100860

BEFORE THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH
HEALTH FACILITIES AND SERVICES REVIEW BOARD

In Re the Matter of:	)
	)
Northwest Community Hospital - Northwest Community Healthcare, Applicant.	) Project 14-021

REPORT OF PROCEEDINGS
PUBLIC HEARING

Arlington Heights Village Hall
33 South Arlington Heights Road
Arlington Heights, Illinois

July 22, 2014
10:30 a.m.

Reported by: Jean S. Busse, CSR, RPR
Notary Public, DuPage County, Illinois

PRESENT:

MR. PHILIP BRADLEY, Board Member; and

MS. COURTNEY R. AVERY, Hearing Officer.

MS. AVERY: Good morning. Sorry I don't have a microphone on. So I hope everyone can hear me.

I'm Courtney Avery from the Illinois Health Facilities and Services Review Board acting as the Hearing Officer for today's proceedings. Present with me today is Board Member Philip Bradley. On behalf of the Board, I would like to thank you for attending this hearing for Northwest Community Hospital, and I'll turn it over to Mr. Bradley.

MEMBER BRADLEY: State law requires that one of the Board members be at every public hearing.

This Board is composed of nine members appointed by the Governor, confirmed by the Senate, and our job is to regulate certain parts of the health care industry.

When certain proposals are subject to regulation, the applicant has to fill out a set of data which explains how they believe the proposal conforms to a set of State regulations and laws.

The material that is reviewed by the Board Staff is to look at all the criteria which must be used to evaluate the project. Their view is put into

a State Board report, which then is presented to the Board in full session.

At the same time, other materials are part of the package which must be considered. Part of those other materials is whatever is said or submitted at a public hearing.

So everything that you say today will be recorded by the court reporter, and any material that you submit will also be added to the file. So the State Board report plus all the public comments then go to the Board members for their consideration. They can discuss it in a full Board meeting, and they vote on it at that point.

This is part of the public's right to petition this government and to speak to its government, and we welcome your participation. I want you to know that you are part of building a record on this, which is designed to tell a bureaucracy what you think ought to be done and to convince a bureaucracy of your point of view.

So we welcome all of you today.

MS. AVERY: Thank you.

As per the rules of the Illinois Health Facilities and Services Review Board, I would like to

read the previously published legal notice into the record:

Notice of Public Hearing and Written Comment. In accordance with the requirements of the Illinois Health Facilities Planning Act, notice is given of receipt to establish a comprehensive rehabilitation unit in an acute care hospital, Project No. 14-0231, Northwest Community Hospital, Arlington Heights. Applicants: Northwest Community Health Care.

The applicants propose to establish a 17-bed rehabilitation unit on the campus of an acute care hospital located at 800 West Central Road, Arlington Heights. Project cost: $3,040,000.

The public hearing will take place pursuant to 20 ILCS 3960. The hearing is scheduled for Tuesday, July 22, 2014, at 10:30 a.m., and sign-in for the hearing will be conducted from 10:00 a.m. to 10:30. It will be held at Arlington Heights Village Hall, Board Room, 33 South Arlington Heights Road, Arlington Heights, Illinois 60005.

The public hearing will be conducted by Staff of the Health Facilities and Services Review Board pursuant to the Illinois Health Facilities

Planning Act. The hearing is open to the public and will afford an opportunity for parties of interest to present written and/or verbal comment relative to the project.

All allegations or assertions should be relevant to the need for the proposed project and be supported with two copies of documentation or material that are printed or typed on paper, size 8-1/2" by 11".

Consideration by the State Board has been tentatively scheduled for the August 27, 2014, State Board Meeting.

The application and documents related to this project may be accessed at www.hfsrb.illinois.gov. The deadline for submission of public comments related to this project is August 7, 2014. Comments should be sent to Mike Constantino. End of Public Notice.

As previously stated, this public hearing is conducted by the Staff of the Illinois Health Facilities and Services Review Board pursuant to the Illinois Health Facilities Planning Act. The hearing is open to the public and affords an opportunity for parties with interest in the project to present

written and/or verbal comments.

Please note that in order to ensure that the Health Facilities and Services Review Board's public hearings protect the privacy and maintain the confidentiality of an individual's health information, covered entities, as defined by the Health Insurance Portability and Accountability Act of 1996, such as hospital providers, health plans, and health care clearinghouses, submitting oral or written testimony that discloses protected health information of an individual shall have a valid written authorization from that individual. The authorization shall allow the covered entity to share the individual's protected health information at this hearing.

If you have not yet signed in, please see me for the appropriate sign-in sheet. In addition, those of you who came with prepared text of your testimony, please note that you can submit the written text only, which will be entered into today's record and made available for all Board Members prior to the August 27th Board meeting.

I ask that you please limit your testimony to three minutes. I will call participants in numerical order, which is on your yellow sheets and

written in red. Prior to your remarks, please clearly state and spell your full name. After you have concluded your remarks, if you have copies, please provide those -- leave them on the table -- along with your sign-in sheets.

Today's proceedings will begin with a representative from Northwest Community Hospital, Michael Hartke.

MR. HARTKE: My name is Michael Hartke, spelled M-i-c-h-a-e-l, last name H-a-r-t-k-e.

My name is Michael Hartke. I'm the Chief Operating Officer of Northwest Community Hospital, and I am pleased to represent the hospital's management team, our physicians, and our staff. And on behalf of our patients, I am prepared to deliver this opening statement as an overview to our proposed 17-bed inpatient rehabilitation unit.

The proposed project converts a floor that previously housed a medical-surgical service. Our medical-surgical bed count will be reduced by 24 beds. NCH has established a partnership with RehabCare, a company with more than 30 years' experience in establishing and/or operating over 100 comprehensive physical rehabilitation programs in the United States,

including seven here in the state of Illinois.

The opportunity for this project is based on several factors:

1) The importance to our patients and to our patients' families;

2) The need in our geographic area; and

3) The available space in our North Tower after our new facility opened in 2010.

First, several of the clinical programs at Northwest Community Hospital are generating a growing need for post acute inpatient rehabilitation. NCH is designated as a Primary Stroke Center, offering the latest in minimally invasive neurointerventional procedures that can significantly diminish, if not reverse, the effects of a stroke.

NCH also offers comprehensive emergency care and serves as a regional resource hospital in the State's EMS system, coordinating the services of six other area hospitals and 25 EMS provider agencies in a 450-square-mile area.

These programs generate a significant volume of stroke and trauma patients, many of whom require hospital rehabilitation following their acute care treatment.

In each of the past two years, more than 200 Northwest Community inpatients received physical rehabilitation care in an acute care rehabilitation hospital after being discharged from Northwest Community Hospital.

Additionally, NCH patients were referred for care but did not get admitted due to the lack of beds at other receiving hospitals, limited insurance coverage, or other issues.

Instead, these patients were seen in less intensive settings of care, such as nursing homes, assisted living facilities, and home care.

You will hear from some of our staff about how alternative care in those less intensive settings, while good in quality, does not match the therapy and treatment that certain patients simply require and which is available only in an inpatient setting. The proposed new unit will provide needed care for these NCH patients.

Having a small unit within Northwest Community Hospital will also facilitate improved continuity of care with the physicians who oversee the acute care stays for these patients.

Quite often there is little or no follow-up

communication with these physicians when their patients receive inpatient rehabilitation at another hospital.

The proposed unit will also lessen the difficulty that patients and the patients' families have when they are referred for inpatient rehab care away from our community.

Having an inpatient rehabilitation unit for stroke, orthopedic, trauma, neurological, and certain other patients at Northwest Community will enhance the quality of care by facilitating ongoing communication with the patients' acute care physicians and clinical staff during their rehabilitation stay.

The unit will also meet the strong preference expressed by patients and their families for care to remain within the Northwest Community Healthcare System, which they have selected and with which they are comfortable.

