MADISON COUNTY MEMORIAL HOSPITAL

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

ANNUAL PROGRESS REPORT

April 2022

Madison County Memorial Hospital
Annual Progress Report 2021

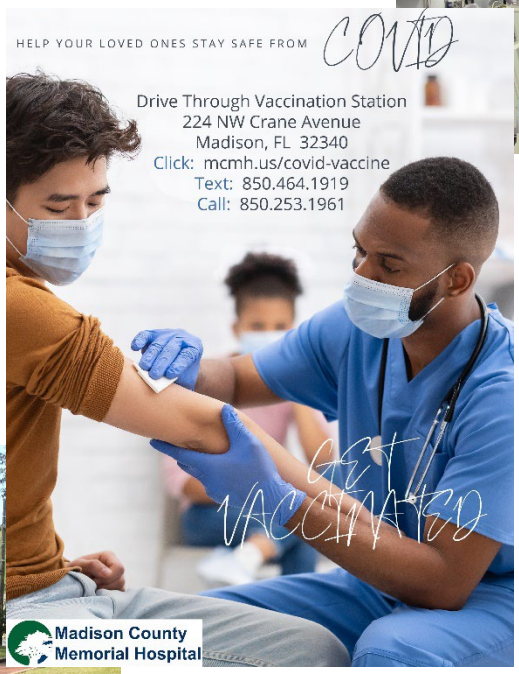
This document serves to provide a progress report on the strategies the hospital adopted to address the needs identified in the Community Health Needs Assessment process.

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.



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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 analyzed and monitored. Three committees are facilitating discussions and monitoring progress: 1) *Health Equity Advisory Council* met bi-annually; 2) Social and Mental Health Committee met quarterly; and 3) Chronic Disease Committee met quarterly. A COVID Implementation Team formed at both the Hospital and Health Department and routine engagement connects the strategies between the two entities through the Mobile Wellness Unit that was funded by HRSA for an eighteen (18) month project to develop capacity, processes, and systems for a long-term response to future pandemics.

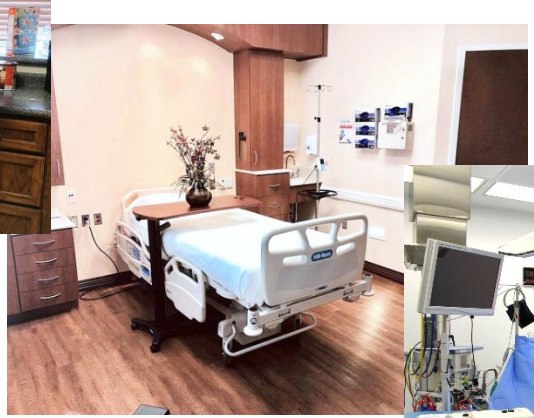
All of the documents cataloguing the activities of this collaborative and the 2021 Health Summit is available at the following link- https://www.mcmh.us/more/health-improve/ and the recording of the Health Summit is preserved online at https://youtu.be/DBckJ8xYqWE.

Updated CHNA data relevant to the priority areas are provided on the following pages and includes extracted information from CHIP committees progress documents. Progress was relayed to the community through quarterly reports, distributed through email and posted on the web. Updated data related to the priority areas was obtained from Florida Charts to address this approved action plan. Unfinished activities are integrated into the plan and/or modified to replace those that were completed in the prior CHIP plan. The 2020 CHNA and its Implementation Strategy was approved by the Hospital Board of Directors and this annual report reflects the progress and challenges in meeting its goals.

In July of 2021 the hospital received grant funding to develop a Mobile Wellness Unit to establish a long-term solution for the pandemic and to allow both the hospital and health department to try to get back to business as usual. MWU retrofitted an ambulance to be able to respond to the COVID pandemic. The long-range plan is to enhance its capabilities to be able to respond to future pandemics, facilitate emergency preparedness and provide overall wellness services to the region. COVID response 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 for 2023 now that vaccination efforts are scaling back. The status update and action plan are 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, 2023. 2. Increase access to key service that promote health equity by renovating the buildings on the southwest side of the hospital.
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. Integrate chronic disease prevention and treatment services by December 31, 2023.
	2. Provide a variety of Breast, prostate and colon cancer screenings and awareness activities at least annually by December 31, 2023.
	3. Develop sustainable COVID education, testing, and vaccination services in both English and Spanish by December 2022.
Emergency Preparedness & Crisis Management	1. Develop an Emergency Preparedness & Crisis Management Facility in the building on the southeast side of the hospital.
	2. Develop process, protocols, policies, digital and print artifacts for a comprehensive long-range plan including future pandemics.
	3. Develop tools, communication strategy, and public relations, to allow internal and external emergency preparedness communication.



