO - HINSDALE
Chicago Campus

CHNA Executive Summary

About our Community

Key Health Indicators

Community Input

Prioritized Health Needs

RML Specialty Hospital - 2025 CHNA

RML Specialty Hospital (RML) conducted a Community Health Needs Assessment (CHNA) from February to May 2025 for its two hospital campuses – RML Specialty Hospital Hinsdale and RML Specialty Hospital Chicago – in accordance with IRS requirements for nonprofit hospitals.

RML desires to continue providing clinical programs and services to respond to patient needs, while also pursuing continuous improvement in existing and future programs to improve the overall health of the communities it serves. As such, RML has conducted a CHNA, using primary and secondary data, to ensure community benefit programs and resources respond to identified significant needs as well as alignment with RML's mission, services and strategic priorities. The CHNA was jointly prepared by RML's two hospitals located in Chicago and Hinsdale.

The community RML serves is a large geographic area but a much more limited segment of the population. The chronically, critically ill patient population that RML serves is a very narrow subset of the general population and is the only type of patient that RML treats. For RML Chicago, the relevant community is people in the Chicago metropolitan area and suburban Cook County who have suffered a severe, life-changing, debilitating illness requiring extensive psychosocial and health support services when they return home. For RML Hinsdale, the relevant community is people in Chicago, suburban Cook County, DuPage County, and Will County who have suffered a severe, life-changing, debilitating illness requiring extensive psychosocial and health support services when they return home.

RML took great effort to solicit input from the community. Community members were asked to complete a community survey using the approach described below:

Feedback Collection Approach:

1. **In-Person Surveying of Discharged Patients:**
   - Members of our team conducted surveys directly with patients at the time of discharge.
   - This approach allowed for immediate, real-time feedback regarding patient experiences, barriers to care, and unmet health needs.
   - Patients were selected from across various service lines to ensure a representative sample.

2. **Community Distribution via Digital Channels:**
   - The survey was shared electronically with community partners and organizations aligned with our mission.
   - Distribution channels included email campaigns and reaching out directly to the partners to request completion of the survey.
3. **Flyers and QR Code Access Points:**
   - Survey access was promoted through printed flyers and posters containing QR codes also provided to partners and
   - This ensured broad visibility and easy mobile access for community participants.
   - Emails sent to providers

RML Specialty Hospital - 2025 CHNA

RML patient data was also compiled and assessed.

Secondary data was assessed including:
- Socioeconomic indicators
- Key health indicators

Information gathered in the above steps was reviewed and analyzed to identify needs for the community served by RML.

The process identified the following health needs:

- Access to Services (Financial Support and Access to 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

The CHNA process 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.

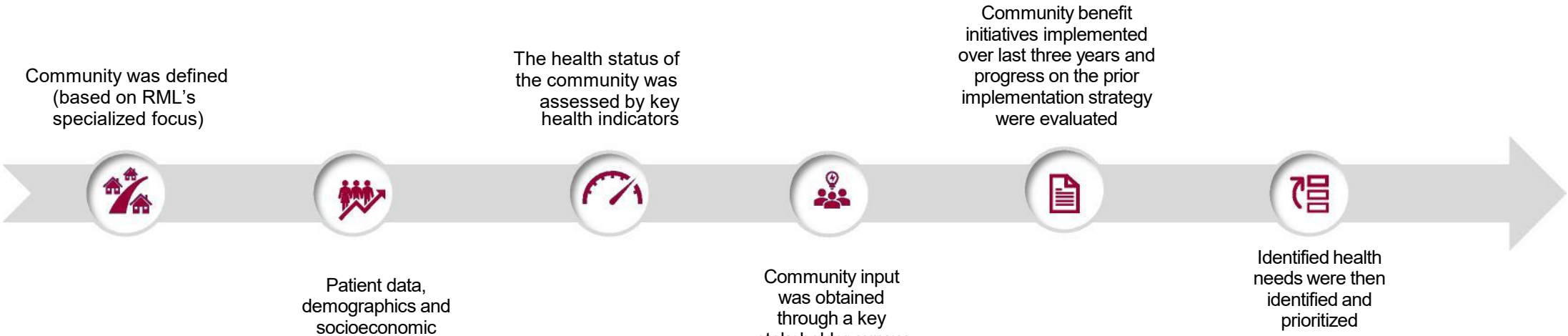
Opportunities for health improvement exist in each area listed above. RML will work to identify areas where the hospitals can most effectively focus their resources to have significant impact and will develop an Implementation Strategy for fiscal years ending 2026-2028.

How the Assessment was Conducted

RML conducted a Community Health Needs Assessment (CHNA) to support its mission responding to the needs in the community it serves and to fulfill the requirements established by the Patient Protection and Affordable Care Act of 2010 and comply with federal tax-exemption requirements. This is the fifth CHNA conducted by RML. The goals were to:

- Identify and prioritize health issues for RML's unique patient population within RML's service area.
- Strategically address identified needs to improve the health and quality of life for patients served by RML.

Based on current literature and other guidance from the United States Department of the Treasury, the following steps were conducted as part of RML's CHNA:



Acknowledgements

The Community Health Needs Assessment for RML supports the organization's mission to *"provide quality, compassionate care to patients from our referring community who suffer from prolonged, severe illness."* This Community Health Needs Assessment was made possible because of the commitment toward addressing the health needs in the community. Many individuals across the organization devoted time and resources to the completion of this assessment.

The CHNA process was led by RML's Chief Operating Officer. RML formed a CHNA team to help guide the 2025 CHNA process, review 2025 assessment data, and to provide input and guidance on the identification of priority issues for the 2026-2028 implementation plan.

This Community Health Needs Assessment has been facilitated by Crowe LLP ("Crowe"). Crowe is one of the largest public accounting, consulting, and technology firms in the United States. Crowe has significant healthcare experience including providing services to hundreds of large healthcare organizations across the country. For more information about Crowe's healthcare expertise visitwww.crowe.com/industries/healthcare.

Written comments regarding the health needs that have been identified in the current Community Health Needs Assessment should be directed to:

Latoya Johnson
ltjohnson@rmlspecialtyhospital.org

General Description of RML

RML Specialty Hospital 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:

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 stay three or more days in 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 skin and tissue injuries.

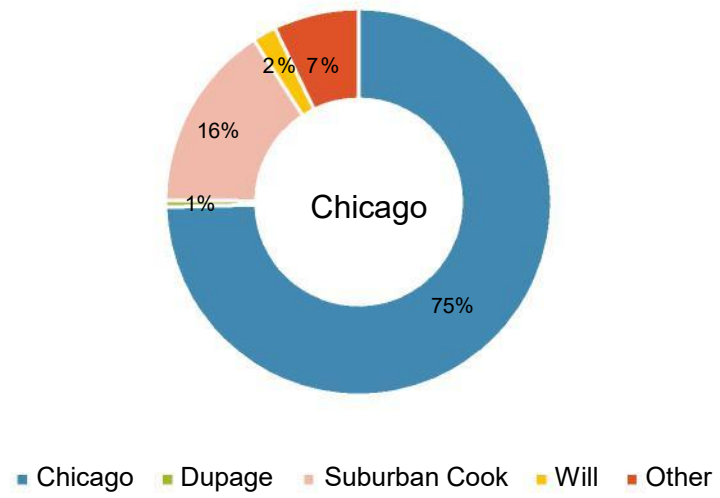
General Description of RML

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 Centers for Medicare and Medicaid Services (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).

