COMMUNITY HEALTH NEEDS ASSESSMENT
&
IMPLEMENTATION PLAN

FY 2017-2019

Approved by the Board of Trustees in 2016

TABLE OF CONTENTS

Executive Summary

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. MRC also provides long-term care for persons with severe disabilities. MRC opened its doors in 1975 to fulfill a vision of its 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.

This Community Health Needs Assessment has been an ongoing process since the completion of the previous assessment in 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 Implementation Plan was approved by the MRC's Board of Trustees in 2016.

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

1. Difficulty assessing outcomes and implementation of rehabilitation services along the continuum of care;
2. Insufficient access and utilization of specialized rehabilitation services throughout the state of Mississippi;
3. Limited opportunities for education and training of professionals providing rehabilitation services

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/community-health-needs-assessment where the progress will be reported on a regular basis.

Introduction

Mission Statement

"In response to the love of God, Methodist Rehabilitation Center is dedicated to the restoration and enhancement of the lives of those we serve. We are committed to the excellence and leadership in the delivery of comprehensive rehabilitation services."

About Us

In 1975, Methodist Rehabilitation Center (MRC) opened its doors to fulfill a vision to provide comprehensive medical rehabilitation services for all Mississippians. The center was created by four visionary founders, led by the late Earl R. Wilson, who served as chairman of the board from the center's inception until his death in 2000.

MRC's primary facility is a seven-floor, 124-bed inpatient hospital located on the campus of The University of Mississippi Medical Center. The entire facility and clinical programs are designed specifically to help patients restore abilities lost to injury or illness. Patients of similar injury types are housed on the same floor and share a dedicated staff of nurses and therapists. This promotes specialized expertise among staff, and the patients are encouraged as they recover with others overcoming similar challenges.

In 2005, MRC opened Methodist Specialty Care Center, a 60-bed, long-term residential center for younger adults with severe disabilities. In addition, MRC operates numerous clinics across Mississippi and Northeast Louisiana to provide outpatient rehabilitation services.

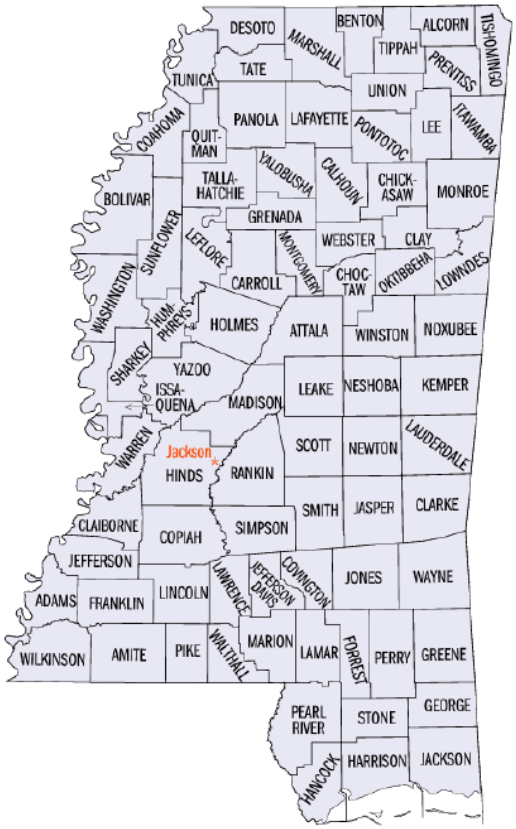
Most all patients admitted to MRC's main hospital are transferred from acute care hospitals located throughout Mississippi and the region. Besides providing inpatient and outpatient care, MRC serves the community through an array of outreach programs ranging from wheelchair sports clinics and competitions, monthly support groups, education events, as well as a clinical research program that allows patients to be part of research discoveries.

MRC is affiliated with the University of Mississippi Medical Center (UMMC) and serves as a teaching facility for students and residents. MRC is a founding member of UMMC's Neuro Institute, established in 2016, to advance clinical care, research and education in three areas: stroke, addictions and neurotrauma. Also, MRC serves as an internship site for undergraduate students from major universities in the state.

Community Served

Definition

MRC serves people across the entire state of Mississippi. Due to our geographic location, the majority of the community served resides in central Mississippi. This includes the city of Jackson and Hinds, Rankin and Madison counties, which is the state's most populated area. Beyond this Tri-County area, MRC serves a significant number of people from other, contiguous counties within a ~100 mile radius. Such a widespread catchment area is driven by the fact that the Jackson area is the major hub for health care across the entire state and by recognition of MRC as the major provider of rehabilitation services (inpatient and outpatient) across different areas of specialty.