Second, there is a need for this type of unit in our immediate geographic area. Despite the excess of physical rehabilitation beds in suburban Cook and DuPage County, over 90 percent of NCH patients come from zip codes in NCH's primary and secondary service areas and beyond to the north.

In the area north of I-90, as depicted on the map, and west of I-294 in northern Cook and Lake Counties, there is a limited number of hospital rehabilitation beds.

The only two hospitals with rehabilitation units between Northwest Community Hospital and the Wisconsin border are Centegra in McHenry County and Vista West east of I-294 in Lake County. These are small programs with only 15 and 25 beds respectively.

Another cut at geography shows that there are only three hospitals with rehab units within an area defined by 30-minute travel times from Northwest Community Hospital, an area with a population of about 2 million people. There is no wonder why our patients are often not admitted due to limited bed availability.

Also, 80 percent of our patients needing hospital rehabilitation are age 65 or older. This group is expected to increase significantly by 16 percent in our service areas during the remainder of the decade, increasing the proposed need for inpatient rehabilitation.

Our analysis of need for rehabilitation beds also utilizes the Rehabilitation Impairment Codes, a

system developed by the Federal Government's Centers for Medicare & Medicaid Services.

Patients matching a Rehabilitation Impairment Code have conditions that qualify them for inpatient rehabilitation care and reimbursement. Using the Rehabilitation Impairment Code system, our application demonstrates the need for inpatient rehabilitation by NCH patients last year exceeded the patients our physicians referred to hospital rehab care.

In fact, the need is so sufficient as to justify full utilization of the unit within NCH and to continue the current referral of the same volume of patients that have been referred by NCH physicians to other area hospital rehabilitation units.

We demonstrate that there is no detrimental impact on area hospitals from the proposed new unit at Northwest Community Hospital.

Third, this proposed unit will fit nicely within our existing campus in space vacated within our North Tower when we moved into the new patient bed tower in 2010. The 17-bed unit will accommodate private rooms, an activity room and dining area as well as a small gym space in the North Tower on our

third floor.

In closing, the proposed unit will meet patient need for ongoing care within our community and within Northwest Community Healthcare System, which they have selected and in which they place their trust.

There is a quantified need for additional rehabilitation beds demonstrated in several geographic analyses. In addition, the facilities on our campus are available to conveniently and economically implement this project.

Thank you for allowing me to provide this opening statement. I urge approval by the Illinois Health Facilities and Review Board.

MS. AVERY: Thank you.

Just for the record, it's common practice to allow more time for the Applicant. I know we had a number two, but I think there's maybe three or four in opposition of the project.

I don't see Jack. Where is he?

I'll allow your party that called the public hearing to go next, and then we'll start in the order, if they are ready. Thank you.

MS. CLANCY: Thank you, Ms. Avery.

Good morning, Board Member Bradley.

MS. AVERY: Can you pull that mic a little closer?

MS. CLANCY: I sure can.

Good morning. My name is Kelley Clancy, and I am the Vice President for External Affairs for Alexian Brothers Health System, the parent of Alexian Brothers Medical Center. I am hear today to voice Alexian Brothers' strong opposition to Northwest Community Hospital's plans to open a comprehensive inpatient rehabilitation unit at its Arlington Heights hospital.

Alexian Brothers, in partnership with the Rehabilitation Institute of Chicago, operate the largest acute care hospital-based inpatient rehabilitation program in the State. The program was expanded from 66 to 72 beds just last fall, and our current occupancy rate is 76 percent.

Northwest Community Hospital and Alexian Brothers Medical Center are located 12 minutes apart.

Our partnership with RIC brings state-of-the-art rehabilitation protocols, therapies, and best practices to the northwest suburbs.

The Alexian Brothers/RIC unit has been the

primary referral site for Northwest Community patients requiring inpatient rehab services for many years. In fact, as noted on Page 60 of Northwest Community's CON application, over 90 percent of Northwest Community's patients transferred from inpatient rehab services were transferred to Alexian Brothers in both 2012 and 2013.

Our physiatrists routinely evaluate patients at Northwest Community, and we are not aware of any problems that have resulted from this evaluation transfer relationship.

The Alexian/RIC program provides evaluations at Northwest Community and accepts transfers seven days a week.

Our inpatient unit has the capacity to provide comprehensive rehabilitation services to Northwest Community's patients, as it is doing now.

The proposed Northwest Community Hospital unit would create an unnecessary duplication of services. Alexian Brothers Medical Center and Northwest Community, as I mentioned earlier, are only 12 minutes apart.

The State of Illinois' determination that there is an excess number of rehabilitation beds in

the planning area supports our position that this project is not needed. As of July 14th, the State's bed need methodology identified in excess of 68 beds in the planning area.

Moreover, the fact that so many of the planning area's inpatient rehabilitation units are operating at less than the State's target occupancy rate corroborates that an additional rehab unit is not needed.

In 2012, the last year for which data is publicly available, only two of the planning area's eleven rehabilitation units were operating at the State's target occupancy rate, and one of those was Alexian Brothers, which has slipped below the target with its recent addition of beds.

In summary: If approved, the proposed Northwest Community project will result in an unnecessary duplication of services;

The proposed project is contrary to the State's bed need determination;

Only one of the planning area's eleven providers of rehab services are operating above the State's target occupancy rate;

The Alexian Brothers/RIC program is located

only 12 minutes from Northwest Community; and

The Alexian Brothers/RIC program has a long history of addressing the inpatient rehabilitation needs of Northwest Community Hospital's patients.

There's no need for this project, and Northwest Community's application should be disapproved. Thank you.

Kelley, K-e-l-l-e-y, Clancy, C-l-a-n-c-y.

MS. AVERY: Thank you.

MS. CLANCY: Thank you.

MS. AVERY: Number 2.

MR. FLEISCHER: Do you want this page as well?

MS. AVERY: Yes. You can set it on the desk.

MR. FLEISCHER: Good morning. Can you hear me okay?

MS. AVERY: Yes.

MR. FLEISCHER: Barry Fleischer, B-a-r-r-y F-l-e-i-s-c-h-e-r.

My name is Barry Fleischer, and I'm one of the persons responsible for strategic planning at the Rehabilitation Institute of Chicago. Thank you for the opportunity to speak with you this morning.

I'm here today to record the Rehabilitation Institute of Chicago's opposition to Northwest Community Hospital's application to establish a 17-bed comprehensive rehabilitation unit.

Since July 1, 1993, as you've heard, RIC has partnered with Alexian Brothers Medical Center for the provision of comprehensive rehabilitation services on Alexian Brother's Elk Grove Village campus.

Our combined services include a 72-bed inpatient rehabilitation unit and outpatient services. As noted in Alexian's testimony, their 72-bed inpatient program has been the primary provider of inpatient rehabilitation services to patients of Northwest Community Hospital for many years.

RIC is opposed to the project because we believe the application does not accurately or sufficiently demonstrate the need to establish rehabilitation services at the applicant's facility, and I will provide three brief rationale for our position.

1. There is ample capacity across other rehabilitation providers to provide services to Northwest Community Hospital patients.

The use rate calculation in the application

suggests there are fewer beds in the immediate service area defined by a 30-minute drive than there are in other planning areas.

This use rate calculation is flawed for several reasons, the most important of which is that a 30-minute drive is an inappropriate measure of a reasonable distance a patient should travel -- it is too short -- to receive treatment for life-changing conditions such as stroke, brain injury, and spinal cord injury that the applicant proposes to treat.

Our experience at both Alexian Brothers and RIC's flagship facility in Chicago demonstrates that people are willing to travel further for high-quality care to get the best chance of recovery from a disabling condition.

2. There is not a lack of access of rehabilitation beds, as claimed by the applicant. The applicant's claim that patients do not have sufficient access to inpatient rehabilitation services is based on an observation that many patients are going home instead of receiving treatment at an inpatient facility.

This is not a demonstration of limited access; it represents a misunderstanding of the types

of patients who qualify for inpatient rehabilitation services.

