Community Health Implementation Strategy FY 2014-16

Frazier Rehab Institute
KentuckyOne Health™

Introduction

Frazier Rehab Institute is a comprehensive rehabilitation system with a mission to help those impaired by accident or illness to realize their highest level of independence, productivity, social adjustment and self-esteem. It does this by providing an impressive array of inpatient and outpatient services for people ranging in age from infancy to senior adulthood. The organization's highly skilled therapists, state-of-the-art facilities and innovative therapeutic techniques have earned Frazier Rehab Institute national recognition. The system offers services in 20 locations including a 135-bed hospital in Louisville's Downtown Medical Center. Frazier's 600-plus employees provide the best care available to patients from across the country to include physical medicine, rehab nursing, nutritional services, physical, occupational, recreational and speech therapies, as well as pulmonary rehab, psychology, and neuropsychological testing.

Frazier Rehab Institute is part of KentuckyOne Health, the largest health system in Kentucky with more than 200 locations including hospitals, outpatient facilities and physician offices, and more than 3,100 licensed beds. An 18-member volunteer board of directors governs KentuckyOne Health, its facilities and operations, including Frazier Rehab Institute, with this mission:

Our Purpose

To bring wellness, healing and hope to all, including the underserved.

Our Future

To transform the health of communities, care delivery and health care professions so that individuals and families can enjoy the best of health and wellbeing.

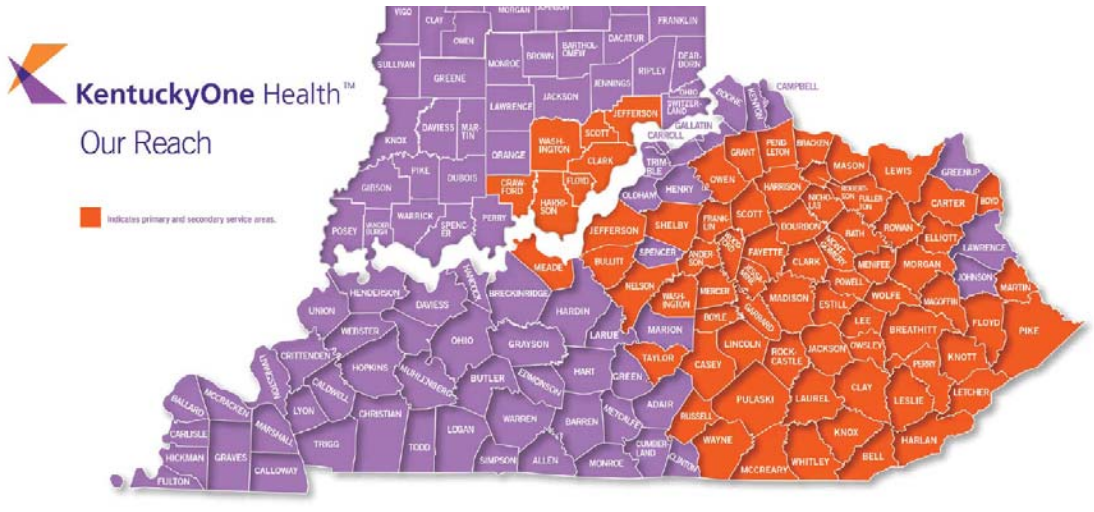
Our Values

Reverence: Respecting those we serve and those who serve.

Integrity: Doing the right things in the right way for the right reason.

Compassion: Sharing in others' joys and sorrows.

Excellence: Living up to the highest standards.



Frazier Rehab Institute is located in Louisville, the largest city in the state of Kentucky and the county seat of Jefferson County. The hospital serves a population of roughly 1.5 million people residing in the Louisville metropolitan area which includes Louisville-Jefferson County and 12 surrounding counties, eight in Kentucky and four in Southern Indiana. The majority (more than 63 percent) of its discharges originate from Jefferson County.

This document provides a summary of Frazier Rehab Institute's plan to develop new and enhance established community benefit programs and services from FY2014-16. This plan is focused on addressing the top community health priorities identified in the community health needs assessment conducted by Frazier Rehab Institute in FY2013.

Identifying Health Needs

Frazier Rehab Institute identified community health needs by undergoing an assessment process in collaboration with the Louisville Metro Department of Public Health and Wellness (LMPHW), the Kentucky Hospital Association and other Louisville area health systems (Baptist Hospital East, Norton Healthcare and University of Louisville Hospital). Nearly 1,900 residents provided input via community forums conducted in all four quadrants of Jefferson County and through an on-line survey (available in both English and Spanish). Another 40 community leaders, physicians, and other health professionals shared their expertise at a special community forum. In addition, secondary data was compiled from demographic and socioeconomic sources as well as national, state and local sources of information on disease prevalence, health indicators, health equity and mortality.