The target population served includes male and female adults and adolescents age 13 and older from ethnic and socio-economic backgrounds that are representative of the state.

Our specialty area further defines the community served to those in need of comprehensive medical rehabilitation for various neurologic and orthopedic conditions, primarily acquired brain and spinal cord injuries or diseases, post-traumatic/post-surgical orthopedic conditions, chronic pain and long-term specialty care for the most severely disabled.

Description

Mississippi Demographics

According to the *U.S. Census Bureau's 2015 population estimates*, the population of Mississippi is nearly 3 million (51% women, 49% men). The median age is 36 years (75% ≥18 years, 13% ≥65 years). Caucasians represent 59% of the population, African-Americans 37%, and Hispanics or Latinos 2.7%. The majority of households consist of married-couple families (45%) followed by single-parent families (24%). Among the people 25 or older, 82% have at least a high school diploma and 20% have a bachelor's degree or higher.

The median household income is ~$39,500 ($53,500 nationally) and the median family income is ~$49,100 ($65,400 nationally). About 23% live below the federal poverty level (16% nationally) – mainly children under 5 years (36%) followed by adults 18 to 64 years (21%). In Mississippi 18.2% of households are enrolled in the supplemental nutrition assistance program (9.2% national level).

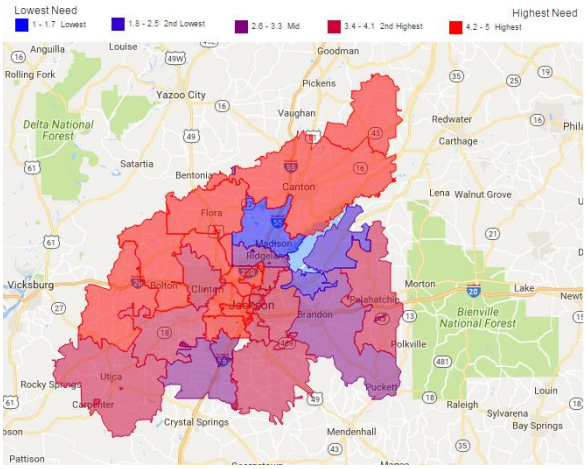
The population is expected to grow to about 3.16 million by 2020 and 3.23 million by 2025. The second and third largest increase is projected for Madison County (19%) and Rankin County (17%), which are part of MRC's primary service area.

Mississippi Health Priorities

It is well known that Mississippi ranks among the lowest in the U.S. in overall health. The main health problems in adults are hypertension (40% prevalence), obesity (36%), and type 2 diabetes (13%). These lead to cardio-vascular diseases including stroke, the main cause of death in the state (30% in 2011 and 37% above the national death rate in 2012-2014). Over the next 20 years, obesity is expected to contribute to over 400,000 of new cases of type 2 diabetes, over 750,000 new cases of hypertension and over 800,000 new cases of coronary heart disease and stroke in Mississippi.

Barriers to Health Care Access

The *Community Need Index*, developed by *Dignity Health* and *Truven Health Analytics*, reflects the barriers to health care access in a given community based on socio-economic indicators (income, ethnicity/language, education, insurance, and housing). The average score is assigned to each ZIP code, from 1.0 (lowest) to 5.0 (highest socioeconomic barriers). The latest available scores for Mississippi range from 2.9-5.0. The "highest need" (score 4.2-5.0) was projected for 56 counties with 1.7 million people (58% of total population), "high need" (score 3.4-4.1) for 21 counties with 800,000 people (27%), and "moderate need" (2.9-3.3) for the remaining 5 counties with 400,000 people (14%). The barriers accounted for by the *Community Need Index* also apply to the communities primarily served by MRC (figure).



Uninsured & Governmental Insurance

In 2015, 372,000 Mississippians (12.7%) are without insurance. There are somewhat more uninsured men (53%) than women (47%). Most uninsured belong to the age group of 18-44 years, which accounts for 64% of all uninsured Mississippians. The rate of uninsured among African-Americans (17%) is higher than among Caucasians (12%). About 63% of all uninsured persons 25 years or older have a high school diploma or less and 60% of the entire uninsured Mississippi population are unmarried. In terms of household income, 37% of the uninsured earn less than $25,000, 31% between $25,000 and $49,999, 16% between $50,000 and $74,999, 8% between $75,000 and $99,999, and 7% earn $100,000 or over.