According to the Center for Medicare and Medicaid Services, a patient must require 24-hour nursing care and multiple therapeutic services in order to qualify for inpatient rehabilitation.

If patients are able to be discharged home safely after an acute care stay, we believe they should be. If the applicant is proposing to treat patients in their new rehabilitation unit who could otherwise be at home, we would suggest the applicant is not properly considering the medical necessity regulations that payers require for inpatient rehabilitation.

The existing programs in the area are currently admitting appropriate patients and have excess capacity to continue to do so for Northwest Community Hospital's patients.

Lastly, RIC provides rehabilitation services throughout the region and beyond. We firmly believe that patients who suffer from disabling conditions, as noted above, will be best served in specialty hospitals and high-quality, large rehabilitation units such as our flagship campus and at Alexian Brothers

where cutting-edge technologies and highly experienced clinicians can be aggregated together to provide the best and most efficient rehabilitation care and hope for recovery.

Smaller units in hospitals across the market will not provide the best opportunity for patients and will create an necessary duplication of resources.

Thank you for your time.

MS. AVERY: Thank you.

Number 3, please.

MS. LUBOWICKI: Angela Lubowicki, A-n-g-e-l-a L-u-b-o-w-i-c-k-i.

I am Angela Lubowicki, a medical social worker at Northwest Community Hospital. In my role I have worked with many patients requiring acute hospital rehabilitation after their stay at NCH, including patients with an undocumented immigration status.

It is extremely disheartening to see them discharged to the community instead of to a rehabilitation unit here or elsewhere to give them the ability to attain their maximum level of physical functioning.

These patients are sent home physically

incapacitated and depleted. Their families, when available in the area, try to accommodate and care for them with little or no services available to bridge their adjustment to their new disabilities.

Our therapists try their best out of the goodness of their hearts to see these patients as much as possible anticipating their discharge but still not anywhere near the three-hour daily treatments these patients need.

Without a rehab unit, NCH is not staffed for this kind of care involvement. These efforts draw staff and cause delays for other inpatients' therapy evaluations and treatment.

Even patients who are eligible for Medicaid but have not yet secured it (known as Medicaid pending patients) are unable to access acute rehab at a nearby rehabilitation hospital.

This nearby hospital mandates a prearranged nursing home placement or a highly detailed after care plan in order to even consider the Medicaid pending patient. This usually makes it impossible to get them admitted there; or waiting around for this perfect plan to be secured consumes valuable time that could have been spent improving the patient, perhaps to a

point where a nursing home may not have even been necessary.

I support the plan to start an inpatient rehab unit at Northwest Community Hospital in order to maximize the resources directed at needed patient care.

MS. AVERY: Thank you.

Number 4?

MS. GOR: Good morning. I'm Pervi Gor, P-u-r-v-i, last name Gor, G-o-r. I'm one of the clinical coordinators at Northwest Community Hospital. I'm here to present the story of a stroke patient at Northwest Community Hospital.

A loving and devoted family made preparations for taking home their mother in her 60s who suffered a severe bleeding stroke known as an intracerebral hemorrhage. She was slowly making some recovery, having been in the NCH's Critical Care Unit and then in the NCH Neurological Medical Unit.

Her family was devoted to her but faced the challenges that all stroke survivors and families incur with this disease process. What type of recovery will happen? How long will it take? Where will she go to receive the best care?

She was nonverbal but was aware and was gaining some progress in her care. She could nod to her family, and she could follow some commands but relied on others to provide her with what we take for granted, activities of daily living.

Her daily living now required others to help nourish her and keep her safe. Because of weakened throat muscles, she could not swallow. She required a gastric tube into her abdomen to provide calories and support for improving her strength. She was also self-pay, having lived in the US for years without any benefit of insurance.

Her family was very private and did not want to ask anybody for favors, though they did not go to their community circle of friends and their church to find volunteers to help with her care.

She needed to be treated at a rehab hospital and then cared for at home once discharged from rehab. However, her eligibility for insurance services or charity were limited by the resources that the rehab hospital could not find for her.

The NCH social workers and discharge planning team worked at many options and could not find bed placement for her.

She was not accepted into rehab services, and the family was faced with finding a long-term solution. The decision to bring her home from NCH with 24-hour care was made when she was medically stable.

The Northwest Community Hospital staff helped with securing a bed, a commode, gastric tube feedings, and the many other items that were necessary for her care at home.

The day before her discharge home, the family was learning how to do the tube feedings and to do the range of motion exercises to supplement the care that would be provided by the NCH Home Health Care staff.

If NCH had an acute care rehab facility, the patient's progress may have improved her recovery. The family was receiving the NCH Home Health Care visits to assess needs and continue to reinforce the family's abilities.

Having an acute care rehab unit at NCH would have meant that this family and patient could have received the necessary care in the right delivery setting.

Thank you for the opportunity to testify.

MS. AVERY: Thank you.

Number 5?

MS. KOLDRAS: Kim Koldras, K-i-m K-o-l-d-r-a-s.

Good morning. I'm Kim Koldras, Clinical Nurse Manager on the Neurological Unit at Northwest Community Hospital.

I am speaking on behalf of a 50-year-old male with a history of multiple strokes. Tom, not his real name, and his wife were very frustrated with the lack of continuity of care provided at one of the local hospital rehabilitation units.

His physicians are all on staff at Northwest Community Hospital. His first stroke was in August 2001. He suffered additional strokes nine years later in May and in September 2010. For both strokes in 2010, Tom was discharged to Alexian Brothers for rehabilitation care.

Their concerns relate to delay in being admitted to Alexian Brothers, lack of continuity of care, and hardships due to not being in a familiar hospital environment.

One admission to Alexian Brothers was delayed for several days. There was a one-day delay

in getting evaluated by the Alexian Brothers physiatrist. This was supposed to happen on Friday but did not. Because there is no therapy on Sundays, this meant that the admission was pushed into the following week. That increased the patient stay at Northwest Community unnecessarily and delayed the start of the rehabilitation.

The patient and wife did not know the hospital layout at Alexian Brothers or any of the staff. The medical doctor there did not know him. The physiatrist was in and out and never seemed to spend time to get to know the patient.

The staff at Alexian Brothers did not send reports to Tom's doctors at Northwest Community Hospital. Because the patient room was a semiprivate room, there was no privacy for family conversations.

One of the roommates was incontinent, causing significant discomfort for the patient and his wife. Access to the shared bathroom was often delayed because the other patient needed to use it frequently. Eventually staff got it and moved Tom to a different room.

Throughout his stays, Tom was offered assistance with a shower only every other day because

of staff limitations. He would have preferred his normal daily shower.

Tom and his wife are familiar with Northwest Community Hospital, with its staff, environment, and its patient-oriented culture from their years of treatment there.

Logistics with admission and discharge at Alexian Brothers were difficult for this family. On one of the transfers from Northwest Community, the wife rode in the ambulance to Alexian Brothers. Her car was at Northwest Community. How to get back to the car was one of the stresses of the transfer.

During one of the stays at Alexian Brothers, discharge planning was not started in advance. When the discharge date was set, the wife was told to take off of work to accommodate. She could not because there was not advanced notice.

The wife had to arrange a caregiver for Tom on discharge day since he had residual disabilities and was not able to care for himself at home.

These and other incidents made it not just an inconvenience but a hardship for Tom and his wife. They expected more understanding.

Tom and his wife feel strongly that the

continuity, timeliness, and compassion of care would have been much better at Northwest Community hospital. They are hopeful that NCH can receive approval for the inpatient rehabilitation unit for them and others in the community.

Thank you.

MS. AVERY: Thank you.

Number 6, please?

After this one, Jack, we'll go with your next person.

MS. NOWAK: Melinda Nowak, M-e-l-i-n-d-a N-o-w-a-k. I'm an RN with NCH for ten years. I currently work as a Clinical Care Coordinator on 7 South Neurology.

