COMMUNITY HEALTH IMPLEMENTATION PLAN

JULY 1, 2013 – JUNE 30, 2015

Approved by the Board of Trustees on May 23rd, 2013

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Introduction

Methodist Rehabilitation Center (MRC), located in Jackson, Mississippi, helps people recover after a stroke, brain or spinal cord injury, post-traumatic and post-surgical orthopedic conditions, or chronic pain and provides long-term care for persons with severe disabilities. MRC opened its doors in 1975 to fulfill a vision of the founders who recognized Mississippi's need for comprehensive medical rehabilitation services.

Methodist Rehabilitation Center serves people across the state of Mississippi, with the largest concentration of patients residing in the three-county Jackson metropolitan area. This broad service area is driven by two factors: The Jackson area is the largest hub for health care in the state, and MRC is the major provider of rehabilitation services across different areas of specialty. The community served by MRC includes adults and adolescents above 13 years of age of all socio-economic backgrounds, consistent with the demographics of the state.

For many years, MRC has conducted an annual community benefit assessment and presented a report to the center's Board of Trustees. The reports demonstrated the various ways the institution fulfills its mission as a 501(c)(3) not-for-profit hospital. The mandatory Community Health Needs Assessment now allows Methodist Rehabilitation Center to formalize and expand this process.

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.

Based on the adopted principles for prioritizing community health care needs, the following key priorities were identified:

1. Utilization of community-based primary health care
2. Provision of family/caregiver education and support
3. Promotion of healthy lifestyle, fitness and recreation

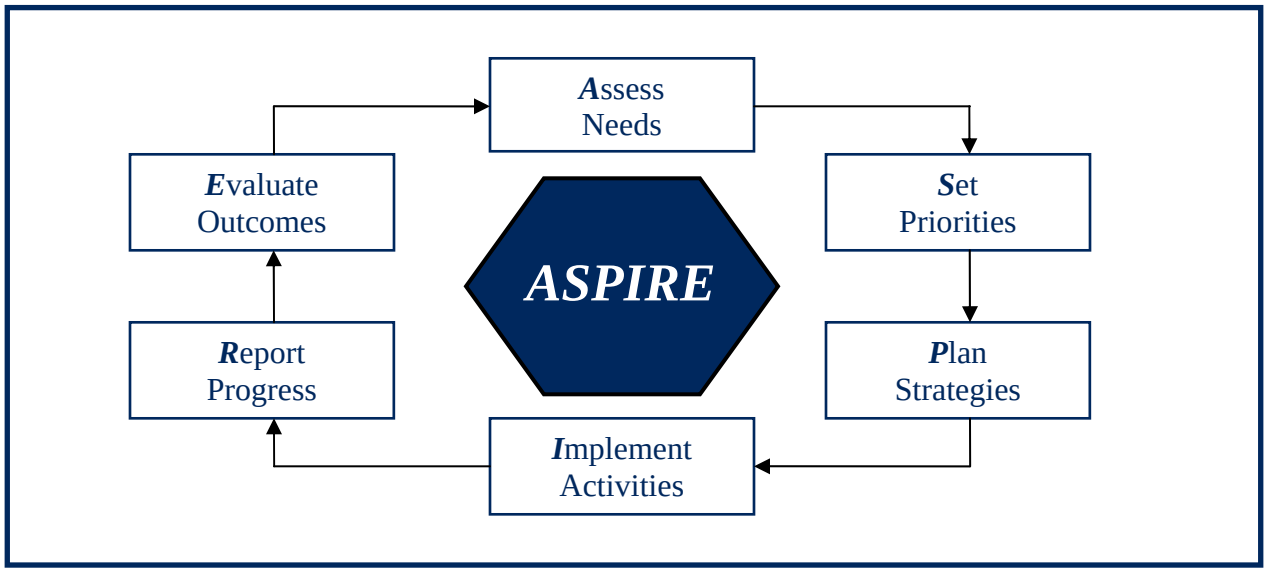
The Implementation Plan describes in detail programs and activities that will address these priorities over the next three years. Both documents are available at MRC's website www.methodistonline.org/CHNA where the progress will be reported on a regular basis.

We would like to express our sincere gratitude to all participants who provided input for this assessment. We look forward to addressing the identified needs.

Plan

Approach

We modified the ASPIRE model for Community Health Needs Assessment and development of Implementation Plan. The steps are illustrated below.



Specific programs

1. UTILIZATION OF COMMUNITY-BASED PRIMARY HEALTH CARE
   Goal: Overcome deficiencies in the utilization of primary health care services. The premise is that maintenance of health and prevention of secondary complications after stroke, spinal cord injury or brain injury can best be achieved through improving utilization of community-based primary health care services because of the rural nature of the State of Mississippi and difficulties with transportation.

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.

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.

The next 3 tables provide details about each program. The specific activities were selected based on the high/low grid of problems and solutions.

