Community Health Needs Assessment & Implementation Plan

Report to the Board of Trustees – activities conducted July 1, 2015 – June 30, 2016

The initial 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 were approved by the Methodist Rehabilitation Center (MRC) Board of Trustees on May 23, 2013.

Implementation Plan

The plan identified three priorities to be the focus of the three-year implementation 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 were created and have met to plan and implement activities related to each priority. The teams were selected among MRC employees based on their professional background and interests.

The Oversight Committee has met on a regular basis to guide each team and review its' progress. The committee has delegated a member to each team to assist with the implementation plan and has provided a report to the Executive Committee of the MRC Board of Trustees on a quarterly basis, and interim reports reviewed by the MRC Board of Trustees.

Status of Activities

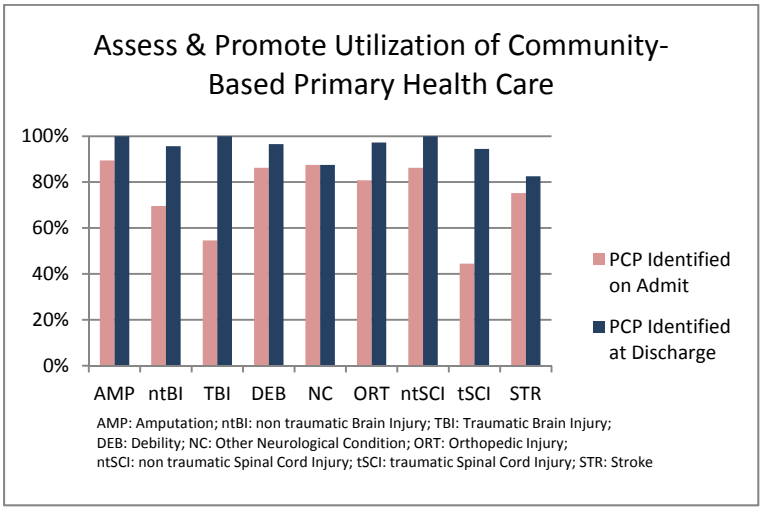
1. UTILIZATION OF COMMUNITY-BASED PRIMARY HEALTH CARE

   Goal: Improve utilization of primary health care services to avoid secondary complications after stroke, spinal cord injury or brain injury. Our interview and focus groups identified a common problem for many MRC patients post-discharge. Due to challenges with transportation and access to primary health care providers – especially in rural areas – many patients fail to ensure community-based primary health care for general health maintenance.

   Progress to date: Medical records were reviewed from a random selection of approximately 25% of patients discharged from MRC between April 1, 2015 and March 31, 2016. The data are used to report progress in FY 2016 in four of the six stated activities listed in the Implementation Plan:

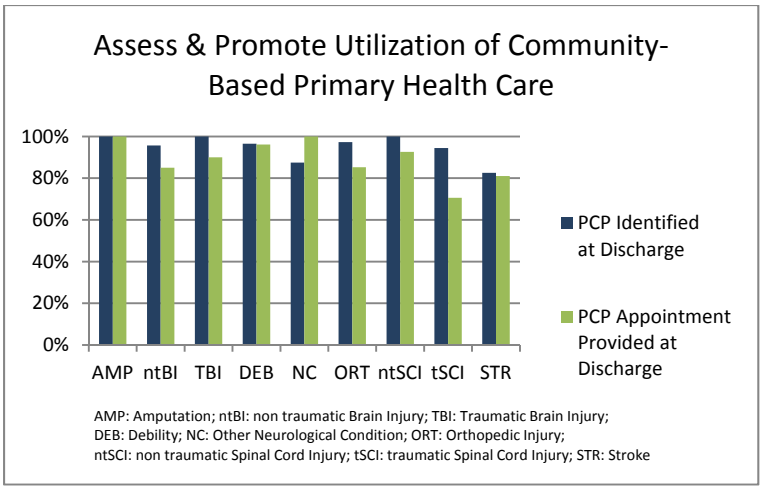
   - Activity 1 – *"Assess prior utilization of community-based primary health care"* Utilization of community-based primary health care prior to injury or disease was assessed in a medical records review. Of the 330 charts reviewed in this period, a

primary health care provider was identified 76% of the time on the admission evaluation. The lowest rate of documented primary health care provider utilization was in the traumatic spinal cord injury (tSCI) population (44%), followed by traumatic brain injury (TBI-55%), non-traumatic brain injury (BI-70%), and stroke (75%). Higher percentages among the TBI and tSCI patients are not surprising since they are generally younger and in good health prior to accidents causing the injury. However, the finding that a fourth of the stroke population did not have a documented primary health care provider at admission is concerning since it is expected that stroke patients have some pre-existing conditions posing risk for stroke, such as diabetes and hypertension.



