METHODIST REHABILITATION CENTER | 50 YEARS

COMMUNITY HEALTH NEEDS ASSESSMENT

FY 2026-2028

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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 13 years of age or older, of all socio-economic backgrounds, consistent with the demographics of the state.

For many years, MRC conducted an annual community benefit report presented 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.

MRC has completed four Community Health Needs Assessments (2013, 2016, 2019, and 2023.) www.methodistonline.org/community-health-needs-assessment In the latter half of 2024 through Spring, 2025, we developed a new triennial assessment that goes into effect July 1, 2025 (Fiscal year 2026). Input for these assessments is provided by patients, staff, community representatives with expertise in public health, and various not-for-profit organizations that serve low-income and disadvantaged populations. Additional information comes from public databases, reports, and publications by state and national agencies.

Based on the adopted principles for prioritizing community health care needs, we will focus on the following key priorities as we implement our FY2026-2028 Community Health Needs Assessment.

1. Broaden and Advance Access to Comprehensive Rehabilitation
2. Educate Rehabilitation Practitioners
3. Strengthen the Continuum of Care

Implementation strategies resulting from these priorities are expected to result in short- and long-term community health benefits, and better outcomes and quality of life for our patients.

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.

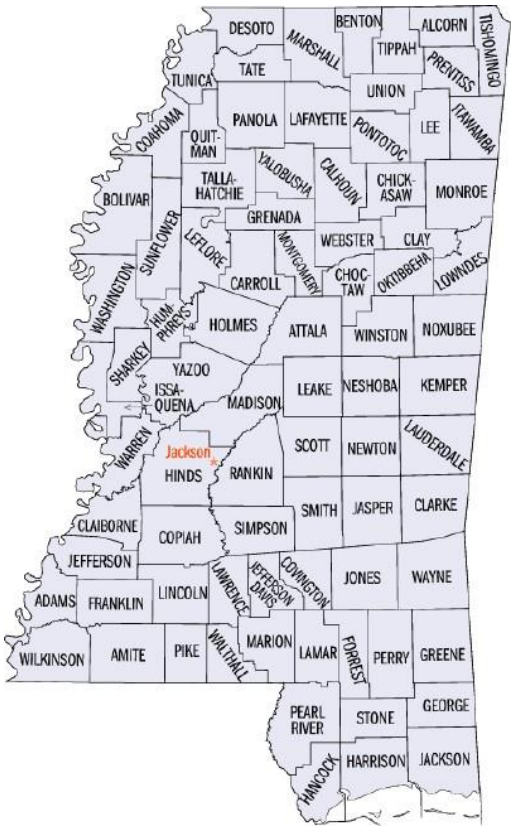
Most all patients admitted to MRC's main hospital are transferred from acute care hospitals located throughout Mississippi and the region. Besides providing inpatient and outpatient care, MRC serves the community through an array of outreach programs and education events, as well as a clinical research 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. In addition, 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, to include strokes, 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 most recent data from the *U.S. Census Bureau*, the population of Mississippi is nearly 3 million (52% women, 48% men). The median age is 39 years (77% ≥18 years, 18% ≥65 years). Caucasians represent 56% of the population and African-Americans 37%. Households of Mississippi consist mostly of single parent families (52%) followed by married couples (44%). Among the people 25 or older, 88% have at least a high school diploma and 26% have a bachelor's degree or higher.

The median household income is ~$54,206 ($77,719 nationally) and the median family income is ~$72,259 ($96,401 nationally). About 18% live below the federal poverty level (13% nationally) – mainly children under 18 years (23%), followed by adults 18 to 64 years (17%) and 65 years and over (16%).

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 (46% prevalence), obesity (40%), and diabetes (17%). These lead to cardio-vascular diseases including stroke, the main cause of death in the state, and the second highest in the nation. 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. In 2022, 36 percent of adults in Mississippi reported having a disability, compared to 29 percent nationally (CDC Disability and Health Data System, 2023).

