MADISON COUNTY MEMORIAL HOSPITAL

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

ANNUAL PROGRESS REPORT

April 2020

Madison County Memorial Hospital
Annual Progress Report 2021

This document serves to provide a progress report on the strategies the hospital adopted to address the needs identified in the Community Health Needs Assessment process.

Madison County Memorial Hospital

Madison County Memorial Hospital Mission
To enhance the quality of life by continuously improving the health of the people of our community.

Madison County Memorial Hospital Vision
The provider of the best family-centered health care in our region.

Madison County Memorial Hospital Values
Faith. Family. History.

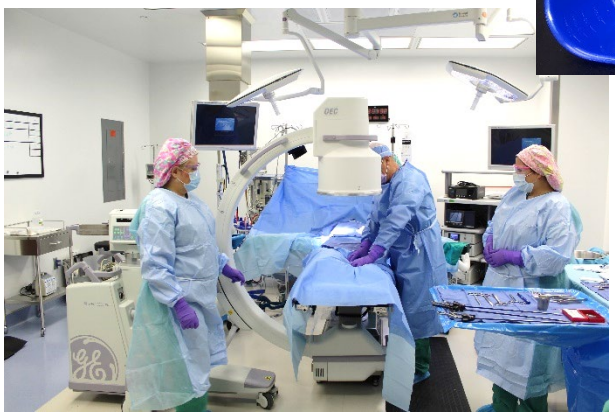


Table of Contents

Introduction & Overview

The Department of Health in Madison County and Madison County Memorial Hospital uses the following structure to plan, manage, measure, and guide strategies. To address the priorities identified for Madison County, primary source, secondary source, Community Health Needs Assessment, and a variety of other data sources are used. The year 2020 mandated a new Community Health Needs Assessment (CHNA) and the development of a Community Health Improvement Plan (CHIP) and Strategy Map for years 2021-2023. Three committees from prior years are restructuring to facilitate discussions and monitor progress going forward: 1) Maternal and Child Health Committee which met bi-annually; 2) Social and Mental Health Committee which met quarterly; and 3) Chronic Disease Committee which met quarterly is going to re-align with the new priorities to migrate the Child and Maternal Health to restructure as the *Health Equity Advisory Council*. The other two committees are going to continue as designed. A COVID Implementation Team has formed at both the Hospital and Health Department and Quarterly meetings connect the strategies between the two entities.

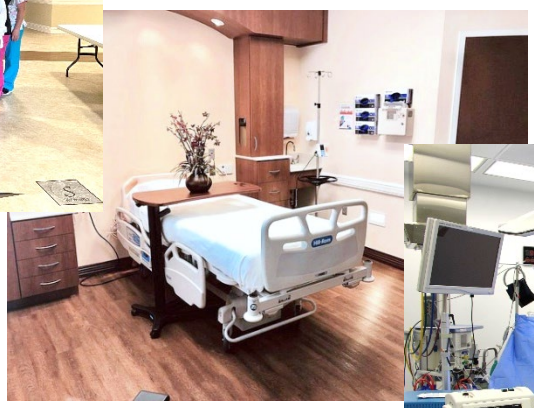
Due to the COVID Pandemic and restrictions at the Hospital and the Health Department it forced the Health Summit to be conducted virtually through Zoom and the resulting presentations are available at the following link- https://www.mcmh.us/more/health-improve/ and the recording of the Health Summit is preserved online at https://youtu.be/DBckJ8xYqWE.

Updated CHNA data relevant to the priority area were presented at the meeting, along with a synopsis of community efforts to address the priority area, lessons learned and strategies to continue and/or modify. CHIP committees reviewed the progress document and provided input on objectives. Progress was relayed to the community through quarterly reports, distributed through email and posted on the web. Updated data related to the priority areas were presented and a new action plan was approved. Unfinished activities were integrated into the plan and new strategies were identified and/or modified to replace those that were completed in the prior CHIP plan. The CHNA was approved by the Hospital Board of Directors and uploaded to the website in December of 2020.

