INTRODUCTION

Executive Resources, LLC (EXEC) was engaged by Regional Medical Center-Anniston (RMC) to provide the medical center with a written report relative to documentation of a Community Health Needs Assessment (CHNA), which has been mandated by the Patient Protection and Affordable Care Act (P.L. 111-148) of 201.50 (PPACA). The CHNA is one of many additional reporting requirements for all 501(c)(3) providers, mandated by the PPACA and regulated by the Internal Revenue Service (IRS). IRS Form 990 for 2010, Regional Medical Center Board, DBA Northeast Alabama Regional Medical Center's is delineated as 501(c)(3) tax-exempt status.

CHNA must be conducted by the end of the hospital's first fiscal year starting after March 23, 2012 and be completed for every facility operating as a hospital in a health system. On July 25, 2011, the IRS released Notice 2011-52 regarding the CHNA requirements of the PPACA for tax-exempt hospitals. The CHNA offers providers to engage their communities in their service area in identifying, addressing, and prioritizing community health needs. The written report relative to the documentation of a CHNA, based on the IRS guidance, is to include the following:

- Description of the community i.e. geographic area, target population served by the hospital and how it was determined;
- Description of the process and methods used by the hospital to conduct the CHNA including sources of information and collaboration with other organizations;
- Description of the process used by the hospital to take into account input from persons who represent the broad interests of the community served by the hospital;
- Delineation or persons and organizations with which the hospital consulted with relative to conducting the CHNA;
- Description of existing healthcare facilities within the community available to meet the community health needs identified in the CHNA; and
- Prioritized description of all of the community health needs identified by the CHNA.

Separate and distinct from this engagement on the written report relative to the documentation of a CHNA, an Implementation Strategy Report addressing each of the community health needs is also required. The Implementation Strategy Report must be approved by an authority or governing body of the hospital organization.

PROJECT OBJECTIVE

The objective of the engagement is provide RMC with a written report relative to documentation of a Community Health Needs Assessment (CHNA), which has been mandated by the Patient Protection and Affordable Care Act (P.L. 111-148) of 201.50 (PPACA).

RMC has undertaken this CHNA in order to set goals for the development of future health services that will meet the needs of the health system's service area population. The CHNA also considered the changing marketplace on a state and national level since there is a need to review, adapt, cease, and commence healthcare programs and services in a changing marketplace as both the population and the healthcare environment continues to evolve. The findings and results could serve as the nucleus for healthcare program and service development, for physician growth, and for revenue enhancement to the betterment of the health of the northeast Alabama service area communities as well as RMC's health system.

PROJECT SCOPE

EXEC's performance of a CHNA, which must be conducted by the end of the hospital's first fiscal year starting after March 23, 2012, will provide the foundation for RMC's submission of IRS Form 990 Schedule H and included the following scope:

- Determination of "community served by the hospital facility,"i.e. geographic area, target population, service area thereby giving RMC the flexibility to focus on communities served;
- Analysis of population and demographics of the community served;
- Analysis of healthcare providers, facilities, and resources in the community;
- Identification of data sources and data determination;
- Identification of health needs and health disparities of the community;
- Identification of primary and chronic disease health care needs of the community, including those specific to low-income and minority populations;
- Identification of areas of unmet need that can be used as the basis of the Implementation Strategy Report to be developed by RMC;
- Community involvement through an interview process (including interview development) to take into account input from persons who represent the broad interests of the community served by RMC: RMC Management, RMC Board, RMC Medical Staff/community physicians, local Anniston/Calhoun County agencies and providers, community leaders; and
- Preparation and completion of Community Health Needs Assessment report.

APPROACH & METHODOLOGY

The Community Health Needs Assessment development approach was to focus on the availability of information of which EXEC incorporated our firm's knowledge and expertise in the strategic planning arena:

- To project need in order to more appropriately target RMC health system resources regarding current and future healthcare program accessibility; and

- To assist on choosing alternatives in order to provide additional healthcare program and service access.

EXEC used a range of qualitative and quantitative approaches in conducting the Community Health Needs Assessment. Specifically, our approach included the following:

- **Key Informant Interviews:** EXEC conducted interviews with key individuals, as recommended by the RMC Management Team, which were performed at the hospital; at governmental; private, and public organizations; and in the community. The interview process was anticipated to provide an indication of the healthcare services and programs in the communities, access issues for various population segments, the apparent gaps in services, challenges posed by the resident and healthcare community and, generally, strategic areas of opportunity for the hospital. Interviews were conducted primarily, direct face-to-face and to a lesser extent, on the telephone, depending on the preference of the interviewee. A list of persons interviewed is included in Attachment A;

- **Secondary Data Analysis:** EXEC reviewed an extraordinary amount of current existing reports and data available specific to the United States; Alabama; and Calhoun, Cleburne; and Talladega Counties on the civilian, resident population and special population groups. Data sources and reports reviewed are listed in the Detailed Findings section and included, but were not limited to, population and demographic information from the U.S. Census Bureau, Claritas, Inc. (now Nielsen), and the Alabama Department of Public Health (ADPH); provider information from ADPH, Health Resources and Services Administration's (HRSA) geospatial website, and hospital/health system provider directories and websites; and utilization and healthcare indicators and statistical information from RMC, ADPH, HRSA, Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS), Countyhealthrankings.org, KidsCount and other sources;

- **Primary Data Collection of Medical Care Sector**: Primary data collection concentrated on analyzing the medical care sector, specifically the availability of physician providers, Federally Qualified Health Center (FQHC) providers, hospitals, and other providers, and estimating unmet need. Information was gleaned through existing data sources and key informant interviews, including those with a sampling of key physician providers. Consideration was also given to emerging healthcare delivery programs and services. We have delineated descriptive data relative to population and population subsets, i.e. total general population, low-income population, specific age groups, current providers contributing to medical care access in Calhoun, Cleburne; and Talladega Counties including type of organization, service site locations, and services offered; and

- **Literary Research:** EXEC conducted a literary research of medical care issues that were applicable to the project including healthcare delivery programs and services that continue to emerge. Our literary research yielded many of the reports and other documents used in the secondary data analysis.

PROJECT LIMITATIONS

The Community Health Needs Assessment (CHNA) was intended to provide RMC and service area community interested parties with a current update regarding medical care provision and accessibility in primarily Calhoun County, but in Cleburne and Talladega Counties as well, since the latter two counties are contiguous to Calhoun County. The hospital also serves residents from these counties, but to a lesser extent than Calhoun County. No consideration was given to other counties, cities and towns outside Calhoun, Cleburne, and Talladega Counties, which were not viewed as the hospital's service area and therefore, not within the scope of the project. Further analyses relative to broadening the scope to include healthcare services in other Alabama counties, cities, and towns, i.e. Randolph County may be warranted for future study to further quantifying healthcare need and gaps.