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). An average score is assigned to each ZIP code, from 1.0 (lowest) to 5.0 (highest socioeconomic barriers), and the county score is comprised of the average score of the ZIP codes within the county. The latest available scores (2021) for Mississippi counties range from 2.8-5.0. The "highest need" (score 4.2-5.0) was projected for 52 counties with 1.28 million people (43% of total population), "high need" (score 3.4-4.1) for 27 counties with 1.22 million people (41%), and "moderate need" (2.6-3.3) for the remaining 3 counties with 448,000 people (15%). The barriers accounted for by the *Community Need Index* also apply to the communities primarily served by MRC (figure).

In 2024, it is estimated that 684,000 Mississippians (23%) received Medicaid benefits. In addition, about 637,000 Mississippi residents (21%) are Medicare beneficiaries, of whom almost 274,000 (43%) have elected to participate in a Medicare Advantage plan. In total, an estimated 44% of Mississippi's population is receiving governmental insurance benefits.

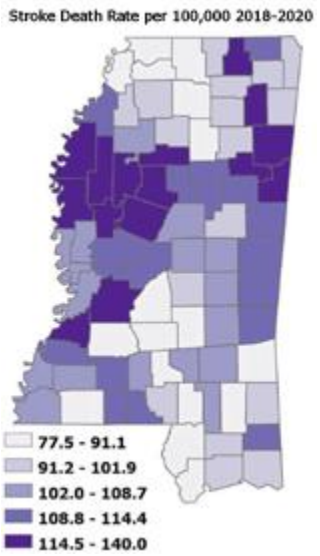
Regarding Medicare Advantage (MA) plans, in October, 2024, the U.S. Senate Permanent Subcommittee on Investigations released a report detailing how MA insurers are increasingly denying post-acute coverage to seniors and individuals with disabilities. Six advocacy organizations, including the American Health Care Association and the American Medical Rehabilitation Providers Association, released a joint statement upon release of the report:

> "Our organizations, representing inpatient rehabilitation hospitals, long-term care hospitals, skilled nursing facilities, and home health agencies, have long raised concerns that MA plans too often inappropriately delay and deny access to post-acute care, causing real harm for patients seeking to fully recover from serious injuries, illnesses, disabilities, and chronic conditions. Our members consistently report that these MA plan practices have a direct negative impact on beneficiaries' long-term health, function, and ability to maximize their recovery, especially when they limit access to benefits that are fully covered for those enrolled in Traditional Medicare." https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf

Uninsured & Governmental Insurance

In 2022, 311,607 Mississippians (11%) are estimated to be without insurance. There are somewhat more uninsured men (53%) than women (47%). Most uninsured belong to the age group of 25-34 years, which nearly 20% are uninsured. The rate of uninsured among African-Americans (10%) is higher than among Caucasians (9%). The uninsured rate is higher among those who did not graduate high school (24%) compared to those who graduated high school (11%) and those who graduated from college or a trade school (4%). In terms of household income, 32% of the uninsured earn less than $25,000, 21% between $25,000 and $49,999, 9% between $50,000 and $74,999, 4% earn $75,000 or over.

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 musculoskeletal system (amputation, broken bone, joint replacement). According to the most recent Mississippi Trauma Care System Report (April – June 2022, prepared July 2022), trauma remains the leading cause of death for Mississippians age 1 to 44, and Mississippi ranks 5th in the nation for number of teens killed in motor vehicle crashes. The population sustaining a trauma increased approximately from 15,000 in 2006 to 24,000 in 2018, and those who sustained unintentional traumatic injuries were more likely to survive. 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 was the sixth leading cause of death in Mississippi in 2021 and occurs at a rate of 57.8 per 100,000 people, the highest in the nation. Although mortality from stroke is on the decline, it is highest in several counties north and south of Hinds County where MRC is located.

Stroke leaves ~2,000 Mississippians disabled each year. The percent of people living with stroke (~4%) has been steady the past 7 years. Better emergency care and survival means more disabled people in need of comprehensive rehabilitation services.

Demographics of People Admitted to MRC

In the fiscal year 2024 (July 1, 2023 - June 30, 2024), 1,814 Mississippians were cared for at MRC inpatient rehabilitation. Of those, 48% were women and 52% men; 55% were Caucasians and 44% African-American. These demographics are representative of the entire state of Mississippi.