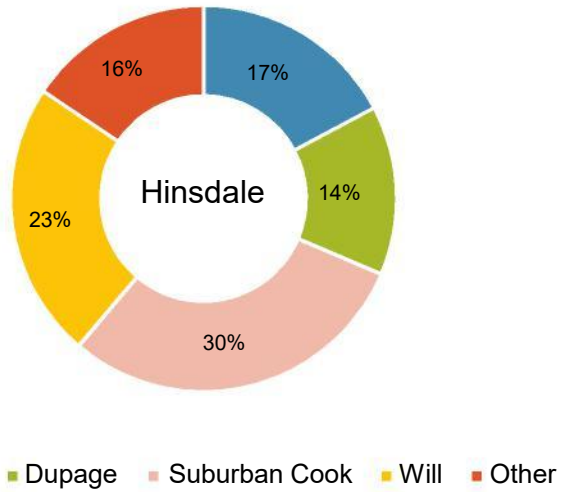
Community Definition

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.

RML Patient Residence
Fiscal Year 2024 Data



RML Patient Residence
Fiscal Year 2024 Data



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 Chicago 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.

RML Hinsdale 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.

Community Overview

To approximate the size of its community, RML evaluated census data. According to census data from 2023, 1,060,872 adults aged 65 and older live in Cook County, DuPage County, and Will County; over a third of those older adults (368,637) 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 310,344 older adults living alone, and an estimated 175,000 older adults have independent living difficulty.

Target Community for this CHNA

As detailed in the Community Definitions section on page 8, 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 five to ten percent of the patients admitted into intensive care units. CCI patients are the vast majority of RML's patient community.

Select demographic information for the community, including Cook County, DuPage County and Will County, is provided below.

$148,172

Average Family Income

310,344

Households with Seniors Living Alone

11.7%

People Living in Poverty (787,398 persons)

10.8%

Adults Age 18-64 without Health Insurance Coverage (444,197 persons)

68%

Percentage of Medicare Beneficiaries With 2 or More Chronic Conditions

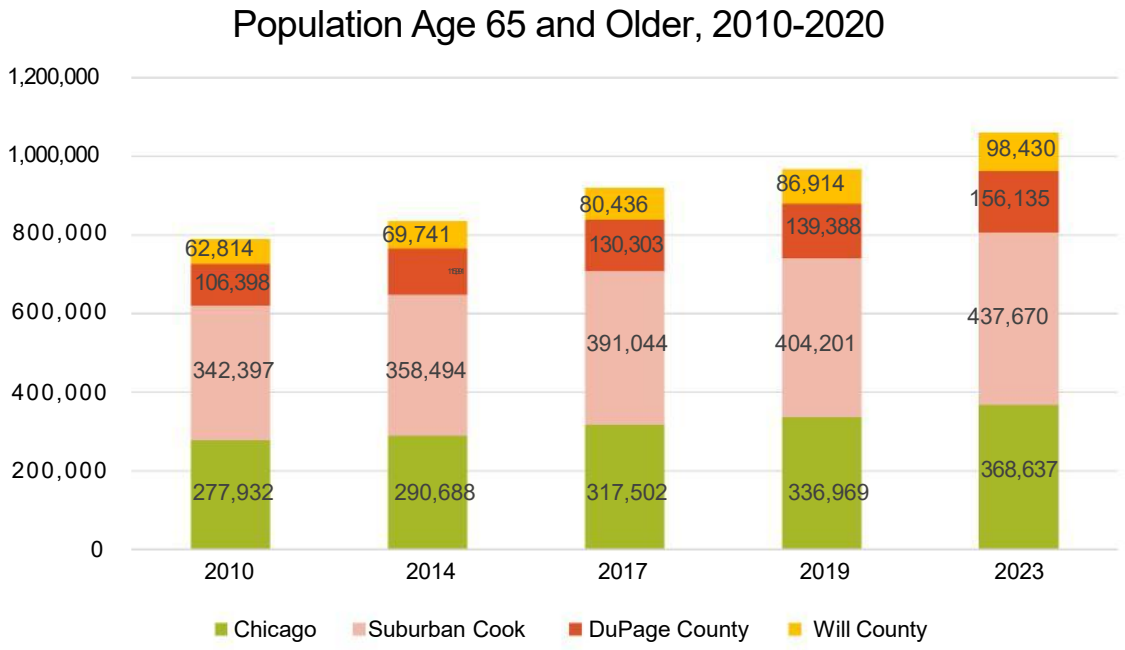
30.7%

317,041 Persons Age 65+ with a Disability

Population Age 65 and Older

As of 2023, the total population of older adults aged 65 and older is 1,060,872, with806,307 (76%) of those older adults living in Chicago and suburban Cook County. Thepopulation of older adults increased by 9.7% between 2019 and 2023 and has increased by over 34% since 2010.

Persons aged 65 and older generally comprise the Medicare population. As shown in the table on the right side of this page, nearly 20% of the Medicare Population has six or more chronic conditions. Within the RML community, over 180,000 Medicare beneficiaries have six or more chronic conditions.



Source: US Census Bureau, American Community Survey. 2019-23

Medicare Population: Number of Medicare Beneficiaries with Chronic Condition

	Diabetes	Heart Disease	High Blood Pressure	Kidney Disease
RML Community	160,249	121,811	383,553	106,164
Cook County, IL	121,168	86,549	281,283	77,894
Dupage County,	21,702	19,815	58,501	16,041
IL Will County, IL	17,379	15,448	43,770	12,230
Illinois	336,283	271,613	853,642	232,811
United States	8,034,095	6,489,077	20,085,238	5,562,066

Medicare Population: Percentage of Medicare Beneficiaries with Chronic Condition

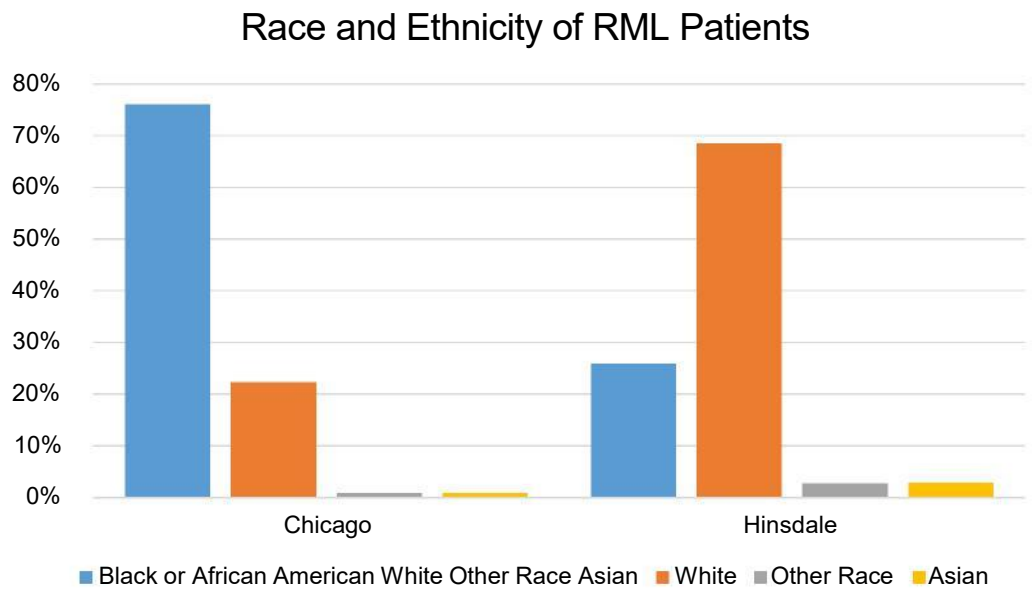
	Diabetes	Heart Disease	High Blood Pressure	Kidney Disease
RML Community	27%	21%	65%	18%
Cook County, IL	28%	20%	65%	18%
Dupage County, IL	23%	21%	62%	17%
Will County, IL	27%	24%	68%	19%
Illinois	26%	21%	66%	18%
United States	26%	21%	65%	18%

Source: Centers for Medicare and Medicaid Services. Mapping and Medicare Disparities 2022.