I just wanted to share a short story about a 37-year-old American war veteran who was brought to Northwest Community Hospital with neurological and behavioral changes due to brain injury.

After days of testing, medical consults and treatments, he was finally stable and ready for transfer to a rehab facility, which had been recommended by our health care team.

Social workers and case managers used every resource available to find him appropriate rehab

placement. His parents recognized his need for ongoing care and were unequipped to handle him at home.

The patient had minimal insurance benefits, and Northwest Community Hospital was unable to find a facility that would accept him. Consequently, his parents had no other resources but to take him home.

I really hope that NCH receives approval for acute rehab so that we can offer an optimal continuum of care for patients with neurological and brain injuries in this area.

Thank you.

MS. AVERY: Thank you.

Jack, your next person?

Are there any other oppositions? That's it? Okay.

Number 7.

MS. CUARTERO: Good morning. I'm Janet Cuartero, J-a-n-e-t C-u-a-r-t-e-r-o.

I am Janet Cuartero, RN, on the orthopedic floor at Northwest Community Hospital. In my role I am responsible for requesting consults by the physician liaison at Alexian Brothers for patient transfers for inpatient hospital rehabilitation.

While this is a good process, often a day is lost before rehabilitation actually starts. If a patient is ready for discharge midday, that is often too late for transfer that day.

Alexian Brothers wants to receive the patient in the morning and have the patient get settled in the afternoon. Physical rehabilitation does not start until the next day. As a result, it can be more than a day between discharge from NCH and the start of inpatient rehabilitation.

There are other causes of delay as well. It can take two or more additional days for pending insurance approval for post acute care rehabilitation.

These delays add cost to the system and frustration for patients and their families. If NCH were to have its own inpatient rehabilitation service, this transfer would be internal quicker and more seamless.

Thank you for the opportunity to express these comments.

MS. AVERY: Thank you.

Number 8.

MR. BRAGG: Good morning. I'm Jerry Bragg, J-e-r-r-y B-r-a-g-g.

My name is Jerry Bragg, Director of Physical Rehabilitation Services at Northwest Community Hospital. I've been at NCH for eight years and have treated many patients in inpatient and outpatient care as a speech pathologist in that time, first as a staff therapist and now as a director.

During my tenure at NCH, I've encountered a number of inpatients who required the intensity of treatment only found in an inpatient acute rehab environment.

Unfortunately, some of these patients instead went to a subacute treatment setting due to unavailability of inpatient acute rehab beds in the area.

During my 14 years as a licensed therapist, I've worked in high-quality subacute, inpatient acute rehab, and acute care settings. Although subacute settings can offer a high-quality rehab experience, this setting does not offer the intensive frequency of treatment some patients need to maximize their recovery.

When a patient is recovering from a complex neurological event, such as a stroke or brain injury, there is a limited window of time when they have the

potential to make the most progress.

For those with significant deficits who need more than one discipline of therapy, receiving the intensity and frequency (at least three hours of therapy per day) can make the difference in whether they are able to fully regain their independence and function.

I have frequently seen patients as a speech pathologist in an outpatient setting who missed out on this opportunity and years later have to deal with continuing deficits that could have been significantly minimized had they received the inpatient acute rehab experience.

For this reason, I strongly support the plan for Northwest Community to open an inpatient physical rehabilitation unit, and I urge approval by the Illinois Health Facilities and Services Review Board to allow this project to move forward.

Thank you.

MS. AVERY: Thank you.

Number 9?

MS. BAKER: Karen Baker, K-a-r-e-n B-a-k-e-r.

Hi, my name is Karen Baker, and I am the

Director of Community Services at Northwest Community Healthcare.

As Michael Hartke noted earlier, the hospital operates one of the largest emergency rooms in the area and serves as the EMS resource hospital for first responders within a 450-square-mile radius.

We're also known for our primary stroke center and have just been recognized by the American Heart Association. We're really relied on by our community for our cutting-edge technology in those areas.

I want to talk to you a little bit about the other things Northwest Community Hospital is known for, and that is the outreach it provides to its community.

We continually collaborate with different organizations to address unmet health care needs. We do regular community health needs assessment, and we're continuously giving back to not everybody who is just our patient but to everybody who lives and works in the community.

Many of the hospital's outreach initiatives are really targeted for the underresourced, often our uninsured and our underinsured. Some really good

examples is our partnership with the Cook County Health and Hospital System and also the ACCESS Community Health Network, which is a Federally qualified health center.

We work with them to run community clinics in the area, which provides access for not only primary health but behavioral health also.

We also work with the local townships in the area to run a Mobile Dental Clinic. It's a full-time clinic that provides oral health care. We recognize the connection between overall health and oral health services.

Lastly, we operate a Community Resource Center up in north Palatine. That center houses over 13 different social service agencies and provides care to over 250,000 people every year.

Some of the partners there are the Cook County Department of Public Health, ECDEC, WINGS, along with our hospital partner, Cook County Health and Hospital System.

The ability to run these programs is really dependent on some of the revenue that the hospital generates. So it's very important we continue to have those service lines as well.

I wanted to just also mention a little bit about our care we provide to our Medicaid and our charity care patients. Last year we had over 9,300 individual charity care patients and over 25,000 Medicare patients. Together these services have been dramatically increasing in cost over the years. We went from $18.5 million to $24.5 million in charity care and Medicaid over the last three years.

Also, the number of patients is increasing. Our charity care patients in particular have increased by 172 percent over the last three years.

We recognize that although many individuals have obtained insurance through the Medicaid expansion and through the Insurance Exchange, the number of individuals, primarily undocumented individuals, continues to grow. Our Hispanic population in the community is about 14.7 percent, and it's projected to grow another 13 percent by 2017.

So the proposed new inpatient unit would benefit our Medicaid and our charity care patients in two ways; number one, by providing the care directly needed for these populations specifically and also by generating the revenues that we need to support our charity care and community outreach initiatives.

So thank you for giving me the opportunity to provide this statement, and I urge you to approve the rehabilitation unit.

Thank you.

MS. AVERY: Thank you.

Are there any other oppositions to the project that have signed in to speak?

Are there any other participants that would like to speak outside of the Northwest Community Hospital System?

Again, if there's anyone that just wants to state their name on the record and their position and would like to submit their written comments, feel free to do so.

So we'll go with number 10 next.

MR. WETT: My name is Michael Wett, W-e-t-t. Six years ago I had a devastating stroke and am now a stroke survivor. I live in Arlington Heights, and all of my doctors are in Arlington Heights and practice at Northwest Community Hospital.

If Northwest Community Hospital were not at the forefront of stroke technology, I would not be speaking to you today.

I was out walking my dog when the stroke

happened. I do not have any memories of the first few weeks of my care. The stroke robbed me of my abilities to remember, speak, or move.

I had an emergency brain procedure at Northwest Community Hospital. It was here I remained until I was ready for rehab. I do not remember this because of the severity of the stroke. I could not speak for my own decisions.

At this point my wife was told I needed to leave the hospital to get acute rehab elsewhere. If I could have made the choices for myself, I would have remained at Northwest Community Hospital, but they do not have an acute rehab unit.

My wife had to make crucial decisions based on the advice she was given by outside sources. She had to travel daily to be at my bedside to watch my progress and to make decisions and to speak on behalf of my needs. She was very nervous about the change provided in care.

I had to be transferred back to Northwest Community Hospital when I developed some complications. The communication process was misinterpreted, further delaying my recovery. It was a very stressful time for my wife, the additional

travel and further change in doctors.

It is my opinion that Northwest Community Hospital is in need of an acute rehab center. Families and patients do not need the additional stress of being in an unfamiliar environment at these crucial moments.

I know that both my wife and family would have preferred my staying at Northwest Community Hospital where our doctors practice and continued care could be provided.