The analysis, findings, and conclusions in this report are based solely on the application of various quantitative and qualitative analytical techniques and methodologies accepted in the healthcare industry and EXEC's independent professional judgment as a duly qualified healthcare consulting firm, generally, to the facts and assumptions gathered from independent sources and based upon EXEC's professional experience. We assume that the facts, as stated, are correct and that no material facts have been omitted. In light of the changing national, state, and local landscape relative to healthcare program policy development, funding, etc. and if some of the facts that we have assumed are incorrect or there are other material facts not disclosed to

EXEC during the course of the project, the analysis and conclusions herein may be affected and may require revision.

DETAILED FINDINGS

A. Description of Community Served by a Hospital

IRS Notice 2011-52 addresses the CHNA requirements described in section 501(r)(3) of the Internal Revenue Code (Code) and related excise tax and reporting obligations, applicable to hospital organizations that are (or seek to be) recognized as described in section 501(c)(3) of the Code. The CHNA requirements are among several new requirements that apply to section 501(c)(3) hospital organizations under section 501(r), which was added to the Code by section 9007(a) of the PPACA, Pub. L. No. 111-148, 124 Stat. 119, enacted March 23, 2010.

Section 501(r)(3)(A) provides that a hospital organization meets the CHNA requirements with respect to any taxable year only if the organization (i) has conducted a CHNA that meets the requirements of section 501(r)(3)(B) in such taxable year or in either of the two taxable years immediately preceding such taxable year, and (ii) has adopted an implementation strategy to meet the community health needs identified through such CHNA. Section 501(r)(3)(B) requires that a CHNA (i) take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and (ii) be made widely available to the public. Although most of the requirements under section 501(r) are effective for taxable years beginning after March 23, 2010, the CHNA requirements are effective for taxable years beginning after March 23, 2012.

Based on IRS Notice 2011-52, "For purposes of section 501(r)(3), Treasury and the IRS intend to provide that a hospital organization may take into account all of the relevant facts and circumstances in defining the community a hospital facility serves. Generally, Treasury and the IRS expect that a hospital facility's community will be defined by geographic location (*e.g.*, a particular city, county, or metropolitan region)."

RMC's community is the medical center's geographic area referred to as the service area in which the majority of its patients reside among factors. RMC, through the medical center's strategic planning process, reviews its service area periodically as follows:

- To ensure that the size of the service area is such that the services to be provided through the medical center are available and accessible to the residents of the service area promptly and as appropriate;

- To ensure that the boundaries of the service area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs; and

- To ensure that the boundaries of the service area eliminate, to the extent possible, barriers to access to the services of the medical center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation.

RMC periodically assess its service area to ensure that the service area description adequately reflects the medical center's current activities in providing programs and services to the community. Patient origin analyses are routinely performed of inpatient services and outpatient services (for example, delineating zip codes of inpatient patient discharge records on file and outpatient emergency department visit records on file), which help to ensure that the reported service area is accurate and help to determine updated service area boundaries by indicating the areas from which the health center draws the majority of its patients.

Patient origin analyses (zip codes of inpatient patient discharge records) are reported relative to the Centers for Medicare & Medicaid Services' (CMS) Medicare hospital cost report, Form 2552-10, subsequently captured by the American Hospital Directory ***(Source: American Hospital Directory/AHD***). Subsequently, annual AHD reporting is the basis of patient origin analyses that are routinely performed, to ensure that the determined service area is accurate.

While RMC may be called upon to serve patients from outside their service area, the service area includes, at a minimum, the geographic area from which the vast majority of patients reside. The service area, to the extent practicable, is identifiable by county and by U.S. Postal Service zip code and 2010 U.S. Census Bureau "places." Based on the 2010 census, Alabama has 578 places; 460 incorporated places and 118 census designated places (CDPs). The incorporated places consist of 167 cities and 293 towns. Cities have a minimum population threshold of 2,000 people and towns have between 300 and 1,999 people. A minimum population of 300 is required to incorporate in Alabama ***(Source: U.S. Census Bureau, 2010 Census).***

Describing service area by a "drilled down" methodology such as zip code and/or place, which is deployed at RMC, is typically necessary to enable analysis of service area demographics. The service area is also analyzed relative to being federally-designated by the Health Resources and Services Administration's (HRSA) Shortage Designation Branch (SDB) as a Medically Underserved Area (MUA) in full, i.e. county, or in part or contain a federally-designated Medically Underserved Population (MUP) ***(Source: HRSA Geospatial Website***).

MUAs/MUPs are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population. MUAs may be a whole county or a group of contiguous counties, a group of county or civil divisions or a group

of urban census tracts in which residents have a shortage of personal health services. MUPs may include groups of persons who face economic, cultural, or linguistic barriers to healthcare.

Therefore, RMC utilizes a combination of different methodologies in determining its service area, including patient origin studies as the base and incorporating MUA/MUP federal designation and Stark II Phase II rules in final service area determination. Stark II Phase II became effective on July 26, 2004 and the geographic area served by the hospital (geographic service area) is defined in the Phase II rule as "the area composed of the lowest number of contiguous zip codes from which the hospital draws at least 75 percent of its inpatients."

In order to determine the geographic service area, the hospital establishes a reference period such as year ending 12/31/2009. This would most likely be either the 12-month period immediately preceding the month in which the recruitment arrangement is proposed (for recruiting physicians), or the most recent 12-month period for which patient zip code data is available, i.e. AHD 2011 reporting for 12/31/2009.

For the reference period, the hospital should next determine its total inpatient population, i.e. discharges and divide that number by 75 percent. Next, the hospital should identify all zip codes in which those inpatients reside as determined from the patient origin study/discharge analysis and array the zip code areas in order of their contribution to the total inpatient population from highest (zip code contributing the most inpatients) to lowest. Using a map ***(Source: HRSA's UDS Mapper***) with a zip code overlay, the hospital can then determine the geographic array of contiguous zip codes that comprises 75 percent or more of the hospital's inpatient population and physically identify its "geographic service area."