RML Patient Data - Demographics

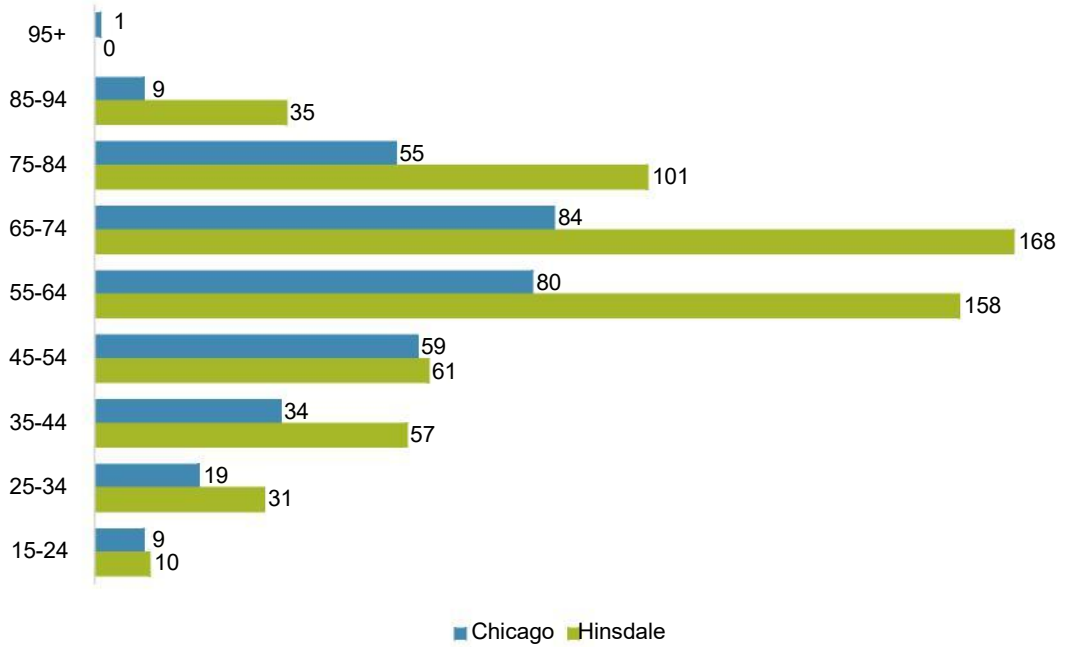
The largest age group of RML Chicago's patients (43%) are adults ages 65 and older, while the largest age group of RML Hinsdale's patients (49%) are 65 and older. RML patients were, on average, older in 2024 than they were in 2021; the proportion of patients 44 or younger decreased at RML Chicago from 20% to 18%, while increased at RML Hinsdale and from 12% to 16%.

The race and ethnicity of RML patients varies by campus. Over 78% of the patients at RML Chicago are non-white while 68% of the patients at RML Hinsdale are white.



Source: RML Fiscal Year 2024 Data

Age Distribution of RML Patients by Campus
Fiscal Year 2024 Data



	RLM Chicago			
Age	2024		2021	
65+	149	43%	190	34%
45-64	139	40%	251	45%
15-44	62	18%	111	20%
Total	350		552	

	RLM Hinsdale			
Age	2024		2021	
65+	304	49%	396	47%
45-64	219	35%	340	41%
15-44	98	16%	99	12%
Total	621		835	

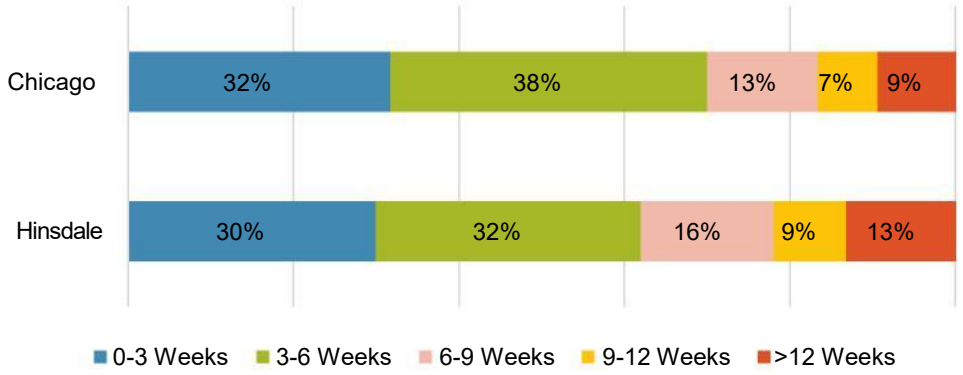
Source: RML Fiscal Year 2024 and 2021 Data

RML Patient Data - Discharge

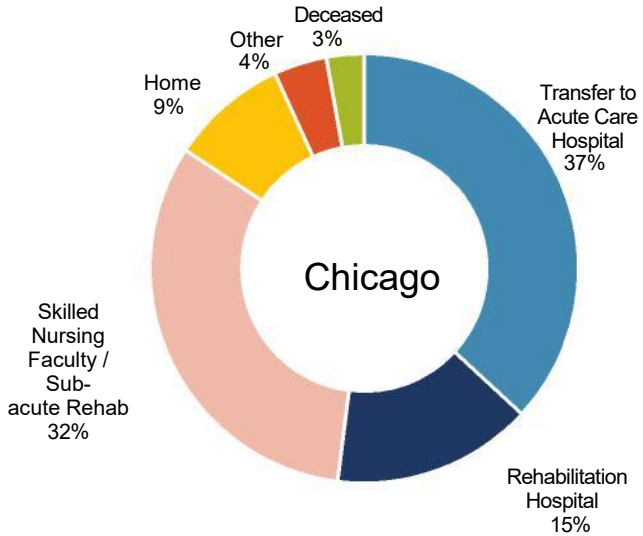
Over 70% of RML patients stay at RML for over three weeks. Patients at the Hinsdale facility tend to stay longer on average than patients at the Chicago facility. As most patients come to RML after three plus weeks in a short-stay hospital as well, the total length of stay in a hospital is usually six 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.

In 2024, discharge profiles were similar for RML's Chicago and Hinsdale facilities. RML Hinsdale had a higher proportion of transfers to rehabilitation hospitals (17%). RML Chicago had a higher proportion of transfers to acute care hospitals (37%) and skilled nursing facilities (32%). 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.