I believe that the patients and families would benefit from having stroke care continue from the Emergency Department through the end of my acute rehabilitation at one facility.

Please allow Northwest Community Hospital the opportunity for an acute rehab unit. Who knows? You may benefit from it one day.

Thank you for allowing me to speak.

MS. AVERY: Thank you.

We're going skip to No. 25.

MR. McCALISTER: I'm James McCalister, Director of Building and Health Services for the Village of Arlington Heights. I'm reading a letter on behalf of Mayor Hayes.

"Dear Ms. Avery: I am writing in support of the proposed plan by Northwest Community Hospital to establish the 17-bed unit for inpatient rehabilitation.

"Northwest Community Hospital is a leading institution in the Arlington Heights community and surrounding areas. Its service and influence goes far beyond the provision of clinical services on the campus on Central Road and at their satellite facilities in Cook and Lake Counties.

"Over the years, Northwest Community Hospital has established strong relationships with the Village of Arlington Heights and social service organizations throughout the area, relationships that add tremendous value to those organizations as well as enhancing the community health care mission of the hospital. Several of those relationships are with local nursing homes, which will benefit from this project.

"With this project, residents can expect a continuity of services, from acute inpatient hospital care to rehabilitation in the hospital and nursing home settings and home care.

"The availability of services is

particularly important as the population over age 65 increases significantly. This is the age group that especially needs rehab services following stroke, orthopedic surgery, and other conditions.

"I encourage approval by the Illinois Health Facilities and Services Review Board.

"Sincerely, Thomas W. Hayes."

MS. AVERY: Thank you. You can leave it on the table.

Number 11?

MS. DEICHSTETTER: Joan Deichstetter, J-o-a-n D-e-i-c-h-s-t-e-t-t-e-r.

Good morning. I'm Joan Deichstetter. I've been a case manager at Northwest Community Hospital since 2005 and prior to that a discharge planner since 2000.

I work with the renal failure patient population extensively who are transferred to acute rehab with some regularity. The end stage renal failure patient who is receiving hemodialysis is a problem for Alexian Brothers Acute Rehab to take, most often because of transfer logistics.

I cannot send my patient to Alexian Brothers on a day the patient has had his dialysis treatment.

The physiatrist from Alexian Brothers will not accept the patient because it would be too late in the day, and the patient would be too tired to participate in therapy.

This means at the very least a one-day delay. If the dialysis is scheduled on a Saturday, the patient will not be accepted on that Saturday. Alexian Brothers does not accept new transfers on a Sunday. So the patient will have to wait until Monday to be transferred.

This results in unnecessary delays and a patient waiting in the wrong care setting. I estimate that type of situation occurs between five to ten times per year.

Alexian Brothers also has a problem with accepting patients requiring isolation. I was told they only have a few private rooms, and often they cannot accept the patient because they cannot provide an isolation room.

This results in our NCH patient going to a skilled nursing facility or us trying another acute rehab, resulting in longer travel times for the family and removes the patient again from his own physician's care.

As a case manager, I've been faced with delays in authorization for insurance patients, late authorizations resulting in delays in transfer because the receiving rehabilitation unit will not accept the patient after 4:00 to 5:00 p.m.

I also had much difficulty in placing the patient without a payer source. I understand that Alexian gives priority to their acute patients who need rehabilitation, which means there is less opportunity for NCH patients to get admitted there.

Each of these problems, transfer logistics, patients with special needs such as isolation, insurance authorization, and underinsured patients would not be issues if Northwest Community Hospital had its own inpatient rehabilitation unit.

I hope that the Health Facilities and Services Review Board will grant approval to the NCH project, resulting in improved access to rehabilitative care for patients in our community.

Thank you.

MS. AVERY: Thank you.

Number 12?

DR. LONGO: Dr. Robert Longo, R-o-b-e-r-t L-o-n-g-o.

Hi, I am Dr. Robert Longo, and I'm a physician on staff at Northwest Community Hospital. I've been on staff there for the past 17 years. I work as a hospitalist in internal medicine. I'm a past President of the Northwest Community Hospital Medical Staff, and currently I'm serving as the Chairman of the Utilization Management Committee.

As has been said many times, most of the patients from Northwest Community who need acute rehabilitation care go to Alexian Brothers Medical Center.

Overall, I would say that the care they receive there is excellent. I think that isn't the major issue that we have. The problem comes in as the delays.

I would say that patients, when they're ready for discharge and they are medically cleared for discharge, are looking at an additional anywhere from one to four days at Northwest due to any number of reasons.

Patients in my experience are virtually never accepted on a Sunday, rarely on a Saturday. There seem to be undue delays in getting insurance approval.

The physiatrist who is seeing the patient, the same patient one day is a great candidate or is a terrible candidate. The next day they're a great candidate and they can come. It's very confusing.

We'll be told, "Well, the patient's potassium is not right today," or, "We don't like this low-grade temperature," which to me does not really fit into the purview of physiatry care, but all these things add up to delays.

Meanwhile, the patient is sitting there, and they're getting weaker, and they're getting more deconditioned. The family is getting frustrated. As a physician, as a case manager, you're going into the room every day and saying, "Well, you're ready to go, but we're waiting."

The amount of rehab you get when you're at an acute care hospital on the regular floors, you're not getting a lot of rehab. You're getting very little, as opposed to the three hours you'd be getting over at acute rehab in an acute rehab unit.

Therefore, as has been said, I think that the patients from Northwest Community Hospital and this Arlington Heights community would benefit greatly if Northwest Community was allowed to have its own

inpatient rehab unit. Therefore, I urge approval by the Illinois Health Facilities and Services Review Board.

Thank you.

MS. AVERY: Thank you.

Number 13?

MR. FOSTER: Larry Foster, L-a-r-r-y F-o-s-t-e-r.

Good morning. My name is Larry Foster. I'm the Chief Executive Officer of Kindred Hospital Chicago North. I am here today to speak in support of the need for greater access to post acute services and the comprehensive inpatient rehabilitation program proposed by Northwest Community Hospital.

I have worked in health care for 25 years and held executive-level roles for the past 17 years.

The hospital that I oversee is a 165-bed specialty hospital known as a long-term acute care hospital. We provide care for medically complex patients requiring extended hospital stay. These patients may include ventilator dependent patients, complex wound care, trauma, multisystem organ failure, and infectious disease.

Patients admitted to long-term acute care

hospitals are evaluated by rehab services upon admission to establish a treatment plan.

Depending on the physical status of the patient, up to one to two hours of rehab therapy may be provided daily. Once the patient is able to tolerate three hours of rehab therapy, the natural progression in the continuum of care would be to transition the patient to an inpatient rehab unit.

The proposed unit at Northwest Community Hospital would provide improved access to the growing number of patients requiring this level of care.

Long-term acute care hospitals are currently required to maintain an average Medicare length of stay of greater than 25 days. In December of 2013, CMS passed legislation defining patient criteria and eliminating the 25-day length of stay rule. This goes into effect in June of 2016.

As our industry criteria changes, the range acuity for our patients will also change. This broader base of patient population will have varying lengths of stays requiring more post acute care networks.

In closing, I am in strong support of the proposed program at Northwest Community Hospital. I

would like to thank the Illinois Health Facilities and Services Review Board for the opportunity to speak in favor of the need for greater access to post acute care services and specifically for the approval of the Northwest Community Hospital CON application for 17 inpatient rehab beds.

MS. AVERY: Thank you.

Number 6 and 14 may have switched, which was Melinda Nowak.

MS. BALEK: Yes. I'm Lori Balek. I'm 14. Lori, L-o-r-i, Balek, B-a-l-e-k.

Hello, my name is Lori Balek. I am the Director of Clinical Care Coordination at Northwest Community Healthcare. I have been at Northwest Community for 38 years.

My previous roles were as a charge nurse, case manager, and manager of 7 South, a medical-surgical neurology unit.