In 2015, it is estimated that 780,000 Mississippians (26%) received Medicaid benefits. In addition, about 560,000 Mississippi residents (19%) are Medicare beneficiaries, of whom almost 77,000 (14%) have elected to participate in a Medicare Advantage plan. In total, an estimated 45% of Mississippi's population is receiving governmental insurance benefits.

Health Problems Leading to MRC Admissions

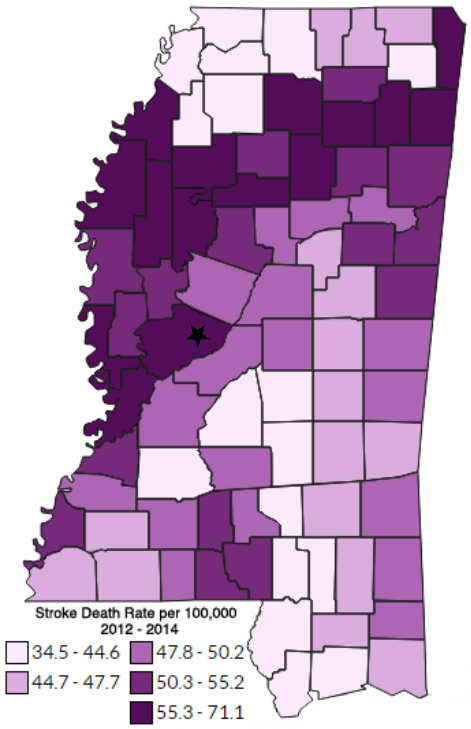
Health problems that lead to admission to MRC result from trauma or diseases affecting the nervous system (stroke, spinal cord injury, brain injury) or musculo-skeletal system (amputation, broken bone, joint replacement). Trauma remains the leading cause of death for Mississippians age 1 to 44, and Mississippi ranks third in the nation for unintentional injury deaths. The population sustaining a trauma increased three-fold from 2000 (8,500) to 2010 (25,500). As a

result, many people are admitted for rehabilitation after traumatic brain or spinal cord injury or broken or lost limb. The number of post-traumatic cases admitted to MRC is likely to increase due to a decline in mortality and the population growth.

The most recent Heart Disease and Stroke Prevention and Control State Plan (2004-2013) reveals that a high prevalence of diabetes, obesity, and hypertension translates into a high rate of stroke in Mississippi. It is estimated that each year about 5,000 Mississippians suffer a stroke for the first time and another 2,000 a recurrent stroke. Stroke occurs twice more often in Mississippians with income of less than $25,000 (~7%) than in those who earn more than $25,000 (~3.5%).

Stroke is the fifth leading cause of death in Mississippi (5% in 2013) and occurs at a rate of 50 per 100,000 people. Although mortality from stroke is on the decline, it is the highest in several counties north and south of Hinds County where MRC is located.

Stroke leaves ~2,000 Mississippians disabled each year. The percent living with stroke (~4%) has been steady from 2005 to 2011. Better emergency care and survival means more disabled people in need of comprehensive rehabilitation services.



Demographics of People Admitted to MRC

In fiscal year 2016 (July 1st, 2015- June 30th, 2016), 1,258 Mississippians were admitted to MRC inpatient rehabilitation. Of those, 48% were women and 52% men; 51% were Caucasians and 48% African-American; 40% were married, 28% single, 15% widowed, and 13% divorced. These demographics are representative of the entire state of Mississippi.

The people admitted to MRC represent 69 of 82 Mississippi counties (84%). Before admission, 47% resided in three counties of the Jackson Metro area and an additional 48% within a radius of 120 miles. The most frequent reasons for admission were stroke (37%), orthopedic (e.g. leg fracture or joint implants) (27%), traumatic or non-traumatic spinal cord injury (13%), and traumatic or non-traumatic brain injury (13%). These conditions represent almost 90% of all admissions. While Medicare remains our most common payer source (45%) upon admission, 13% of people admitted in fiscal year 2016 were uninsured.

Rehabilitation facilities outside of MRC primary service area

Other providers of comprehensive rehabilitation outside of MRC primary service area are in the northern counties (De Soto, Washington, Lee) and southern counties (Forrest, Harrison). They are two or more hours driving distance from MRC and account for a combined 64% of all licensed rehabilitation beds in the state.

Impact of Preceding CHNA/Implementation Plan

The previous CHNA was completed in FY 2013 based on which the three-year implementation plan was developed (FY 2014-2016). Three priority areas were identified and the impact of our activities is described below.