Length of Stay for RML Patients
Fiscal Year 2024 Data



Discharge Destination for RML Patients
Fiscal Year 2024 Data



Discharge Destination for RML Patients
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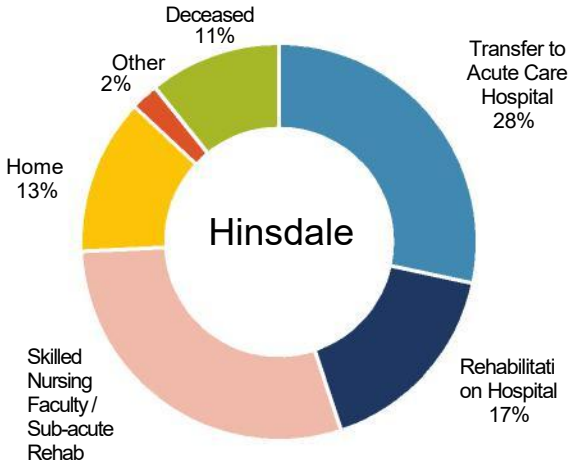
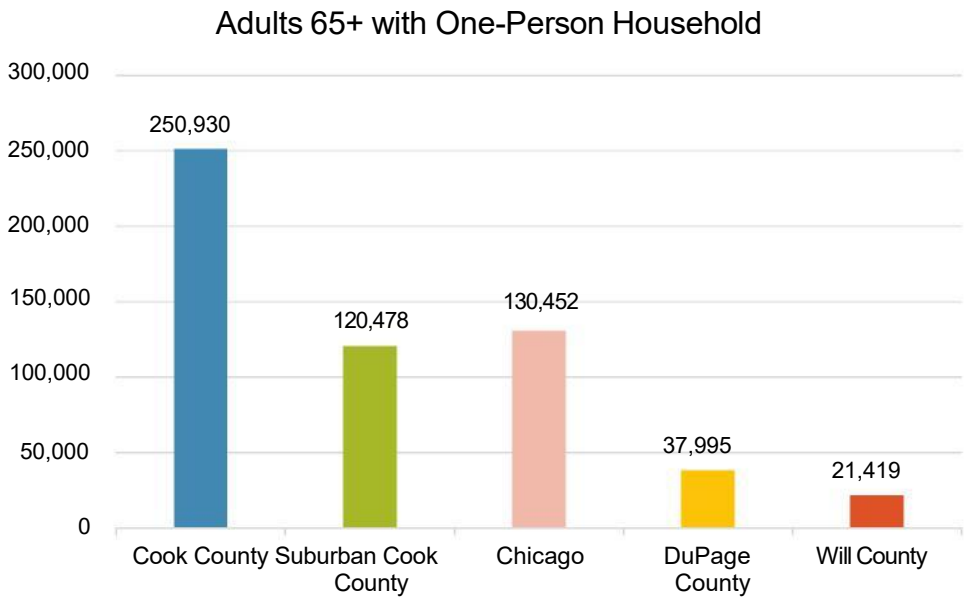


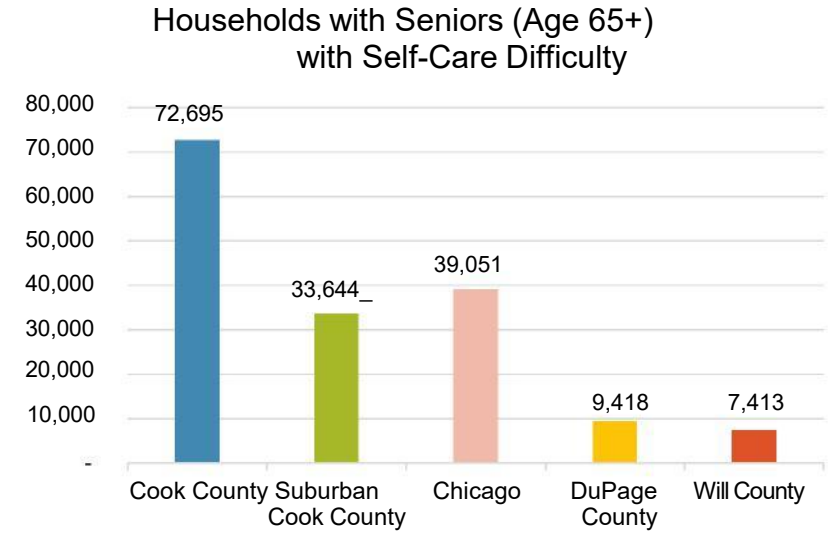
Home Support for Adults (Age 65+)

There were approximately 310,344 households with adults aged 65 and over living alone in the RML service area. The average percentage of senior households among Chicago, Cook County, DuPage County, and Will County was 39%. This indicator is important because older adults who live alone are vulnerable populations who may have challenges accessing basic needs, including health needs.

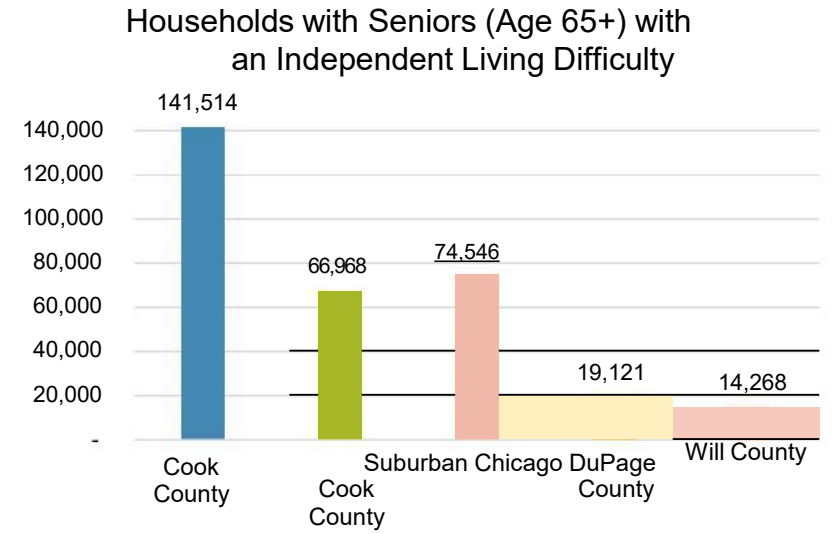
It is often not possible for patients returning home after a long-term illness to live independently. There were approximately 175,000 older adults with independent living difficulty and approximately 89,000 older adults with self-care difficulty in the RML service area in 2023.