- Activity 2 – *"Promote utilization of community-based PHC services"*
  At time of discharge, 92% of the charts reviewed named a documented primary health care provider. Of the patients without a documented primary health care provider at the time of admission, a provider was identified at discharge 84% of the time. Also of note:
  - For 83% of patients, a follow-up appointment with the primary health care provider was made prior to discharge from MRC.
  - Among the remaining 17% (N=34) without scheduled primary care follow-up, 64% were discharged home (including home with home health services) and 36% were discharged to a skilled nursing facility or other residential care facility.
  - Among those discharged without a scheduled primary care appointment, two thirds were advised to make an appointment on their own, and the remaining one third (3% of the overall sample) was missing follow-up documentation.

  As illustrated in the chart below, overall, the results suggest that MRC meets the expected goals of identifying and referring patients to primary health care providers for long-term medical management and prevention of secondary complications.



- Activity 3 – *"Assess post-discharge utilization of community-based PHC"*
  Beginning in May 2014, several questions were added to a three-month, post-discharge phone survey to assess primary health care utilization after discharge from MRC. Of those contacted in calendar year 2015, nearly all surveyed patients (97%) reported having a primary health care provider and 82% of these patients reported having seen their primary health care provider since discharge from MRC. These results are encouraging and will continue to be monitored as more data is available.

- Activity 4 – *"Assess use of PHC available for low income persons"*
  As a result of MRC's affiliation agreement with the University of Mississippi Medical Center (UMMC) in July 2014 (beginning of FY15), there has been a significant increase in uninsured and under-insured patients treated at MRC. These patients eventually apply for Medicaid (FY14=28; FY15=97; FY16=133); however, the process is typically slow and tedious, especially for those suffering from conditions other than traumatic SCI or TBI. To facilitate the process, MRC employed a full-time financial counselor to assist patients applying for Medicaid coverage. As of this report, 69 patients in FY15 and 54 patients in FY16 have enrolled in Medicaid. This will continue to be monitored as more data is available.

- Activity 5 – *"Educate PHC providers about the unique needs of persons we serve"*
  As part of the affiliation between MRC and UMMC, the MRC-employed physicians have become UMMC physicians, and will be part of a new Division of Rehabilitation Medicine, eventually to include a residency program. This will create opportunities for both formal and informal education of primary health care and other medical providers at UMMC about the unique needs of persons with disabilities.

- Activity 6 – *"Explore need & feasibility for developing an electronic personal health record"*
  MRC is actively considering options for an Electronic Medical Records (EMR) system. If brought to fruition, development of an electronic personal health record will become feasible.

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:

- Activity 1 – *"Educate community about the role of the caregiver during rehabilitation"*
  The annual 2014 report noted that a caregiver was named close to 100% of the time during the patient's admission assessment. Formal documentation did not extend beyond naming the caregiver. In 2015, the team expanded formal documentation at admission and during the inpatient stay to include a caregiver assessment and document changes in the caregiver status that might occur during the patient's admission. The "Case Manager Patient / Family Update" form was revised to formally document assessment of progress to date and to document if the caregiver changes over the course of rehabilitation. Use of this form was initiated in July 2015 and a random chart review indicated it has been consistently completed, however the quantity and quality of the information entered by case managers remains to be determined.

- Activity 2 – *"Enhance content / format of the Resource & Education Guide"*
  According to current practice, the resource guide is given to patients upon admission by their case manager. It is unclear from documentation in the medical record if 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 survey indicated that the current process does not promote use of the resource guide. For example, in 2014, 59% of patients queried did not recall having received the guide. In 2015, this number dropped to 39%. Among patients who recalled having received the guide, more of them found it useful than before, (28% in 2014 and 57% in 2015).

  The most significant obstacle for the use of the resource guide does not appear to be its content or format; in future years it may be beneficial to explore the process of distribution.

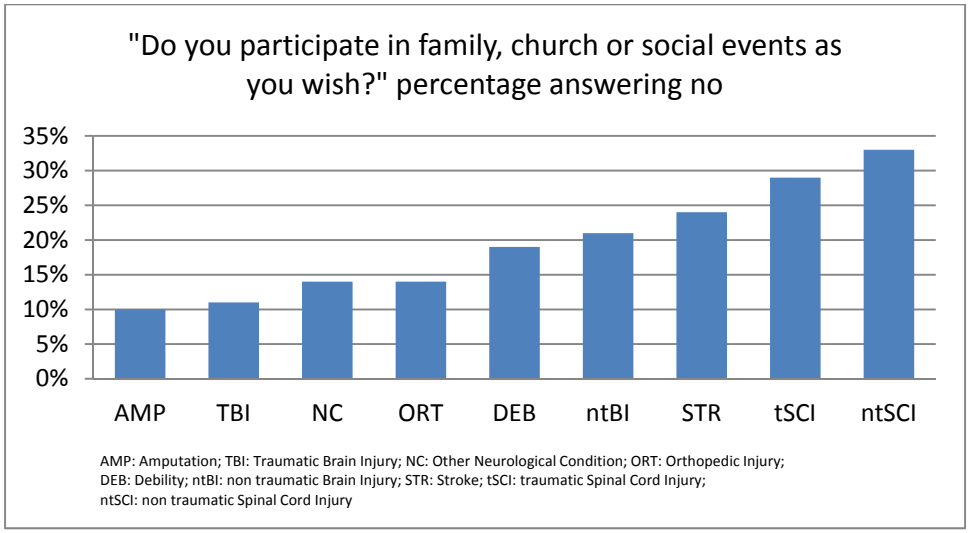
- Activity 3 – *"Enhance caregiver education"*
  During 2015, the number of therapy teams providing treatment on Saturday remained at six (an increase from previous years.) This continues to allow more regular therapists to be available for one-on-one family training sessions during the Saturday therapy schedule. Education nurses continue to serve in the regular nurse staffing schedule so that they are available to provide patient and family education on weekends. In order to promote opportunities for family or caregivers to field questions and provide return demonstration of skills, one-on-one education continues to be provided seven days a week.