1. Utilization of community-based primary health care

   The main goal of this activity was to determine to what extent a primary care provider was identified on admission and at discharge from inpatient rehabilitation and how primary care was utilized after discharge. For this, we reviewed medical records of about 25% of all admitted patients across different diagnoses. We found that a primary health care provider was identified in 76% of admission records and in 92% of discharge records. Based on follow-up phone calls in calendar year 2015, nearly all surveyed patients (97%) reported having a primary health care provider and 82% of them went to see their primary health care provider after discharge from MRC. In summary, the gaps in accessing community-based primary health care were minimized and the utilization of primary health care services by our patients seems to be sufficiently met.

2. Provision of family/caregiver education and support

   Through activities defined in the implementation plan, we expanded our documentation about caregivers beyond the time of admission to also include weekly updates on the family/caregiver's readiness to provide care following discharge. In order to increase opportunities to acquire and demonstrate caregiver skills, one-on-one family/caregiver education continues to be provided seven days a week. This was complemented by developing a new version of our resource guide and encouraging its greater use. Since that time, twice as many patients than before found the new resource guide useful (28% in 2014 compared to 57% in 2015). Thus, family and caregiver education and support improved as a result of this activity.

3. Promotion of healthy lifestyle, fitness and recreation

   We were able to identify 59 organizations in Mississippi that reportedly provide community-based opportunities for fitness and recreation. Nearly all reported that they are accessible to persons with disabilities. However, it was not feasible to determine to what extent their equipment is suitable for the disabled population and how well their trainers are knowledgeable about their unique needs. To close that gap, MRC hosted an education event that focused on challenges and opportunities for promoting fitness and recreation as critical components for maintaining the health and wellness of individuals who sustained a life-altering injury or illness. In addition, our Sports & Recreation department organized many events to educate the public and enhance participation in community-based sports and recreational opportunities.

Throughout the previous cycle, MRC did not receive any written comments regarding our CHNA and Implementation Plan. All verbal comments received have been positive.

Process and Methods

Publicly Available Data Sources

Publicly accessible databases, reports, and publications by various state and national agencies were extensively searched for the purpose of the CHNA.

DATA – MISSISSIPPI		
Source	**Title (Year)**	**Summary**
Mississippi Insurance Department	Mississippi Health Benefit Exchange Report (2011)	Insights for designing and implementing health benefit exchange in Mississippi under the Patient Protection and Affordable Care Act
	http://www.mid.ms.gov/healthcare/pdf/Health_Benefit_Exchange_Final_Report.pdf	
Mississippi State Department of Health	Mississippi State Plan for Heart Disease and Stroke Prevention & Control (2004-13)	Call for action to improve cardiovascular disease outcomes, including from stroke, at multiple levels in Mississippi
	http://www.msdh.ms.gov/msdhsite/_static/resources/1670.pdf	
Mississippi State Department of Health	Mississippi Stroke System-of-Care Plan (2015)	Plan for developing statewide tiered system of stroke care
	http://msdh.ms.gov/msdhsite/_static/resources/6401.pdf	
Mississippi State Department of Health- Trauma Care System	Fact Sheets (2014)	The only functioning mandatory Trauma System in the country nationally recognized as a model Trauma System; the registry includes injury data captured by 92 facilities in the state
	http://msdh.ms.gov/msdhsite/_static/resources/4648.pdf	
Board of State Institutions of Higher Learning	Mississippi Population Projections 2015, 2020, and 2025	Projections of an increase in Mississippi population by county, sex and race
	http://www.mississippi.edu/urc/downloads/PopProjections/PopulationProjections.pdf	

DATA - NATIONAL		
Source	**Title (Year)**	**Summary**
US Census Bureau	State & County QuickFacts (2015)	Summary of demographic and socio-economic statistics for the state of Mississippi
	https://www.census.gov/quickfacts/table/PST045215/00	
Dignity Health	Community Need Index-Interactive web application (2016)	Community Need Index scores the severity of health disparity for every zip code in the US and demonstrates the link between health need, access to care, and preventable hospitalizations
	www.cni.chw-interactive.org/	
Centers for Disease Control and Prevention	Behavioral Risk Factor Surveillance System survey (2015)	The largest on-going telephone survey system tracking health conditions and risk behaviors in the United States yearly since 1984
	www.cdc.gov/brfss/	

DATA - NATIONAL		
Centers for Disease Control and Prevention	Outpatient Rehabilitation Among Stroke Survivors -- - 21 States and the District of Columbia, 2005	Report from 21 States, including Mississippi, indicates lower than expected utilization of outpatient rehabilitation services among stroke survivors
	www.cdc.gov/mmwr/preview/mmwrhtml/mm5620a4.htm	
Model Systems Knowledge Translation Center	Multiple documents	Summarizes research, identifies health information needs, and develops information resources related to traumatic brain injury
	http://www.msktc.org/tbi	
National Spinal Cord Injury Statistical Center	Spinal Cord Injury Facts and Figures at a Glance (2016)	Largest source of information about causes, demographics, and consequences of traumatic spinal cord injury in the U.S.
	https://www.nscisc.uab.edu/Public/Facts%202016.pdf	