My current responsibilities include overseeing the Clinical Care Coordinators, Utilization Managers, and the Social Workers. I oversee the progression of care from admission to discharge. I work with the above disciplines to facilitate the patient plans of care, implement and coordinate care

progression, monitor and assist the care team in evaluating options, services, and interventions to meet patients' health care needs.

This is accomplished through effective communication, collaboration, and coordination requisite to clinical care progression.

I work with the entire care team to ensure the patient is receiving the appropriate level of care in the appropriate setting and progressing according to the plan. This allows the patients to receive quality care in a cost-efficient setting in a timely manner.

The barriers I have witnessed to acute rehab include several times in the last year when we have had a disconnect in our continuity of patient care satisfaction and have barriers to discharge. This is evidenced when a patient receives a physical therapy evaluation that recommends acute rehab.

The primary care doctor puts a physiatrist consult in as an order for the patient to be assessed for acute rehab. The Clinical Care Coordinator talks with the patient and gives them choices of acute rehab facilities.

Most patients and families want their family

member to stay close, and they are too stressed to travel. Many choose Alexian Brothers Acute Rehab because it is the closest.

The Clinical Care Coordinator calls the physiatrist for a consult to come and see the patient. If the physiatrist has already made rounds that day, they do not come in that day, and that is a delay in discharge.

When the physiatrist comes in the next day, she may accept the patient or ask for more therapy notes on the patient.

In the meantime, the family is stressed and the Clinical Care Coordinator has to tell the patient they need a second choice of an acute rehab facility in case there is not a bed at Alexian Brothers or the doctor won't accept them.

Then the patient and family also have to look at a subacute facility if the second choice of acute rehab will not accept them. This is another delay in discharge.

This is very stressful to the patients and family members. This upsets many patients and families and causes decreased patient satisfaction and progression of care.

Finally, once Alexian Brothers would accept the patient, they have strict guidelines in what time they will take the patient for admission to their facility. They want all of their patients there before noon.

So if the patient has other consults that need to see the patient for discharge, they cannot come there. The latest they have taken them is maybe up until 1:00 p.m. So again, we have a delay in discharge, progression of care, and patient and family satisfaction.

This would not be a problem if Northwest Community Healthcare had its own inpatient acute rehab unit. Patients could be sent when the patient is ready for discharge, such as 8:00 p.m. at night or Saturday and Sunday.

There would be no extending the patient's length of stay due to waiting for an inpatient acute rehab bed. This would also cut the cost of an ambulance transfer for the patient and family. This truly would increase patient and family satisfaction.

I urge the Health Facilities and Services Review Board to approve our request, especially and most importantly for our patients like Mike.

Thank you.

MS. AVERY: Thank you.

Number 15?

MS. MIRAGLIA: My name is Jennifer, J-e-n-n-i-f-e-r, last name Miraglia, M-i-r-a-g-l-i-a.

Good morning. My name is Jennifer Miraglia, and for the past nine years I've served as Regional Vice President of Operations for RehabCare.

In addition, I'm a licensed physical therapist in the state of Illinois. I've lived in the Chicagoland area my entire life and have practiced therapy in Illinois since 2008.

My current responsibilities within RehabCare include overseeing the clinical and operational functions of 56 sites of care across the Midwest, including the Chicagoland area.

Currently within Illinois, RehabCare has set up and/or operates seven comprehensive inpatient rehabilitation units, as well as numerous outpatient LTACH units.

Kindred Healthcare is a Fortune 500 health care services company based in Louisville, Kentucky, and employs approximately 63,000 employees across 47 states.

As of March 31, 2014, Kindred through its subsidiaries provided health care services in 2,313 locations.

Ranked as one of Fortune Magazine's "Most Admired Health Care Companies" for six years in a row, Kindred's mission is to promote healing, provide hope, preserve dignity, and produce value for each patient, resident, family member, customer, employee, and shareholder we serve.

RehabCare is a wholly owned division of Kindred Healthcare and is a post acute management organization that provides program management and therapy services for hospitals through hospital rehabilitation units, outpatient rehabilitation programs, skilled nursing units, and medical-surgical therapy services and as a partner both in setting up and managing these units.

RehabCare is the largest provider of therapy services in the United States. In 2013, RehabCare delivered therapy to more than 500,000 patients across the nation. Of those, RehabCare served over 43,000 patients in Comprehensive Inpatient Rehabilitation programs. 3,738 of those patients received care in our Illinois Comprehensive Rehabilitation programs.

RehabCare has been managing Comprehensive Inpatient Rehabilitation programs in Illinois for 29 years.

RehabCare's national presence provides a vast knowledge base and experience level to bring about the best outcomes for each patient we treat.

Integral to RehabCare's success as a partner to our hospitals are our outstanding clinical outcomes. RehabCare's managed acute rehabilitation units outperform national averages in every key performance quality metric, including rehospitalization rates, FIM Gain, FIM Efficiency, and Discharge to Community.

Northwest Community Hospital will work with RehabCare, who will bring its over 30 years of experience in the establishment and operation of over 105 comprehensive inpatient rehabilitation programs across the United States.

The partnership will combine the clinical strengths of Northwest Community Hospital with RehabCare's acute rehabilitation unit expertise.

Within this partnership Northwest Community Hospital will be responsible for recruiting and employing a nursing and secretarial staff.

RehabCare will recruit and employ the remaining rehabilitation staff, including medical director, program managers, physical therapists, occupational therapists, speech and language pathologists, Master's-level social workers, and clinical liaisons.

In closing, since 1992 RehabCare has worked with and developed the expertise to support acute and post acute strategies of our host hospitals throughout Illinois.

RehabCare's depth and breadth of experience in opening and operating ARUs in conjunction with hospitals makes this partnership with Northwest Community Hospital optimal.

While the need for the delivery of cost-effective and medically necessary therapies to drive down the overall cost of care is at an all-time high, timely patient access to ARU beds at Northwest Community Hospital is critical. This unit will improve access to patients and ensure they are receiving the right level of care at the right time.

Thank you very much for the opportunity to speak on behalf of RehabCare and in support of the CON application.

MS. AVERY: Thank you.

Number 16?

MS. STRENG: Hadley, H-a-d-l-e-y, Streng, S-t-r-e-n-g.

Good morning. My name is Hadley Streng, and I am the Director of Planning and Business Development at Centegra Health System.

I am here in support of Project 14-021 for Northwest Community Hospital to establish a 17-bed physical rehabilitation unit on the campus of their acute care hospital in Arlington Heights.

Centegra Hospital, McHenry, a 179-bed acute care facility with a 22-bed inpatient rehabilitation unit, is more than 28 miles and almost 50 minutes northwest of Northwest Community Hospital.

It is the closest facility to offer inpatient comprehensive physical rehabilitation services in this direction and the only facility in the quadrant to the west and north of Northwest Community Hospital, as shown on the map earlier. Large parts of this area are underserved for physical rehabilitation services.

The establishment of a rehabilitation unit at Northwest Community Hospital will bring needed

services to the residents of this area and enhance the hospital's ability to provide continuity of care for its patients.

I urge the Illinois Health Facilities and Services Review Board to approve the Project No. 14-021.

Thank you.

MS. AVERY: Thank you.

Number 19?

DR. MARAMREDDY: Good morning. My name is Sailaja Maramreddy, S-a-i-l-a-j-a M-a-r-a-m-r-e-d-d-y.

Good morning. I am Dr. Maramreddy, and I am a vascular neurologist at Northwest Community Hospital. I'm on staff at Northwest Community Hospital for the last 12 years.

I deal with a lot of disabilities, and most of them include strokes and brain bleeds and also other conditions like nerve and muscle disorders and spinal cord disorders. Often these conditions require inpatient rehabilitation following acute care at Northwest Community Hospital.

I want to talk today on behalf of the patients and the need for continuity of care that

would be enhanced if Northwest Community Hospital were to have an inpatient physical rehabilitation unit on its campus.