Source: US Census Bureau, American Community Survey. 2019-2023



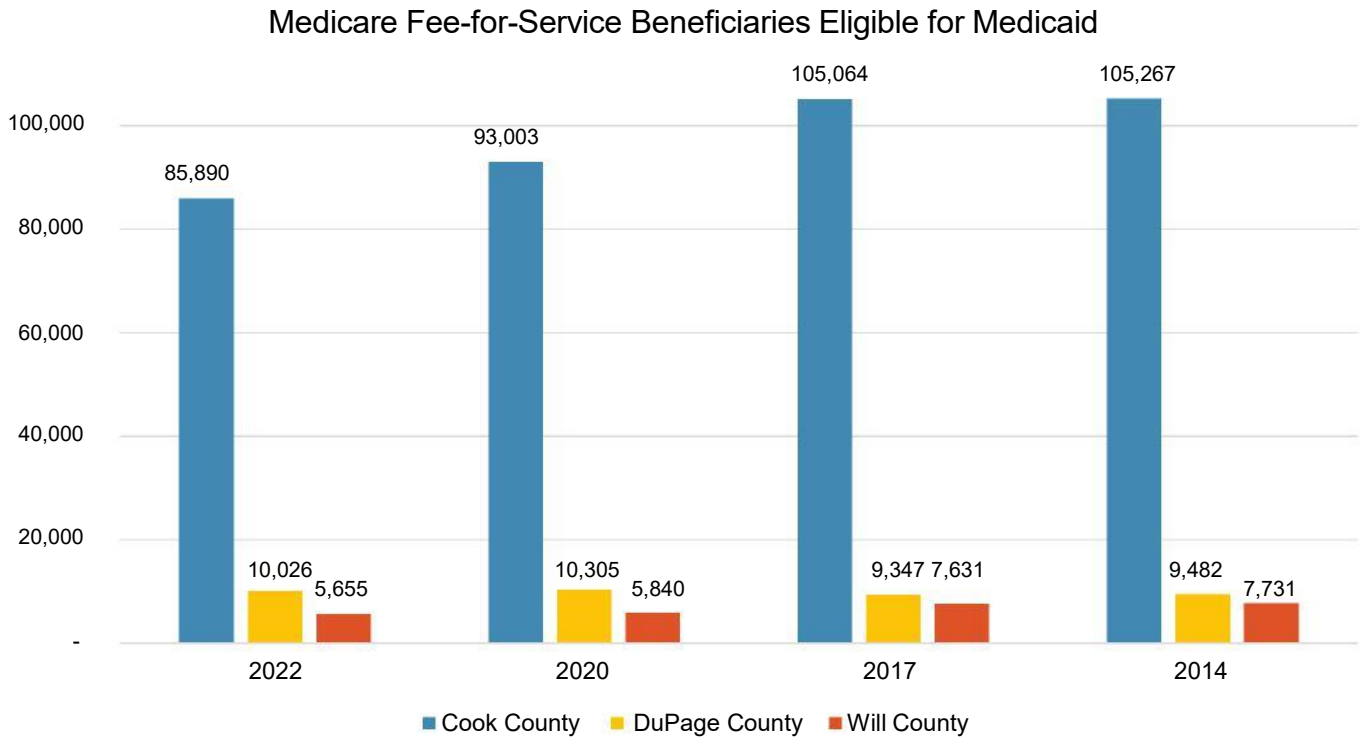
Source: US Census Bureau, American Community Survey. 2019-2023



Source: US Census Bureau, American Community Survey. 2019-2023

Medicare and Medicaid Dual Eligible Population

Medicare is available for people age 65 or older, younger people with disabilities, and people with End Stage Renal Disease. Medicaid provides health coverage to eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Some individuals qualify for both programs, including low-income seniors and younger people with disabilities, and are known as dual eligible beneficiaries. Dual eligible beneficiaries have complex and often costly health care needs and have been the focus of many initiatives to improve the coordination and quality of their care. Roughly 102,000 people in the RML region are considered dual eligible, as measured by Medicare, fee-for service beneficiaries who are eligible for Medicaid for at least one month in the year. The number of dual eligible individuals has declined about 17% from 2014.

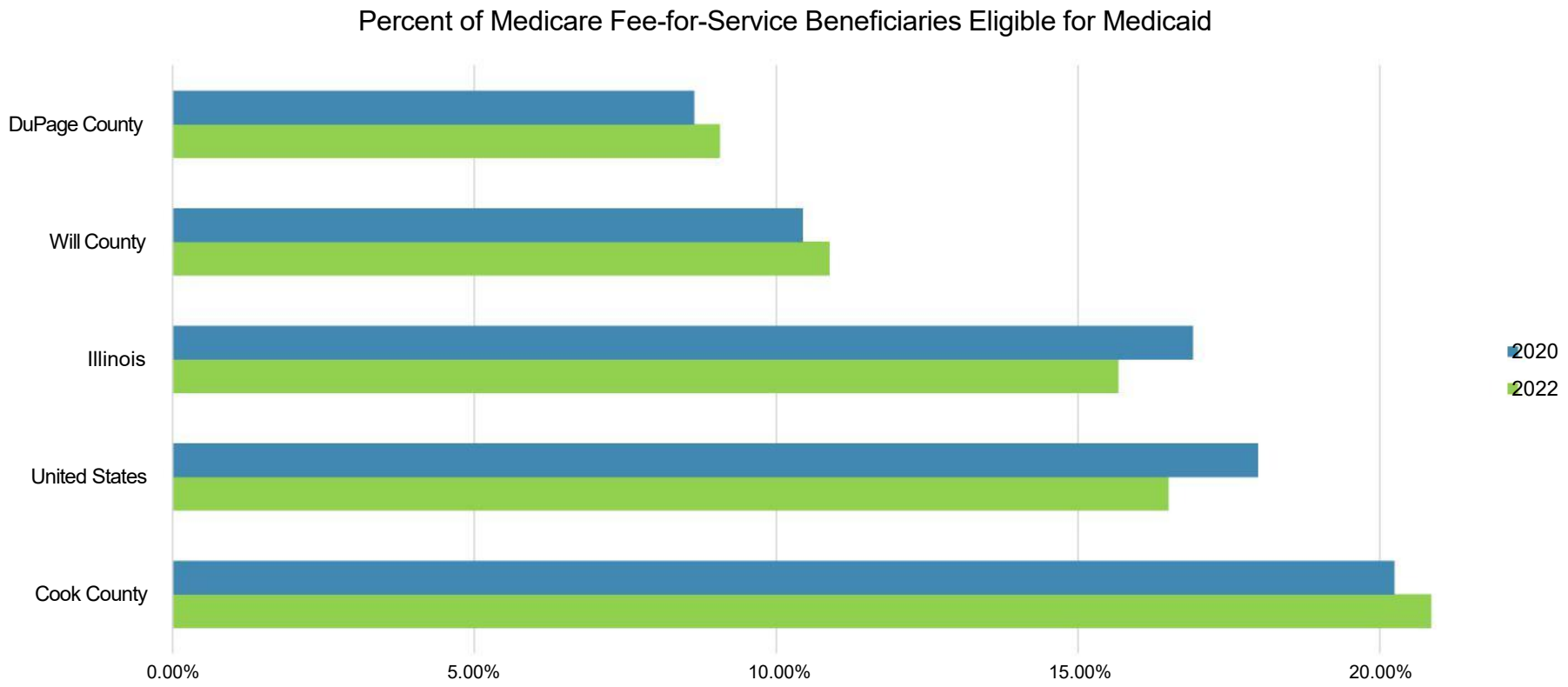


Source: Centers for Medicare & Medicaid Services Geographic Variation Public Use File, 2022

Medicare and Medicaid Dual Eligible Population

Cook County has the highest proportion of Medicare fee-for-service beneficiaries who are eligible for Medicaid (20%), while roughly 9% of DuPage and 11% of Will County Medicare beneficiaries are dual eligible.

