



CATHOLIC HEALTH SERVICES

Community Health Needs Assessment – Implementation Strategy

**ST. ANTHONY'S REHABILITATION
HOSPITAL**

October 1, 2016 – September 30, 2019

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I. Executive Summary

Introduction

When Catholic health care began in the United States, it was clear community benefit would be provided. Catholic Health Services (“CHS”) continues its tradition of community healing through rehabilitation and ministry services offered by St. Anthony’s Rehabilitation Hospital (“St. Anthony’s”). CHS is a ministry of the Archdiocese of Miami and is the largest most comprehensive faith-based post-acute provider in the southeast United States. CHS provides a full continuum of healthcare and social services to the southeast Florida community through various controlled entities, including St. Anthony’s.

St. Anthony’s extends mission-driven services into the communities served. Excellence in rehabilitation services goes beyond the walls of the rehabilitation hospital through its outreach to the wider community. St. Anthony’s responds especially to the elderly and those with physical disabilities requiring rehabilitative services due to physical impairments. In addition to charity care and unpaid costs of Medicaid and other government indigent care programs, other healthcare and social services are provided by St. Anthony’s to the community. These are services and programs that are needed in the community, but that would be discontinued if a decision were made on a financial basis alone.

As a mission-driven, faith-based hospital, St. Anthony’s operates according to the directives established by the United States Conference of Catholic Bishops. The *Ethical and Religious Directives for Catholic Health Care Services* articulates the work of Catholic sponsored health care hospitals. These directives define the work of St. Anthony’s. In this document the values and social responsibility of St. Anthony’s include:

- Promoting and defending human dignity
- Caring for the poor
- Contributing to the common good
- Exercising responsible stewardship

By living its mission and values, St. Anthony’s is rooted in the work of nurturing and improving the health and well-being of the people and communities served.

The objective of the community health needs assessment conducted by St. Anthony’s is to identify the most important health needs in the community served by the hospital and to identify ways in which St. Anthony’s can help to address those needs. Due to the nature of a rehabilitation hospital, the focus of the community health needs assessment is defined by St. Anthony’s principal function—the provision of rehabilitation services—within the geographic area served by the organization.

Specifically, St. Anthony’s has defined its community as: *Those individuals who have activity limitations and participation restrictions due to functional impairments.*

Community Served by St. Anthony's

St. Anthony's primarily serves those individuals who have activity limitations and participation restrictions due to functional impairments.

The Centers for Medicare & Medicaid Services (CMS) requires that 60% of the inpatient population of a rehabilitation hospital must meet one of 13 medical conditions. This requirement is outlined in 42 CFR § 412.29(b)(2). Because the organization is required to treat these specific conditions, the "community" served by St. Anthony's is restricted to individuals who have functional limitations resulting in activity limitations and participation restrictions.

The following are the medical conditions treated by St. Anthony's and collectively made up 64.4% (2/3) of the total patient population treated in fiscal year 2015 (baseline):

- Stroke: 22.1%
- Brain Injury: 11.6%
- Other Neurological Disorders: 12.4%
 - Multiple sclerosis
 - Muscular dystrophy
 - Parkinson's disease
 - Motor neuron diseases
 - Polyneuropathy
- Spinal cord injury: 5.7%
- Amputation: 3.2%
- Hip fracture: 8.4%
- Major multiple trauma: <1%

The remaining 35.6 % of patients treated include a wide range of diagnoses (e.g. cardiac conditions, pulmonary conditions, cancer, metabolic syndrome, etc.) all of whom had debilitating functional impairments, activity limitations, and participation restrictions.

Referrals to the acute inpatient rehabilitation hospital program are most often generated from an acute care hospital via the physician, family/patient request or via the case management department.

Once a referral is received, a prescreening process is initiated. Whenever possible, an onsite visit is made by the clinical community liaison to the acute care hospital to review the medical records, meet the patient/family and review the patient's status with the current healthcare providers. In lieu of an onsite visit (if not permitted by the acute care hospital), medical records may be reviewed. A comprehensive pre-admission assessment is then completed to validate that the patient requires an intensive level of rehabilitation to be provided in an acute rehabilitation hospital setting by an interdisciplinary team of rehabilitation professionals, along with close medical management by the physician to address current medical conditions and to monitor potential medical risks. The potential patient must be reviewed by the rehabilitation hospital's medical director and approved for admission into the program.