Major Accomplishments

Priority	*Accomplishments*
Social Determinants of Health	1. Implementation of a Speaker's Bureau for presentations about COVID and Vaccines. Presentations to date: 1) Rotary Club; 2) Madison County Public Schools; 3) Local Apartment Complex; 4) ROTA; 5) Chamber; 6) Library; 7) Kiwanis; 8) Pediatric Event; 9) Lions; 10) MCDC; and 11) Opioid Response Coalition. 2. Expanded elective surgery capacity to promote health equity. 3. Expanded Spanish Speaking -online Forms, Fact Sheets, and other artifacts to encourage non-English speaking residents to seek healthcare and preventive services. Increased number of Spanish speaking student who received the vaccine. 4. Launched Wellness Coaches and Health Educators to conduct community and family outreach around myths and facts about the vaccine and overall wellness. 5. Developed an enhanced patient nutrition counseling and individualized meal plans. 6. New Electronic Health Record system evaluated, selected-customization in progress.
Social & Mental Health	1. Researched, developed and pilot testing mental wellness services for employees, patients, and community. 2. Continuing Research and Development to integrate key Coding and Billing requirements into the new EHR. 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. Continued participation in Social & Mental Health Advisory Council to monitor progress, refine the project plan and continue developing resources. 4. Launched mental wellness services internally for patients and staff including individual, group, and expressive art therapy. 5. Dietary tray presentation has improved with printing of color tray cards and adding spiritual versus and activities. This enhances the presentation of the tray and provides an activity for the patients that is documented in the medical record.
Chronic Disease	1. Launched new online health and wellness tools for employees, patients, providers, and community related to COVID and chronic disease. Further development is needed related to content once all the digital assets have been configured and tested. 2. Replicated health awareness campaigns: 1) Conducted breast cancer awareness and provided wellness information including vaccination information. 3. Continued monthly Chronic Disease Awareness campaign via advertising, social media, and radio. 4. Continued Chronic Disease committee work to monitoring and continue developing resources.
COVID Vaccination Implement-ation	1. Drive through Vaccination Station fully developed and tested, completed 2,972 vaccinations. 2. Mobile Wellness website in development, forms created, online scheduling launched, help desk opened, and staff trained, materials translated to Spanish. 3. The Mobile Wellness Unit conducted a total of 1,706 to the U65 population and 1,266 to O65. A total of 7,126 vaccines were provided by CVS, Department of Health, and local providers for a total of 10,098. 4. Database and reporting capabilities expanded including COVID HRSA surveys. 5. Added COVID testing capabilities and treatment capacity.

Conclusion

Considering the increase capacity needed by the Health Department and the hospital to be able to response to the COVID-19 pandemic and vaccination efforts there was a need to establish data collection and analysis capabilities within the hospital. Therefore, it created a slight change in how the data is being represented. This was necessary due to the changes in requirements for the Health Department compared to the hospital. For example, exemptions were made for the Health Department but not for the hospital and therefore they did not have to present a report. To adapt to this the hospital decided to establish a means of pulling data consistently across time using the data system developed by the Department of Health - Florida Charts, Florida Shot Records, Center for Disease Control (CDC) and the hospital Electronic Health Record (EHR). Moving forward a minimum of a three-year trend will be provided from key performance indicators. Rather than pulling data from the Community Assessment Survey (CAS) that is conducted by the Health Department, the hospital will present data from these sources. When CAS data is available this information will be included in a summary narrative.

The following appendix depict the strategies outlined in the 2021 Action Plan, the percentage of the work completed, the next steps required to reach the established goals and objectives. Completed actions have been removed from the report. This Annual Report format allows 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 aligned to the status update. The status is depicted with key bullet points, due dates, percentage complete and a green, yellow, or red 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. Baseline indicators and data trends are now presented at the end of the appendices and organized by category i.e., heart health, healthy habits, chronic disease.

- 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.

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, 2023.

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 & Next Steps (baseline & trend in appendix)
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.	12/30/23		80%	-RCORP is organized and functioning as the WAC and efforts are underway to expand efforts and recruit new members. -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 90% complete, next steps- digitize and print artifacts based on research. -New EHR functionality launched, review existing Mental Wellness ICD codes activated and identify new codes to add including TeleMental Health. -Continue to educate staff on communication and diet types. - Documented referral procedure with DOH and other mental wellness partners.
Research, develop and maintain mental health resources - print and online.	-Feasibility & interest of mental wellness Internship model launching December 2022. -Develop online resources for mental wellness. -Establish a variety of therapy internal/externally.	12/31/2023		35%	
Launch a collaborative Mental Health Education and Awareness campaign.	-Launch Mental Wellness communication and public relations campaign internally and externally. -Distribute presentation and supporting materials.	4/30/22-December 2023		65%	
Integrated screening and referral process and tools.	-Policy, screening, and referral tools available online and in facilities.	6/30/23		75%	-Integrated care team, key partners and Mobile Wellness Unit offering mental wellness education and services. -Next steps determine feasibility of finding space to provide in-class services. -Develop online resources for drug, alcohol, and smoking cessation services. -Develop online resources for Mental Wellness. - Interoperability Compliance. IT Manager and Quality Director improved interoperability compliance. Since June 2021 MCMH has met and exceeded required interoperability compliance.
National Alliance of Mental Illness (NAMI) chapter.	-Assessing ROI and interest for local 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		40%	

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, 2023.