In the later part of December 2020 both the hospital and the Health Department received shipments of the COVID-19 Vaccine and an intense and concerted effort to develop and roll out a Vaccination Implementation Plan was launched in January of 2021. Those efforts slightly derailed the community health improvement efforts and therefore the next step is to review the goals, objectives, and strategies and to realign the timeline and management plan now that vaccination efforts are scaling back. The status update and draft plan that is going to be reviewed by advisory is outlined on the following pages.

Population Health Plan Summary

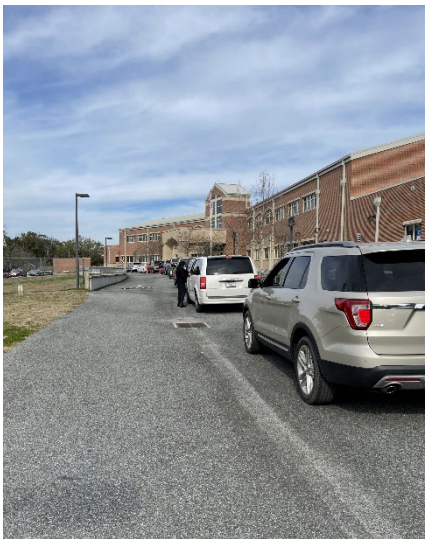
Priority Goal	*Objectives*
Social Determinants of Health	1. Establish shared understanding across all sectors in Madison County concerning information and issues surrounding Health Equity (HE), Cultural Competency/Sensitivity, and how Social Determinants of Health influence the health of Florida's residents and communities by December 31, 2021.
Social & Mental Health	1. Decrease **drug, alcohol,** and **smoking** through Mental Wellness Network delivering education, counseling, cessation, and medication services by December 31, 2023.
	2. Decrease **suicide** and improve **mental wellness** through an Integrated Care Network that aligns social and mental health services between the health department, the hospital, local providers, nonprofit, faithbased and government entities by December 31, 2023.
Chronic Diseases	1. Integrated chronic disease prevention and treatment services by December 31, 2023.
	2. Breast, prostate and colon cancer screenings, and awareness at least annually by December 31, 2022.
	3. Decrease the rate of COVID positive cases, hospitalizations, and deaths by December 2021.
COVID Vaccine Implementation Plan (New strategy adopted after December 2020 Plan was approved and launched)	1. Develop a Vaccination Implementation Plan with a phased approach.
	2. Develop process, protocols, policies, digital and print artifacts to rollout vaccines to region and train staff.
	3. Develop marketing, communication, and public relations strategies, sign up participants and administer the vaccine.



Major Accomplishments

Priority	*Accomplishments*
Social Determinants of Health	1. Development of a Speaker's Bureau for presentations about COVID and Vaccines. Presentations to date: 1) Kiwanis Club; 2) Chamber; and 3) Rotary. 2. Recruited surgeons to expand elective surgery capacity. 3. Integrated Wound Care Clinic with Rehabilitation. 4. Developed Spanish Speaking online Forms, Fact Sheets, and Facebook Communication to encourage non-English speaking residents to seek healthcare and preventive services. 5. Increased transportation via Department of Health partnership to expand access to vaccinations. 6. Expanded Barnes Healthcare partnership to provide a Health Educator to conduct community and family outreach around myths and facts of the vaccine.
Social & Mental Health	1. Updated the MOU with Disc Village to enhance the work of the Regional Coalition (RCORP) to expand services for drug and alcohol use. 2. Continuing Research and Development project to conduct an analysis of the hospital's patient panel, to research TeleBehavioral Health models, and to identify key Coding and Billing requirements. The purpose is to assess the feasibility of adding a new Line of Business in the hospital or to establish a formal Provider Network to extend this type of care to our patients. 3. Revamping internship and job shadowing program due to COVID restrictions for students and volunteers and updating policy and compliance to restart programming. 4. Establishing new partnership with local provider who is launching mental health services. Exploring referral processes and service capacity.
Chronic Disease	1. Launched Healthy You digital tools for health and wellness and chronic disease. 2. Replicated health awareness campaigns and revamped drive-through format due to COVID: 1) diabetes & Flu awareness; and 2) breast cancer awareness and provided healthy snacks, health education and Flu shots. 3. Continued monthly Chronic Disease Awareness campaign via advertising, social media, and radio.
COVID Vaccination Implementation	1. Plan fully developed. 2. Website built, forms created, online scheduling launched, staff trained. 3. Hospital marketed vaccinations and provided a total of 1,081 vaccines to the over sixty-five (065) and 1,182 to the under sixty-five (U65). The remaining 6,700 vaccines were provided by the Health Department, CVS, and Winn Dixie. 4. Database and reporting capabilities built.