How the Implementation Strategy was developed

The implementation strategy was developed after the comprehensive community health needs assessment (CHNA) was completed. Please refer to the complete CHNA for the full report. Strategies and action plans were developed based on a consensus among steering committee members and were prioritized based on results from surveys used in the CHNA, current evidence regarding the effectiveness and impact of planned programs (STEADI), and re-hospitalization rates.

St. Anthony's intends to expand its outreach in the areas of education and prevention as described below.

The organization intends to take the following actions to: (1) improve the overall health status of its community and (2) facilitate overall improvement by focusing on narrowing the health disparities present in the community – within its mission. Below are the three programs St. Anthony's will undertake to meet the identified community health needs:

1. STEADI Fall prevention program implementation
2. Health Promotion and Wellness Community Educational Events
3. Neurorehabilitation Follow up Clinic for all patients admitted with neurological diagnoses

II. Identified Community Health Needs

Health Needs Identified

The health needs that have been identified by St. Anthony's as being within the organization's capacity and expertise are as follows:

1. **Reduce Admissions.** Hospitalizations and subsequent re-hospitalizations are among the costliest consequences of any illness or injury. It is through community-based educational programs, care transitions, and preventative services that St. Anthony's hopes to reduce the need for costly admissions by preventing future strokes, fractures, and brain injuries. The organization's plan will also attempt to address reducing re-admissions to acute care by enhancing follow up services, care transitions, and preventative education for patients, caregivers, and the community at large.
2. **Reduce Falls.** The cost and consequences of falls have been described in detail within the community health needs assessment. They are inherently linked to hospitalizations, disability, and death. Given the impact falls and subsequent injuries have on activity limitations and participation restrictions in the community, reducing falls and related complications is foremost among St. Anthony's goals. St. Anthony's will address this need through community fall risk reduction programs (STEADI), and through community education on fall prevention.

Expand Educational Services. Disability resulting from catastrophic illness or injury, such as stroke, results in a higher prevalence of activity limitations and participation restrictions by those impacted by these life-changing medical conditions. Stroke is a leading cause of disability, as well as one of the primary diagnosis treated by St. Anthony's. As a Joint Commission stroke certified provider, St. Anthony's has a specialized program for patients with this condition. Stroke support group as well as education is provided to patients and family members with collaboration from staff and other professionals within the community for various topics of interest. Other neurological illnesses/injuries also rank high among disabling conditions and those treated by St. Anthony's. The organization will address this community need by expanding follow-up services to those impacted by these conditions, as well as offering educational services to facilitate independence, health promotion, and wellness.

3. **Expand Follow-Up and Prevention Services.** Access to rehabilitation services was identified as a community need based on survey results. The organization will expand services by offering a wider array of outpatient follow-up and prevention services as well as providing transportation to patients (if needed) to comply with their follow-up medical or therapy visits. The organization will also address this need by working closely with Medicare Advantage and commercial providers to provide further education regarding appropriate triage of post-acute care services in an effort to improve community health and quality of life and minimize the impact of re-hospitalization.

How Health Needs Are Prioritized

Health needs were prioritized by reviewing the organization's strategy and capacity, reviewing priorities identified in the community survey, and by taking into account local, state and national priorities.

When prioritizing the health needs, St. Anthony's looked closely at the organizational strategy, strengths, resources and capacity. As a rehabilitation hospital, the strengths and expertise lie within the realm of maintaining and restoring, when needed, physical function to minimize activity limitations and participation restrictions. Therefore it was important to incorporate those strengths into the needs that the organization will intend to address.

The survey data revealed that a large percentage of those surveyed reported issues with falls and balance and many reported resulting fractures. This information supports the need for programs to address these avoidable injuries. Implementation of programs to address these functional deficits before injury occurs will result in better health in the community.

On a state and national level, there is a strong focus on reducing readmissions to acute care following a recent hospitalization as well as reducing falls and their consequences. Programs to address functional impairments and issues which can be offered to the general population will help in minimizing those readmissions that may occur due to falls, or balance issues with resulting injury.

Programs that address general health, wellness, and preventative measures may help reduce the incidence of stroke, falls, hospitalizations, re-hospitalizations, as well as the activity limitations and participation restrictions that might result from a stroke or fall.

III. Addressing Health Needs

1. Reduce Readmissions

Actions the hospital intends to take to address the health need

As an organization, St. Anthony's has aggressively approached the issue of re-admissions to acute care while a patient is in the rehabilitation hospital. Interventions have been put into practice that have helped to reduce the percentage of re-admissions to acute care but the results are highly variable and the lower re-admission rates which have been periodically achieved are not sustainable from month to month.