Input from Community Representatives

COMMUNITY REPRESENTATIVES			
Name/Degree	Title	Affiliation	Expertise/Leadership Role
Roger Bullock[2,3]	Independent Living Specialist	LIFE of MS	Peer counseling and resources for disabled community
Sheila Burnham[2,3]	Community Coordinator	Mississippi Paralysis Association	Peer counseling and resources for disabled community
Teletha Johnson [1]	Trauma Data Analyst	Mississippi State Department of Health	Public health
Susanne Sonik[3]	Director for Long-Term Care and Rehabilitation	American Hospital Association	Representation, advocacy and national health policy development

[1] **Mandatory:** Representative of state/local/tribal/regional governmental public health department with knowledge, information, or expertise relevant to the health needs of the community
[2] **Mandatory**: Members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of such populations
[3] **Optional**: Health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives.

Input from Methodist Employees

MRC PARTICIPANTS	
PANELISTS	
Matt Cliburn, RN Community Outreach Representative	Patricia Oyarce, PT, MS Physical Therapist
Martha Davis, LSW Financial Counselor	K.K. Ramsey, CFNP Nurse Practitioner
Connie Flanagin, RN Community Outreach Representative Manager	Thomas Sturdavant, MD Admitting Physiatrist
Megan Glorioso, PT, DPT, NCS Physical Therapist	Lori Towery, PT Physical Therapist
Lisa Indest, PT, NCS Director of Neuro Outpatient	Chris Wallace, CPO, FAAOP Director of Orthotics and Prosthetics
Marcia King, OT Director of Education	

Data Review

All collected information was reviewed by the Steering Committee which discussed community needs during weekly meetings. The members of the Steering Committee are listed below.

MRC PARTICIPANTS	
STEERING COMMITTEE	
Mark A. Adams President & CEO	Gary Armstrong Chief Financial Officer
Chris Blount Director, Wilson Research Foundation	Doug Boone VP of Business Development
Arash Sepehri SCI Care Coordinator	Dobrivoje S. Stokic, MD, DSc Director of Research
Tammy Voynik VP of Legal Affairs	

The Steering Committee developed criteria for identifying community health needs, as indicated below, and used there criteria to define community health care needs that will be addressed in the 2017-2019 Implementation Plan.