Many of my patients have been coming to Northwest Community Hospital for many years and see a number of specialists on the staff here. When these patients are hospitalized for rehabilitation elsewhere, they are not followed by our physicians who have knowledge about the individual needs of their patients. These physicians include neurologists, orthopedic surgeons, hematologists, cardiologists, and so on.

If one of our patients is having rehabilitation at another hospital, for example, if they fall or if they develop chest pain, they go to another acute care setting, the hospital in that area. The specialists at Northwest Community Hospital are not aware or not asked to consult, as they are not on staff there.

I see many times repeated tests done there, including CAT scans, MRI of the brain and other testing, which increases the amount of tests that they do for the patient. This lack of continuity of care could also prove to be problematic for the patient.

Also, the important baseline test information that we have, because we know them for a long time, is not used in the treatment plan.

I'm also on staff of Alexian Brothers where my NCH patients go for inpatient rehabilitation after their care here. My issue is not the quality of care at Alexian Brothers. It is very good care.

My issue is lack of continuity of care. While I can go to Alexian Brothers to see the patients because I'm on staff, the other team of other specialists at NCH cannot. It is the team approach that is missing, and continuity of care does not occur when the patients are hospitalized elsewhere.

Also, Northwest Community Hospital has excellent nursing care and also ancillary services and support services in place already which can help enable the continuity of care and support patient recovery.

Apart from the continuity of care, I see the problems like other staff here have mentioned, the referral of patients for rehabilitation at other hospitals.

Many NCH patients are not getting placed in the inpatient rehabilitation when they are ready.

Sometimes that is because there is no bed available, other times because the patient is self-pay with no insurance.

It's well known that rehabilitation can be the most effective if it's started within 20 days of the stroke or other neurological event.

If a patient is in an acute care bed for a long time and is finally ready for discharge to rehab, he or she should not have to wait extra days to get to rehab due to bed availability or insurance issues. The longer the wait, the less the patient will be able to have timely rehab and subsequently good recovery.

I also want to talk briefly about self-pay. Other hospitals with inpatient rehab units do take self-pay, but their acute care patients receive the priority.

Some of our patients don't make it to the acute rehab, and they finally settle for either outpatient rehab or a nursing home; but there is a big difference between the rehabilitation in the hospital compared to the nursing home.

Hospitals have three-hour-per-day treatment regimens for controlled intensive therapy. They have splints and the right equipment, such as devices that

assist patients in walking, et cetera. All these patients needing the rehab should have access to the care in the right settings.

In closing, I see an enormous number of stroke patients. Many of my patients ask why Northwest Community Hospital does not have a physical rehabilitation unit here. I can see their anxiety and stress over whether they will not be known in the other hospital setting and that continuity of care will not happen for them.

I strongly believe that we should have such a unit, and I ask approval by the State Board for same. Thank you.

MS. AVERY: Thank you.

Number 21?

MS. SCHUMACHER: Karen, K-a-r-e-n, Schumacher, S-c-h-u-m-a-c-h-e-r.

Hello, I'm Karen Schumacher, Manager of Rehab Services at Northwest Community Hospital. I speak today in support of establishing an inpatient rehab unit at NCH.

In thoughtfully considering the addition of an acute rehab facility to its spectrum of services, I believe that NCH possesses both the right location and

the right motivation.

Keeping it local means something to us here at NCH. We are a community whose prime directive is to care for its neighbors, and we want to bring them the full spectrum of care, including facilities where medically stable patients can be stretched to meet aggressive functional goals that will transition them back to a quality life.

In a time when an illness, injury, or surgery has done nothing but add stressors, I believe that NCH has the opportunity to create comfort with seamless on-campus transitions, easy access to family and familiar physicians and, most importantly, the assurance that the services align with what the community has come to expect from NCH, holistic, individualized, and evidence-based care.

The story of an NCH patient was recently shared by one of my therapy staff, the case of a vibrant, active, and independent individual who sustained injuries to both legs making a return to home with more than ten steps an impossibility without further rehab.

Despite considerable motivation on the part of the patient, she was not accepted by an acute rehab

facility due to concerns that her progression to a functionally independent level free of family support would be too slow.

The hospital therapist had already worked with this patient several times and seen how committed she was to achieving her personal goals of getting home. This was the case of knowing our patients and the unrealized desire by her therapy and medical team to enable her to recover in an acute rehab unit on campus.

I stand by the excellent work of NCH and believe that it will be even better positioned to live its mission statement of serving the community's health care needs with the addition of an acute rehab facility.

Thank you.

MS. AVERY: Thank you.

Number 22, please?

MS. DINSMORE: Beth Dinsmore, B-e-t-h D-i-n-s-m-o-r-e.

Good morning. I'm Beth Dinsmore, lead occupational therapist at Northwest Community Hospital.

Having an acute care rehab facility within

the NCH health care system would greatly benefit our community by providing both excellent continuity of care and coordination of services.

When a patient is ready to be discharged from the hospital for continued rehabilitation, it places an added burden on the patient and family to leave a caring and familiar environment. Patients and family have frequently voiced concerns about transferring to a facility where they don't know anyone.

Having a rehabilitation unit would help ease patients' and families' anxieties. Alleviating stress is a significant component in recovery, and enabling a patient to stay in a trusted environment where continuity of care is provided should be the goal.

Northwest Community Hospital is known for comprehensive patient care, which can be compromised once the patient leaves our health care system.

Given the complexities of treating illness and injuries, the coordination of services is an extremely important part of the patient's recovery and can be devastating to patients and families when it doesn't happen.

Recently the case manager, physical

therapist, and I had an extended conversation with the tearful mother of a chronically ill patient. The patient's mother stressed many concerns regarding the lack of continuity of care her daughter had received in various health care settings over the last few years, including home care and rehab.

This took the form of poor communication between health care providers across health care systems and specifically lack of information on resources that could provide her daughter with additional assistance. The mother stated that she was grateful that staff at Northwest Community heard her concerns.

In closing, I believe an acute rehab unit on-site would benefit the community by providing continuity of care which fosters a sense of comfort for patients and families dealing with illness or injury in a time of crisis. This seamless transition from hospital to acute rehab, then home or outpatient would improve health care delivery for patients and their families.

Thank you.

MS. AVERY: Thank you.

Number 23?

MS. SMITH: Good morning. Leeanne Smith, L-e-e-a-n-n-e S-m-i-t-h.

Good morning. My name is Leeanne Smith. I currently serve as the lead physical therapist for Northwest Community Hospital where I have cared for patients for over 17 years.

In my tenure of over 25 years as a therapist, I've worked in both subacute and acute rehabilitation environments, along with outpatient home health care, giving me a broad perspective on patients' needs across the continuum of care.

Opening an acute rehab facility on the NCH campus would allow hospitalized patients a timely transfer to an environment where multiple hours of daily therapy would be available.

I've personally worked with patients who have had extended stays in the hospital due to lack of bed availability at area hospital rehabilitation units and/or insurance issues, which has ultimately delayed the more intensive and more frequent therapy that is critical to maximizing their functional outcomes.

Case in point, I recall a young underinsured patient who was dealing with multiple medical problems. This patient had a lengthy hospital stay

made longer unnecessarily by the inability to secure placement at an acute rehab environment.

This patient truly needed all three therapy disciplines, occupational therapy, physical therapy, speech language pathology services to maximize potential in the shortest possible time frame.

Ultimately, this patient's only option was admission to a subacute facility where the therapy was both less intense and less frequent.

Many patients have spent too long in the acute care environment waiting for admission to a hospital rehab unit, which could result in delayed recovery.

Simultaneously having an on-site option does matter to our locally based patients. Families want to be close to their loved ones and provide them the needed support that so critically aids in their recovery.

Proximity to home is not just a convenience. It avoids hardships for many families, particularly those who have nondriving spouses or family members. The ease of access, the proximity to home, and familiarity with our NCH campus decreases the stress of the families, allowing them to focus on being a

partner in the recovery efforts.