Analyzing AHD 2011 reporting for 12/31/2009 and based on Medicare IPPS claims data (Regional Medical Center-Anniston, Medicare provider number 010078), RMC performed a patient origin study of inpatient patient discharges to ensure that the determined service area is accurate. RMC identified all zip codes in which those inpatients reside as determined from the AHD patient origin study/discharge analysis and arrayed the zip code areas in order of their contribution to the total inpatient discharge population from highest (zip code contributing the most inpatients) to the lowest based on the following figure, which has been determined to be the community (service area) served by the medical center:

Figure 1: Community Served by the Hospital

Zip Code	Place	County	Discharges	Percent	Cumulative
36201	Anniston	CA	1,116	18.8%	19%
36207	Anniston	CA	806	13.6%	32%
36203	Oxford	CA , CL, TCL	695	11.7%	44%
36264	Heflin	CL	399	6.7%	51%
36206	Saks	CA	383	6.5%	57%
36265	Jacksonville	CA	376	6.3%	64%
36277	Weaver	CA	215	3.6%	67%
36272	Piedmont	CA	169	2.8%	70%
36271	Ohatchee	CA	136	2.3%	72%
Total Service Area	Talladega	T	131	2.2%	75%
Other ZIP Codes			1,504	25.4%	
Total Discharges			5,930	100.0%	

Source: 2009 AHD, Legend: CA-Calhoun, CL-Cleburne, T-Talladega

The three counties delineated above in the Community Served by the Hospital, of which Calhoun County is the dominant county and where RMC is domiciled, are all MUA-designated by HRSA's SDB as demonstrated in Attachment B. Calhoun County's Index of Medical Underservice (IMU) score is 61.90, Cleburne County is 54.40, and Talladega County is 45.00 ***(Source: HRSA Geospatial Website***). As stated, MUAs and MUPs are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population. MUAs may be a whole county (all three counties' MUA designations) or a group of contiguous counties (Talladega and Cleburne Counties are both contiguous to Calhoun County, but the MUA designation is individual whole county designation, not contiguous counties) ***(Source: HRSA Geospatial Website***).

The community (service area) served by the medical center, which includes predominantly zip codes of Calhoun County, but inclusive of Cleburne County and Talladega County as well, albeit to a lesser extent, has been mapped to UDS Mapper, a detailed map of which is included in Attachment C along with other maps in Attachment D of this report. The combined nine-zip code community (service area) constitutes 138,167 total population ***(Source: U.S. Census Bureau, 2010 Census)***, which includes 54,819 (39.7%) low-income individuals, those having income equal to or less than 200 percent of federal poverty level.

Figure 2: Community Served by the Hospital - Population

Zip Code	Place	Total Pop	Low-Income	Percent
36201	Anniston	20,156	11,835	58.7%
36207	Anniston	19,801	5,575	28.2%
36203	Oxford	18,799	6,452	34.3%
36264	Heflin	8,659	3,845	44.4%
36206	Saks	11,427	3,896	34.1%
36265	Jacksonville	21,060	7,790	37.0%
36277	Weaver	5,420	2,036	37.6%
36271	Ohatchee	6,023	2,141	35.5%
35160	Talladega	26,822	11,246	41.9%
Total Zip Codes		138,167	54,816	39.7%

Source: UDS Mapper, UDSmapper.org, 2012

Calhoun County is bounded by Etowah and Cherokee Counties to the north, Talladega and Clay Counties to the south, Cleburne County to the east, and St. Clair County to the west. Calhoun County encompasses 608 square miles and based on the 2010 population of 118,572; the population density is 195.1 persons per square mile.

B. Description of Process and Methods Used by the Hospital to Conduct the CHNA

Based on IRS Notice 2011-52, "Treasury and the IRS intend to provide that a CHNA will satisfy the CHNA requirements with respect to a hospital facility only if it identifies and assesses the health needs of, and takes into account input from persons who represent the broad interests of, the community served by that specific hospital facility. Treasury and the IRS intend to allow a hospital organization to base a CHNA on information collected by other organizations, such as a public health agency or non-profit organization. Treasury and the IRS also intend to allow a hospital organization to conduct a CHNA in collaboration with other organizations, including related organizations, other hospital organizations, for-profit and government hospitals, and state and local agencies, such as public health departments."

In another section of this report, RMC will detail the description of the process used by the hospital to take into account input from persons who represent the broad interests of the community served by the hospital. In this section of the report, RMC will detail the description of the process and methods used by the hospital to conduct the CHNA including sources of information and collaboration with other organizations.

The purpose of conducting a CHNA is to get community "buy-in" and to improve health and to facilitate access to health, preventive, and wellness resources in the community. The process involves getting a pulse on the community relative to its population base, health indicators, health disparities, and basic well-being by analyzing quantitative and quantitative information

such as leading causes of death, illness, and disability. Relative to conducting the CHNA, sources of information, included, but were not limited to the following:

- Internal Revenue Service (IRS) Notice 2011-52;
- IRS Instructions for Schedule H (Form 990);
- Regional Medical Center-Anniston internal and external reporting information;
- U.S. Census Bureau, 2010 Census Bureau;
- American Hospital Directory – www.ahd.com;
- Health Resources and Services Administration (HRSA) Geospatial Website – www.hrsa.gov;
- HRSA Community Fact Sheets (Calhoun, Cleburne, and Talladega Counties);
- UDS Mapper - www.udsmapper.org;
- HRSA/Shortage Designation Branch (SDB);
- Alabama Department of Public Health (ADPH) Selected Health Status Indicators (Calhoun, Cleburne, and Talladega Counties);
- Local Health Departments (Calhoun, Cleburne, and Talladega Counties);
- Substance Abuse and Mental Health Services Administration (SAMSHA) – Facility Locator;
- HRSA Community Health Status Reports;
- Appalachian Region Commission;
- Centers for Disease Control – Behavioral Risk Factor Surveillance System (BRFSS) – www.cdc.gov;
- Kaiser State Health Facts;
- KidsCount;
- United Health Foundation, America's Health Rankings 2011;
- Countyhealthrankings.org; and
- HRSA – Affordable Care Act - Health Center Planning Grants, HRSA-11-021

In another section of this report, RMC will detail the description of the process used by the hospital to take into account input from persons who represent the broad interests of the community served by the hospital. In this section of the report, RMC details the description of the process and methods used by the hospital to conduct the CHNA including sources of information and collaboration with other organizations.

The CHNA process involved comparing the community, i.e. service area, which is predominantly Calhoun County, and to a lesser amount, Cleburne and Talladega Counties to each other as well as to the State of Alabama and where applicable, to the Nation relative to health indicators. Local public health agencies such as the Calhoun County Health Department may be able to ascertain reasons for rate differences and share information relative to model programs that are making a difference, either in other counties or other areas and that may provide excellent resources while concurrently working to improve the health of the residents of

the community served. If communities, i.e. counties, work collaboratively, they can derive innovative solutions for improving the overall health of the community.

The CHNA process utilized national-level data from the above-mentioned sources (U.S. Census Bureau, HRSA, CDC, SAMSHA, Kaiser), many of which contain valuable county-level data, for example, from HRSA, Community Fact Sheet and Community Health Status Report. Examining this data helps identify areas where local Calhoun County or State data can fill critical gaps or where national data can be enhanced.

The CHNA process utilized local Calhoun County and State of Alabama data as well, from the above-mentioned sources (ADPH, local health departments). Where the CHNA process shows areas in Calhoun County that need improvement, results might offer the funding justification for additional surveillance to track health status indicators. Further validation based on additional data may be needed to target specific programs and policies.