Process and criteria for prioritizing health needs

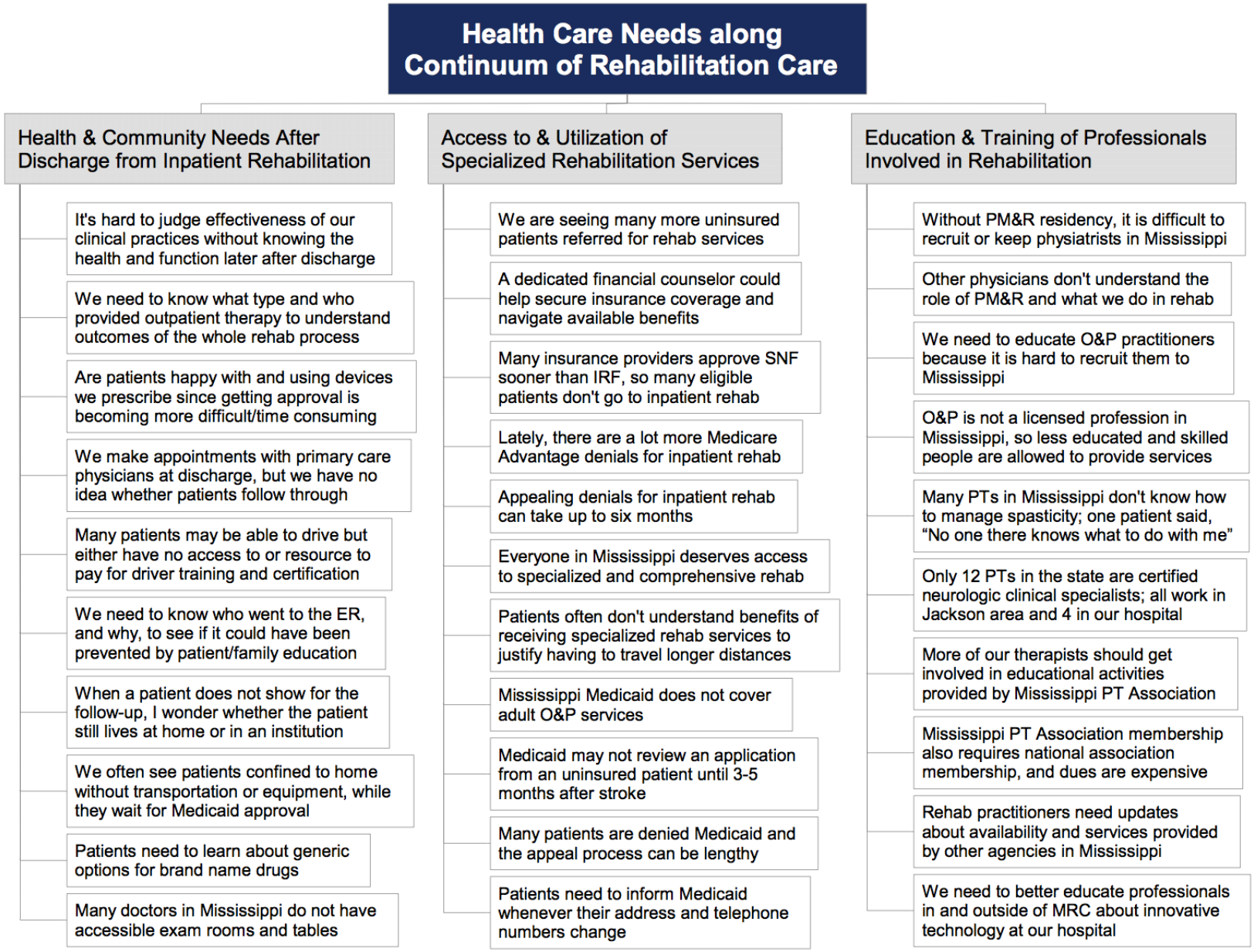
The process analogous to "multi-voting technique" was chosen for prioritizing community health care needs. This was done through a series of meetings during which each round of votes was followed by narrowing of the priority list. Before voting, the Steering Committee agreed upon the following guiding principles:

1. *Define a "health care need":* We adopted the definition of health care need as a "capacity to improve health".[1] This was understood to include the capacity (ability) of a community to improve health and the capacity of providers to overcome identified deficiencies given the available evidence and resources. Equal weight was given to each capacity. If both were scored low, the presumed "need" was considered a "desire" and received a lower priority. It was recognized, however, that the "need" and "desire" represent ends of the spectrum and that efforts are warranted toward changing circumstances that would potentially elevate "desire" to a "need".
2. *Give priority to input from community representatives over the results of desk research:* Given the paucity of research on health care needs of the community we serve, it was considered that themes which emerged from interviews and focus groups are most relevant for addressing immediate health care needs. At the same time, the potential bias of the participants was acknowledged as a shortcoming.
3. *Give priority to the needs with potential to create partnerships and eliminate redundancies:* Community health care needs unlikely can be met by a single organization. Therefore, higher priority is given to those needs that can be met through collaboration with another public or private entity for which the opportunity to create a partnership exists.
4. *Give priority to the needs with measurable performance indicators, including both "outputs" and "outcomes":* Outputs relate to activities or "what was done and whom we reached," whereas outcomes refer to "what difference did it make". Both are justified because the activity must be delivered as intended before the expected outcomes can occur. It is recognized that early performance indicators will mainly be limited to outputs before outcomes can be reliably assessed.
5. *Give higher priority to the needs where significance of problem has about the same weight as likelihood of implementing a solution:* Based on the items in the table below, both significance of problem and solution implementation were scored low, medium, or high. Lower priority was given to needs with discrepant scores (low-high or high-low) in favor of the needs scored above low and equal (e.g., medium-medium, high-high).

Priority of Problem	Solution for Problem
▶ Impact of problem	▶ Expertise to implement solution
▶ Urgency of solving problem	▶ Effectiveness of solution
▶ Availability of solutions	▶ Potential impact on health
▶ Availability of resources to solve problem	▶ Ease of implementation/maintenance
▶ Cost and/or return on investment	▶ Potential negative consequences

Comments received from participants during this community needs assessment are summarized on the following page.

[1]Stevens A, Raftery J. Introduction Health care needs assessment. Oxford: Radcliffe Medical Press, 1994:1-30.