The people admitted to MRC represent 73 of 82 Mississippi counties (89%). Before admission, 53% resided in three counties of the Jackson Metro area and an additional 40% within a radius of 120 miles. The most frequent reasons for admission were stroke (32%), orthopedic (e.g. leg fracture or joint implants) (24%), traumatic or non-traumatic brain injury (14%), and traumatic or non-traumatic spinal cord injury (9%). These conditions represent 79% of all admissions. While Medicare remains our most common payer source (41%) upon admission, 3% of people admitted in the fiscal year 2024 were uninsured.

Rehabilitation facilities outside of MRC primary service area

Other providers of Level 1 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 Level 1 licensed rehabilitation beds in the state (FY 2022 State Health Plan, MS Dept. of Health).

Preceding CHNA/Implementation

The previous CHNA was conducted in FY 2022 and implemented FY2023-FY2025, with three priority areas identified.

1. Improve Access to Comprehensive Rehabilitation
2. Educate & Train Rehabilitation Practitioners in the Community
3. Monitor Outcomes & Build Relationships along the Continuum of Care

Annual reports were presented to the hospital Board of Trustees detailing implementation progress in each area. Highlights include:

- opening of outpatient clinics in underserved areas, improving access to care
- providing transportation from referring hospitals to MRC, and upon discharge to home when needed
- clinicians earning dozens of advanced skills and certifications
- clinical research translated to useful therapies and improved care
- investments in new therapy technology
- follow up surveys and assistance with resources needed post-discharge
- new/strengthened relationships with organizations that serve our patient population

Throughout the previous cycle, MRC received no 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 insurance marketplace 2025 guide (2025)	Information about health insurance carriers, enrollment process, premium changes, the number of people enrolled through Mississippi's health insurance exchange
	https://www.healthinsurance.org/aca-marketplace/mississippi	
Mississippi State Department of Health	Heart Disease and Stroke Resources (2023)	Information on stroke facts, prevention, protocols for treatment, rehabilitation options, and patient quality of care issues
	https://msdh.ms.gov/page/43,0,297.html	
Mississippi State Department of Health	Mississippi Stroke System-of-Care (2024)	Collaborative effort between the Mississippi State Department of Health, the Mississippi Healthcare Alliance, the American Heart Association, and the Mississippi Hospital Association.
	https://msdh.ms.gov/page/44,0,397,689.html	

Mississippi State Department of Health- Trauma Care System	Fact Sheets (2018)	The only functioning mandatory Trauma System in the country nationally recognized as a model Trauma System
	http://msdh.ms.gov/msdhsite/_static/resources/4648.pdf	
The State Data Center of Mississippi	Population Projections for Mississippi, 2020 – 2050	Projections of an increase in Mississippi population by county, sex and race
	https://sdc.olemiss.edu/population-projections/	

DATA – NATIONAL		
Source	**Title (Year)**	**Summary**
US Census Bureau	Explore Census Data (2020-2023)	Summary of demographic and socio-economic statistics for the state of Mississippi
	https://data.census.gov/profile/Mississippi?g=040XX00US28	
ATSDR - CDC	Place and Health - Geospatial Research, Analysis, and Services Program (GRASP) (2024)	Place-based index, database, and mapping application designed to identify and quantify communities experiencing social vulnerability.
	https://www.atsdr.cdc.gov/place-health/php/svi/svi-interactive-map.html	
Centers for Disease Control and Prevention	Behavioral Risk Factor Surveillance System Survey Data and Documentation (2023)	The largest on-going telephone survey system tracking health conditions and risk behaviors in the United States yearly since 1984
	https://www.cdc.gov/brfss/annual_data/annual_2023.html	
Centers for Disease Control and Prevention	Outpatient Rehabilitation Among Stroke Survivors -- 20 States and the District of Columbia, 2013, and Four States, 2015 (2018)	Report from 21 States, including Mississippi, indicates lower than expected utilization of outpatient rehabilitation services among stroke survivors
	https://www.cdc.gov/mmwr/volumes/67/wr/mm6720a2.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 (2025)	Largest source of information about causes, demographics, and consequences of traumatic spinal cord injury in the U.S.
	https://bpb-us-w2.wpmucdn.com/sites.uab.edu/dist/f/392/files/2025/02/2025-Facts-and-Figures.pdf	

