OhioHealth Rehabilitation Hospital
Community Health Needs Assessment
December, 2015

OhioHealth Rehabilitation Hospital (OHRH) is a 44 bed inpatient facility in Columbus, Franklin County, Ohio which has provided rehabilitation services to central Ohio since 2013. The hospital offers a comprehensive mix of inpatient services, including stroke, orthopedics, brain injury, amputee, and spinal cord injury.

Mission: The Mission of OhioHealth Rehabilitation Hospital is to provide an exceptional patient care experience that promotes healing and recovery in a compassionate environment.

Core Values:

- We deliver superior quality in all that we do.
- We treat others as they would like to be treated.
- We are results-oriented and achieve our objectives.
- We are team players.
- We are resourceful in overcoming obstacles.

The OHRH is pleased to present this Community Health Needs Assessment (CHNA) report to fulfill a requirement in the federal Patient Protection and Affordable Care Act, enacted in March 2010, requiring every tax-exempt hospital to conduct a CHNA to identify and prioritize the significant health needs of the community and develop an implementation strategy to address those significant health needs identified. The Franklin County Health Map 2013 (attached as Exhibit C) serves as the basis for this CHNA report. The Franklin County Health Map 2013 assessed the health needs of the Franklin County community and took into account the broad interests of that community, including leaders, representatives or members of medically underserved, low-income, and minority populations and those with special knowledge of or expertise in public health. This report identifies additional data and information focused on the specific populations served by OHRH.

Eric Yap, FACHE
Chief Executive Officer

Facility: OhioHealth Rehabilitation Hospital
Location: 1087 Dennison Avenue, Columbus, Ohio 43201, Franklin County
Tax ID: 46-2458436
Board approval of CHNA report: November 17, 2015
Date of initial website posting of CHNA report: December 31, 2015

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EXECUTIVE SUMMARY

A. COMMUNITY SERVED

OhioHealth Rehabilitation Hospital (OHRH) is located at 1087 Dennison Avenue, Columbus, Franklin County, Ohio 43201.

In developing this community health needs assessment (CHNA), we identified the "community served" by OHRH as Franklin County, Ohio. Communities within Franklin County include Amlin, Blacklick, Dublin, Hilliard, New Albany, Reynoldsburg, Westerville, Columbus, Brice, Canal Winchester, Galloway, Grove City, Groveport, Harrisburg, and Lockbourne. Other communities that cross into Franklin County but are not primarily within Franklin County include Pataskala, Plain City, Powell, London, and Orient.

The Ohio Department of Health requires each hospital that is registered in Ohio to file an Annual Hospital Registration and Planning Report by March 1 of each calendar year for the previous calendar year. A review of the patient origin data from the Annual Hospital Registration and Planning Report for OHRH for 2014 supports the definition of the "community served" as being the community and residents of Franklin County, Ohio. Of the 897 total admissions to OHRH in 2014, 484, or 54%, reside in Franklin County at the time of admission. Franklin County accounts for a vast majority of admissions to OHRH, as the next county with the second most admissions is Delaware County, with only 7% of OHRH admissions.

B. DEMOGRAPHICS OF THE COMMUNITY

Please refer to the Franklin County Health Map 2013, pages 12-17 for the community profile. The following additional information provides an updated summary of some of the profile characteristics.

Population. In 2014, Franklin County had a total population of 1,231,393. The Franklin County population is projected to increase to 1,237,960 by 2020 and to 1,302,110 by 2030.

Race/Ethnicity. In 2014, among Franklin County residents, 69.7% were Caucasian, 21.2% were African-American, 4.8% were Hispanic or Latino, 4% were Asian, .2% were Native American, 1.6% were from other races, and 3.2% were from two or more races.

Age. In 2014, approximately 23.9% were less than 18 years of age, 11.4% were 18-24 years of age, 30.3% were 25-44 years of age, 24.2% were 45-64 years of age, and 10.2% were 65 years of age or more. The median age was 33.6 years.

Income. Median household income was $50,877. In 2013, the per capita personal income was $43,506. 13% have a family income below the poverty level.