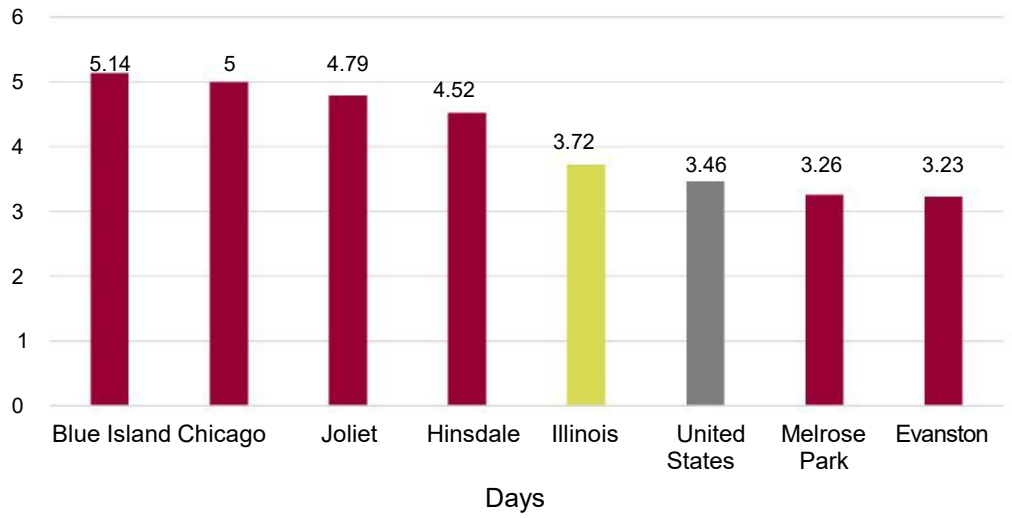
Older adults are nearly universally covered by Medicare and some older adults also qualify for Medicaid coverage to assist with payment of deductibles and co-payments. In Illinois, about 11% of Medicare fee-for-service beneficiaries aged 65 and over were eligible for Medicaid for at least one month in the year in 2022. The rate for the Chicago Hospital Referral Region (HRR) was over double (24%) while the rate for the Hinsdale HRR was less than half (5%) of the state rate.



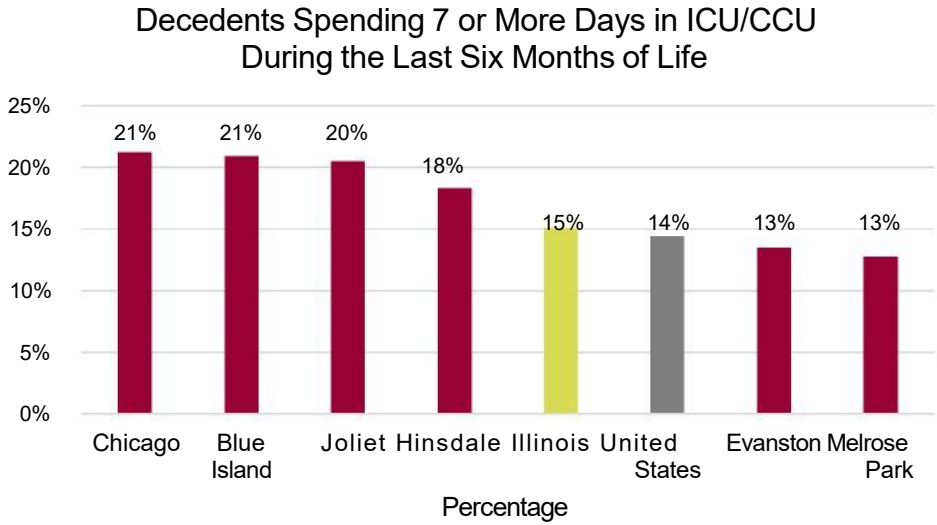
Source: Centers for Medicare & Medicaid Services Geographic Variation Public Use File, 2022

Individuals Living with Chronic Critical Illness

Long-term Acute Care Hospitals (LTCHs) have a high proportion of chronic critical illness (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. Data from the Dartmouth Atlas of Health Care suggest that the RML service area has a high proportion of CCI patients compared to the national average.



Source: Dartmouth Atlas of Health Care, 2019



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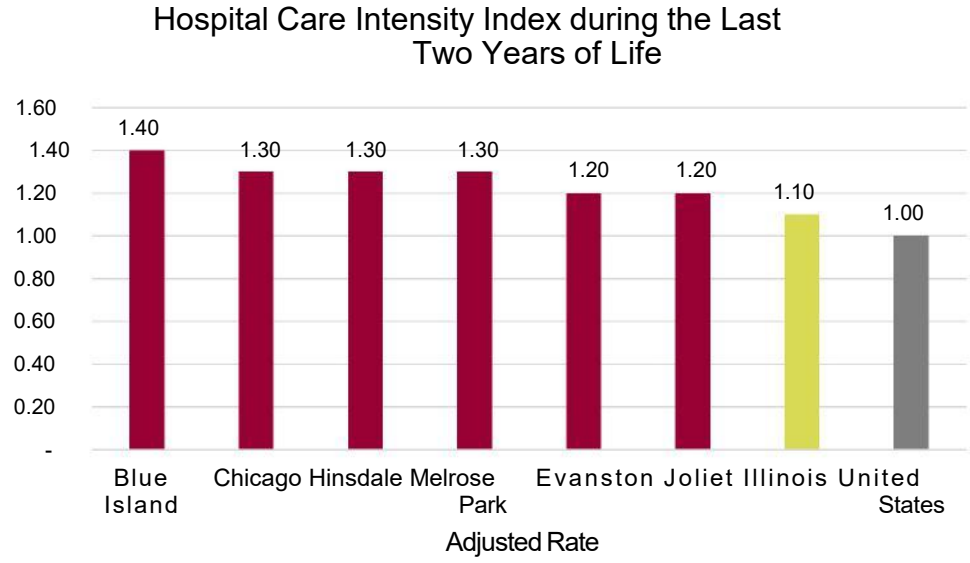


Source: Dartmouth Atlas of Health Care, 2019

Key Stakeholder Survey- Most Pressing Health Concerns

RML obtained input from 27 key stakeholders representing patients, caregivers, physicians and community partners who work with RML patients in the community through a key stakeholder survey. Insights from these parties helps RML better serve its future patients by learning from their experiences and helping RML understand how to improve services to this small but very sick patient population. The survey was conducted from March 5th through March 31st. Below is a summary of the responses for the initial question that asked respondents to describe their most pressing health concerns.

Limited Access to Adequate Funding and Care Resources

- Funding limitations impact the ability to provide necessary care.
- Insurance restrictions and lack of access to appropriate non-ICU, non-skilled nursing facilities hinder long-term care management.
- Patients require extended recovery periods and home care services for conditions that cannot be managed in standard acute settings.
- There is a lack of facilities that can support long-term complex care needs.
- Delayed treatment due to access issues results in deteriorating conditions.
- Preventative care is often missed, leading to worsened health outcomes.

Severe and Complex Medical Conditions

- Many patients have suffered severe, life-changing illnesses or injuries (e.g., anoxic brain injury, respiratory failure).
- Multiple chronic conditions (e.g., hypertension, diabetes, heart failure) complicate treatment
Clil C and recovery.
- Complex medical needs include ventilator support, dialysis, wound care, and prolonged antibiotic therapy.
- Challenges in handoffs between medical providers and lack of communication with referring hospitals can impact patient outcomes.

Rehabilitation and Recovery Needs

- High demand for rehab services (PT/OT) and support during prolonged recovery phases.
- Patients often experience severe deconditioning due to acute and chronic illnesses.
- Patients are at risk for MDRO infections, and infection prevention during visitation is a priority.

Key Stakeholder Survey

Identification of Most Underserved Populations
(alphabetical order)

Low-Income Individuals and Families: Financial hardship limits access to skilled care, custodial care, and long-term recovery options.

Minorities and Communities of Color: African American and Latinx populations identified as high-risk groups. Inequities are linked to systemic issues like poverty, geographic location, and historical disparities.

Medicaid and Medicare Advantage Plan Holders: These insurance plans frequently deny access to Long-Term Acute Care Hospitals (LTACHs) and other essential services. Patients with these plans struggle more to secure appropriate post-acute care.