Input for the Methodist Rehabilitation Center Community Health Needs Assessment

Methods

Representatives of the community and others with knowledge of challenges/gaps/barriers experienced by those we serve were identified for interviews through internal and external sources. The response rate was 100%. Some interviews were conducted in-person, others telephonically. Hospital leadership and trustees provided input in group meetings as part of MRC's 2025 strategic planning process. Thematic content analysis was used to identify and cluster common themes.

PARTICIPANTS	
CHNA STEERING COMMITTEE	
David McMillin, Chief Executive Officer	Arash Sepehri, MA, Director, Quality Management & Medical Informatics
Gary Armstrong, President & Chief Financial Officer	Dobrivoje S. Stokic, MD, DSc, Vice President, Research & Innovation
Chris Blount, Executive Director, Wilson Research Foundation	Tammy Voynik, Vice President, Legal Affairs
EMPLOYEES AND TRUSTEES PROVIDING INPUT IN GROUP MEETINGS	
Hospital Officers and Department Directors	Inpatient Physicians and Nurse Practitioners
Members of the Board of Trustees	

CHNA Input from Community Representatives

Representatives of the Community Who Provided Input				
Date	Name/Degree	Title	Affiliation	Expertise/Leadership Role
4/25/2025	Thomas Dobbs III, MD, MPH[1,2]	Dean of the School of Population Health, former State Health Officer	University of Mississippi Medical Center	25+ years of experience as a clinician, educator, researcher, and public health leader
3/28/2025	Kate Beller, JD[1,2,4]	Executive VP for Government Relations and Policy Development	American Medical Rehabilitation Providers Assoc.	30+ years of association/public health legal/policy experience

4/4/2022	Desmeon Thomas, BS[3,4]	Independent Living Specialist	LiFe of Mississippi	Information and referral, peer support, advocacy, skills training and community transition for those living with disabilities
3/18/2025	Jamie Tucker, BS[3,4]	Director, Project START	Mississippi Department of Rehabilitation Services	Information and referral, advocacy, equipment loaner program for those living with disabilities
3/20/2025	Kris Geroux, ATP[3,4]	Director, Assistive Technology	Mississippi Department of Rehabilitation Services	26 years experience in state rehabilitation services, statewide information technology assistance coordinator for those living with disabilities
3/20/2025	Laura Jones, CTRS[3,4]	Trust Fund Coordinator, Office of Special Disability Programs	Mississippi Department of Rehabilitation Services	Direct assistance to individuals and subgrants to NPOs in Mississippi to support those with traumatic brain injuries and spinal cord injuries
3/25/2025	Johnny McGinn, BA, BS[4]	Recently-retired Client Assistance Program Coordinator	Mississippi Society for Disabilities	Peer support counselor, promoter of wheelchair sports and recreation opportunities
12/5/2024	David Storto, BA, JD[4]	Strategic advisor and planner	Storto Healthcare Strategies	40+ years rehabilitation hospital leadership

[1] **Mandatory:** Representative of federal/tribal/regional/state/local health departments/agencies with current data/information relevant to the needs of the community
[2] **Mandatory**: Person with special knowledge/expertise in public health (provide name, title, affiliation, a brief description of special knowledge/expertise)
[3] **Mandatory**: "Leaders/Representatives"/member of medically underserved, low-income, minority populations, and populations with chronic disease needs
[4] **Optional**: Consumer advocates; nonprofit organizations; academic experts; local government officials; community-based organizations; health care providers (with focus on low-income persons, minority groups, or those with chronic disease needs); private businesses; and health insurance and managed care organizations.

The Steering Committee developed criteria for identifying community health needs, as indicated below, and used these criteria to define community health care needs that will be addressed in the implementation strategy.