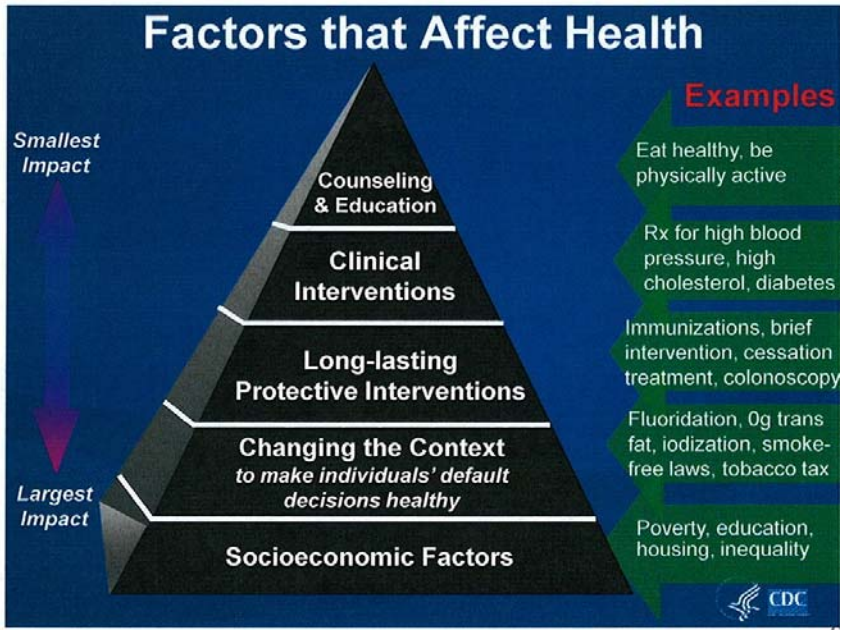
This was analyzed and reviewed to identify health issues of uninsured persons, low-income persons and minority groups, and the community as a whole. Health needs were prioritized utilizing a method that weighs: 1) the impact on vulnerable populations; 2) the importance to the community; 3) the size of the problem; 4) the seriousness of the problem; 5) prevalence of common themes; 6) how closely the need aligns with the strategies and strengths of the hospital and KentuckyOne Health; and 7) an evaluation of existing hospital programs responding to the identified need. The hospital engaged **BKD, LLP** to assist with compiling secondary data and prioritizing identified health needs.

Subsequently, Frazier Rehab Institute leadership entered into a dialogue with other key community partners, including representatives of LMDPHW, to discuss the results of the evaluation and select health priorities. Participants were given the opportunity to revise rankings and debate issues until a consensus was reached on a composite ranking of health issues. The process identified the following issues:

- Stroke/cerebrovascular disease
- Chronic diseases in vulnerable neighborhoods (defined by health outcomes, race and socieo-economic status)
- Adult obesity
- Cancer
- Heart disease
- Physical inactivity
- Access to care
- Increased heart disease and stroke rates for African Americans
- Need for improved communication of available services, education and support groups, etc.
- Need for additional physician specialists
- Lack of physical activity in vulnerable populations
- Violent crime

With an understanding that collaborative efforts have the greatest opportunity for measurable, collective impact, Frazier Rehab Institute has mapped these needs to the health improvement efforts of the Mayor's Healthy Hometown Movement which envisions a community-wide culture where healthy eating and active living are the norm and fosters an environment that promotes increased physical activity, better nutrition, healthy public policy and access to needed resources.

Mayor's Health Hometown Priority	Correlated Community Health Need
Healthy Eating and Active Living	Chronic Diseases in Vulnerable Neighborhoods Adult Obesity Heart Disease Physical Inactivity Lack of Physical Activity in Vulnerable Populations
Chronic Disease Prevention and Management	Stroke/Cerebrovascular Disease Cancer Heart Disease Chronic Lower Respiratory Disease Improved Communication, Education and Support Groups Chronic Diseases in Vulnerable Neighborhoods
Access to Services (Addressing Health Disparities)	Increased Heart Disease/Stroke Among African Americans Access to Care Violent Crime



Furthermore, the goals and strategies outlined in this implementation plan span the range of factors affecting health as outlined by the Centers for Disease Control.

PRIORITY: Healthy Eating and Active Living

Community Health Needs: Chronic diseases in vulnerable neighborhoods, adult obesity, heart disease, physical inactivity, and lack of physical activity in vulnerable populations

Goal 1: Improve opportunities for Louisville residents to participate in physical activities, particularly within at-risk neighborhoods.

Strategies:

A. Continue to operate the Community Fitness & Wellness program, offering people with disabilities the opportunity to exercise through a subsidized program with staff and equipment tailored to their needs; enhance communication with residents about the Community Fitness & Wellness program to increase the number of members from at-risk neighborhoods.