Education. In 2014, of persons 25 years of age and over, 10.3% had no high school diploma, 25.7% were a high school graduate, 21% had some college but no degree, 6.7% had an Associate degree, 23.4% had a Bachelor's degree, and 13% had a Master's degree or higher.

Source: Ohio County Profiles, Prepared by the Office of Research, on October 6, 2015 at http://development.ohio.gov/files/research/C1026.pdf

C. SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY

Representatives from OhioHealth were part of the Franklin County CHNA Steering Committee who identified and prioritized significant health needs of the community using health indicators identified in the Franklin County Health Map 2013. The significant health needs of the Franklin County community include (in prioritized order):

1. Access to Care
2. Chronic Disease
3. Infectious Disease
4. Behavioral Health
5. High Incidence of Cancer
6. Interpersonal Violence
7. High-Risk Pregnancy
8. Unintentional Injuries

D. AVAILABLE HEALTHCARE FACILITIES AND RESOURCES WITHIN THE COMMUNIITY TO RESPOND TO THE SIGNIFICANT HEALTH NEEDS IDENTIFIED

Please refer to the Franklin County Health Map 2013, pages 5-10 for the list of potential facilities and resources available to respond to each of the significant health needs identified.

In addition to the resources available to address the significant health needs noted in the Franklin County Health Map 2013, OHRH is available to address the following:

- Chronic Disease – treatment and prevention of stroke
- Unintentional injuries – treatment of status post motor vehicle accidents, falls, bicycle accidents, etc.

The following identifies the total number of healthcare facilities, by type, which are available in Franklin County:

Facility Type	Number of Active Facilities
Ambulatory Surgery Center	29
Ambulatory Surgical Facility	35
Community Mental Health Center	2
Comprehensive Outpatient Rehab	0
Dialysis Center	28
End Stage Renal Disease	28
Health Maintenance Organization	7
Home Health Agency	264

Facility Type	Number of Active Facilities
Hospice	16
Hospital (includes OHRH)	21
Development Disability	31
Nursing Home	61
Outpatient physical/speech pathology	12
Licensed Freestanding Inpatient Rehabilitation Center	0
Residential Care/Assisted Living	51
Federally Qualified Health Center	16

Source: Ohio Department of Health long-term care, non-long-term care, and CLIA Health Care Provider Search on October 6, 2015 at http://publicapps.odh.ohio.gov/eid/Provider_Search.aspx
FQHC Link on October 6, 2015 at http://www.fqhc.org/find-an-fqhc/

E. PROCESS OF OBTAINING DATA

The Franklin County CHNA Steering Committee met on March 30, 2011 to determine the scope of the Franklin County Health Map 2013 and to identify the health indicators to be included in the report as well as the specific indicators within each category. The Steering Committee chose indicators which reflect a healthcare issue that is pertinent to central Ohio and came from sources that are reliable and are likely to be available in the future.

The Central Ohio Hospital Council contracted with the Center of Public Health Practice of The Ohio State University College of Public Health to prepare a summary of common health status indicators. During the spring, summer, and fall of 2011, data was collected and compiled into an electronic database and, when available, comparable data for Ohio and the United States was included. Data used for this report is presented in the Franklin County Health Map 2013.

Data sources and dates for this CHNA are found on page 47 of the Franklin County Health Map 2013. These data sources include:

- U.S. Census
- American Community Survey
- Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System
- American Hospital Association
- Centers for Disease Control & Prevention
- Public Children Services Association of Ohio
- Department of Public Safety
- Ohio Department of Health
- Ohio Family Health Survey
- Ohio Hospital Association
- Ohio State Dental Board
- Ohio Board of Optometry
- State Medical Board of Ohio
- Ohio Board of Nursing
- Central Ohio Trauma System

In addition to the data from the Franklin County Health Map 2013, OHRH included additional data specific to inpatient rehabilitation services (Exhibit B). In October, 2015, OHRH contracted with the Quality Management Consulting Group to collect the additional data and prepare this CHNA report.