Process and criteria for prioritizing health needs

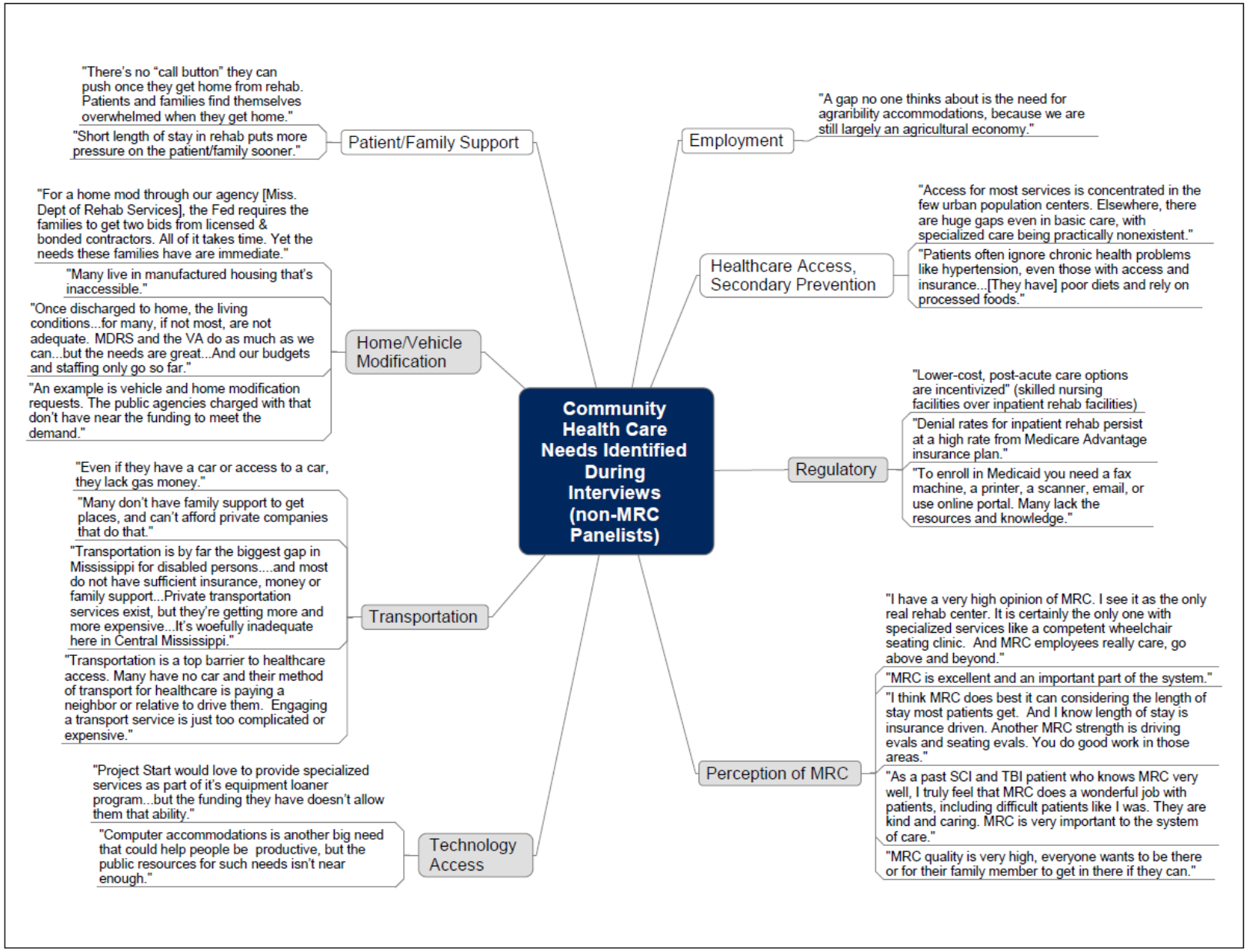
The process analogous to "multi-voting technique" was chosen for prioritizing community health care needs. This was done through a series of meetings during which each round of votes was followed by narrowing of the priority list. Before voting, the Steering Committee agreed upon the following guiding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