Conclusion



Strategic partnerships have never been as evident as the response to the COVID-19 pandemic and vaccination efforts. During these efforts, the partners were still able to ensure an increased awareness of health issues and expanded access to healthcare services.

Both the Health Department and the Hospital successfully launched a collaborative effort to roll out vaccinations and completed the requirements of the Community Assessment Surveys, the Community Health Needs Assessment (CHNA), a Virtual Health Summit, and the Community Health Improvement Plan (CHIP). This collaborative has demonstrated the ability to leverage data for driving decision making and program planning.

The following appendix converted the December 2020 CHNA to a status update format to depict the strategies outlined, the percentage of the work completed, the next steps required to reach the established goals and objectives. It also outlines the changes in scope due to the interruptions of the project plan by COVID related activities and/or restrictions. The Health Department has been conducting vaccines at a mobile vaccination station at North Florida College and MCMH has a drive through vaccination station at the hospital. Just over 9,000 vaccines have been administered to almost 6,000 Madison County residents (30%) of the population. Efforts thus far demonstrates that diverging strategies to address COVID have been successful. For example, in December 2020 when the CHIP was adopted the percentage of hospitalization was 5% and at the time of this Annual Review it has dropped to 4%. Likewise, the percentage of deaths from COVID was at 2% in December 2020 and at 1% today.

Moving forward, the CHIP document is going to be converted to this Annual Report format to allow consistency of information and historical context for progress. Each priority is outlined with the Goal in the heading, key partners in the subheading and then objectives, strategies and action steps all aligned to the status update. The status is depicted with key bullet points, due dates, percentage complete and a green, yellow, or red light to provide an at-a-glance look at where additional focus and efforts are needed to stay on track with the timeline and management plan.

- Red indicates little to no movement towards objective target and represents zero (0) to thirty-three (33%) complete.
- Yellow indicates some progress towards meeting the objective target and represents thirty-four (34%) to sixty-six (66%) complete.
- Green indicates the objective is almost or has been reached or passed and represents sixty-seven (67%) to one hundred (100%) complete.

With the concerted effort to push the vaccine rollout now slowing down, the CHNA work resumes by revamping strategies between April and June of 2021 with anticipated launch/re-launch of strategies beginning in June of 2021. Objective and timelines have been adjusted accordingly along with a need to integrate sustainable COVID management and vaccine strategies as a new way of work.

Action Plan – GOAL: Improved Behavioral & Mental Health Network

(Key Partners: MCHD, DISC, MCMH, AHEC, Apalachee Center, CRMC, FSU, NFC, St. Leo, Hand in Hand)

Objective: Decrease **drug, alcohol,** and **smoking** through Mental Wellness Network delivering education, counseling, cessation, and medication services by December 31, 23.

Strategy: Strategic partnerships between the health department, the hospital, mental health providers, and Mental Health Councils to establish and deliver mental wellness services to Madison County residents.