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 & Next Steps (baseline & trend in appendix)
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.	12/31/23 12/31/23		20%	-Complete new online portal upgraded and expand content with MCMH, MWU, COVID, Wellness and partners. -MCMH collaborating with local provider-new mental wellness services partnership, next step formal process. -DISC Village collaborative grant submitted, expand Madison. -COVID hindered new engagement opportunities up to this point. With decrease in hospitalization and death, revisit opportunities to establish outside spaces for health promotion.
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.	12/31/23		60%	
Improve **mental wellness** through COVID education, screening & vaccinations.	-Expanded partners hosting MWU. -Distributed cause related campaign materials. -Vaccinate 60% of the population.	12/31/23		90%	-Conducted group and individual therapy sessions. -Conducted expressive art therapy with employees and patients. -Next steps offer opportunities in the community through organizations, businesses, schools, and churches.
Develop assessment protocols and referral processes for Health Department & Hospital Emergency Room and Inpatient Services.	-Timeline and management plan. -Develop process, protocols, and policies. -Develop MOU and/or affiliation agreements. -Acquire HRSA 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		40%	

Action Plan – GOAL: Decrease Chronic Diseases (Key Partners: MCHD, MCMH, AHEC, Barnes)

Objective: Integrated chronic disease prevention and treatment services by December 31, 2023.

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 & Next Steps (baseline & trend in appendix)
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.	04/19/23		80%	-In person events still restricted due to COVID, developing digitized resources, next step relaunch post-COVID model by end of 2022. -Develop communication and outreach plan for promoting healthy living habits. -Develop communication and outreach for promoting health heart habits. -MWU & marketing collaborate to test annual Francis Walk-a-thon. -Currently in mid-year of grants and quality project regarding the evaluation of SwingBed project. Continue to monitor and report financial measures. - Participating in voluntary quality clinical measures for MBQIP and HQIC. Continue to participate in QI measures.
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.	07/31/23 11/12/23		20%	
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.	12/30/23		67%	-Classroom materials and teacher ready for launch with Barnes and AHEC partnership. Assess feasibility in current hospital buildings or postpone till additional facilities are renovated. -Identify guest speaking opportunities and collaboration between MWU and marketing to implement. - HCAHPS Ambassador team active setting goals to improve the patient experience and improve patient survey return rate. Goals are to improve communication with new medication and side effects. -Establish team(s) to focus on action items to improve communication, preferences and needs response.
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. -Submitted Mobile Wellness Unit for Nursing grant. -Thank Your Lucky Stars in November.	12/31/23		67%	

Action Plan – GOAL: Decrease Chronic Diseases (Key Partners: MCHD, MCMH, AHEC, Barnes)

Objective: Breast, prostate and colon cancer screenings, and awareness at least annually by December 31, 2023.

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

Short-Term Objectives	Action Steps	Date	Status	Current	Status & Next Steps (baseline & trend in
Enhance tobacco cessation referral process.	-Big Bend AHEC to discuss and revise procedure. -Update Discharge Planning Process and Tools. -Increase marketing & Public Relations.	12/30/23	🟡	45%	-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. -Next steps identify new hosting opportunities and expand outreach. - Continue to educate staff on diet types and patient communication i.e., Nutrition/meds. - Partner with a mobile cancer screening unit and/or coordinate with DOH to utilize hospital services and MWU for cancer screening.
Improve health outcomes by ensuring awareness of services and key health and wellness practices through community health education and awareness presentations to patients, 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.	12/31/23 03/16/23	🟡	45%	
Integrate Strategic Partnerships for cancer screening, awareness, education, and healthcare access.	-Enhanced Breast Cancer Awareness Event added Women's Health issues and mental wellness. -Replicate BCA to launch other cancer awareness events, screenings, and services. -Expand FSU College of Medicine partnership. -Increase marketing & Public Relations.	10/01/23	🟡	45%	-Due to COVID new awareness and screening events were delayed. -Next step, initiate collaborative network and explore opportunities in 2022-2023. -Develop and integrate a community outreach plan for health promotion.

* 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, MCDC)

Objective: Breast, prostate and colon cancer screenings, and awareness at least annually by December 31, 2023.

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 & Next Steps (baseline & trend in appendix)
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. -Confirm COVID test, vaccine, treatment benefits w/policies.	12/31/23		40%	-Implemented surgical affiliation agreements, surgery currently conducted several times per month. -Finalizing partnerships with Orthopedics. -Work with AHEC to establish MWU opportunities with Navigators.
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 internships and affiliation enhancement. -Expand health care service with addition specialties through partnerships and affiliation agreements. -Increase branding and awareness of screening prevention, and treatment services to 60-mile radius.	12/31/23		50%	-One new primary care doctor engaged with the hospital. -Develop and produce Physician Recruitment Brochure and target region for potential candidates. -Launch regional campaign for potential rotating specialist. -Renovate the building on the southeast side of the hospital campus. -Renovate the building on the southwest side of the hospital campus. -Negotiate rotating specialist contracts. -Develop nutrition education resources online. -New menus showing the healthier items – collaboration NFC and DOH and MCMH dietary.
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 in development. -Farmers Market potential with Chamber, TDC, and Downtown Development. -Submit Department of Agriculture grant.	12/31/23		38%	