Regarding national sources in data gathering and analysis for the CHNA, HRSA and the CDC are paramount agency sources, especially relative to projects involving health needs and health disparities. HRSA is an agency within the U.S. Department of Health and Human Services (DHHS). As the Nation's "Access Agency," HRSA focuses on uninsured, underserved, and special needs populations. The HRSA Geospatial Data Warehouse provides a single point of access to current HRSA information, health resources, and demographic data for reporting on HRSA activities, which includes community health, health indicators and health disparities drilled down to county level.

The CDC is also an agency within DHHS. CDC.gov provides users with credible, reliable health Data and Statistics, as well as information on Diseases and Conditions, Emergencies and Disasters, Environmental Health, Healthy Living, Injury, Violence and Safety, Life Stages and Populations, Travelers' Health, Workplace Safety and Health and more. HRSA's and CDC's resources assist communities plan, implement and evaluate community health interventions and programs to address chronic disease and health disparities issues.

C. Population, Socioeconomic, and Demographic Profile

The health of a community is largely related to the characteristics of its residents; it has been well documented that an individual's age, sex, race, ethnicity, education, income level, as well as access to nutritious food, transportation and housing affects health status and access to healthcare. The latter is supported by a recent Robert Wood Johnson Foundation survey that found the following:

- 85% of physicians surveyed say unmet social needs are leading to worse health and say that social needs are as important to address as medical conditions;

- 76% of physicians surveyed wish that costs of connecting patients to services that would meet their social needs would be covered; and

- Only 20% of physicians feel confident or very confident in their ability to address their patients' unmet social needs.

Physicians realize the impact that these unmet social needs are critical for their patients but don't know how to help address them. The following sections will take into consideration these characteristics for Calhoun, Cleburne, and Talladega Counties.

C.1 Population Age Subgroups and Estimates

The ages of a population impacts the prevalence and severity of disease as well as program needs. Therefore, it is paramount to examine the population age composition and changes over time. Population figures were derived from the U.S Census Bureau, along with HRSA and ADPH statistics and population estimates and projections were obtained from the U.S. Census Bureau and Claritas, the latter which is included as Attachment F.

Figure 3 – Population and Population Estimates

	Calhoun	Cleburne	Talladega	Alabama
Population, 2011 estimate	117,797	14,835	81,664	4,802,740
Population, 2010 (April 1) estimates base	118,572	14,972	82,291	4,779,735
Population % change, April 1, 2010 to July 1, 2011	-0.7%	-0.9%	-0.8%	0.5%
Population, 2010	118,572	14,972	82,291	4,779,736
Persons under 5 years, percent, 2011	6.1%	6.0%	5.9%	6.3%
Persons under 18 years, percent, 2011	22.8%	23.4%	23.1%	23.5%
Persons 65 years and over, percent, 2011	14.6%	16.2%	14.4%	14.0%
Female persons, percent, 2011	51.9%	50.4%	51.4%	51.5%

Source: U.S. Census Bureau, 2010 Census

In 2010, relative to the need for children's and adolescent programs, the pediatric population of Calhoun (26.2%), Cleburne (26.4%), and Talladega Counties (26.2%) all had a similar percentage of the population that is 0 - 19 years than the State (26.7%). Relative to 2013 Claritas data, Calhoun County's and Alabama's total population are estimated at 116,800 and 4,828,123 respectively, with the County indicating a 1.5% decrease and the State indicating a 1.0% increase.

Figure 4 – Pediatric Population

	Calhoun County	Cleburne County	Talladega County	Alabama State
Total population	118,572	14,972	82,291	4,779,736
Under 5 years	7,204	938	4,941	304,957
5 to 9 years	7,521	942	5,199	308,229
10 to 14 years	7,719	997	5,645	319,655
15 to 19 years	8,607	1,080	5,747	343,471
Children 0-19	31,051	3,957	21,532	1,276,312
2010 census %	26.2%	26.4%	26.2%	26.7%

Source: U.S. Census Bureau, 2010 Census

In 2010, the working years' population of Calhoun (59.5%), Cleburne (57.5%), and Talladega Counties (59.7%) all had a similar percentage of the population that is 20-64 years than the State (59.5%) with Cleburne slightly less than the other counties.

Figure 5 – Working Years Population

	Calhoun County	Cleburne County	Talladega County	Alabama State
Total population	118,572	14,972	82,291	4,779,736
20 to 24 years	9,022	769	4,857	335,322
25 to 29 years	7,601	859	4,867	311,034
30 to 34 years	7,186	764	5,113	297,888
35 to 39 years	7,232	1,014	5,613	308,430
40 to 44 years	7,395	1,048	5,623	311,071
45 to 49 years	8,291	1,109	5,973	346,369
50 to 54 years	8,695	1,040	6,261	347,485
55 to 59 years	8,024	1,030	5,704	311,906
60 to 64 years	7,085	1,021	5,157	276,127
Working Years 20-64	70,531	8,654	49,168	2,845,632
2010 Census %	59.5%	57.8%	59.7%	59.5%

Source: U.S. Census Bureau, 2010 Census

Nationally, the biggest shift in the population over the next 15 years will be the impact of the aging the baby boomer population; the first baby boomers reached 65 years of age in 2011. In 2010, Calhoun (14.3%, Cleburne (15.8%), and Talladega (14.1%) Counties all had a higher percentage of the population that are 65 years and older than the State (13.8%), and the Nation (13.3%) with Cleburne slightly higher than the other counties.

The population is still aging quickly and, in many areas, the growth is continued to occur through 2017. The large increase in the average annual growth in the 65+ population between 2000 and 2010 compared to between 2010 and 2013 and beyond (2018) clearly demonstrates the aging.

Overall in 2010, the State was comparable to the Nation and is projected to have a similar percentage of the population over 65 in 2017 as the overall United States. Relative to 2013 Claritas data, Calhoun County's 65 and older population is estimated to increase to 15.4 percent, whereas Alabama's 65 and older population is estimated to increase to 14.8 percent.

Figure 6 – Population 65 and Older

	Calhoun County	Cleburne County	Talladega County	Alabama State
Total population	118,572	14,972	82,291	4,779,736
65 to 69 years	5,337	817	3,817	209,637
70 to 74 years	4,100	568	2,917	160,864
75 to 79 years	3,374	470	2,154	122,836
80 to 84 years	2,375	267	1,505	88,771
85 years and over	1,804	239	1,198	75,684
Elderly 65+	16,990	2,361	11,591	657,792
2010 Census %	14.3%	15.8%	14.1%	13.8%

Source: U.S. Census Bureau, 2010 Census

In 2010, relative to the need for obstetrical programs (prenatal, postpartum, and delivery), the women of childbearing years' percentage of the population of Calhoun County (20.1%) is the same as the State, whereas Cleburne (18.5%), and Talladega Counties (19.3%) both had a percentage of the population 15 - 44 years that is lower than the State (20.1%). Women of childbearing years are expected to decline into 2013 for both Calhoun County (19.9%) and for Alabama (19.8%) based on Claritas estimates.