  Based on discharge survey results, family satisfaction with receipt of pertinent information and inclusion in the patient's care shows a slight improvement over previous years.

Response to the Question: "The extent to which your family was given information and included in your care":

	Excellent	Very Good	Total of Excellent & Very Good
2015	73.9%	17.5%	91.4%
2014	66.5%	22.1%	88.6%
2013	68.9%	19.8%	88.7%
2012	66.1%	21.4%	87.6%

- Activity 4 – *"Increase awareness of community-based services for persons with disabilities"*
  Nearly all patients surveyed upon follow-up continued to report that they are able to get to the places they want to go (2014 – 92%, 2015 – 91%). There was a slight drop in the number of patients who reported that there are no barriers that prevent them from getting to places they would like to go (2014 – 91%, 2015 – 86%). The percent of patients who reported that they participate in family, church or social events as they wish was about the same (2014 – 72%, 2015 – 75%). The distribution of the remaining twenty-five percent (25%) who responded "no" to this question, is represented in the chart below:



It is possible that three months after discharge from inpatient rehabilitation is too soon for some patients to feel that they have become as involved in their family, church or social events as they would like to be.

- Activity 5 – *"Enhance peer support for patients and caregivers"*
  Strong peer support is made available at MRC to patients who have sustained a spinal cord injury or limb loss. An active network provides peer support to persons with spinal cord injury through collaborative efforts of area organizations and individuals, and is further supported by follow-up efforts of the MRC SCI Navigator Program. Peer support efforts conducted by the MRC Division of Orthotics and Prosthetics have also been extremely well received. Employees who share the experience of limb

loss visit all newly admitted amputee patients to provide information and a living example of successful adaptation.

3. PROMOTION OF HEALTHY LIFESTYLE, FITNESS AND RECREATION

Goal: Create an environment conducive of broader participation of people with stroke, spinal cord and 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:

- Activity # 1 – *"Increase awareness of community-based resources for fitness and recreation"*
  We completed a survey of organizations that provide community-based opportunities for fitness and recreation. Fifty-nine organizations in Mississippi were identified through this survey. Most facilities/programs reported that they are accessible to persons with disabilities.

- Activity # 2 – *"Educate fitness trainers how to meet needs of persons we serve"*
  A one day education event was held on November 6, 2015 that focused on challenges and opportunities to promote fitness and recreation as components of health and wellness for individuals who have sustained a life-altering injury or illness. The target audience included Occupational Therapists, Physical Therapists, Therapeutic Recreation Specialists, Athletic Trainers and Fitness Center owners and managers. Four contact hours or 4 CEU were offered for the event. On the evaluation, a majority of participants stated that the goals and objectives were well addressed.

- Activity # 3 – *"Promote participation of persons served in community-based sports and recreation"*
  A number of events are occurring or are being scheduled:
  - Continue to work with Mississippi State University's wheelchair fencing program.
  - Continue to work with the Memphis VA Medical Center and New Orleans Fencing Club to further develop their wheelchair fencing program and create regional competitions.
  - 2016 National Wheelchair Softball Championship will be held in Biloxi, MS in August 2016.
  - Continue to work with MRC Quest program participants and SCI support groups to provide in-service opportunities for staff and patients.
  - Obtained a grant from USOC to introduce Powerlifting at Methodist Rehabilitation Center in October 2016.
  - Obtained a grant from USOC to introduce Boccia Ball, a team sport now offered at MRC.

Report Summary:

The selected priorities have resulted in short-term and long-term community health benefits. The short-term benefits are reflected by an increase in interactions with community-based primary health care providers, increased reliance on and satisfaction with the resources available for each member of the community served and increased utilization of adaptive sports, fitness and recreation opportunities. This, in turn, results 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.

Collaboration Partners:

- University of Mississippi Medical Center (UMMC)
- Living Independence for Everyone (LIFE)
- Mississippi Paralysis Association (MPA)
- Metro Area Community Empowerment (MACE)
- Major fitness facilities in the area and organizers of recreational programs
- USA Fencing
- State universities (Mississippi State University, University of Mississippi, Jackson State University, University of Southern Mississippi, etc.)