1. Utilization of Community-Based Primary Health Care (PHC)

#	Activity	Target	Timeframe	Output	Desired Outcome	Prospective Partners	MRC Personnel
1	Assess prior utilization of community-based PHC	Representative sample of admitted patients	Yrs 1-3 (year around)	Survey results	Identify rate & demographic indicators of PHC utilization	None	Outreach Representatives; Case Managers; Research
2	Promote utilization of community-based PHC services	All patients admitted to MRC	Yrs 1-3 (year around)	Print/website material; In-person interactions	≥90% of charts sampled indicate provision of information	None	Case Managers; Discharge Planners; Social Workers
3	Assess post-discharge utilization of community-based PHC	Sample of patients surveyed at 3 months after discharge	Yrs 1-3 (year around)	Results of follow-up survey	≥75% of scheduled visited PHC provider after discharge	None	Performance Improvement; Research
4	Assess use of PHC available for low income persons	Persons with stroke/SCI/BI/ amputation	Annually (Yrs 2-3)	Database results	Identify rate, demographics, reasons for PHC services	MPHCA; MSDH	Research
5	Educate PHC providers into unique needs of persons we serve	Primary care physicians and allied professionals	Yrs 2-3 (annually)	Program evaluation (objectives, satisfaction)	>80% rate program objectives as met/satisfactory	MPHCA; Miss. Acad. of Family Phys.; UMMC	Education Department; Physicians; Nurses
6	Explore need & feasibility for developing electronic PHR	Patients; IT & Mobile Technology professionals	Yrs 1-3 (year around)	Results of surveys & interviews	>50% perceive the need/foresee benefits of PHR	IT & Mobile Technology providers	IT; Human Resources; Research

MRC- Methodist Rehabilitation Center; MPHCA-Mississippi Primary Health Care Association; MSDH- Mississippi Department of Health; UMMC- University of Mississippi Medical Center; PHR- personal health record; IT- Information Technology; N/A- not applicable.

2. Provision of Family/Caregiver Education and Support

#	Activity	Target	Timeframe	Output	Desired Outcome	Prospective Partners	MRC Personnel
1	Educate community about the role of caregiver during rehabilitation	Referral sources; Family members; Community at-large	Yrs 1-3 (year around)	Print/website/ public media material; In-person interactions;	≥90% of charts sampled indicate caregiver was identified, if needed	None	Outreach Representatives; Nurses; Case Managers; Therapists
2	Enhance content/format of Resource & Education Guide	Patients; Caregivers; Family members	Yrs 1-3 (year around)	Print/website material; Survey at discharge and 3-month follow-up	≥80% rate Guide as useful/user-friendly	None	Nurses; Case Managers; Therapists
3	Enhance caregiver education	Family members	Yrs 1-3 (year around)	Print/website material; In-person interactions; Survey results	>80% rate education program as satisfactory	None	Nurses; Case Managers; Therapists
4	Increase awareness of community-based services for persons with disabilities	Patients; Caregivers; Family members	Yrs 1-3 (year around)	Print/website material; In-person interactions	≥90% of charts sampled indicate provision of information	State/non-profit agencies serving persons with disabilities	Nurses; Case Managers; Therapists; Social Workers
5	Enhance peer-support for patients and caregivers	Patients; Caregivers; Family members	Yrs 1-3 (monthly to quarterly)	Program evaluation (objectives, satisfaction)	>80% rate program objectives as met/satisfactory	Hospitals & non-profits providing peer-support	Nurses; Therapists; Psychologist; Sport & Recreation

3. Promotion of Healthy Lifestyle, Fitness and Recreation

#	Activity	Target	Timeframe	Output	Desired Outcome	Prospective Partners	MRC Personnel
1	Increase awareness of community-based resources for fitness & recreation	Patients; Family members	Yrs 1-3 (year around)	Print/website material, In-person interactions	≥90% of charts sampled indicate provision of information	Community-based fitness facilities	Therapists, Sport & Recreation
2	Educate fitness trainers how to meet needs of persons we serve	Fitness professionals; Undergraduate exercise science students	Yrs 2-3 (annually)	Courses, Lectures	>80% rate program objectives as met/ satisfactory	Community-based fitness facilities & undergraduate exercise science programs	Education Department; Therapists; Sport & Recreation
3	Promote participation of persons we serve in community-based sports & recreation events	Patients; Family members; Events organizers	Yrs 1-3 (year around)	Print/website material, In-person interactions	Increased participation from Yr 1 to Yr 3	Non-profit agencies serving persons with disabilities	Sport & Recreation

Implementation Strategy

We will create a team for each selected priority. The team will be responsible for planning and implementation of activities described under the respective priorities. The team leader will select other members of the team among the MRC employees based on their professional background and interests with respect to specific program activities. The team will meet approximately every four months to plan and implement activities, review progress, identify barriers and propose solutions.

The current Steering Committee will transform into the Oversight Committee that will oversee and coordinate activities across the three priorities. The Oversight Committee will delegate a member to each team, who will work closely with other team members on plan implementation. The Oversight Committee will meet on a quarterly basis to review the overall progress and guide each team activities. The Oversight Committee will report to the Executive Committee of the MRC Board of Trustees on a quarterly basis and also be responsible for developing interim reports that will be reviewed by the MRC Board of Trustees on an annual basis.

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 organization, 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 the need to improve access to various modes of transportation for the persons we serve given the scope of the problem and the likelihood that any solution that we can offer may have true and lasting impact. 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.