Short-Term Objectives	Action Steps	Due Date	Status	Current	Status & Baselines
Establish a work group - Mental Wellness Advisory Council (WAC).	-Invite school system representatives, NFC representatives to subcommittee meeting, school system, mental health providers, law enforcement, and domestic violence.	~~6/1/21~~ 12/30/21		70%	-RCORP is organized and functioning as the WAC and efforts are underway to expand efforts and recruit new members. -NFC expressed interest in looking at program expansion for Mental Health, next steps Action Team to explore potential solutions. -MCMH engaged with local provider to establish a new partnership for counselor and Psychiatrist, next steps formal referral process and outreach plan. -Research and development 80% complete, next steps-digitize and print artifacts based on research. -Spoke to NAMI at Jax Mental Health Summit, received materials and a contact for further exploration. -New EHR functionality demo launch May 4.
Research, develop and maintain mental health resources - print and online.	-Feasibility & interest of Internship model with NFC, St. Leo, and/or FSU hybrid model for in person and virtual. (was put on hold due to COVID restrictions and Vaccination Station-re-launching June 2021.	~~12/31/21~~ 6/30/22		35%	
Launch a collaborative Mental Health Education and Awareness campaign.	-Develop communication plan to distribute to the community in-person after COVID and virtually. -Create presentation and supporting materials.	4/30/22		33%	
Integrated screening and referral process and tools.	-Policy, screening, and referral tools available online and in facilities.	6/30/22		35%	-2019 Adult smoker 19% -Tobacco Related Cancer rate 70.5 -Youth Tobacco use vaping 15.7% -Chronic liver death rate 13.2-70% white & 64% male) -Alcohol vehicle death rate 10.4-64% male, 55% white) -Alcohol liver deaths 13-62% Hispanic, 77% males, rate 583.6 -Youth drugs prior 30 days-47% black & 35% white) -Youth selling drugs 4.3%
National Alliance of Mental Illness (NAMI) chapter.	-Confirm interest and launch chapter if applicable.	2/1/23		40%	
Integrated Care Team for delivering drug, alcohol, and smoking cessation services.	-Determine/develop assessment process and tools, referral process and policy.	12/31/23		33%	

Action Plan – GOAL: Improved Behavioral & Mental Health Network

(Key Partners: MCHD, DISC, MCMH, AHEC, Apalachee Center, CRMC, FSU, NFC, St. Leo, Hand in Hand)

Objective: Decrease **suicide** and improve **mental wellness** through an Integrated Care Network that aligns social and mental health services between the health department, the hospital, local providers, nonprofit, faithbased and government entities by December 31, 23.

Strategy: Strategically align local and regional services to combat suicide and establish prevention strategies that meet the needs of Madison County residents.