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

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, 2023.					
Strategy: Guest speaking at community events, action teams, and advisory councils.					
Short-Term Objectives	**Action Steps**	**Date**	**Status**	**Current**	**Status & Next Steps (baseline & trend in appendix)**
Develop/implement Social Determinants of	-Reorganize the Maternal and Child Health action team to establish the	12/31/23		67%	-Identify timeline and connect MWU and marketing to the SDOH committee.
Incorporate health equity into community presentations.	-Prior to educating the community on chronic diseases and mental health, incorporate health equity into the	12/31/23		50%	-Develop health promotion presentation with SDOH information included. -Identify speakers bureau. -Developed and launched enhanced nutrition counseling for patients.
COVID Vaccine Implementation	-Ensure health equity for all residents.	06/30/23 12/31/23		75%	-Conducted Vaccination Clinic at three schools. -Provided health education and COVID myth busters at local apartment complex. -Developed Spanish version of flyers, posters and online registration forms, next step expands community educator outreach apartments, churches, festivals, etc. - Vaccination Station narrowed down and Mobile Wellness Unit fully operational, sustainability practices in development. -Update internship model and promote to surrounding counties.

(Following aligns 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. Information is provided solely for the purpose of understanding SDOH. Most current data available is from 2030)

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, MCDC, MCCC	**Vision 2030**
Reduce **poverty** and increase **employment** capacity by improving soft skills/workforce capabilities through **education/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/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

Madison County Memorial Hospital

Social Determinants of Health

Florida HEALTH Madison County

Individuals Under 18 Below Poverty Level, Percentage of Population Under 18, Single Year		
	Madison	Florida
Data Year	Percent (%)	Percent (%)
2019	44.4	20.1
2018	43.3	21.3
2017	51.4	22.3
2016	38.1	23.3
2015	33.3	24.1

Families Below Poverty Level, Percentage of Families, Single Year		
Data Year	Madison Percent (%)	Florida Percent (%)
2019	20.7	10.0
2018	21.8	10.6
2017	24.7	11.1
2016	23.5	11.7
2015	20.5	12.0

Unemployment Rate, Percentage of Labor Force, Single Year		
	Madison	Florida
Data Year	Percent (%)	Percent (%)
2020	6.0	7.7
2019	4.0	3.3
2018	3.9	3.6
2017	4.4	4.2
2016	5.2	4.8

Population Living Within ½ Mile of a Healthy Food Source, Percentage of Population, Single Year		
	Madison	Florida
Data Year	Percent (%)	Percent (%)
2019	2.3	27.7
2016	1.5	27.9

Population Uninsured Under Age 65 (Census), Single Year		
	Madison	Florida
Data Year	Count	Count
2019	2,076	2,586,534
2018	2,157	2,692,935
2017	2,305	2,929,460
2016	2,808	3,158,355
2015	3,211	3,421,765

Food insecurity rate, Percentage of Population, Single Year		
	Madison	Florida
Data Year	Percent (%)	Percent (%)
2019	11.5	12.0
2018	18.5	13.0
017	22.2	13.4

The **Social Determinants of Health (SDOH) indicators** in Madison are continuing to climb. Individuals under eighteen living in poverty 44.4% in Madison is more than twice the state at 20.1%. Likewise, families living in poverty in Madison is 20.7 compared to the state at 10%. Unemployment rose from 4 to 6% in 2020. Almost 12% of the population under sixty-five is uninsured and 11.5% living with a food insecurity.

Madison County Memorial Hospital

Social & Interpersonal Relations

Florida HEALTH Madison County

Tobacco-related Cancer Deaths, Rate Per 100,000 Population, Single Year								
	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	30	19,254	155.8*	55.7	19,656	21,640,766	90.8	1.3
2019	14	19,533	71.7	37.5	19,698	21,268,553	92.6	1.3
2018	20	19,420	103.0	45.1	19,816	20,957,705	94.6	1.3

Alcohol Confirmed Motor Vehicle Traffic Crash Fatalities, Rate Per 100,000 3-Year								
	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	
2018-20	4	58,207	6.9		1,134	63,867,024	1.8	
2017-19	4	58,248	6.9		1,124	62,781,986	1.8	
2016-18	2	57,967	3.5		1,212	61,744,525	2.0	

Deaths from Alcoholic Liver Disease, Rate Per 100,000 Population, 3-Year Rolling Crude								
	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2018-20	6	58,207	10.3	8.2	5,685	63,867,024	8.9	0.2
2017-19	5	58,248	8.6	7.5	5,176	62,781,991	8.2	0.2
2016-18	2	57,967	3.5		5,201	61,744,530	8.4	0.2

Adults who are current smokers, overall		
Year	Madison	Florida
2019	16.9% (13.4% - 20.3%)	14.8% (13.7% - 15.9%)
2016	16.2% (12.1% - 20.3%)	15.5% (14.7% - 16.2%)
2013	19.7% (13% - 26.4%)	16.8% (15.9% - 17.7%)