B. Establish Walk With a Doc events at west and south Louisville public parks to provide free monthly opportunities for residents to exercise with the support of a physician and supportive walking community.

C. Continue established Walk With a Doc event monthly at the Parklands of Floyds Fork in eastern Jefferson County.

Goal 2: Support collaborative initiatives to address Louisville's food deserts, to raise the "food IQ" of residents, and promote access to nutrition education/counseling and exercise programs.

Strategies:

A. Participate in local collaborative efforts to include the 2013 Bingham Fellows (developing long-term strategies to foster a smart food culture) and the Mayors' Healthy Hometown Movement committees on healthy eating and active living.

B. Explore the feasibility of partnering with the YMCA to expand exercise opportunities for people with disabilities.

C. Explore the feasibility of facilitating patient referrals to community-based resources to include exercise programs, community gardens, Fresh Stop markets, and community supported agriculture programs (CSAs).

PRIORITY: Chronic Diseases Among Vulnerable Populations

Community Health Needs: Stroke/cerebrovascular disease, chronic diseases in vulnerable neighborhoods, and improved communication/education/support

Goal 1: Improve the health status of people with chronic health conditions to include Parkinson's disease, chronic lung disease, and for stroke survivors.

Strategies:

A. In partnership with the Parkinson's Support Center of Kentuckiana, Frazier staff will provide support and education to people in vulnerable neighborhoods to enhance access to diagnostic and treatment services.

B. Working in collaboration with primary care offices, health clinics, and area churches, provide educational lectures and written materials on the prevention of initial stroke and recurring stroke, stroke identification, and healthy lifestyle post-stroke.

C. In partnership with primary care offices and health clinics, enhance community awareness about the Better Breathers Support Group which offers people with COPD an array of resources to prevent and manage chronic lung disease.

Goal 2: In partnership with residents of challenged neighborhoods in Louisville's urban core, LMPHW and its Center for Healthy Equity, continue implementation of an action plan to promote improved health status and to reduce disparities.

Strategies:

A. Continue the Transitions of Care Program to provide support to patients with Medicaid or no insurance who live in neighborhoods within zip codes 40203, 40211 and 40212 in an effort to improve their ability to self-manage their condition at home. This free program includes the coaching support of a nurse navigator by phone, home visits from peer advisors (aka community health workers) trained to link residents with community resources, and a visit from a dietitian when nutritional counseling is needed.

B. Implement the addition of a peer specialist to the Transitions of Care Program to provide residents identified with substance use disorders, depression or mental illness with a specially trained community member who is in recovery.

C. Explore the feasibility of expanding the Transitions of Care Program to serve more Louisville residents.

D. Continue implementation of educational training in culturally competent care at the Louisville WIC clinics and at Frazier Rehab Institute.

E. Continue to engage clients of Louisville's WIC clinics in implementing health equity practice changes that improve satisfaction.

F. Support the Family Health Center in Butchertown, a free clinic serving predominantly Hispanic residents from across Louisville, and the Volunteers of America primary care clinic for those who are homeless or in transitional status.

Goal 3: Working in partnership with the Network Center for Community Change, continue striving to improve the health status of residents in Louisville's urban core neighborhoods with a particular focus on Shelby Park, Smoketown, Phoneix Hill, and California.

Strategies:

A. Improve the civic engagement of residents through the implementation of public policy initiatives designed and championed by residents.

B. Improve educational achievement of students through training, education and development initiatives designed to reduce dropout rates for engaged youth.

C. Increase enrollment in WIC among eligible families.

Goal 4: Research, develop and test innovative, evidence-based practices in collaboration with community partners to reduce unnecessary hospital readmissions and emergency department visits while improving patient experience and health outcomes.

Strategies:

A. In partnership with UofL Hospital and Family Health Centers (federally qualified health centers), explore the feasibility of implementing a collaborative case management program to identify vulnerable populations and better serve their needs—physical, emotional and social—in the appropriate community-based setting.

B. Explore the feasibility of implementing congregation-based health programs in partnership with area churches and synagogues.
C. Provide leadership to the Louisville coalition addressing the causes of chronic disease in children (pending funding support from the Foundation for a Healthy Kentucky).
D. Explore the feasibility of partnering with UofL faculty on research projects to address the needs of people with chronic diseases to include both high-tech (technology) and high-touch (community health workers) approaches.