Health Care Needs along Continuum of Rehabilitation Care
Health & Community Needs After Discharge from Inpatient Rehabilitation
It's hard to judge effectiveness of our clinical practices without knowing the health and function later after discharge
We need to know what type and who provided outpatient therapy to understand outcomes of the whole rehab process
Are patients happy with and using devices we prescribe since getting approval is becoming more difficult/time consuming
We make appointments with primary care physicians at discharge, but we have no idea whether patients follow through
Many patients may be able to drive but either have no access to or resource to pay for driver training and certification
We need to know who went to the ER, and why, to see if it could have been prevented by patient/family education
When a patient does not show for the follow-up, I wonder whether the patient still lives at home or in an institution
We often see patients confined to home without transportation or equipment, while they wait for Medicaid approval
Patients need to learn about generic options for brand name drugs
Many doctors in Mississippi do not have accessible exam rooms and tables
Access to & Utilization of Specialized Rehabilitation Services
We are seeing many more uninsured patients referred for rehab services
A dedicated financial counselor could help secure insurance coverage and navigate available benefits
Many insurance providers approve SNF sooner than IRF, so many eligible patients don't go to inpatient rehab
Lately, there are a lot more Medicare Advantage denials for inpatient rehab
Appealing denials for inpatient rehab can take up to six months
Everyone in Mississippi deserves access to specialized and comprehensive rehab
Patients often don't understand benefits of receiving specialized rehab services to justify having to travel longer distances
Mississippi Medicaid does not cover adult O&P services
Medicaid may not review an application from an uninsured patient until 3-5 months after stroke
Many patients are denied Medicaid and the appeal process can be lengthy
Patients need to inform Medicaid whenever their address and telephone numbers change
Education & Training of Professionals Involved in Rehabilitation
Without PM&R residency, it is difficult to recruit or keep physiatrists in Mississippi
Other physicians don't understand the role of PM&R and what we do in rehab
We need to educate O&P practitioners because it is hard to recruit them to Mississippi
O&P is not a licensed profession in Mississippi, so less educated and skilled people are allowed to provide services
Many PTs in Mississippi don't know how to manage spasticity; one patient said, "No one there knows what to do with me"
Only 12 PTs in the state are certified neurologic clinical specialists; all work in Jackson area and 4 in our hospital
More of our therapists should get involved in educational activities provided by Mississippi PT Association
Mississippi PT Association membership also requires national association membership, and dues are expensive
Rehab practitioners need updates about availability and services provided by other agencies in Mississippi
We need to better educate professionals in and outside of MRC about innovative technology at our hospital

Priority Areas Identified

In prioritizing health care needs, members of the Steering Committee were guided by the above stated criteria. The following key priority areas were selected:

1. MONITOR HEALTH AND NEEDS WITHIN 3 MONTHS OF INPATIENT DISCHARGE
   This need was rated the highest because the most valid information about health and functional status is obtained directly from patients once they are discharged to community settings. The priority areas include place of residence, level of independence, access to outpatient services and durable medical equipment, utilization of heath care resources, degree of community reintegration, and participation and access to peer-support. This priority is expected to help develop plans of care for meeting the health needs of rehabilitation patients.

2. INCREASE ACCESS TO AND UTILIZATION OF SPECIALIZED REHABILITATION SERVICES
   Many Mississippi residents are un-/underinsured or denied rehabilitation services by insurance providers, which requires raising the awareness about available options. We identified an opportunity for advancing multi-disciplinary care through a recently developed Neuro Institute between MRC and UMMC. We also recognized the need to foster research, development, and use of innovative rehabilitation technology in Mississippi. Finally, given the rural nature of Mississippi, we will explore the feasibility of incorporating telemedicine into rehabilitation.

3. IMPROVE EDUCATION AND TRAINING OF PROFESSIONALS INVOLVED IN PROVISION OF REHABILITATION SERVICES
   We recognized the lack of specialized training in Mississippi for rehabilitation nurses, therapists, orthotists and prosthetists, and psychologists. We also recognize the difficulty of recruiting and retaining Physical Medicine and Rehabilitation (PM&R) physicians due to not having a PM&R program in Mississippi.