In closing, I believe an acute rehab facility at NCH could allow for finally transitions and greater options for patients, especially those who are underinsured.

Thank you.

MS. AVERY: Thank you.

Number 24?

MR. HEMMER: Phil, P-h-i-l, Hemmer, H-e-m-m-e-r.

Good morning. I am Phil Hemmer, the Executive Director of the Lutheran Home in Arlington Heights.

The Lutheran Home is a skilled nursing facility comprised of 392 licensed nursing beds and 100 units of assisted living. The Lutheran Home was established in Arlington Heights in 1892 and receives an average of 70 referrals per month from Northwest Community Hospital for skilled nursing services, including post acute rehabilitation care.

Northwest Community Hospital also provides high-quality acute care resources when our residents and patients need emergency care and other hospital services.

The Lutheran Home supports Northwest Community Hospital's proposed project to establish a 17-bed comprehensive inpatient physical rehabilitation unit at the hospital. The Lutheran Home and Northwest Community Hospital have had a long and collaborative relationship in serving the residents in our community.

There is a need for additional acute care physical rehabilitation resources in the area, especially for older adults in Arlington Heights and the surrounding communities who are reluctant or unable to travel out of the area for this care.

An inpatient unit at Northwest Community Hospital will be part of the continuum of care for patients in our community. It will help fill the gap between acute hospital care and the post acute rehabilitation care provided at the Lutheran Home.

It is consistent with the underlying purposes of the Liaison in Nursing Care Transitions program the Lutheran Home and Northwest Community Hospital started together over 2 1/2 years ago to enhance the transition of care from the inpatient hospital to the skilled nursing setting.

The new unit at Northwest Community Hospital

will not compete with our service but will enable a true continuum of rehabilitation care to be offered to service area residents. Northwest Community Hospital will continue to refer patients needing our level of post acute rehabilitation care in the skilled nursing setting.

On behalf of the Lutheran Home, I urge the Health Facilities and Services Review Board to approve the new rehabilitation unit at Northwest Community Hospital.

Thank you.

MS. AVERY: Thank you.

Before we ask for closing remarks from the applicant or representative from Northwest, is there anyone who wishes to testify who has not had an opportunity?

Hearing none, we'll hear from the closing.

MR. BUXTON: Thank you. Brad Buxton, B-r-a-d B-u-x-t-o-n.

I am Brad Buxton, Vice President for Strategy and Business Development at Northwest Community Hospital. As the final speaker in support of the project, my role is to wrap up and summarize and comment on the testimony delivered at today's

public hearing.

First, in pursuing this project, it is not the intent of Northwest Community Hospital to compete with Alexian Brothers Medical Center in any way. We've enjoyed a good relationship, and we appreciate collaborating with them in many areas, especially in emergency medical services.

As you know, Alexian has a large unit, 72 beds. Our 17-bed program will be a quarter of the size; and based on past data from 2012 and beyond, at many times they were above and met the 85 percent occupancy standard. As you could hear, we've had some issues in getting patients admitted.

We also feel that, as we've outlined in our application, the Impairment Codes, as we explained, we anticipate to continue to refer patients to Alexian Brothers and other rehab units even when our unit is opened because it will only be 17 beds. We think there are many more patients than that that will need to be referred.

It is Northwest Community's purpose to serve our community, especially the residents of our primary and secondary areas, especially inpatients in NCH who need acute rehabilitation after their inpatient stays

who are not getting this care sometimes in a timely fashion.

Let me talk about that for a minute. First, patients that are not getting admitted for rehabilitation care due to the following reasons:

Lack of available beds at periods of time; patients who need special needs, such as isolation; patients who lack insurance and self-pay.

I'm not saying that people are always deferring patients who are self-pay or don't have the means, but sometimes the beds are not available when other patients who come from that facility are paying patients and have the ability to be put in those beds first. De facto, these patients are not sometimes getting the care they need, and we want that to be available for the residents of our service areas.

Second, admissions to rehab units are sometimes delayed. We've heard today one to four days is a pattern, not really an exception. The reasons are sometimes it's lack of bed, transfer logistics, insurance authorization, and sometimes, quite frankly, we can't get a patient in because of lack of coverage.

The result is that patients get upset. They are ready to go and can't. This adds stress and

anxiety, as we've heard, for them and their families. It also creates a lot of stress for people recovering from strokes.

Results: Our patients get weaker and become increasingly deconditioned while waiting. We also know that we do not experience these delays when we're discharging them to skilled nursing facilities, such as Lutheran Home, who just basically talked about that. We get them going when the patient is ready to go.

Third, continuity of care suffers when patients are transferred to another hospital for rehab care. We heard Dr. Maramreddy talk about NCH specialists who care for patients who can't get in to see their patients or are not getting reported back to on those patients.

When a patient is having rehab at another hospital and has an acute care episode there, he or she is hospitalized at the rehab hospital, and there is usually no continuity of care then either.

Patients and families stress when "they don't know me" or they are so far from home and it's hard for them to get there or they're in an unfamiliar environment in a different hospital with unfamiliar

staff, additional travel time. That is very stressful and creates a lot of anxiety.

Today's patient expects seamless care, but they don't experience that when care is delivered in different systems. They expect continuity of care across a continuum of acute care services and in their recovery, as you've heard many times today from many of the therapists and caregivers and physicians who work with our patients.

You've heard many testify that a small rehabilitation unit at NCH would address these three problems, access of care, timely rather than delayed care, and continuity of care where the patient is known and followed by the NCH staff.

This proposed project is based on patient need and expectations. This is the right time, and NCH is the right place to initiate this program.

NCH has a large stroke program. It has the largest emergency room in the northwest suburbs, and a source of brain injury and trauma cases are generated through that.

An inpatient physical rehab unit complements these stroke and trauma cases. 80 percent of the patients NCH refers for rehab care are over age 65 in

the NCH service area. As you heard before, this group will increase by 16 percent in the remainder of this decade.

A continuum of care is needed for NCH patients, acute hospital care, acute hospital rehab, subacute rehab in a nursing home setting, and home care. For many NCH patients, the weakest link in this continuum is the lack of an inpatient hospital rehabilitation unit.

Thank you for your interest and attention. I urge you to support this project.

MS. AVERY. Thank you.

Please note that this project is tentatively scheduled for consideration by the Board at its August 27th meeting. The meeting will be held in Normal, Illinois, at the Bloomington-Normal Hotel and Conference Center located at 201 Broadway Street, Normal, Illinois.

Please refer to the Board's Web site at www.hfsrb.illinois.gov for more details and possible agenda changes.

I ask that you be prepared to take note of the following times and dates: The deadline to submit written comments pertaining to this project is

9:00 a.m. on August 7th. The State Board Staff Report will be posted on the Web site on August 13th. The deadline to submit written responses to the State Board Staff Report is 9:00 a.m., August 19th.

Written comments and responses should be sent to the Illinois Health Facilities and Services Review Board, Attention Courtney Avery, Administrator, 525 West Jefferson Street, Second Floor, Springfield, Illinois 62761.

Are there any questions regarding the dates and times?

Any questions regarding today's proceedings?

Hearing that there are no additional questions or comments, I deem this public hearing adjourned, and I thank you for your participation.

Thank you.

(Which were all of the proceedings had in the above-entitled matter, concluding at 12:00 p.m.)

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

I, Jean S. Busse, Certified Shorthand Reporter No. 84-1860, Registered Professional Reporter, a Notary Public in and for the County of DuPage, State of Illinois, do hereby certify that I reported in shorthand the proceedings had in the above-entitled matter and that the foregoing is a true, correct and complete transcript of my shorthand notes so taken as aforesaid.

IN TESTIMONY WHEREOF I have hereunto set my hand and affixed my notarial seal this 28th day of July 2014.

Jean S. Busse

Notary Public

My Commission Expires
July 25, 2017.