Figure 7 – Women of Childbearing Years

	Calhoun County	Cleburne County	Talladega County	Alabama State
Total population	118,572	14,972	82,291	4,779,736
15 to 19 years	4,264	540	2,820	168,320
20 to 24 years	4,548	363	2,529	167,802
25 to 29 years	3,890	438	2,486	157,318
30 to 34 years	3,669	385	2,491	151,464
35 to 39 years	3,708	500	2,800	157,352
40 to 44 years	3,758	537	2,779	158,364
Childbearing Years 15-44	23837	2763	15905	960620
2010 Census %	20.1%	18.5%	19.3%	20.1%

Source: U.S. Census Bureau, 2010 Census

In 2010, the median age of Calhoun, Cleburne, and Talladega Counties was older than the State. Calhoun (38.2) was more comparable to the State (37.9) then both Cleburne and Talladega Counties with Cleburne's median age of 40.6 years almost 3 years greater than the State. The

male/female percentages split (approximately 52/48) of all three counties is comparable to the same percentage split of the State with males in the minority. Based on Claritas estimates for 2013, the median age for Calhoun County and for Alabama are increasing to 38.4 and 39.6 respectively.

Figure 8 – Median Age and Male/Female

	Calhoun County	Cleburne County	Talladega County	Alabama State
Total population	118,572	14,972	82,291	4,779,736
Median age (years)	38.2	40.6	39.3	37.9
Male population	57,176	7,453	40,077	2,320,188
2010 Census %	48.2%	49.8%	48.7%	48.5%
Female population	61,396	7,519	42,214	2,459,548
2010 Census %	51.8%	50.2%	51.3%	51.5%

Source: U.S. Census Bureau, 2010 Census

C.2. Population Race and Hispanic Origin

In 2010, relative to racial composition, Calhoun and Talladega Counties are more comparable to the State regarding White and Black/African American percentages. Almost three-quarters of the State (70.1%) is White, similar to Calhoun (76.2%) and Talladega (65.9%), whereas Cleburne is 94.4 percent White.

Since 1992, Alabama has experienced a dramatic increase of the Hispanic/Latino population. Alabama's rural population has greater ethnic diversity primarily due to the relatively sudden increase in the Hispanic population. Alabama's Hispanic/Latino population increased by nearly 208 percent between the 1990 and 2000 Censuses, the seventh greatest increase among all 50 states and this trend has continued into the 2010 census. There is general agreement that estimates of the Hispanic/Latino population are likely to be understated as many are undocumented and as such do not appear on any official enumerations.

The Hispanic population has been steadily increasing in the last few years and now represents 4.0% 2010) vs. 2.3% (2000) of the population ***(Source: U.S. Census Quick Facts***). This increase in Alabama's Hispanic/Latino population has posed a challenge in counties where this growth has been the greatest. The presence of a language barrier in many instances makes the services of an interpreter necessary. There is also a lack of knowledge about and experience with the cultural differences in providing healthcare to persons of Hispanic/Latino ethnicity. There have also been financial challenges in the service area where Alabama's new Hispanic/Latino population has a low rate of insurance. Alabama's Rural Hospital Flexibility Program subcontract funding has been used to greatly assist in providing care for Hispanic/Latino Alabamians by securing training in medical Spanish for RMC's emergency department staff.

Figure 9 – Race and Hispanic Origin

	Calhoun	Cleburne	Talladega	Alabama
White persons, percent, 2011	76.2%	94.4%	65.9%	70.1%
Black persons, percent, 2011	20.9%	4.0%	32.0%	26.5%
American Indian and Alaska Native persons, percent, 2011	0.5%	0.4%	0.4%	0.7%
Asian persons, percent, 2011	0.8%	0.2%	0.4%	1.2%
Native Hawaiian and Other Pacific Islander persons, percent, 2011	0.1%	0.1%	.0%	0.1%
Persons reporting two or more races, percent, 2011	1.6%	1.0%	1.3%	1.4%
Persons of Hispanic or Latino Origin, percent, 2011	3.4%	2.4%	2.1%	4.0%
White persons not Hispanic, percent, 2011	73.3%	92.2%	64.2%	66.8%

Source: U.S. Census Bureau, 2010 Census

In summary, the older age population will require more services for prevention, early identification and treatment of chronic healthcare problems. Older adults are also more likely to experience functional limitations due to changes associated with advancing age. The older adults in the lower income categories will have increasing difficulty in accessing services. Although obstetric services are still important, the women of childbearing years 15-44 is declining and specific services for women should increasingly focus on issues of women who are past childbearing ages 15-44 including cardiac, orthopedic, rehabilitation and cancer.

The use rate for hospital and physician services is customarily, substantially higher in the older population. Based on EXEC's experience in states that have a common inpatient database that can be utilized and compared, i.e. New Jersey, the use rate for the population over 65 years is almost three times that of the population 45-64 years of age. Higher use rates could indicate a sicker population or could indicate differences in delivery choices and options as well as patient and physician behavior. Downward pressures on utilization from payors and healthcare reform will decrease the magnitude of the difference in the aging population but there is still expected to be some growth as the aging becomes significant. The age related level of increase will depend, in part, on the ability of the healthcare system and community to prevent and manage acute and chronic disease in this elderly population group.

The health status in Calhoun, Cleburne, and Talladega Counties can be expected to decline as the population ages, the extent of which will be somewhat related to preventive seeking and healthy behaviors of the population throughout their life cycle as well as the ability of the healthcare system to respond to the population needs.

The diversity of the population will have a substantial impact on the overall health of the area because of known health disparities by race/ethnicity, which includes:

- Minorities are over-represented in the population without insurance and without a usual source of care (National Healthcare Disparities Report);

- Hispanics and non-Hispanic Blacks are less likely to have prenatal care;

- Hispanics are nearly twice as likely to die from complications of diabetes than are non-Hispanics;

- Black/African Americans have death rates that are higher than Whites as summarized in the figure below from the Kaiser Family Foundation, which also shows that Hispanics and Asian/Pacific Islanders have lower death rates; and

- Relative to the Overall Death Rate along with White and Black Death Rates, when comparing Alabama to the U.S., Alabama's rates are 24%, 22%, and 14% higher respectively.