Tobacco-related Cancer Deaths, Rate Per 100,000 Population, 3-Year Rolling								
	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2018-20	64	58,207	110.0	26.9	59,170	63,867,024	92.6	0.7
2017-19	47	58,248	80.7	23.1	59,330	62,781,986	94.5	0.8
2016-18	53	57,967	91.4	24.6	59,300	61,744,525	96.0	0.8

Chronic Liver Disease and Cirrhosis Deaths, Rate Per 100,000 Population, 3-Year Rolling								
	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2018-20	12	58,207	20.6	11.7	10,266	63,867,024	16.1	0.3
2017-19	9	58,248	15.5	10.1	9,608	62,781,991	15.3	0.3
2016-18	6	57,967	10.4	8.3	9,647	61,744,530	15.6	0.3

Social & Interpersonal Relations Indicators in Madison are exceeding those of the state. Tobacco-related cancer death rates in Madison 155.8 compared to Florida at 90.8 almost doubled from 2019 (71.7) to 2020 (155.8).

The percentage of adults who are **current smokers** 16.9% a slight increase from 2019 compared to the state at 14.8%. Further, **alcohol confirmed** motor vehicle crash fatalities has remained consistent since 2017 and five times that of the state - Madison 6.9 and Florida 1.8. Alcohol XXX

Madison County Memorial Hospital

COVID

Total Population Count	At Least One Dose	Fully Vaccinated
Total Population Count	10,098	8,489
% Of Total Population all ages	54.60%	45.90%
Population ≥ 5 Years of Age Count	10,098	8,489
% Of Population ≥ 5 Years of Age	57.30%	48.20%
Population ≥ 12 Years of Age Count	9,959	8,395
% Of Population ≥ 12 Years of Age	61.20%	51.60%
Population ≥ 18 Years of Age Count	9,464	7,982
% Of Population ≥ 18 Years of Age	62.70%	52.90%
Population ≥ 65 Years of Age Count	3,358	3,069
% Of Population ≥ 65 Years of Age	86.10%	78.70%

*Vaccinations in Madison County, Florida as reported by CDC, Date Ascertained 3/28/2022

Deaths from COVID-19, Rate Per 100,000 Population, Single Year

	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	34	19,254	176.6*	59.3	19,157	21,640,766	88.5	1.3

Deaths from COVID-19, Rate Per 100,000 Population, Single Year by Race & Gender

	Madison								Florida							
	White				Black				White				Black			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	18	11,452	157.2	72.6	16	7,290	219.5*	107.4	15,034	16,713,931	89.9	1.4	3,515	3,671,185	95.7	3.2
	Male				Female				Male				Female			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	17	10,228	166.2	78.9	17	9,026	188.3*	89.4	10,938	10,576,322	103.4	1.9	8,219	11,064,444	74.3	1.

*Florida Charts Madison and Florida Comparison Date Ascertained 3/28/2022

Vaccination Station and Mobile Wellness Unit COVID Activity

Row Labels	Count of Patient ID	Percentage
AMERICAN INDIAN/ALASKAN	11	0.4%
ASIAN INDIAN	2	0.1%
BLACK/AFRICAN AMERICAN	722	24.3%
FILIPINO	2	0.1%
HAWAIIAN	3	0.1%
OTHER ASIAN	5	0.2%
OTHER NONWHITE	210	7.1%
OTHER PACIFIC ISLANDER	10	0.3%
UNKNOWN	231	7.8%
WHITE	1778	59.8%
Grand Total	**2974**	

Row Labels	Count of Patient ID	Percentage
FEMALE	1736	58.4%
MALE	1236	41.6%
Grand Total	**2972**	

Doses	Count of Patient ID	Percentage
1	1373	46.2%
2	1247	42.0%
3	335	11.3%
4	12	0.4%
Grand Total	**2972**	

*Florida Shots, MCMH Vaccination Performance Indicators 4/4/22

COVID death rate 176.6 in Madison is more than twice that of the state at 88.5. Of those deaths the African American population 219.5 compared to white at 157.2. Female 188.3 were slightly higher than males at 166.2 in Madison whereas in Florida the male death rates were higher than female.

According to the Center for Disease Control (CDC), as of March 28, 2022, Madison's total population fully vaccinated was 45.9% and those with at least one dose 54.6%. The sixty-five and older population as the best rate with 86.1% with one dose and 78.7% fully vaccinated. Only 37.9% of the total population is vaccinated with a booster with 58.9% in the over sixty-five (O65) population.

ıent Plan (CHIP)

Madison County Memorial Hospital

Mental Wellness

Florida HEALTH Madison County

Hospitalizations for mood and depressive disorders, Rate Per 100,000 Population, Single Year

	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	72	19,254	373.9	86.2	93,121	21,640,766	430.3	2.8
2019	60	19,533	307.2*	77.6	101,899	21,268,553	479.1	2.9
2018	56	19,420	288.4*	75.4	101,218	20,957,705	483.0	3.0
2017	51	19,295	264.3*	72.4	97,983	20,555,728	476.7	3.0
2016	60	19,252	311.7*	78.7	97,313	20,231,092	481.0	3.0