Community Health Care Needs Identified During Interviews (non-MRC Panelists)
Patient/Family Support
"There's no "call button" they can push once they get home from rehab. Patients and families find themselves overwhelmed when they get home."
"Short length of stay in rehab puts more pressure on the patient/family sooner."
Employment
"A gap no one thinks about is the need for agrarability accommodations, because we are still largely an agricultural economy."
Healthcare Access, Secondary Prevention
"Access for most services is concentrated in the few urban population centers. Elsewhere, there are huge gaps even in basic care, with specialized care being practically nonexistent."
"Patients often ignore chronic health problems like hypertension, even those with access and insurance...[They have] poor diets and rely on processed foods."
Home/Vehicle Modification
"For a home mod through our agency [Miss. Dept of Rehab Services], the Fed requires the families to get two bids from licensed & bonded contractors. All of it takes time. Yet the needs these families have are immediate."
"Many live in manufactured housing that's inaccessible."
"Once discharged to home, the living conditions...for many, if not most, are not adequate. MDRS and the VA do as much as we can...but the needs are great...And our budgets and staffing only go so far."
"An example is vehicle and home modification requests. The public agencies charged with that don't have near the funding to meet the demand."
Regulatory
"Lower-cost, post-acute care options are incentivized" (skilled nursing facilities over inpatient rehab facilities)
"Denial rates for inpatient rehab persist at a high rate from Medicare Advantage insurance plan."
"To enroll in Medicaid you need a fax machine, a printer, a scanner, email, or use online portal. Many lack the resources and knowledge."
Transportation
"Even if they have a car or access to a car, they lack gas money."
"Many don't have family support to get places, and can't afford private companies that do that."
"Transportation is by far the biggest gap in Mississippi for disabled persons....and most do not have sufficient insurance, money or family support...Private transportation services exist, but they're getting more and more expensive...It's woefully inadequate here in Central Mississippi."
"Transportation is a top barrier to healthcare access. Many have no car and their method of transport for healthcare is paying a neighbor or relative to drive them. Engaging a transport service is just too complicated or expensive."
Perception of MRC
"I have a very high opinion of MRC. I see it as the only real rehab center. It is certainly the only one with specialized services like a competent wheelchair seating clinic. And MRC employees really care, go above and beyond."
"MRC is excellent and an important part of the system."
"I think MRC does best it can considering the length of stay most patients get. And I know length of stay is insurance driven. Another MRC strength is driving evals and seating evals. You do good work in those areas."
"As a past SCI and TBI patient who knows MRC very well, I truly feel that MRC does a wonderful job with patients, including difficult patients like I was. They are kind and caring. MRC is very important to the system of care."
"MRC quality is very high, everyone wants to be there or for their family member to get in there if they can."
Technology Access
"Project Start would love to provide specialized services as part of it's equipment loaner program...but the funding they have doesn't allow them that ability."
"Computer accommodations is another big need that could help people be productive, but the public resources for such needs isn't near enough."

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. Broaden and Advance Access to Comprehensive Rehabilitation
2. Educate Rehabilitation Practitioners
3. Strengthen the Continuum of Care

Implementation

Facilities/Resources Available to Meet the Needs

MRC will utilize existing resources and facilities (hospital and outpatient locations) to address the selected priority areas. The activities will mainly be provided by staff representing clinical, research, education, quality, and leadership. Volunteers and donors will also have a role. The expertise and interests will be matched to the designated activities in each priority area.

Collaboration

As appropriate, MRC plans to collaborate with public entities and private community-based organizations to address the key priority areas. This includes, but is not limited to, the University of Mississippi Medical Center, State Department of Health, Department of Rehabilitation Services, LiFe of MS, Mississippi Paralysis Association, Brain Injury Association, Parkinson's Foundation, MS Society, other similar nonprofit organizations.

Reporting

The MRC Board of Trustees will receive annual reports from the Steering Committee of activities resulting from this implementation strategy.

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 greater access to and quality of inpatient and outpatient rehabilitation care, as well as access to specialized services; focused efforts to improve continuing education and advanced skills for rehabilitation professionals; improved coordination/collaboration with referring acute-care providers and community-based organizations; and advocacy efforts related to ensuring the most appropriate level of care for those we serve, and a stronger continuum of care. 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.