Data was collected in October, 2015 from the following sources:

- Report to the Congress: Medicare Payment Policy, Inpatient rehabilitation facility services, March 2013
- Utilization Trends in Inpatient Rehabilitation: Update Through Q2: 2011, November 2011, The Moran Company
- The Uniform Data System for Medical Rehabilitation Report of Patients with Debility Discharged from Inpatient Rehabilitation Programs in 2000-2010,Published in final edited form as AM J Phys Med Rehabil 2013 Jan; 92(1): 14-27

F. PROCESS FOR IDENTIFYING AND PRIORITIZING COMMUNITY HEALTH NEEDS AND SERVICES TO MEET THE SIGNIFICANT HEALTH NEEDS IDENTIFIED

A multi-stakeholder collaborative (the Franklin County CHNA Steering Committee), including a range of organizations representing the broad interests of the community, worked together to identify, collect, and analyze health indicators, identify and prioritize significant health needs of the community, and identify resources available to address the significant needs identified. The Steering Committee worked during two half-day sessions to identify and prioritize the health needs for Franklin County, using the health indicators contained in the Franklin County Health Map 2013. The first half day session was on March 30, 2011. During this session, the Steering Committee determined the scope of the report and identified the categories to be included and specific indicators within each category.

Data collection occurred during the spring, summer, and fall of 2011. This activity included drafting narratives and preparing charts for the report.

The second half day session was on February 7, 2012. During this session, the Steering Committee reviewed health indicators where Franklin County fared worse than state or federal data. Indicators similar to or better than state or federal data were dropped from further analysis. The Steering Committee rated the remaining indicators using a set of nine criteria identified on page 4 of the Franklin County Health Map 2013.

After rating the indicators, Steering Committee members met with clinical experts within their institutions to determine whether the rated indicators were consistent with what clinicians' experience. The Steering Committee then grouped related health indicators, identifying eight local health needs.

The Steering Committee prioritized the health needs by ranking the health needs using a 1 to 8 scale, with 1 being the top priority and 8 being the lowest priority. The needs were ranked based on the input from the clinical experts, the number of health indicators in each group,

and the rating the health indicator received. The rankings were added together and the group with the higher scores identified as higher priorities.

Finally, the Steering Committee identified potential healthcare facilities and resources which may be available to address and improve the significant health needs identified.

Please refer to the Franklin County Health Map 2013, pages 4-5 for a detailed description of this process.

G. EVALUATION OF IMPACT OF ACTIONS IN PRIOR CHNA

OHRH was created through a joint venture with Select Medical Specialty on April 8, 2013. As this is the first CHNA report for OHRH, we cannot evaluate the impact of actions to address the significant health needs identified in prior CHNAs.

H. PROCESS FOR CONSULTING WITH PERSONS REPRESENTING THE COMMUNITY INTERESTS

Persons representing the broad interests of the community, including those with knowledge of or expertise in public health, participated in the CHNA process as members of the Franklin County CHNA Steering Committee. The Steering Committee held meetings on March 30, 2011 and February 7, 2012 to review indicators, identify and prioritize significant health needs of the community, and identify existing healthcare facilities and resources which are potentially available to address the significant needs identified. Please refer to Appendix A for participating organizations and the groups each organization represent.

Community input was obtained from all required sources.

As this is the first CHNA report for OHRH, there are no written comments received on a previously conducted CHNA.

I. INFORMATION GAPS THAT LIMIT THE HOSPITAL'S ABILITY TO ASSESS THE COMMUNITY HEALTH NEEDS

The Steering Committee did not identify any information gaps during the CHNA process.

J. COLLABORATING PARTNERS

OHRH, through OhioHealth, collaborated with the Central Ohio Hospital Council and organization participating on the Steering Committee (identified in Appendix A) to conduct the CHNA.

