# Community Health Needs Assessment & Implementation Plan

*Report to the Board of Trustees – activities conducted July 1, 2014 – June 30, 2015*

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:** We randomly selected and reviewed about 25% of medical records of patients discharged from MRC between April 1st, 2014 and March 31, 2015. The data are used to report progress in FY 2015 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 continuing to study a representative sample of admitted patients to determine utilization of community-based primary health care prior to injury or disease requiring admission to MRC. Of the 289 charts reviewed, a primary health care provider was identified in 79% of patients during the admission evaluation. The highest rate of undocumented primary health care providers fell within the traumatic brain injury (TBI) population (41%), followed by traumatic spinal cord injury (SCI), stroke, and amputees (33%, 31%, and 21%, respectively). Higher percentages among the TBI and SCI patients is expected since they are generally younger and in good health prior to accidents causing the injury. On the other side, one third of the stroke population without documented primary health care provider at admission is somewhat of concern since the majority is expected to have well-known pre-existing conditions posing risk for stroke, such as diabetes and hypertension, which ideally should be managed in the interest of primary prevention.
- Activity 2 – *"Promote utilization of community-based PHC services"*
  At time of discharge, 90% of the charts reviewed had a documented primary health care provider. Of the patients that had no documented primary health care provider at the time of admit, one was identified at the time of discharge for 71% of those patients. For 59% of patients, a follow-up appointment with the primary health care provider was made prior to discharge from MRC. Among the remaining 41% with no follow-up appointment made, 69% were discharged home (including home with home health), 29% were discharged to a skilled nursing facility or a hospital based Medicare approved swing bed, and 2% were discharged to another facility. Those discharged home were typically advised to make an appointment on their own. The overall results suggest that MRC helps with identifying and referring patients to primary health care providers in the interested of long-term medical management and prevention of secondary complications.
- Activity 3 – *"Assess post-discharge utilization of community-based PHC"*
  Beginning May, 2014, several questions have been added to our three-month-post-discharge phone survey in order to assess primary health care utilization after discharge from MRC. Nearly all surveyed patients (96%) reported having a primary health care provider and 84% had seen their primary health care provider since discharge from MRC. These results are encouraging and we will continue to monitor this in the future as more data become available.
- Activity 4 – *"Assess use of PHC available for low income persons"*
  We deferred this activity to FY 2016 because the hospital has hired a financial advisor in charge of securing health care coverage for uninsured and under-insured patients.
- Activity 5 – *"Educate PHC providers about unique needs of persons we serve"*
  Two of our physicians made a presentation in January of 2015 at the annual meeting of the Mississippi Osteopathic Medical Association to address rehabilitation needs of people who suffered stroke or amputation. This activity will continue in FY 2016 by

reaching out to UMC Geriatrics and Family Medicine departments to explore participation opportunities in Grand Rounds presentations.

- Activity 6 – *"Explore need & feasibility for developing electronic personal health record"*
  The team has begun to survey available options.

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 FY 2015, the team focused on conducting a thorough assessment of ongoing activities intended to address the provision of family/caregiver education and support. This assessment focused on determining which components were well addressed by existing or recently modified programs and which could benefit from the investment of further time and effort.

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 conducted thorough review of inpatient charts and has determined that a caregiver is named in the preadmission process 99% and at admission 98% of the time. The caregiver changed between pre-admission and admission 47% of the time. Anecdotal evidence indicates that the caregiver may change during the course of the admission; however, the caregiver is not recorded at the time of discharge. This may be considered as a documentation improvement for FY 2016.
- Activity 2 – *"Enhance content / format of the Resource & Education Guide"*
  According to current practice, the resource guide is given to patients upon admission by the case manager. It is not clear from documentation in the medical record that the patient or family is specifically oriented to the material or shown how to access the resource guide on the MRC website. Data from the follow up surveys indicates that this process does not promote use of the resources guide as 59% of patients queried did not recall having received the guide. Of those who recalled having received the guide 28% replied that they found it useful. During FY 2016 we will conduct focus groups to determine a more opportune time to distribute the Resource Guide.
- Activity 3 – *"Enhance caregiver education"*
  During FY 2015, the number of therapy teams providing treatment on Saturday was increased from four to six. This creates more opportunities for one-on-one family education on Saturdays, which is important for caregivers who work during the week. Education nurses have been added to the regular nurse staffing schedule so that they are available to provide patient and family education on the weekend. Individual, one-on-one education continues to be provided seven days a week.
  Based on discharge survey, family satisfaction with receipt of pertinent information continues to be positive and steady since the community health needs assessment was launched (87% in FY13 and 89% in FY15 for scores of excellent and very good).

- Activity 4 – *"Increase awareness of community-based services for persons with disabilities"*
  A majority of patients surveyed at follow up (92%) report that they can get to the places they want to go and (91%) report that there are no barriers that prevent them from getting to places they would like to go. Fewer (72%) say that they participate in family, church or social events as they wish. In the coming year we will seek to learn more about the 28% who say they are not as engaged in their community as they would like to be; targeted efforts to increase awareness of community-based services may be beneficial for this group.
- Activity 5 – *"Enhance peer-support for patients and caregivers"*
  MRC recently joined the City-Wide Stroke Support Connection, a collaborative effort between Jackson area hospitals (MRC, UMC, Baptist, and St. Dominic) to provide support and information for stroke patients and their families regardless of where they receive care. . The support meetings are scheduled on a monthly basis. MRC also provides support group sessions on a monthly basis for spinal cord injury and traumatic brain injury patients. Opportunities for peer counseling are readily available through MRC staff and through partnering with the Mississippi Department of Rehabilitation Services. We will continue to explore where the greatest needs and opportunities are for enhancing peer-support activities for patients and caregivers.

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:** In FY 2015, the team completed a survey of 59 organizations that offer community-based opportunities for fitness and recreation. We have offered a number of opportunities to the community we serve.
   - Activity #1 *"Increase awareness of community-based resources for fitness & recreation"*
     The team has completed a survey of organizations that provide community-based opportunities for fitness and recreation, identifying 59 organizations in Mississippi. Most facilities/programs report that they are accessible to persons with disabilities, and the team feels that additional education will be beneficial. The survey served a broader purpose as well, helping to educate these facilities/programs about Methodist Rehabilitation Center and vice versa, so that we may better coordinate our services.
   - Activity #2 *"Educate fitness trainers how to meet needs of persons we serve"*
     In the fall of 2015, we are planning a workshop for fitness and recreation service providers, therapists and students, to share information and resources. Continuing Education credit will be offered where appropriate. The workshop will involve MRC wheelchair athletes offering a hands-on demonstration of the abilities and potential of persons with disabilities to excel in fitness and recreation.

- Activity #3 *"Promote participation of person we serve in community-based sports & recreation events"*
  There are a number of events that are occurring or are being scheduled:
  - Continue to work with Mississippi State University – wheelchair fencing program.
  - Scheduled Boccia Ball sessions at Methodist Rehabilitation Center.
  - Boccia Ball is being introduced around the state.
  - MRC SCI support group – February 27, 2015.
  - Quest support group – May 8, 2015 in-service to staff and patients.
  - MRC members of the USA Wheelchair Fencing Team will introduce wheelchair fencing at the National Veterans Wheelchair Games in June, 2015.
  - 2015 National Wheelchair Softball Championship in Biloxi, MS in August.

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.

Community 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.