Hospitalizations for mental disorders, Rate Per 100,000 Population, Single Year

	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	176	19,254	914.1	134.4	200,907	21,640,766	928.4	4.0
2019	141	19,533	721.9*	118.7	213,969	21,268,553	1,006.0	4.2
2018	156	19,420	803.3*	125.6	210,058	20,957,705	1,002.3	4.3
2017	135	19,295	699.7*	117.6	206,707	20,555,728	1,005.6	4.3
2016	142	19,252	737.6*	120.9	204,463	20,231,092	1,010.6	4.4

Suicide Deaths, Rate Per 100,000 Population, 3-Year Rolling

	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2018-20	10	58,207	17.2	10.6	10,092	63,867,024	15.8	0.3
2017-19	10	58,248	17.2	10.6	10,166	62,781,991	16.2	0.3
2016-18	4	57,967	6.9		9,861	61,744,530	16.0	0.3
2015-17	6	57,747	10.4	8.3	9,461	60,684,587	15.6	0.3
2014-16	5	57,717	8.7	7.6	9,235	59,708,725	15.5	0.3

Emergency room visits for mental disorders, except drug and alcohol-induced mental disorders, Rate Per 100,000 Population, 3-Year Rolling

	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2018-20	366	58,207	628.8	64.2	376,949	63,867,024	590.2	1.9
2017-19	373	58,248	640.4	64.8	392,718	62,781,986	625.5	2.0
2016-18	358	57,967	617.6	63.8	388,401	61,744,525	629.0	2.0
2015-17	351	57,747	607.8	63.4	389,880	60,684,582	642.5	2.0
2014-16	342	57,717	592.5	62.6	384,903	59,708,725	644.6	2.0

Total Domestic Violence Offenses, Rate Per 100,000 Population, Single Year

	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	119	19,254	618.1*	110.7	106,515	21,640,766	492.2	2.9
2019	114	19,533	583.6	106.8	105,298	21,268,553	495.1	3.0
2018	98	19,420	504.6	99.7	104,914	20,957,705	500.6	3.0
2017	179	19,295	927.7*	135.3	106,979	20,555,728	520.4	3.1
2016	147	19,252	763.6*	123.0	105,640	20,231,092	522.2	3.1

Mental Wellness in Madison has been steady declining since 2016 - mood and depressive disorders and hospitalization for mental disorders - 176 admissions. Suicide death rates have remained steady since 2017 and higher than the state. Emergency room visits for mental health, drug and alcohol has been steady increasing since 2014 nearing 400 admissions at a rate of 628.8 compared to the state rate of 590.2. Domestic violence also on the rise.

Madison County Memorial Hospital

Chronic Diseases-Heart

Florida HEALTH Madison County

Hospitalizations from Congestive Heart Failure, Rate Per 100,000 Population, Single Year

	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	342	19,254	1,776.3	186.6	382,249	21,640,766	1,766.3	5.5
2019	383	19,533	1,960.8	194.4	401,153	21,268,553	1,886.1	5.8
2018	377	19,420	1,941.3	194.1	375,660	20,957,705	1,792.5	5.7
2017	337	19,295	1,746.6	184.8	353,154	20,555,728	1,718.0	5.6
2016	305	19,252	1,584.3	176.4	327,131	20,231,092	1,617.0	5.5

Deaths from Acute Myocardial Infarction (Heart Attack), Rate Per 100,000 Population, Single Year

	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	8	19,254	41.5	28.8	7,500	21,640,766	34.7	0.8
2019	11	19,533	56.3	33.3	6,874	21,268,553	32.3	0.8
2018	10	19,420	51.5	31.9	7,204	20,957,705	34.4	0.8
2017	3	19,295	15.5		7,268	20,555,733	35.4	0.8
2016	8	19,252	41.6	28.8	7,311	20,231,092	36.1	0.8

Deaths from Heart Diseases, Rate Per 100,000 Population, Single Year

	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	55	19,254	285.7	75.4	49,208	21,640,766	227.4	2.0
2019	62	19,533	317.4*	78.9	47,044	21,268,553	221.2	2.0
2018	65	19,420	334.7*	81.2	46,929	20,957,705	223.9	2.0
2017	40	19,295	207.3	64.2	46,159	20,555,733	224.6	2.0
2016	57	19,252	296.1	76.7	45,625	20,231,092	225.5	2.1

Deaths from Hypertension, Rate Per 100,000 Population, Single Year

	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	6	19,254	31.2	24.9	3,185	21,640,766	14.7	0.5
2019	10	19,533	51.2*	31.7	2,737	21,268,553	12.9	0.5
2018	6	19,420	30.9	24.7	2,773	20,957,705	13.2	0.5
2017	8	19,295	41.5*	28.7	2,618	20,555,733	12.7	0.5
2016	1	19,252	5.2		2,454	20,231,092	12.1	0.5

Although Madison still exceeds the state in most heart health indicators, **Heart Health** in Madison has seen slight improvements with the addition of Mobile Wellness and heart health education through partnerships with the Chronic Disease Coalition. Hospitalizations and deaths from CHF, Heart Attacks, Hypertension, and heart disease all seeing slight decreases in counts and rates. The area in need of most attention is the serious heart diseases that result in death. Likewise, as indicated in the chart of the following page there is a need to increase activities with the African American population which at a rate of 2,139.9 for blacks compared to 1,501.9 for whites.