OHRH engaged Bricker & Eckler LLP/Quality Management Consulting Group, located at 100 South Third Street, Columbus, Ohio, to prepare this CHNA report. Jim Flynn is a partner with Bricker & Eckler's Health Care group, where he has practiced for 25 years. His general healthcare practice focuses on health planning matters, certificate of need, non-profit

and tax-exempt healthcare providers, and federal and state regulatory issues. Mr. Flynn has provided consultation to healthcare providers, including non-profit and tax-exempt healthcare providers and public hospitals on community health needs assessments. Christine Kenney is the director of Regulatory Services with the Quality Management Consulting Group of Bricker & Eckler LLP. Ms. Kenney has over 36 years of experience in healthcare planning, policy development, federal and state regulations, certificate of need, and Medicare and Medicaid certification. She provides expert testimony on community need and offers presentations and educational sessions regarding community health needs assessments. She has been conducting community health needs assessments in accordance with the affordable care act requirements since 2012.

APPENDIX A

Member Organizations of the Franklin County CHNA Steering Committee

Organization	Populations Represented
Mount Carmel Health System • Mission Services • Community Benefit Ministry	All populations of Franklin County, including the medically underserved, low-income, and minority populations
Nationwide Children's Hospital • Community Relations • Planning • Data Resources	All non-adult populations of Franklin County, including the medically underserved, low-income, and minority populations
OhioHealth • Community and Government Relations • Finance	All populations of Franklin County, including the medically underserved, low-income, and minority populations
Wexner Medical Center at The Ohio State University • Medical Center Outreach • Community Development • Strategic Planning and Business Development	All populations of Franklin County, including the medically underserved, low-income, and minority populations
Central Ohio Trauma System	All populations of Franklin County, including the medically underserved, low-income, and minority populations
Columbus Neighborhood Health Centers (including Heart of Ohio Family Health Centers and Lower Lights Christian Health Center) • Quality Improvement/Risk Management • Operations	All medically underserved, low-income, and minority populations of Franklin County
Columbus Public Health (Expertise in public health) • Epidemiology	All populations of Columbus, including medically underserved, low-income, and minority populations of Franklin County
Franklin County Public Health (Expertise in public health) • Planning and Assessment	All populations of Franklin County, including medically underserved, low-income, and minority populations of Franklin County
United Way of Central Ohio • Health	All medically underserved, low-income, and minority populations of Franklin County
Central Ohio Hospital Council	Franklin County hospitals
Center for Public Health Practice, The Ohio State University College of Public Health	All populations

APPENDIX B

Summary of Inpatient Rehabilitation Service Data

Source: Report to the Congress: Medicare Payment Policy, Inpatient rehabilitation facility services, March 2013

Report Summary

- The aggregate supply of Inpatient rehabilitation facilities (IRF's) declined slightly in 2011
    - The total number of freestanding facilities increased slightly while the number of hospital-based facilities decreased by 1.6%
- The number of rehabilitation beds declined moderately for both hospital-based and freestanding facilities (0.8% decline to about 35,250 beds)
- Occupancy rate increased for both freestanding and hospital-based IRF's (1.4% increase to 63.3%)
- Despite the overall supply of IRF beds decreasing slightly, other measures such as low occupancy rates, growth in volume, and availability of other rehabilitation alternatives suggest that capacity remains adequate to meet demand
- Research studies do not conclusively identify one post-acute care setting as having better outcomes for rehabilitation patients

Background

- Approximately 80% of facilities are hospital-based and 20% are freestanding
    - Hospital-based units account for only 55% of Medicare discharges to IRFs in 2011
- In general, IRFs are concentrated in highly populated states that have large Medicare populations
- IRFs are not the sole provider of rehabilitation services; skilled nursing facilities, home health agencies, comprehensive outpatient rehabilitation facilities, and independent therapy providers also furnish rehabilitation services
- Over 371,000 Medicare fee for service (FFS) beneficiaries received care in IRFs in 2011
- 95% of IRF Medicare patients were admitted to an IRF directly from an acute care hospital in 2011
    - 2.4% were admitted from a community setting
    - 2.6% were admitted from other health care facilities

IRF Patient Demographics 2011

- 81% white
- 58% female
- 10% African American
- 4% Hispanic

Capacity and Supply

- The supply of IRFs has been declining since 2005
- 2011 continued a trend of hospital-based facilities leaving he market and the number of freestanding facilities slowly increasing