The strong focus on the part of CMS (Centers for Medicare and Medicaid Services) as well as commercial payers and Medicare HMO's to control readmissions to acute care has made it of paramount importance to St. Anthony's Rehabilitation Hospitals to demonstrate sustainable outcomes reflected by a discharge to home with no acute care readmission during the 30 days following discharge.

This will be achieved by aggressively managing all medical issues as they arise in the inpatient rehabilitation hospital setting and analyzing, for trends and possible future interventions, all discharges to acute care from the rehabilitation hospital. This review will occur with identified medical physicians who are active at the hospital and engaged in the process of identifying ways to reduced readmissions.

Education aimed at patients displaying the ability to manage their health issues/conditions will be incorporated into all of the in-patient rehabilitation patients' plans of care. This education regarding disease and health management will be a primary focus of the education provided during community based educational sessions as well.

Anticipated impact of the actions

It is anticipated that discharges to acute care from the rehabilitation hospital will be reduced to 10% of total discharges. This is lower than the current National Benchmark rate of discharges to acute care which is at 14%. Re-admissions within 30 days following discharge to the community will be at 15%.

A plan to evaluate the impact

The organization will monitor readmission percentages from selected community hospitals to determine if there is any community impact.

Programs/resources the hospital plans to commit to address the health need

The organization will conduct monthly reviews of all patients discharged acute from the rehabilitation hospital to help identify factors that contributed to the need for the transfer

and possible interventions to help mitigate the need for the patient to be returned to an acute care setting.

This requires a commitment on the part of the Co-Medical Directors, the Medical Directors, the Director of Nursing and the Administrator.

The organization will provide clinical staff to conduct, in conjunction with community acute care hospitals, community educational seminars to address disease management, management of acute medical issues, and general health and wellness skills.

2. Reduce Falls

Actions the hospital intends to take to address the health need

Falls and related post-fall injuries are treated by the organization when an individual suffers an injury and therefore the issue is typically addressed *after* an injury. However, the organization addresses fall prevention currently by offering the following services:

- A limited osteoporosis/fracture prevention clinic
- Participation in the National Falls Prevention Day (first day of Fall each year)
- A robust and active internship program for students in nursing, physical therapy, occupational therapy, and speech-language pathology
- A post-graduate residency training program in geriatric physical therapy
- A variety of evidence-based fall risk reduction strategies intended for the inpatient and outpatient populations

St. Anthony's will adopt the STEADI program that has been created and endorsed by the CDC. "STEADI" is the acronym for *Stopping Elderly Accidents, Deaths, and Injuries Program*. This program was developed in early 2013 by the CDC to encourage health care providers to continue to address the need of fall prevention.

The STEADI program involves using a tool kit which is based on a simple algorithm in order to treat older adults who are at risk of falling or may have fallen in the past. The toolkit provides basic information about falls, case studies, conversation starters, and standardized evidence-based gait and balance assessment tests. The toolkit also provides instructional videos and educational handouts in order to educate the patients who will participate in the program. These materials have been designed by experts to specifically educate patients and their families with the ultimate goal of fall prevention. Screening materials are designed to identify individuals who are at risk of falling. For those individuals at risk, appropriate follow up care will be recommended.

In addition, St. Anthony's will provide to the community interdisciplinary fall and fracture prevention clinics.

Anticipated impact of the actions

Older adults value their independence and a fall can significantly limit their ability to remain self-sufficient. More than one-third of people aged 65 and older fall each year, and those who fall once are two to three times more likely to fall again.

Fall injuries are responsible for significant disability, loss of independence, and reduced quality of life. In 2000, direct medical costs for fall injuries totaled \$19 billion.

However, we know that falls are not an inevitable result of aging. In recent years, systematic reviews of fall intervention studies have established that prevention interventions can reduce falls.

A reduction in falls will subsequently reduce fracture rates among individuals at risk for fracture (osteoporotic/osteopenic). Furthermore, screening events raise awareness about fall/fracture prevention (secondary impact).

A plan to evaluate the impact

The impact of this program will be measured by surveying participants in screening events to determine if they have had a fall over the course of one year. This will be compared to the number of falls they have had the previous year. A reduction in fall rates would be expected. We would hope that fracture rates among the entire population in Broward County, specifically in areas near our facilities, would decrease over time. This population-based data will be monitored periodically.