Madison County Memorial Hospital

Chronic Diseases-Heart Continued & Diabetes

Hospitalizations from Congestive Heart Failure, Rate Per 100,000 Population, Single Year

	Madison								Florida							
	White				Black				White				Black			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	172	11,452	1,501.9	222.8	156	7,290	2,139.9	332.2	286,903	16,713,931	1,716.6	6.2	69,974	3,671,185	1,906.0	14.0
2019	233	11,630	2,003.4	254.7	146	7,384	1,977.2	317.5	304,676	16,439,624	1,853.3	6.5	71,641	3,603,599	1,988.0	14.4
2018	234	11,525	2,030.4*	257.5	137	7,390	1,853.9	307.5	285,957	16,219,736	1,763.0	6.4	67,776	3,549,464	1,909.5	14.2
2017	210	11,361	1,848.4	247.7	124	7,449	1,664.7	290.6	271,181	15,944,707	1,700.8	6.3	62,931	3,470,100	1,813.5	14.0
2016	194	11,306	1,715.9	239.4	99	7,487	1,322.3*	258.7	253,051	15,722,428	1,609.5	6.2	57,274	3,408,734	1,680.2	13.6

Hospitalizations From or With Diabetes, Rate Per 100,000 Population, Single Year

	Madison								Florida							
	White				Black				White				Black			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	267	11,452	2,331.5*	276.4	235	7,290	3,223.6*	405.5	454,415	16,713,931	2,718.8	7.8	135,113	3,671,185	3,680.4	19.3
2019	349	11,630	3,000.9	310.1	235	7,384	3,182.6*	400.4	482,854	16,439,624	2,937.1	8.2	137,354	3,603,599	3,811.6	19.8
2018	353	11,525	3,062.9	314.6	256	7,390	3,464.1	416.9	471,270	16,219,736	2,905.5	8.2	133,977	3,549,464	3,774.6	19.8
2017	325	11,361	2,860.7	306.5	196	7,449	2,631.2*	363.5	468,807	15,944,707	2,940.2	8.3	132,055	3,470,100	3,805.5	20.1
2016	278	11,306	2,458.9*	285.5	230	7,487	3,072.0*	390.9	459,431	15,722,428	2,922.1	8.3	128,038	3,408,734	3,756.2	20.2

Adults who are obese, overall

Year	Madison	Florida
2019	44.5% (39.1% - 49.8%)	27% (25.6% - 28.5%)
2016	35.4% (30.1% - 40.8%)	27.4% (26.4% - 28.5%)
2013	33.4% (25.9% - 40.9%)	26.4% (25.3% - 27.4%)

Adults who are inactive or insufficiently active, overall

Year	Madison	Florida
2016	57.8% (51.9% - 63.6%)	56.7% (55.5% - 58%)
2013	57.9% (49.3% - 66.5%)	52.9% (51.6% - 54.3%)

Adults who have ever been told they had diabetes, overall

Year	Madison	Florida
2019	13.7% (10.8% - 16.6%)	11.7% (10.8% - 12.6%)
2016	20.4% (16.5% - 24.3%)	11.8% (11.1% - 12.4%)
2013	17.2% (12.5% - 22%)	11.2% (10.5% - 11.9%)

Madison has seen a slight improvement with Diabetes. Before the COVID outbreak the Chronic Disease committee launched strategies and activities to address Diabetes. Restrictions on visitation resulted in postponing in person and supplementing with virtual solutions. And although there has been a slight decrease each year since 2018 at a rate of 2,331.5 it is still extremely high with a need to again focus on the African American population with a rate of 3,223.6. Additionally, obesity at 44.5% compared to the state at 27% is an underlying condition that influences heart and diabetes. Both treatment and prevention strategies should be an area of concentration for the Mobile Wellness Unit. Please see page 28 for additional performance indicators for Diabetes.

Madison County Memorial Hospital

Chronic Diseases-Diabetes

Florida HEALTH Madison County

Total Aggregate Deaths from Diabetes, Rate Per 100,000 Population, Single Year

	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	9	19,254	46.7	30.5	7,516	21,640,766	34.7	0.8
2019	9	19,533	46.1	30.1	6,158	21,268,553	29.0	0.7
2018	7	19,420	36.0	26.7	6,195	20,957,705	29.6	0.7
2017	8	19,295	41.5	28.7	6,151	20,555,733	29.9	0.7
2016	7	19,252	36.4	26.9	5,780	20,231,092	28.6	0.7

Deaths from Diabetes, Rate Per 100,000 Population, Single Year (Male/Female)

	Madison								Florida							
	Male				Female				Male				Female			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	2	10,228	19.6		7	9,026	77.6	57.4	4,440	10,576,322	42.0	1.2	3,076	11,064,444	27.8	1.0
2019	4	10,332	38.7		5	9,201	54.3	47.6	3,645	10,396,776	35.1	1.1	2,513	10,871,777	23.1	0.9
2018	5	10,302	48.5	42.5	2	9,118	21.9		3,687	10,244,293	36.0	1.2	2,508	10,713,412	23.4	0.9
2017	4	10,162	39.4		4	9,133	43.8		3,566	10,042,919	35.5	1.2	2,585	10,512,814	24.6	0.9
2016	5	10,160	49.2	43.1	2	9,092	22.0		3,367	9,887,164	34.1	1.2	2,413	10,343,928	23.3	0.9