    - Between 2006 and 2011, the number of freestanding IRFs increased by an average of 1.8% each year
- Occupancy rates increased from 62.4% in 2010 to 63.3% in 2011
    - 2011 occupancy rates were higher for freestanding IRFs (68.3%) than for hospital-based IRFs (59.8%) and higher for IRFs in urban areas (64.5%) than in rural areas (49.6%)
- Between 2004 and 2011, the number of beds declined by an average of 0.8% each year
- In 2011, the number of cases grew by 3.3%

Case Mix

- From 2004 through 2011, among stroke cases, the share of hospital patients discharged to IRFs and other settings remained unchanged
- For hip and knee replacement cases, the relative share of hospital patients discharged to IRFs declined by more than half between 2004 and 2011
    - For the same period, the share of patients with hip and knee replacements discharged to SNFs and home health agencies grew by the same proportion
- Between 2004 and the first half of 2012, the percentage of IRF patients with stroke, brain injury, and neurological disorders increased
- Since 2004, the share of debility cases and other orthopedic conditions increased by 3.8% and 2.4%, respectively
- Between 2011 and the first half of 2012, the distribution of case type remained relatively stable
- Stroke patients constitute a smaller share of freestanding IRF cases than of hospital-based IRF cases (16% and 21%, respectively)
- Patients with neurological disorders constituted a larger share of freestanding IRF cases than of hospital-based IRF cases (13% and 7%, respectively)

Source: The Moran Company, Utilization Trends in Inpatient Rehabilitation: Update Through Q2: 2011, November 2011

- Immediately following implementation of the IRF Prospective Payment System in 2004, the prior growth trend in IRF discharges ended and volume declined steadily until the third quarter of 2007
- More stringent and restrictive admission criteria for IRFs in 2010 affected the number of patients admitted to IRFs as well as overall case-mix, with fewer less functionally impaired, less medically complex cases admitted compared to the pre-2010 period
- Overall IRF volume declined by 29,863 cases, or by 9.8%, from 2006 to 2010 from 305,226 to 275,363 (see table 1)
    - Greatest decline was with replacement of lower extremity joint from 55,000 in 2006 to 31, 425 in 2010
    - Greatest increase was with neurological cases from 20,105 in 2006 to 26,517 in 2010

Table 1

Impairment Category	2006	2010
Replacement of Lower Extremity	55,000	31,425
Fracture of Lower Extremity	47,481	37,751
Stroke	61,927	55,332
Nontraumatic spinal cord	11,882	10,022
Amputation, lower extremity	9,171	7,554
Pain Syndrome	4,140	2,746
Osteoarthritis	1,933	1,190
Traumatic spinal cord	2,270	1,980
Rheumatoid, other arthritis	1,857	1,626
Amputation, other	464	329
Burn	237	227
Guillain Barre	543	542
Major Multiple Trauma with Central Nervous System damage	816	1,025
Pulmonary	4,431	4,653
Major Multiple Trauma without Central Nervous System damage	3,498	3,920
Traumatic brain injury	7,517	8,136
Cardiac	13,030	14,077
Nontraumatic brain injury	11,398	12,586
Other orthopedic	16,646	18,959
Miscellaneous	30,880	34,766
Neurological	20,105	26,517
Total	305,226	275,363

Source: The Uniform Data System for Medical Rehabilitation Report of Patients with Debility Discharged from Inpatient Rehabilitation Programs in 2000-2010,Published in final edited form as AM J Phys Med Rehabil 2013 Jan; 92(1): 14-27

- The percentage of debility cases in freestanding inpatient rehabilitation facilities was higher in 2007-2010 (46%-48%) compared to previous years (31%-39%)
- 93% of patients were admitted to inpatient rehabilitation directly from acute care
- Approximately three fourths of patients were discharged to the community after rehabilitation
- Mean length of stay decreased by 1.4 days between 2001 and 2002 and overall by another .8 day from 2002 to 2010
- Patients discharged to a community setting after rehabilitation were, on average, only 1.5 years younger than patients who discharged to other settings.