Figure 10 - 2009 Deaths/100,000

	US	AL
Overall Death Rate	741.1	921.3
White	732.6	890.9
Black	922.9	1,056.5
Other	442.9	317.16

Source: Kaiser Family Foundation

C.3. Population Subgroups Poverty, Income, Employment, Costs and Education

Inequalities in income and education underlie many health disparities and, generally, population subgroups that suffer the worst health status are also those that have the highest poverty rates and the least education. Poverty is generally more common among racial and ethnic minorities, thereby adversely affecting health status by decreasing healthcare access and contributing to lifestyles and behaviors that place individuals at risk for chronic disease.

Based on Claritas estimates for 2013, Median Household Income and Average Household Income for Calhoun, Cleburne, and Talladega Counties are all lower than that for the State and significantly so relatively to both Cleburne and Talladega. Talladega is less that the State in both indicators by approximately one-third. The absolute amounts are not projected to change drastically over time.

Figure 11 - Median and Average Household Income

	2013 Med HHD Income	2013 Avg. HHD Income	2013 HHD Size
Calhoun County	$37,600	$50,743	2.45
Cleburne County	36,586	48,238	2.51
Talladega County	30,244	38,564	2.48
Alabama – Statewide	40,890	56,697	2.47

Source: Claritas

Other selective socioeconomic indicators from the Health Resources and Services Administration's (HRSA) Community Fact Sheets (Attachment G) show the difficulties that children and families in Calhoun, Cleburne, and Talladega Counties face relative to living in poverty. There are more people and, specifically, children living in poverty and in neighborhoods with a concentration of poverty, more children under 18 with no parent in the labor force and more children in single parent homes; all indicators of potentially worse access to healthcare.

Figure 12 – Selective Socioeconomic Indicators

Indicator	Calhoun County	Cleburne County	Talladega County
Family Poverty Below Poverty Level 100% 2006-2010	15.24%	11.61%	15.32%
Family Poverty Below Poverty Level 150% 2006-2010	24.82%	21.08%	27.56%
Family Poverty Below Poverty Level 200% 2006-2010	33.90%	37.00%	37.40%
Estimate Living Below USFPL All Ages 2005	18,450	2,217	14,835
Estimate Living Below USFPL Ages 0-18 2005	9,818	1,160	8,376
Uninsured 2006	13,036	2,147	8,051

Source: HRSA Community Fact Sheets

Educational issues further compound the income disparities, particularly among children. In two key indicators below (percent of population ages 16-19 who are high school dropouts and those who are not working), Calhoun, Cleburne, and Talladega Counties' children are shown to be at a disadvantage compared to the State overall. Statewide, some college is higher than it is for each of the individual counties; however, both Calhoun and Cleburne have higher percentages of high school graduation that the State.

Figure 13 - Education Indicators

Indicator	Calhoun County	Cleburne County	Talladega County	Alabama
High School Graduation	72%	86%	68%	70%
Some College	49%	38%	45%	56%
Unemployment	9.5%	8.4%	11.5%	9.5%
Inadequate Social Support	22%	25%	28%	23%
Percent of population ages 16-19 who are high school dropouts	12.5%	17.6%	12.4%	12.0%
Percent of population ages 16 to 19 who are not at school and not working	10.0%	11.8%	12.4%	10.0%

Source: KidsCount.org, Countyhealthrankings.org

D. Health Status Indicators and Population Behaviors

Individual behaviors and environmental factors are responsible for a large percentage of all preventable deaths in the U.S.; having a healthy lifestyle is crucial to maintaining good health throughout the lifecycle. A poor diet, being overweight or obese, getting little or no exercise, drinking excessive amounts of alcohol on a regular basis, and/or smoking can contribute to a multitude of health problems, which become chronic over time. These health problems can be prevented to a great extent by changes in personal behavior. For people with lower income levels, the ability to change behaviors is made more difficult by the struggle to maintain financial solvency.

The behaviors in the following figure, if reversed, would lead to improved health. In all indicators, Alabama relatively poorly compared to the US. The three counties also perform poorly with Cleburne often better than the other two and, in some cases, better than the State. Obesity has become a problem nationwide leading to many health problems and chronic disease; the US rate of 25% is too high and Alabama is even higher indicating an unhealthy community.

The lack of women receiving prenatal care and high hospitalization rate for ambulatory sensitive conditions show lack of access to primary and preventive services, either through choice, lack of insurance payment or lack of understanding how to access services. As evidenced by the chlamydia and teen pregnancy rates, teens are engaging in risky behaviors too

Figure 14 - Selected Behavioral Risk Factors
(Sources: BRFSS, CDC, Countyhealthrankings.org)

Indicator	Calhoun County	Cleburne County	Talladega County	AL	Nat'l Benchmark
Adults smoked > 100 cigarettes; currently smoking	27%	21%	25%	23%	14%
Obese: BMI greater than 30 (note: all are high)	34%	30%	37%	33%	25%
Overweight (BMI 25.0-29.9)					
Adults 20+ with no leisure time physical activity	34%	34%	35%	31%	21%
Recreational facilities per 100,000 Population	6	0	4	8	16
Adults with binge drinking in last 30 days or daily heavy drinking	13%	10%	10%	12%	8%
Medicare diabetics receiving HbA1c in past year	79%	83%	80%	82%	89%
Medicare enrollees (age 67-69) had at least 1 mammogram in past two years	61%	56%	54%	66%	74%
Women Receiving Prenatal Care (2010)	70%	82%	79%	73%	90%
Percent of live births with low birth weight (<2500 gms)	9%	8%	13%	10%	8%
Teen Birth Rate per 1,000 female ages 15-19	58	65	63	53	22
New Chlamydia Cases per 100,000 (no screening policy, similar to nationally)	543	122	533	556	84
Hospitalization rate for ambulatory sensitive conditions per 1,000 Medicare enrollees*	91	80	92	83	49
Diagnosed Diabetes. *NOTE based on estimates, another 40% of the population will not have yet been diagnosed*	14%	12%	15%	13%	8%

** Ambulatory Care Sensitive conditions include asthma, pneumonia, diabetes, and congestive heart failure whose medical management could be performed by a primary care provider, but unattended, these conditions often result in more severe episodes, leading to the use of more expensive treatment options, including emergency room visits and hospital admissions.*

Despite these indicators, and the relatively high mortality rates shown below screening indicators are similar in Alabama and the US. Exceptions are the level of diabetes, childhood asthma and the following of mammogram screening guidelines. County level data is not available for many of the indicators.