Goal 5: Continue to offer an array of support groups and educational offerings to address the needs of patients with disabilities and their family members to include:

A. Derby City Chapter of the Spinal Cord Injury Association
B. Friends of Frazier
C. Parkinsons' Support Center of Kentuckiana
D. Education group meetings (i.e. assistive technology, driving transportation, skin care, leisure activities, home modification, grief and loss, etc.)
E. Caregiver Support Group for Brain Injury Patients
F. Speakers Bureau on request for community groups

PRIORITY: Access to Services (Addressing Health Disparities)

Community Health Needs: Access to care and violent crime

Goal 1: Reduce barriers to rehabilitation care for individuals who have survived disabling accidents or injuries and provide resources to support both them and their families in living to their full potential.

Strategies:

A. To reduce barriers to rehabilitation for people who've suffered catastrophic injuries, implement a pilot project to create a replicable model of outpatient rehabilitation for people with spinal cord injuries. The pilot will address two major obstacles to accessing rehabilitation care: the lack of transportation and dearth of accessible, affordable housing.
B. Continue to operate the Michael Brent Resource Center designed to provide free information and resources to patients and their families about spinal cord impairment and other disabilities. The Center brings the community together to increase awareness, education, and accessibility, and fosters partnerships between individuals and the agencies that serve them, representing an important expansion of community reintegration and vocational rehabilitation programs.
C. Continue to operate a toll-free help line and website to answer questions from people and caregivers about the availability of rehabilitation services.
D. Partner with the University of Louisville School of Medicine to serve as a national hub for translational research serving individuals with disabilities, to include serving as the lead center for the NeuroRecovery Network, a collaboration with the Christopher and Dana Reeve Foundation.
E. Provide competitive recreational activities for people with disabilities through continued operation of comprehensive adaptive sports program.

Goal 2: Continue working to achieve a 10% reduction in the incidence of domestic violence involving adults and youth in the 40210 zip code by 2020 as measured by Louisville Metro Police Department data.

Strategies:

A. In partnership with the Center for Women and Families, mobilize teens in the Parkhill, Algonquin and California neighborhoods through PACT in Action, a youth-led initiative focused on building community capacity to develop teen dating violence prevention programming to their peers.

B. Through PACT in Action: 1) strengthen individual knowledge and skills; 2) promote community education; 3) educate providers; 4) foster coalitions and networks; 5) change organizational practices; and 6) influence policy and legislation, all as it pertains to teen dating and intimate partner violence.

Needs Not Addressed

Some issues identified through the community health needs assessment have not been addressed in this plan. In initial discussion and subsequent prioritization, Frazier Rehab's Community Needs Assessment Team considered the levels to which some needs were already being addressed in the service area. Additionally, some community needs fall out of the scope of expertise and resources of Frazier Rehab Institute. The following chart outlines how some of the needs identified in the assessment are addressed by others or in different ways:

Community Need	How Need is Addressed
Chronic Lower Respiratory Disease Increased Heart Disease/Stroke Among African Americans	While this plan does include some initiatives that address COPD and heart disease, there are many other area organizations providing resources to support education, support and treatment in this area of these illnesses. The Mayor's Healthy Hometown Movement has made smoking cessation a pillar priority and is offering free classes at locations throughout the community year-round. In addition, there are numerous community support groups for people with heart disease and COPD at many hospitals and other free resources offered through the local chapter of the American Heart Association and American Lung Association.
Cancer	As a rehabilitation hospital, cancer care is not a primary area of emphasis or expertise of Frazier Rehab Institute. There are many providers in the community already effectively addressing comprehensive cancer care including the James Graham Brown Cancer Center, Jewish Hospital, and Norton Healthcare.

Next Steps

Frazier Rehab Institute's Community Needs Assessment Team initiated the development of implementation strategies for each health priority identified through the assessment process. This Implementation Plan will be rolled out over the next three years, from FY2014 through the end of FY2016. The Team will work with community partners and health issue experts on the following for each of the approaches to addressing the identified health needs:

- Develop work plans to support effective implementation
- Create mechanisms to monitor and measure outcomes
- Develop a report card to provide on-going status and results of these efforts to improve community health

Frazier Rehab Institute is committed to conducting another health needs assessment within three years.

Adoption/Approval

KentuckyOne Health's Board of Directors includes representation across the state and support the work that each facility completes to improve the health of their community. The Board of Directors approves Frazier Rehab Institute's Implementation Strategy that has been developed to address the priorities of the recent Community Health Needs Assessment.

Harmonious with the mission of KentuckyOne Health, Jewish Hospital will utilize this Implementation Strategy as a roadmap to collaborate with their community to address the priorities, particularly for the most vulnerable. KentuckyOne Health approves Frazier Rehab Institute's Implementation Strategy and is a champion for a healthier Kentucky.

Robert N Hewett
Chair, KentuckyOne Health Board of Directors

4/10/13
Date

Ruth W. Brinkley
President & Chief Executive Officer, KentuckyOne Health

4/10/13
Date