Programs/resources the hospital plans to commit to address the health need

1. St. Anthony's Rehabilitation Hospital will host or participate in community-based falls screening events 3-4 times per year. Staff will administer the STEADI program and triage patients for appropriate follow-up care with a provider of their choice.
2. Appropriate staff members employed by St. Anthony's Rehabilitation Hospital will be trained in the STEADI screening program.
3. Fall screenings (using STEADI toolkit materials) and fall risk reduction management programs will become a standard part of a physical therapist's management for all in-house and community-dwelling patients.

3. Expand Educational Services

Actions the hospital intends to take to address the health need

Existing educational seminars that are provided in partnership with a community based acute care hospital and their physicians will be expanded to include independent living facilities and assisted living facilities within the community in order to reach a broad group of individuals. Topics to be discussed will include, but not be limited to:

- Early signs and symptoms of stroke
- High Blood Pressure “Prevention and Management”
- Diabetes
- Osteoarthritis, “Prevention and complications”
- Good nutrition in the elderly
- Depression in the elderly
- Dehydration and the prevention of complications
- Flu and the importance of immunization

As mentioned above, St. Anthony’s will also provide to the community fall and fracture prevention education and screening events on a regular basis.

Anticipated impact of the actions

Education raises awareness, and a heightened awareness of healthcare related topics improves health literacy. Through these efforts we hope to improve general health, and reduce activity limitations and participation restrictions in the community we serve. Additionally, the long term impact of improved health literacy may lead to improved community health overall, and could reduce disability associated with chronic disease as well as new conditions.

A plan to evaluate the impact

Attendance at the educational sessions will be tracked and participant satisfaction will be monitored. In the long-term, we may be able to compare local health literacy rates to broader populations to see if there are differences between the groups. Additionally, admission/re-admission rates for diagnoses of interest (those relevant to the topics presented) can be monitored over time.

Programs/resources the hospital plans to commit to address the health need

St. Anthony’s Rehabilitation Hospitals will provide qualified staff, educational materials, and space to host community education and outreach programs on a regular basis. Staff training and education will also be provided by the organization.

Planned collaboration with other facilities or organizations

St. Anthony's Rehabilitation Hospitals plans to collaborate with local and national organizations and agencies, such as the Multiple Sclerosis Foundation, the National Parkinson's Foundation, the National Stroke Association, the American Heart Association, the American Diabetes Association, the Amputee Coalition, the Christopher and Dana Reeve Foundation, the Miami Project to Cure Paralysis, the Arthritis Foundation, and others.

4. Expand Follow-up and Prevention Services

Actions the hospital intends to take to address the health need

Current medical evidence suggests that recovery after neurological injury/insult can continue for months and even years. Morbidity after other types of injuries and illness can also respond to treatment for many months, if not years as well. Examples of this described in current literature include: stroke, traumatic brain injury, spinal cord injury, hip fractures, neuropathies, myopathies, and progressive neurological diseases. Management of chronic medical conditions often requires ongoing, coordinated rehabilitative efforts. Current intense inpatient medical and rehabilitative management typically occurs rapidly (the average length of stay nationally is 14 days in inpatient rehabilitation facilities). While many of these patients receive home healthcare or outpatient rehabilitative services post discharge, there is typically no one with direct oversight and management of the recovery process after such catastrophic events. The recovery process is dynamic, fluid and often varies from patient to patient. Strategies are required to manage impairments and symptoms as they emerge to prevent further activity limitation and participation restriction later. Furthermore, management by rehabilitation specialists trained to identify signs and symptoms of functional decline, loss of independence, and complications that may lead to higher healthcare expenditures in the long run is warranted.

Therefore the organization will manage a neurorehabilitation follow-up clinic for all patients admitted to St. Anthony's with neurological diagnoses in order to offer follow-up visits with a physician. The clinic will schedule 3-month, 6-month, and 12-month follow-ups with both a physician and physical therapist to address ongoing needs of the patient. In addition, a formal re-assessment will be conducted by the physician to identify additional medical or therapy needs. The purpose of this clinic will be to provide comprehensive follow-up for former inpatients regarding the ongoing management of their activity limitations and participation restrictions.

Since recovery from neurological insult or injury often results in months, years, or even a lifetime of management; the clinic will address ongoing and new issues that may present after patients have been discharged from our acute rehabilitation services.