Figure 15 - Additional Selected Behavioral Risk Factors

Indicator	Calhoun County	Cleburne County	Talladega County	AL	US
Adults 65+ who had a flu shot in past year 2010 Target: 90				62.6%	61.0%
Had Colorectal Screening 5-+ past 2 years Blood Stool/sigmoid/colonoscopy				63.9%	64.2%
Told You Have Diabetes*				11.8%	9.5%
Adults ever told they have Asthma				8.8%	8.2%
Children ever told they have Asthma				18.2%	9.4%
Visited dentist in past year any reason				64.7%	69.7%
Women 67-69 mammogram in past 2 years 2010 Target: 70	61%	56%	54%	66%	77%
Women 18+ Pap Smear in past three years 2010 Target: 90				83.2%	80.9%

Sources: StateHealthFacts.org and Countyhealthrankings.org,
** This is significant because of the relatively high mortality in the County. If the relatively same proportion of people was told they have diabetes but a higher number are dying from it, then they are potentially coming in to be diagnosed and treated too late in the disease stage.*

Likely, as the result of some of the behaviors identified above, as well as other issues, the population in the three counties has worse access to primary care providers or others in the healthcare system, sees itself as sicker with less social and emotional support than the State and is above the benchmark in almost all areas, as indicated by the 90th percentile in the US.

Figure 16 - Reported Indicators in Calhoun, Cleburne and Talladega Counties

Indicator	Calhoun County	Cleburne County	Talladega County	AL	Nat'l Benchmark
Fair or Poor Health reported in Adults	23%	21%	30%	20%	10%
Physically Unhealthy Days in Adults in Last Month	5.1	5.4	5.3	4.2	2.6
Mentally Unhealthy Days in Adults in Last Month	4.9	4.8	5.2	4.1	2.3
Uninsured, Adults under 65 years	16%	18%	16%	16%	11%
Population per PCP	1,304:1	2,597:1	14,736:1	1,254:1	631:1
Adults without adequate social/emotional support	22%	25%	28%	23%	14%
% of restaurants that are Fast Food	59%	64%	52%	55%	25%

**The US Benchmark was based on the 90th percentile for the US*
Red numbers are worse than the State; Green numbers are close to the US Benchmark
Sources: BRFSS 2010, Countyhealthrankings.org; 2012

The National Women's Law Center's 2010 Healthcare Report Card shows a dramatic difference in the percentage of uninsured women across racial/ethnic groups. This likely contributes to poorer health among the uninsured groups, particularly if there is not a strong community of caring for them.

Figure 17 - Uninsured Women by Ethnicity

Race/Ethnicity	% Uninsured of Adult Women
Hispanic	34.7%
American Indian/Alaskan Native	27.4%
Black	25.6%
White	15.9%
Asian/Pacific Islander	13.6%

Intimate Partner Violence ("IPV") has been linked to long-term as well as short-term health issues. Long-term issues include neurological, gastroenterological, cardiac as well as other medical and mental issues. Up to 29 percent of women and 10 percent of men, as well as 32 percent of pregnant women experience intimate partner violence.

Children who witness the violence also have neurological, mental and physical health issues. Only a small percentage of physicians indicate that they routinely inquire about IPV; 6% of internists, 10% of family practitioners and 17% of OBGYNs. There are no specific data on IPV in these Counties against adults but the level of abuse against children is higher in the Counties compared to the State.

Figure 18 - Indicators of Abuse Among County Children

Indicator	Calhoun County	Cleburne County	Talladega County	AL
Child Abuse/Neglect Investigations per 1,000 children <18 (2011)	9.3	19.3	10.7	7.8
Investigations Substantiated	NA	NA	NA	NA

Source: Kidscount.org

Healthy behavior generally varies widely across different age groups and also across different races and ethnicities. National trends delineate that adults < age 65, males, racial and ethnic minorities, and adults in poverty are more likely to engage in unhealthy behaviors as contrasted to older adults, women, whites, and adults with higher incomes. Whatever the population subgroup, healthy behaviors are related to many complex social, biological, and environmental

factors and the BRFSS and ADPH information needs to be used to target health education programs to population subgroups.

In addition, any programs that target specific population subgroups need to be tailored to remove financial, cultural, and other barriers to access. This requires an approach that is coordinated with the other provider and non-provider members of the community.

E. Health Indicators – Incidence and Mortality

The implications of the behaviors and related health status outlined in the prior section can be further supported by Incidence and Mortality data. As shown below, the US, AL. and each of the counties have similar leading causes of death, but in slightly different orders. In Calhoun County, Influenza and Pneumonia appears in the top five and Accidents does not, unlike the others. For Cleburne County, Accidents is higher than in the other areas at #3.

Figure 19 - Top 5 Leading Causes of Death, US, Alabama and 3 Counties

Rank	US	AL	Calhoun County	Cleburne County	Talladega County
1	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease
2	Cancer	Cancer	Cancer	Cancer	Cancer
3	Chronic Lower Resp.	CLRD	CLRD	Accidents	CLRD
4	Cerebrovascular/Stroke	Stroke	Stroke	CLRD	Accidents
5	Accidents	Accidents	Inf. & Pneumonia	Stroke	Stroke

Source: County Health Profiles 2010, Montgomery, AL/December 2011 and CDC

The figure below summarizes the death rate per 100,000 population for the leading causes of death. In almost all areas, the Alabama and the three Counties have higher death rates than the US, in some cases significantly higher. The only areas where the rates in the three Counties are not higher than the US are Diabetes and HIV; the State rate is higher. In addition, Cleburne has a lower rate for Cerebral Disease/Stroke. The level of preventable teen deaths is high compared to the State in Cleburne and Talladega Counties.

Figure 20 - Mortality Data (Deaths per 100,000 Age-Adjusted Population)

Indicator	Calhoun County	Cleburne County	Talladega County	AL	US
Heart Disease	**323.3**	**420.8**	277.1	251.8	186.5
Cancer	**221.0**	193.7	207.8	212.5	175.3
Chronic Lower Respiratory Disease	**73.4**	**86.8**	69.3	59.5	44.0
Cerebral Disease/Stroke	52.3	33.4	53.5	54.4	40.7
Influenza/Pneumonia	**48.1**	26.7	**30.4**	19.6	16.2
Accidents	57.7	**93.5**	58.3	53.0	39.7
Preventable Teen Deaths (suicide, homicide, accidents) per 100,000 teens ages 15-19	34.9	92.6	104.4	54.4	NA
Diabetes	15.2	0.0	18.2	27.5	21.8
HIV	1.7	0.0	2.4	3.1	3.1
Overall	**1,168.9**	**1,162.2**	1,064.5	1,002.1	793.8

County Health Profiles 2010 Montgomery, AL / December 2011, Kidscount.org 2010

Heart disease affects every segment of the population. It is the leading cause of death among all segments of the population. It is also the leading cause of death among Whites and Blacks and the second leading cause of death among Hispanics and Asians. Many behaviors including smoking, poor diet/obesity and poor primary care and prevention can lead to heart disease, all of these are present in the area as shown previously. To reduce the mortality from heart disease, changes need to be made on all fronts of care delivery: prevention, treatment, control and rehabilitation.

Alabama and Calhoun County have higher incidences of cancer than the US. In both the State and Calhoun County it is the males with substantially higher incidences that are pushing the overall rate up since the female incidence is similar to the US.