<u>Facilities/Resources Available to Meet the Needs</u>

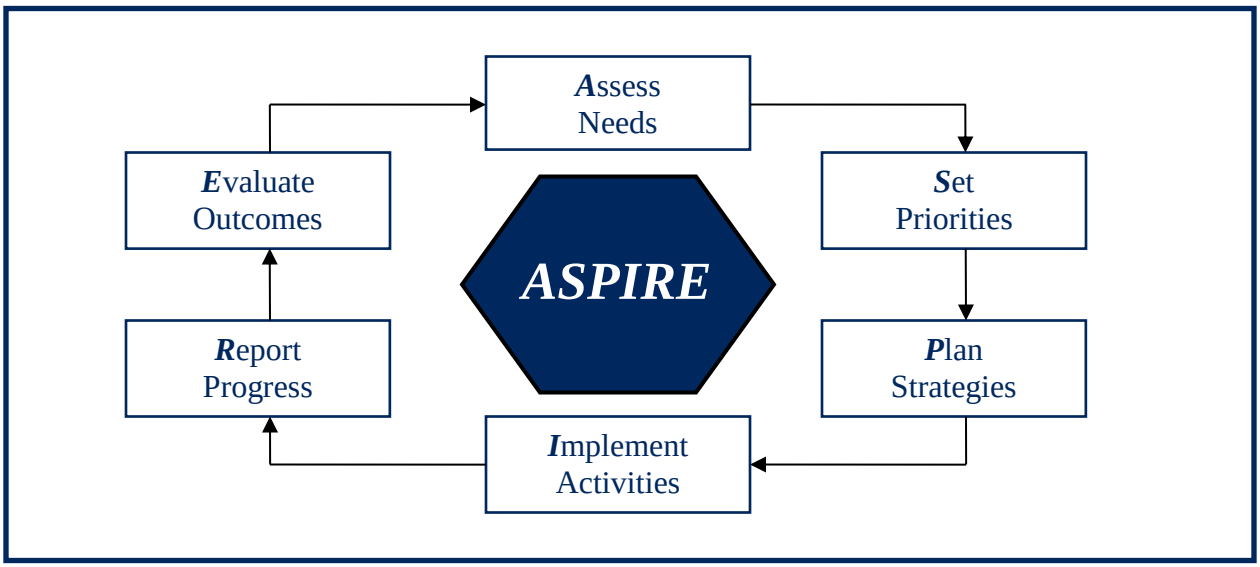
MRC will utilize the existing facilities and resources to address the selected priority areas. The activities will mainly be provided by the clinical, research, education, process improvement and volunteer personnel. The expertise and interest will be matched to the designated activities in each priority area. MRC will utilize the existing facilities at different locations for conducting these activities, including the main hospital and several outpatient facilities.

As appropriate, MRC plans to partner with public and private organizations and agencies to address the key priority areas, including, but not limited to the UMMC, State Department of Health, LIFE of MS, Mississippi Paralysis Association, Mississippi Primary Health Care Association, and appropriate municipal departments.

Implementation Plan (FY 2017- 2019)

Approach

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



Specific programs

1. HEALTH & COMMUNITY NEEDS AFTER DISCHARGE FROM INPATIENT REHABILITATION
   Goal: Monitor multiple facets of functional recovery and community integration at 3 months after discharge from inpatient rehabilitation. This will be conducted by a telephone interview and will address the following areas: place of residence and community reintegration, change in health and independence, access to therapy and equipment, use of healthcare resources, and involvement in peer support.

2. ACCESS TO & UTILIZATION OF SPECIALIZED REHABILITATION SERVICES
   Goal: Assess and promote opportunities for maximizing rehabilitation potential by means of facilitating the acquisition of healthcare coverage, providing education on healthcare rights, advocating use of innovative technology and treatments, and increasing access to specialized outpatient services in the communities where the population growth is estimated to be high over the next 15 years.

3. EDUCATION & TRAINING OF PROFESSIONALS INVOLVED IN REHABILITATION
   Goal: Elevate and modernize rehabilitation services in the state of Mississippi by improving education and training of professionals involved by serving as the clinical facility for Mississippi's first PM&R (rehabilitation physician specialist) department and residency training at UMMC. We will also enhance specialized education and training of professionals involved in rehabilitation nursing, physical/occupational/speech therapy, orthotics and prosthetics, and neuropsychology.

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 Steering Committee will oversee and coordinate activities and review progress. The Committee will report to the Executive Committee periodically and develop annual reports for the MRC Board of Trustees.

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, LIFE of MS, Mississippi Paralysis Association, Metro Area Community Empowerment and other organizations.

Health Needs Not Addressed

Based on the adopted guiding principles and the criteria for prioritizing identified health care needs, we chose not to address other needs that emerged out of this assessment process given the scope of the problem and the unlikelihood our solutions would have a true and lasting impact. Some of the needs not addressed fall under the scope of activities of other state and non-governmental agencies, such as Independent Living and Vocational Rehabilitation under Mississippi Department of Rehabilitation Services, LIFE of MS, and Mississippi Paralysis Association.

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.