Anticipated impact of the actions

The goals (and potential impact) of the clinic are to:

- Maximize recovery after an illness/injury that has previously required inpatient rehabilitation; and
- Prevent functional decline by managing impairments and recovery across the continuum of care and in concert with individual patient progression; and
- Promote independence so that individuals may remain in the community; and
- Prevent avoidable hospitalizations/institutionalizations.

A plan to evaluate the impact

Clinic visits will be monitored. Additional monitoring may include monitoring of patient independence (living arrangements), patient/physician feedback, readmission rates (as compared to non-clinic patients), etc.

Programs/resources the hospital plans to commit to address the health need

St. Anthony's Rehabilitation Hospital will develop a Physical Medicine & Rehabilitation Follow-Up Clinic on all of its Hospital campuses.

Clinic Protocol:

1. Patients will be referred to the Physical Medicine & Rehabilitation Follow-Up Clinic by Case Management at the time of discharge from inpatient care at St. Anthony's. The patient will be scheduled to be seen by the physician assigned to the clinic approximately 30 days after discharge. Appointments should be scheduled prior to the patient's actual discharge from the facility so that appointment cards can be given and the purpose/importance of follow-up is explained to the patients and their caregivers.
2. On the initial follow-up clinic visit (approximately 30-days post discharge from inpatient rehabilitation), the patient will be seen by the physician assigned to the clinic. The physician should assess the following:
 - History and physical examination
 - Current medications/medication reconciliation
 - Current DME, including whether or not the patient received all DME prescribed at the time of discharge from acute rehabilitation
 - Whether or not the patient has had to return to a hospital or emergency department since the time of discharge from acute rehabilitation
 - Current participation in rehabilitation programs (outpatient or home healthcare)
 - Management of new or developing impairments (e.g., spasticity/rigidity, contractures, subluxations, edema, dysphagia, pain, etc.)

- The need for additional or new referrals including but not limited to: DME, adaptive equipment, assistive devices, augmented communication devices, home modifications, environmental adaptations, orthotics, prosthetics, community services, social services, support groups, driver's rehabilitation, and vocational rehabilitation.
 - Consideration of appropriateness to begin new interventions that may not have been appropriate during acute rehabilitation. For example, neuroprosthetics (Bioness®), aquatic rehabilitation, advanced balance training, body-weight supported treadmill training, driver's training, etc.
 - Consideration of referrals to specialty clinics or disciplines to address other medical or rehabilitative needs. For example, physical therapy, occupational therapy, speech language pathology, spasticity/contracture management, Fall & Fracture Prevention Clinic (osteoporosis), etc.
3. After the initial follow-up visit, the physician may determine when (or if) further follow-up is warranted. Subsequent follow-up visits will be scheduled in accordance to the physician's recommendation. These subsequent follow-up clinic visits will include physician follow-up, as well as an assessment by a physical therapist, *provided* the patient is not receiving physical therapy services under a home healthcare or outpatient plan of care by another provider. This will be verified by the Clinic Manager. A referral for the physical therapy evaluation will be written by the physician prior to the provision of physical therapy services.
 4. Once the physician and the physical therapist have completed their respective assessments of the patient, they will collaborate to discuss the best strategies required to manage the continued rehabilitative needs and the recovery process over the long term, keeping in mind the goals of the clinic. Consideration will be given for additional services or referrals needed to promote the greatest recovery, decrease the burden of care, prevent avoidable re-hospitalizations, and allow patients to remain in the community as a productive member of society.
 5. Additional follow-up visits will as long as necessary at intervals determined by the physician.
 6. Clinic services will be discontinued when services are no longer needed, patients have reached their maximum benefit from the clinic, or recovery from the effects of illness/injury being managed has plateaued.

Planned collaboration with other facilities or organizations

St. Anthony's physicians who are participating in the clinics will communicate and collaborate directly with the patient's primary care/personal physician to coordinate the provision of care and services throughout the episode of care.

IV. Conclusion

St. Anthony's Rehabilitation Hospitals believe that the new programs to be developed will be a step in the right direction to addressing identified health needs of the community. Through new resources identified by St. Anthony's as well as collaborations with the University of Miami Department of Medicine as well as local community organizations, the impact on these new programs will be significant.

Comments regarding the Community Health Needs Assessment and/or Implementation Strategy can be submitted to the organization by contacting Jorge Casauay at jcasauay@chsfla.com.

V. Works Cited

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“Improving and Measuring Osteoporosis Management.” The Joint Commission. 2007. Web, 20 July 2013.