Short-Term Objectives	Action Steps	Due Date	Status	Current	Status & Baselines
Decrease **suicide** by improving and integrating social, spiritual, and environmental assets.	-Assess the local parks/organizations to identify places to put Healing Gardens-promote social, spiritual, and mental wellbeing. -Convene with Parks and Recreation to determine feasibility and available resources. -Convene volunteer group. -Collaborative grant and Chamber open house when built.	12/31/21 12/31/22	🔴	20%	-Researching grant opportunity to collaborate with NFC for new program with internships. -NFC vaccination host and Nestle. -Online Portal upgraded and expanded DOH & MCMH. -MCMH collaborating with local provider-new mental wellness services partnership, next step formal process. -DISC Village collaborative grant submitted, expand Madison. -Vaccination Station fully developed and activated, next steps migrate to mobile and narrow down drive through. -Internships leveraged with NFC redesign vaccination to expand use of interns and add volunteers to plan.
Improve **mental wellness** through partnerships, awareness, counseling, workforce development and medication management.	-Develop presentation and communication plan for community in-person after COVID and virtually-print and digital artifacts. -Shorten Mental Health First Aid-public service announcement. format and deliver digitally and through community presentations. -Explore feasibility of NFC expansion to mental wellness program.	12/31/21	🔴	20%	
Improve **mental wellness** through COVID education, screening & vaccinations.	-Identify partners interested in hosting a Vaccination Station. -Develop cause related campaign materials. -Vaccinate 70% of the population (revamp 50% ended up vaccinating regionally instead of just locally).	9/1/21 12/31/23	🟢	90%	-Suicide death rates 16.7-70% male, 91% white, Death rates drugs total 20 (75% white) -Youth delinquent behavior 10.5% suspension, carrying handgun 7.7%, At times no good at all Youth-25.2% middle, 38% high -Domestic violence rate 583.6 -Youth life not worth it 25.2% middle, 26.4% high -Hospitalization rate mental 499.4(53% black) -Depressive disorders 18-44=13.0, 45-64=15.7, 65+=16.7. -Decrease COVID impact, Deaths-37, Cases-1,791, Hospitalization: 82, Vaccinated-10
Develop assessment protocols and referral processes for Health Department & Hospital Emergency Room and Inpatient Services.	-Establish timeline and management plan. -Develop process, protocols, and policies. -Develop MOU and/or affiliation agreements. -Collaborative grant to cover start up. -Add codes to Charge Master for new Line of Business. -Decrease cases by zip 32331-293, 32340-1,148, 32059-193.	12/31/23	🔴	30%	

Action Plan – GOAL: Decrease Chronic Diseases

(Key Partners: MCHD, MCMH, AHEC, Barnes Healthcare)

Objective: Integrated chronic disease prevention and treatment services by December 31, 23.

Strategy: Establish and maintain a Diabetes Prevention Program (DPP) and a Diabetes Self-Management Education Program (DSME) and healthy living services.

Short-Term Objectives	Action Steps	Date	Status	Current	Status & Baselines
Improve **nutrition** and decrease **obesity** through partnerships, awareness, education, screening, and healthcare access.	-Communication & Public relations plan for Fitness Classes, Nutrition classes, and Diabetes. -Engage with IFAS i.e., nutrition classes, online portal, and canning kitchen and identify capabilities and opportunities. -Review SNAP Education MCHD develop communication & public relations campaign. -Business After Hours Chef Demonstrations and Tasting.	~~6/30/21~~ 12/31/21 04/19/22		80%	-Wise Woman canceled by DOH when vaccinations started, next steps migrate back to Healthy You model and identify and apply for grant to revamp. -Barnes COVID community educator launched artifact developed, next step outreach plan, artifact production. -DOH/MCMH staff fully trained, process, protocols, communication launched, next steps, volunteer framework to sustain vaccination efforts. -All in person events canceled due to COVID restrictions, digitized resources, next step relaunch post-COVID model by end of 2021. -Volunteer/student interns modified model resume 06.21
Improve **heart health** through partnerships, awareness, education, screening, healthy living habits, and healthcare access.	-Review MCHD Heart Health Program capacity, referral, resources, and marketing. -Cause related marketing campaign and heart health fair. -Feasibility and timeline and management plan for Lake Francis Walk-a-Thon.	~~08/30/21~~ 10/31/21 02/01/22 07/31/22 11/12/22		10%	
Decrease the prevalence of **Diabetes** and **Diabetes deaths** through partnerships, awareness, education, screening, healthy living habits, and healthcare access.	-Timeline and management plan for Diabetes management and prevention classes (DPP & DSME). -Marketing and communication plan and materials. -Online portal registration and tracking. -Calendar of Events in person and online. -Diabetes awareness Celebrity Cook Off.	~~4/31/21~~ 6/30/21 9/30/22		67%	-Obese Risk-34% -Physically Inactive Risk -31% -Access to exercise opportunities Risk -50% -Limited access to healthy foods-10% -2018: 34% cause death heart -2018: 29.6 death rate Heart attack -Hypertension death rate 20.4 -CHF hospitalization rate 1,377.30 (62% white) -Diabetic Risk-17% -Hospitalization rates white (24%) & black (42%) -2018 Diabetes cause of death-4% -Percentage diabetes deaths, White (54%) and male (65%)
Community health education and awareness presentations to civic groups, faith-based groups, and local government.	-Feasibility of Local Chef demonstrations virtually/in person. -Develop timeline and management plan and communications and marketing. -Submit collaborative grant. -Thank Your Lucky Stars. -Long-term Vaccination Station model-plan addition	12/31/21 ~~6/30/21~~ 11/13/23		67%	