Seniors / Elderly: Fixed incomes and reliance on Medicare/Medicaid plans limit care options, particularly for long-term or post-ICU recovery. Older adults often denied extended care services due to plan limitations.

Spanish-Speaking Communities: Language barriers hinder understanding of care options, especially after critical illness. These communities often receive inadequate discharge planning or care coordination.

Uninsured and Underinsured Individuals: With no payor source or insufficient insurance coverage, these individuals are frequently denied care or discharged early. Insurance limitations disproportionately affect those who need prolonged or specialized care.

Barriers to Improving Health in the Community

Insurance and Financial Barriers
- Lack of adequate insurance or being underinsured.
- Insurance denials for continuation of care, follow-up, or specialized services (even with private insurance).
- Medicare expense limitations and insurance choosing cost over quality.
- Cost of living, low wages, and unemployment reduce ability to afford care or medication.
- Out-of-pocket expenses for post-discharge needs and supplies.

Access to Care
- Limited access to preventative care, follow-up care, and specialized facilities (e.g., acute neuro-rehab like Shirley Ryan).
- Geographic barriers, such as lack of nearby facilities or services close to family dwellings.
- Living in food deserts or poor socioeconomic areas further limits health resources.

Health Literacy and Communication
- Poor health literacy leads to difficulty navigating the healthcare system or recognizing severity of illness.
- Language barriers and inability to communicate (due to illness or speech issues) hinder effective care.
- Lack of patient and caregiver education on resources and recovery options.

Social Support Deficits
- Lack of willing or able caregivers or family involvement.
- Some patients have no support network despite financial resources.
- Isolation after discharge complicates recovery and adherence to medical plans.

Systemic and Provider-Related Issues
- Inadequate discharge planning and provider awareness of available community resources.
- Lack of clinician education about long-term care and recovery pathways.
- Insurance peer reviews often made by unfamiliar providers who may not

Key Stakeholder Interviews

What are the most the most challenging resources to access and/or navigate?

Specialized Post-Acute and Long-Term Care
- Long-Term Acute Care Hospitals (LTACHs)
- Rehabilitation facilities (e.g., for brain injuries like Shirley Ryan Ability Lab)
- Skilled nursing or custodial care
- Follow-up care after hospital discharge

Social and Community Support
- Lack of family caregivers, transportation, or nearby care facilities.
- Food insecurity, housing instability, and mental health support remain ongoing challenges.

Preventative and Primary Care Services
- Preventative care access is often limited due to cost, transportation, or lack of providers.
- Patients struggle to find primary care or manage chronic conditions proactively.

Medications and Medical Supplies
- High cost of prescriptions and lack of coverage make it difficult to adhere to treatment.
- Necessary medical supplies may not be covered or easily available.

Affordable and Adequate Insurance
- Many patients are uninsured, underinsured, or have plans that deny needed care.
- Medicare and Medicaid plans often have limited coverage for extended or specialty services.

Health Literacy Support
- Lack of resources for education about health conditions, discharge plans, or care coordination.
- Patients and caregivers often do not understand how to navigate the system or use available benefits.

Key Stakeholder Interviews

What should RML focus on over the next 3-5 years to improve health and qualify of life for persons in the CHNA community? What changes would make the biggest positive impact to individuals and their caregivers?

1 Improve Access to Services and Financial Support
- Assist with payments and access to home care services.
- Initiate financial aid programs (e.g., PAP processing) earlier to support smoother transitions to the next level of care.
- Advocate for insurance improvements and broader access to home health services.

2 Enhance Discharge and Transitional Care
- Improve transitional care coordination from LTACH to SNFs or home.
- Help maintain patients longer in LTACHs when medically appropriate instead of premature transfers.
- Offer guidance on post-discharge services like outpatient care, therapies, and caregiver support.

3 Boost Communication and Family Involvement
- Use technology to provide timely updates to families.
- Strengthen communication with caregivers to align on treatment plans and discharge expectations.
- Offer emotional support groups for family members.

4 Increase Health Literacy and Patient Education
- Educate patients and families on:
- Chronic illness management
- Available resources and follow-up options
- Medical terminology and health literacy

5 Expand Mental and Emotional Health Support
- Provide more psychological support for both patients and families.
- Support coping skills, especially for those dealing with traumatic brain injuries or long recoveries.

6 Invest in Staffing and Multidisciplinary Care
- Strengthen multi-specialty teams (pulmonary, ID, psychology, PT/OT, etc.).
- Hire additional social workers to focus on:
  - Longitudinal care
  - Community reintegration
  - Resource navigation

7 Promote Preventative Care Awareness
- Create initiatives around preventative care education to reduce long-term hospital dependency.

8 Focus on Continuity and Long-Term Outcomes
- Foster long-term follow-up connections, especially for patients discharged to SNFs or home.
- Encourage community outreach and support systems to ensure post-discharge success.

Evaluation of the Impact of Actions Taken Since the Last CHNA

RML's FY 2022 Community Health Needs Assessment (CHNA) (approved by the Board in May 2022) identified ten key needs existing in RML's "community." At the time, RML's CHNA team prioritized those ten needs as follows:

High Priority (full consideration and development of Implementation Strategy)

1. Training and education for caregivers.
2. Post-discharge care coordination, including changes to care plan.
3. Post-discharge social services (e.g., assistance with food, utilities, home services).
4. Post-discharge answers to medical questions.

Intermediate Priority (to be pursued if initiative is quick, easy, and with low resource needs)

1. Caregiver support (e.g., psychological).
2. Access to equipment, prescriptions, and supplies.
3. Transition to primary care physicians.

Low Priority (may be re-evaluated at a later time)

1. Setting of realistic expectations of time and energy post-discharge.
2. Respite care and/or in-house nursing.
3. Financial assistance.

Actions taken to address the high priority and intermediate priority needs listed above are summarized on the following pages.

Evaluation of the Impact of Actions Taken Since the Last CHNA

High Priority Implementation

Training and Education for Caregivers:

- Conducted a comprehensive review and standardization of the discharge education process.
- Enhanced discharge documentation, ensuring it is need-based with additional time available as requested by caregivers.
- Expanded the use of materials in caregivers' native languages and increased access to language services to improve communication during discharge training.

Post-Discharge Care Coordination:

- Implemented updates to the social assessment to include questions on social determinants of health (SDOH), supported by a scoring tool. This tool prompts care coordinators to provide referrals when additional assistance is needed. To date, one referral has been made based on this assessment, aligning with The Joint Commission's NPSG.16.01.01 to improve health equity.

Post-Discharge Social Services:

- RML Specialty Hospital has prioritized staff training on a social services referral tool, that aids in connecting patients and their caregivers to essential health and social service support and information. As needs are discovered using our SDOH scoring tool our staff have the resources needed to make appropriate referrals to social services when additional support is required.

Post-Discharge Answers to Medical Questions:

- Updated our discharge follow-up tool within the EHR to include a discharge education rating system.

Evaluation of the Impact of Actions Taken Since the Last CHNA

Intermediate Priority Implementation

Caregiver support: RML

- RML has partnered with Lincoln and it's EmployeeConnect Plus SM platform. This confidential employee assistance program provides the advice, resources and referrals for caregiver needs to overcome work, family and personal issues. Help is available 24/7

Access to equipment, prescriptions, and supplies:

- RML will collaborate with DME providers and other organizations to work to ensure patients have access to the equipment, prescriptions and supplies upon discharge.
- RML patients and their families in need can apply for the RML Patient and Family Needs Fund. This fund is used for families in need to cover incidental costs associated with transportation, housing, meals and equipment.

