# Community Health Needs Assessment & Implementation Plan

*Report to the Board of Trustees – activities conducted July 1, 2013 – June 30, 2014*

The Community Health Needs Assessment was conducted between July, 2012 and April, 2013. The main input was provided by patients, employees and community representatives with expertise in public health and various not-for-profit organizations that serve low-income and disadvantaged populations. Additional information came from public databases, reports, and publications by state and national agencies. This Community Health Needs Assessment and the Implementation Plan was approved by the MRC's Board of Trustees on May 23rd, 2013.

## Implementation Plan

The plan identified three priorities we will focus on over the three-year period:

1. Promote utilization of community-based primary health care
2. Improve provision of family/caregiver education and support
3. Promote healthy lifestyle, fitness and recreation

## Implementation Strategy

Teams have been created and are meeting to plan and implement activities related to each priority. The team leaders have selected members among the MRC employees based on their professional background and interests.

The Oversight Committee has convened on a regular basis to guide each team and review the progress made. The Oversight Committee has delegated a member to each team to assist with plan implementation. The Oversight Committee has provided a report to the Executive Committee of the MRC Board of Trustees on a quarterly basis and has developed interim reports that will be reviewed by the MRC Board of Trustees.

## Status of Activities

1. UTILIZATION OF COMMUNITY-BASED PRIMARY HEALTH CARE

   **Goal:** Improve utilization of primary health care services to avoid secondary complications after stroke, spinal cord injury or brain injury. Due to challenges with transportation and access to primary health care providers, especially in rural areas, a common theme heard in our interviews and focus groups, many Methodist Rehab Center patients post-discharge fail to engage community-based primary health care providers for general health maintenance. Many of these persons prior to illness/injury had no relationship with a primary health care provider, so this disconnect continues.

**Progress to date:** The team has made progress in FY2014 in four of the six stated activities listed in our Implementation Plan:

- Activity 1 – *"Assess prior utilization of community-based primary health care"* The team is studying a representative sample of admitted patients to determine prior utilization (prior to injury) of community-based primary health care. Of particular interest are demographics and rates of utilization.
- Activity 2 – *"Promote utilization of community-based PHC services"* The team is studying the rate of post-discharge appointments made with a primary health provider.
- Activity 3 – *"Assess post-discharge utilization of community-based PHC"* Several questions have been added to our three-month-post-discharge phone survey related to primary health care utilization (beginning May, 2014). The team will evaluate this new input.
- Activity 4 – *"Assess use of PHC available for low income persons"* This will be addressed in FY2015 and FY2016.
- Activity 5 – *"Educate PHC providers about unique needs of persons we serve"* This will be addressed in FY2015 and FY2016.
- Activity 6 – *"Explore need & feasibility for developing electronic personal health record"* The team has begun to survey available options.

Our recently developed *Navigator Program*, funded through the 3-year quality of life grant from The Craig H. Neilsen Foundation, is expected to have a significant impact on this activity. The *Navigator Program* is designed for persons with traumatic spinal cord injury with the goal to ease transition from in-patient rehabilitation to home and improve access to available services. Since utilization of PHC in community settings is vital for maintaining health and preventing secondary complications after traumatic spinal cord injury, the *Navigator Program* will serve as a model for exploring avenues for how to assess, promote, and increase utilization of PHC throughout Mississippi.

2. PROVISION OF FAMILY/CAREGIVER EDUCATION AND SUPPORT

**Goal:** Enhance the content and broaden the delivery of services related to education and support of families and caregivers across the continuum of care, starting with the screening for inpatient admission, during inpatient rehabilitation, and after community discharge.

**Progress to date:**

In FY2014, the team conducted a literature review to gain a deeper understanding of conventional caregiver support and training and what weaknesses may be inherent with this approach. This has provided us with a functional definition of a continuum of caregiver education from conventional to exceptional.

Progress toward specific activities from the implementation plan is evidenced in four of the five areas as follows:

- Activity 1 – *"Educate community about the role of the caregiver during rehabilitation"* The team has met with the Community Outreach Team to gain insight about the pre-admission education needs and limitations. The team is currently conducting chart

reviews to determine how frequently a caregiver was identified during the pre-admission assessment process.

- Activity 2 – *"Enhance content / format of the Resource & Education Guide"* Based on anecdotal feedback, some revisions to the guide have already been made. The guide will be reformatted, reprinted and made available on the new MRC website by June 30. In addition, we are considering adding several questions to our three-month-post-discharge phone satisfaction survey related to this activity.
- Activity 3 – *"Enhance caregiver education"* Currently, patient satisfaction is measured with a survey upon discharge, and they are asked if the family was given pertinent information. In 2013 68% of discharged patients responded to this question; 69% rated their satisfaction as excellent while 20% rated their satisfaction as very good. The team is exploring improved methods for surveying family satisfaction at discharge and at follow up intervals.
- Activity 4 – *"Increase awareness of community-based services for persons with disabilities"* The team is currently conducting chart reviews to determine how frequently documentation on the patient's comprehensive education record indicates that this information was provided.
- Activity 5 – *"Enhance peer-support for patients and caregivers" This* will be addressed in FY 2015 and FY 2016.

3. PROMOTION OF HEALTHY LIFESTYLE, FITNESS AND RECREATION

**Goal:** Create an environment conducive of broader participation of people with stroke, spinal cord or brain injury in community-based activities that promote healthy lifestyle, fitness, and recreation in order to improve or maintain their physical health and overall well-being.

**Progress to date:** The team has focused in FY2014 on the first activity listed in our Implementation Plan.

- Activity #1 *"Increase awareness of community-based resources for fitness & recreation"* The team has collected information on community-based opportunities across Mississippi, dividing the state into five segments with a team member assigned to study each segment. This information will be compiled and made available through various means.
- Activity #2 *"Educate fitness trainers how to meet needs of persons we serve"* This will be addressed in FY2015 and FY2016.
- Activity #3 *"Promote participation of person we serve in community-based sports & recreation events"* This will be addressed in FY2015 and FY201.

Anticipated Impact

We anticipate that the selected priorities will result in short- and long-term community health benefits. The short-term benefits will be reflected in increased interactions with community-based primary health care providers, increased reliance on and satisfaction with the Resource and Education Guide provided to each member of the community that we serve, and increased utilization of adaptive sports, fitness and recreation opportunities. This, in turn, is expected to result in long-term community health benefits, such as improved day-to-day disease management, prevention of secondary complications, improved overall well-being, and thereby better quality of life.

Planned Collaboration

We plan to partner with different state and non-profit agencies and organizations, as appropriate for each selected priority. The prospective partners include, but are not limited to, Mississippi State Department of Health, Mississippi Primary Health Care Association, Mississippi Academy of Family Physicians, University of Mississippi Medical Center, Living Independence for Everyone, Mississippi Paralysis Association, Metro Area Community Empowerment, major fitness facilities in the area and organizers of recreational programs.

Health Needs not Addressed

Based on the adopted guiding principles and the criteria for prioritizing identified health care needs, we chose not to address assessment findings that regarded systemic societal barriers such as lack of transportation, given the scope of the problem and the likelihood that Methodist Rehab is not in a position to make a true and lasting impact in such an area. Similarly, we opted not to address issues related to a coordination of post-discharge rehabilitation care because of the existence of other entities that primarily focus on these needs, such as Independent Living or Vocational Rehabilitation under Mississippi Department of Rehabilitation Services.