Action Plan – GOAL: Decrease Chronic Diseases

(Key Partners: MCHD, MCMH, AHEC, Barnes Healthcare)

Objective: Breast, prostate and colon cancer screenings, and awareness at least annually by December 31, 22.

Strategy: Provide cause related campaigns to provide cancer screening and treatment to residents

Short-Term Objectives	Action Steps	Date	Status	Current	Status & Baselines
Enhance tobacco cessation referral process.	-Big Bend AHEC to discuss and revise procedure. -Update Discharge Planning Process and Tools. -Increase marketing & Public Relations. -Establish kiosk and guest speaking opportunities.	9/30/21		35%	-MCMH & MCHD Breast Cancer Awareness event 3rd Annual in 2021, tested drive through model due to COVID, next steps expand to Heart and Colon Awareness. -Test drive through wellness and Flu event, next steps revamp, add COVD replicate November 2021. -Met with new Colon Cancer sponsor, had to delay COVID, next steps 2022 launch.
Improve health outcomes by ensuring awareness of services and key health and wellness practices through community health education and awareness presentations to civic groups, faith-based groups, and local government.	-Identify topics and develop a sample presentation that can be used in the different forums (PowerPoint, flyers, hand- outs, etc.). -Ascertain which community partners want to co-present. -Schedule presentations with organizations. -Increase marketing & Public Relations. -Colon Cancer Awareness event. -Increase health rankings through population health management strategies.	~~6/30/21~~ 12/31/21 03/16/22		35%	
Integrate Strategic Partnerships for cancer screening, awareness, education, and healthcare access.	-Enhance Breast Cancer Awareness Event to add Women's Health issues. -Replicate BCA to launch other cancer awareness events, screenings, and services. -Expand FSU College of Medicine partnership. -Increase marketing & Public Relations.	10/01/21		35%	-Breast Cancer Death Rate 18.5. -Total of 85 Mammograms in October and 14 on Breast Cancer Awareness Day.

* Status indicators are as follows:  = Little to no movement towards objective target  = some progress towards meeting the objective target  = reached or surpassed objective target

Action Plan – GOAL: Improved Social Determinants of Health (SDOH) (Key Partners: MCHD, MCMH, AHEC, Barnes Healthcare)

Objective: Breast, prostate and colon cancer screenings, and awareness at least annually by December 31, 22.

Strategy: Expand access to healthcare through Integrated Care Teams, aligned Provider Networks, and Collaborative Strategic Partnerships.