Transition to primary care physicians:

- RML care coordination team has increased focus on facilitation of patients transition to primary care physicians. We have built relationships with physicians across the Chicagoland area to For those patients without transportation we have been using MD at Home's services for continued medical care at home for homebound that require ongoing medical attention.

Additional Progress Summary

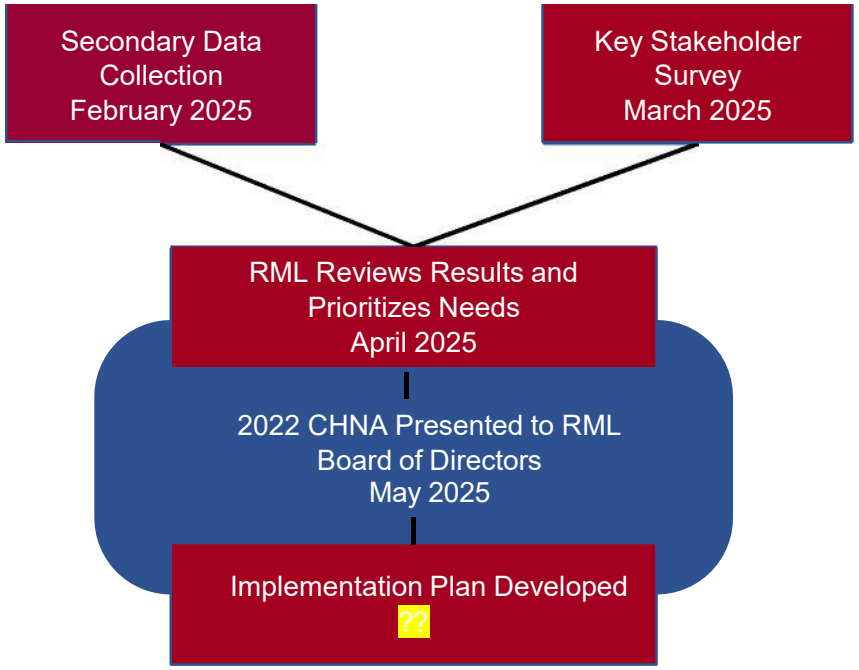
- Documentation Standardization: Improved caregiver satisfaction and communication through tailored and language-accessible discharge training.
- Patient Assessments: Enhanced social assessments have proven to be effective, triggering appropriate interventions and aligning with national patient safety goals.
- Discharge Follow-Up and Feedback: Follow-up calls were made to patients discharged to home, yielding an average satisfaction score of 3.75 (out of 4) at Hinsdale and 3.9 at Chicago (with 42 out of 44 discharged patients participating). High average satisfaction ratings demonstrate effective education delivery and patient readiness post-discharge.

Prioritization of Identified Health Needs

Primary and secondary data was gathered and compiled during February and March 2025. Based on key themes and input gathered through the CHNA process, the following list of needs identified.

- Access to Services (Financial Support and Access to 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

Prioritization process will be explained.



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Internal Hospital Services

- Care Coordination: Each patient is assigned a care coordinator for discharge planning and referrals.
- Special Needs Fund: Assists with transportation, DME, hotel stays, and more.
- Patient Handbook: Includes rights, services, and safety guidelines.
- Chaplaincy & Psychology Support: Available for emotional and spiritual care.
- Interpreters & Accessibility Aids: 24/7 access for patients and families.
- Patient Financial Services: Guidance on billing, insurance, Medicare/Medicaid eligibility, and hospital financial aid.
- Private Duty Nursing Directory: Detailed listing of caregivers and home health providers.
- SNF Selection Tools: 'What to Look for When Touring a SNF' and 'Essential Questions to Ask a Nursing Home'.
- Burial Benefits Guide: Information for veterans and their families.
- Room Amenities include admission kits with personal items, free Wi-Fi access, and television services.
- Dining Services provide meal options tailored to patient needs, with online ordering and pick-up services available.
- Parking is free and available at both the Hinsdale and Chicago campuses, with designated visitor parking areas.
- Visiting Hours are daily from 8:30 AM to 8:00 PM, allowing up to two visitors in a patient's room at a time.
- Family Rooms are available on each unit for visitors to wait while care is being provided.
- Zero Tolerance Policy ensures a safe and respectful environment for all patients, visitors, and staff.
- Rehabilitation Services include physical therapy, occupational therapy, and speech-language pathology, tailored to individual patient needs.
- Respiratory Care is provided by certified therapists specializing in ventilator weaning and pulmonary hygiene.
- Wound Care is managed by certified Wound, Ostomy, and Continence Nurses (WOCNs) with advanced training.

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Physician Involvement in LTACH Admission & Insurance Appeals

To support timely access to medically necessary care, RML physicians actively collaborate with referring acute care hospitals during the insurance authorization process. When an insurance denial is received for a patient referred to RML, RML physicians often participate in peer-to-peer reviews with the insurance provider, leveraging their clinical expertise to advocate for the patient's admission.

This process involves:

- Reviewing the patient's medical records to determine clinical appropriateness for LTACH care.
- Communicating directly with insurance providers to explain why RML is the most appropriate next level of care based on the patient's complex needs.
- Highlighting how RML's specialized services—including ventilator weaning, wound care, and rehabilitation—differ from those available at skilled nursing facilities (SNFs).

RML physicians have been instrumental in overturning denials through clinical advocacy and case-specific justifications. This collaboration has proven successful in securing approvals for patients requiring a higher level of care than typically offered at SNFs.

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Community-Based Resources

- Area Agencies on Aging – support with DME, transportation, and home health.
- Township DME Lending Closets – available in many local municipalities.
- Help at Home Resource List: Includes local area aging offices, social security, food pantries, caregivers, and clinics.
- Local Hotels – discounted lodging for families.
- Traveling Notaries – for POA and financial documentation.
- Air Ambulance Companies – available for transport if needed.

Verified External Resource Links

- Elder Care Management | Silver Connections:https://www.silverconnections.org
- Illinois Department on Aging:https://www2.illinois.gov/aging/
- DuPage County Community Services:https://www.dupageco.org/Community_Services/
- Mental Health Facilities in Cook County, IL:https://www.cookcountyil.gov/agency/department-mental-health
- Long-Term Care Hospital Compare (CMS):https://www.medicare.gov/care-compare/
- Medicare Provider Compare Tool: https://www.medicare.gov/care-compare/

Limitations and Information Gaps

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As with all data collection efforts, there are several limitations related to the assessment's research methods that should be acknowledged. Years of the most current data available differ by data source. In some instances, 2021 may be the most current year available for data, while 2014 may be the most current year for other sources. Likewise, survey data based on self-reports, such as the Behavioral Risk Factor Surveillance Survey (BRFSS), should be interpreted with particular caution. In some instances, respondents may over or under report behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked.

In addition, respondents may be prone to recall bias – that is, they may attempt to answer accurately, but they remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys analyzed in this CHNA benefit from large sample sizes and repeated administrations, enabling comparison over time. Similarly, while the qualitative data collected for this study provide valuable insights, results are not statistically representative of a larger population due to nonrandom recruiting techniques and a small sample size. Data were collected at one point in time and among a limited number of individuals.

Therefore, findings, while directional and descriptive, should not be interpreted as definitive.