Hospitalizations From or With Diabetes, Rate Per 100,000 Population, Single Year

	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	512	19,254	2,659.2*	227.3	648,464	21,640,766	2,996.5	7.2
2019	600	19,533	3,071.7	242.0	677,859	21,268,553	3,187.1	7.5
2018	625	19,420	3,218.3	248.2	658,129	20,957,705	3,140.3	7.5
2017	534	19,295	2,767.6*	231.5	648,827	20,555,728	3,156.4	7.6
2016	521	19,252	2,706.2*	229.2	632,161	20,231,092	3,124.7	7.6

Deaths from Diabetes, Rate Per 100,000 Population, Single Year (Race White/Black)

	Madison								Florida							
	White				Black				White				Black			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	5	11,452	43.7	38.3	4	7,290	54.9		5,643	16,713,931	33.8	0.9	1,606	3,671,185	43.7	2.1
2019	4	11,630	34.4		5	7,384	67.7	59.3	4,728	16,439,624	28.8	0.8	1,235	3,603,599	34.3	1.9
2018	5	11,525	43.4	38.0	2	7,390	27.1		4,813	16,219,736	29.7	0.8	1,203	3,549,464	33.9	1.9
2017	6	11,361	52.8	42.2	2	7,449	26.8		4,732	15,944,707	29.7	0.8	1,234	3,470,105	35.6	2.0
2016	3	11,306	26.5		4	7,487	53.4		4,495	15,722,428	28.6	0.8	1,107	3,408,734	32.5	1.9

Deaths and hospitalizations for Diabetes requires a concentrated effort. The target population for consideration is both females at a rate of 77.6 compared to males at 19.6 and blacks at a rate of 54.9 compared to whites at 43.7.

Madison County Memorial Hospital

Cancer & Causes of Death

Madison/Florida

Deaths from Breast Cancer, Rate Per 100,000 Female Population, Single Year								
	Madison				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	4	9,026	20.8		3,060	11,064,444	14.1	1.0
2019	4	9,201	20.5		3,183	10,871,777	15.0	1.0
2018	2	9,118	10.3		2,997	10,713,412	14.3	1.0
2017	2	9,133	10.4		2,985	10,512,814	14.5	1.0
2016	3	9,092	15.6		2,932	10,343,928	14.5	1.0

Female Breast Cancer Cases at Advanced Stage when Diagnosed, Percentage of Breast Cancer Incidence, Single Year								
	Madison				Florida			
Data Year	Count	Denom	Percent (%)	MOV	Count	Denom	Percent (%)	MOV
2018	6	10	60.0		5,658	17,923	31.6	0.7
2017	5		62.5		5,266	16,785	31.4	0.7
2016	2		28.6		5,445	16,721	32.6	0.7
2015	2	10	20.0		5,178	15,860	32.6	0.7
2013	3	13	23.1		5,071	15,268	33.2	0.7

Selected Causes of Death, Madison County, Florida										
		County					State			
3-Year Age-Adjusted Resident Death Rates	Data Year	County Quartile (1=most favorable, 4=least favorable)	White	Black	Hispanic	All Races	White	Black	Hispanic	All Races
Total Deaths	2018-20	4	987.5	985.5	450.2	980.8	688.1	809.7	548.9	698.4
Cancer	2018-20	3	181.1	143.9	108.9	170.4	142.6	149.0	109.1	142.5
CLRD*	2018-20	3	67.2	23.9	0.0	53.6	38.1	23.4	20.8	36.2
Cirrhosis	2018-20	3	21.2	8.3	0.0	16.8	13.5	6.2	8.7	12.1
Diabetes	2018-20	4	23.9	51.6	71.2	31.9	18.6	41.1	19.8	21.1
Motor Vehicle Crashes	2018-20	2	10.9	18.0	0.0	13.9	14.9	17.1	12.6	15.0
Stroke	2018-20	4	44.8	80.7	0.0	55.3	40.1	61.2	41.9	42.3
Pneumonia /Influenza	2018-20	2	11.8	8.8	0.0	10.5	9.1	11.1	7.5	9.3
Heart Disease	2018-20	4	234.9	200.0	0.0	219.4	142.5	172.8	117.2	145.7
HIV/AIDS	2018-20	4	0.0	14.1	0.0	5.8	1.4	10.8	1.6	2.8

The partnership between the Mobile Wellness Unit, the hospital and the health department has seen a slight improvement in breast cancer prevalence. Although deaths and advanced stage diagnosis has seen improvements it is quite a bit higher than the state with death rates in Madison at 20.8 compared to Florida at 14.1 and advanced stage diagnosis at a rate of 60 for Madison and 31.6 for Florida. Continued efforts are recommended. Diabetes, Stroke, Heart Disease and HIV are top priorities in need of attention with Cancer and Cirrhosis as secondary.