Short-Term Objectives	Action Steps	Date	Status	Current	Status & Baselines
Reduce **Poverty** and increase **Healthcare Access** by increasing the percentage of people with healthcare benefits.	-Navigator campaign with AHEC. -Managed plan counselors with MCHD and Business office. -Enhance scripting and training for Financial Counselor MCMH. -Explore enhanced/replicated partnerships with HUMANA and other Commercial Policies.	~~4/30/21~~ 11/21 annually		36%	-Added two new surgical affiliation agreements, first surgery June 2021 delayed due to COVID. -Finalizing partnerships with Orthopedics. -Added Tubal, Vasectomy, and Circumcision. -Integrated Wound Care with Rehabilitation. -Submitted grant DISC collaborative.
Increase **Healthcare Access** by establishing a comprehensive Provider Network as indicated by additional primary care and specialty providers serving in Madison County.	-FSU College Medicine expanding internships and affiliation. -Establish collaborative grant with FSU Humanities internship and mental wellness screening and research. -TMH prenatal care with MCHD. -Expand health care service with addition specialties through partnerships and affiliation agreements.	12/31/23		45%	-Uninsured Adults 17% & children 6%. Medicaid eligible U18 is 52% -Family Practice: 4, Physician Assistant: 1, Nurse Practitioners: 22 -Internal: 1, Pediatrician: 1, Cardiologist: 2 -Dentist: 4, -Chiropractors: 3, -Other: 0 -Mental Health: 4, -Psychologist: 1, -Clinical Social Workers: 2 -Food insecurity-23% -Limited access to healthy foods-10%
Reduce **food** insecurities by improving access to healthy eating and delivering nutrition education.	-IFAS partnership expansion. -Enhance Farm Share program and explore potential Farm Coop. -United Methodist Food Pantry and Chamber Partnership. -Land Project Community Garden with DISC. -Farmers Market potential with Chamber, TDC, and Downtown Development. -Submit Department of Agriculture grant.	12/31/21 12/31/23		36%	

Action Plan – GOAL: Improved Social Determinants of Health (SDOH) (Key Partners: MCHD, MCMH, AHEC, Barnes Healthcare)

Objective: Establish shared understanding across all sectors in Madison County concerning information and issues surrounding Health Equity (HE), Cultural Competency/Sensitivity, and how Social Determinants of Health influence the health of Florida's residents and communities by December 31, 23.					
Strategy: Guest speaking at community events, action teams, and advisory councils.					
Short-Term Objectives	**Action Steps**	**Date**	**Status**	**Current**	**Status & Baselines**
Develop/implement Social Determinants of Health Council.	-Reorganize the Maternal and Child Health action team to establish the SDOH timeline and management plan.	~~06/31/21~~ 12/31/21		67%	-Active council - change scope of work. -Actively pursuing Research/development for SDOH.
Incorporate health equity into community presentations.	-Prior to educating the community on chronic diseases and mental health, incorporate health equity into the presentations.	12/31/21		50%	-Individual poverty: 28.2% -Children in families in poverty: 37% -Unemployment: 3.9%
COVID Vaccine Implementation	-Ensure health equity for all residents.	06/30/21 12/31/23		75%	-Developed Spanish version of flyers, posters and online registration forms, next step community educator outreach apartments, churches, etc.

(Following Strategies align to Vision 2030- MCMH offers education/training opportunities for employees, Medical Staff & internships, however, does not have the personnel/financial to assist in this goal.)

Reduce **Poverty** and increase **employment** opportunities by attracting businesses.	-Individual poverty: 28.2% -Children in families in poverty: 37% -Unemployment: 3.9%	1102, 1103.02, 1103.01	Career Source, Madison County, MCDC, MCCC	**Vision 2030**
Reduce **poverty** and increase **employment** capacity by improving soft skills and workforce capabilities through **education and training.**	-SSI 1101: 13%, 1103.01: 12.4%, 1103.02: 10% -SNAP 1103.02: 36.2% & 1102: 21.4% -Early Steps <3 served: 66.6% -Elementary not promoted: 12.9% -Graduation Rate 82.5% -High School diploma: 38.1% -Likely to pursue college 13.8%, Bachelors + 13.8%	1102, 1103.02, 1103.01	School District, NFC, St. Leo	**Vision 2030** -State Representative, Local and National systems on Poverty
Reduce **poverty** by improving housing infrastructure.	-Lack plumbing: 1.4% and lack of kitchen 1103.02: 2% -Not heated/inadequate: 1103.02 @ 1%, 1101 & 1102 @ 3.6%	1103.02, 1101, 1102	County, City of Madison	**Vision 2030** -HUD Development