Cleburne and Talladega Counties have lower incidences overall but in Cleburne County, the black population has a higher incidence than the US and the white population has a lower incidence; this is particularly striking for black males. In all areas black males have a higher incidence than white males and black females have a lower incidence than white females, except Cleburne County where black females are higher than white females.

The mortality rates are also higher than the US. Even in Cleburne and Talladega Counties where the incidence is lower, the mortality is higher. The higher mortality is relative to overall and by gender in Talladega and for males in Cleburne. This indicates that patients are not getting timely treatment and, possibly, not getting timely screenings where appropriate.

Figure 21 - Cancer Incidence in Alabama and US

Cancer Incidence: All Cancer	Calhoun County	Cleburne County	Talladega County	AL	US
Total Population	486.4	409.7	435.4	480.9	462.1
Males	606.9	491.6	531.8	588.4	532.6
Females	407.7	356.5	371.9	403.8	412.9
Black Males	649.7	800.0	529.6	652.4	599.2
Black Females	393.8	473.4	323.1	377.5	388.8
White Males	602.0	482.4	522.6	563.0	523.6
White Females	410.2	350.6	386.7	409.1	417.0

Source: Centers for Disease Control and Prevention, National Program of Cancer Registries, US Cancer Statistics, Alabama Cancer Facts & Figures 2011, Alabama Statewide Cancer Registry. US ethnic rate is just for Blacks

Figure 22 - Cancer Mortality in Alabama and US

Cancer Mortality: All Cancers	Calhoun County	Cleburne County	Talladega County	AL	US
Total Population	221.0	193.7	207.8	212.5	175.8
Males	255.4	254.9	242.0	239.4	215.7
Females	188.9	133.0	175.3	187.1	148.4
Blacks and Other Race	158.1	191.8	254.9	239.4	222.0
Whites	242.0	224.0	119.1	153.8	192.4

Source: Centers for Disease Control and Prevention, National Program of Cancer Registries, US Cancer Statistics, Alabama Cancer Facts & Figures 2011, Alabama Statewide Cancer Registry. US ethnic rate is just for Blacks

The Cancers where the incidence is relatively higher in the Counties and State include Lung/Bronchus and Colorectal for males. Overall, mortality for Colorectal Cancer is similar to the State and US. For Breast Cancer, in all areas, and Lung and Prostate Cancer in Cleburne County, as summarized below, the incidence is similar to or is lower than the US but the mortality is higher. Non-Hodgkin Lymphona mortality is elevated in Calhoun County

Figure 23 - Selected Cancer Incidence and Mortality per 100,000 Population (Age Adjusted) 2006-2008

Indicator	Calhoun County	Cleburne County	Talladega County	AL	US (SEER)
Breast Cancer Incidence	113.2	87.4	108.8	117.3	124.3
Breast Cancer Mortality	**30.7**	**33.4**	**30.2**	28.4	23.0
Lung and Bronchus Incidence	96.6	64.1	76.1	76.1	62.6
Lung Cancer Mortality	90.6	**74.9**	72.8	67.1	50.6
Colorectal Incidence Male/Female	68.7/54.3	66.4/54.0	61.2/48.9	60.5/49.8	54.0/40.2
Colorectal Mortality	22.5	27.7	21.6	19.7	20.2/14.1
Bladder Mortality	6.8	4.2	5.4	4.1	4.4
Prostate Incidence	139.0	107.4	135.8	155.8	154.8
Prostate Mortality	18.5	**30.4**	15.3	23.4	23.6
Pancreas Mortality	12.7	9.7	9.2	11.8	10.8
Non-Hodgkin Lymphoma Mortality	**9.5**	1.4	4.6	7.0	6.6
Kidney and Renal Mortality	4.7	4.2	5.0	4.3	4.0

Sources: SEER 2005-2009, Alabama Cancer Facts & Figures (Incidence) 2011, Alabama DOH (Mortality)2009, Selected Health Status Indicator By The Office of Primary Care and Rural Health, Alabama DOH and the Alabama Rural Health Association

The State appears to have similar behavior to the US in following the guidelines for screening for Colorectal Cancer, as shown below which would explain the similar mortality despite the higher incidence. County data is not available.

Figure 24 - Colorectal Cancer Screening, Adults 50+

Screening	AL	US
Sigmoidoscopy/Colonoscopy	63.9%	65.3%
Fecal Occult Blood Test in Past 2 Years	16.7%	17.3%

Source: Alabama Cancer Facts & Figures 2011, Alabama Statewide Cancer Registry

Derived from the Health Status and Health Indicators sections, the following, while not necessarily all-inclusive, demonstrates ***selective*** goal areas to be considered in a healthcare plan specific to

RMC's service area constituting Calhoun, Cleburne, and Talladega Counties with specific relevance to chronic diseases:

- **HEART DISEASE - Problem/Need**: The age adjusted death rate from heart disease is higher in Calhoun, Cleburne, and Talladega Counties than the State and the US. The State rate is higher than the US. The Counties' and State rates are higher than the Healthy People 2010 target rate of 166.0/100.000 population. The Counties' White rates are higher than Black rates. Hypertension, smoking, high blood cholesterol levels and obesity are all risk factors in chronic heart disease. Based on United Health Foundation, America's Health Rankings 2011, over 1.2 million people in Alabama are obese, 410,000 more than 10 years ago. Most of the behaviors of the area population show elevated levels for all risk factors, including limited physical activity. Diet and lifestyle interventions should be the treatment focus.

- **CANCER - Problem/Need**: The age adjusted death rate from cancer (all cancers) is higher in Calhoun, Cleburne, and Talladega Counties than the State and the US. The State rate is higher than the US. Calhoun and Talladega Counties' White rates are higher than Black rates and the reverse situation exists in Cleburne County. In addition to community education services regarding lifestyle changes that impact on chronic and preventable diseases, programs must be developed that bring patients in to get screened and educated on health awareness so that they don't die at a relatively higher rate from these diseases.

- **DIABETES - Problem/Need:** The age adjusted death rate from diabetes is less in Calhoun, Cleburne, and Talladega Counties than the State and the US. The State rate is higher than the US and based on United Health Foundation, America's Health Rankings 2011, the prevalence of Diabetes in Alabama has doubled in the last 10 years with 481,000 affected. The White and Black rates are comparable in Calhoun and Talladega, with White slightly higher. There is no detailed reporting for Cleburne. However, even though the diabetes incidence, as measured by diagnosed diabetics was less in the three Counties to the State and US, the situation still may exist that people may not get appropriate treatment and education in a timely manner. It was indicated during the key informant surveys that diabetic treatment is adequate.

- **CEREBROVASCULAR DISEASE - Problem/Need:** The age adjusted death rate from cerebrovascular disease is higher in Calhoun, Cleburne, and Talladega Counties than the State and the US. The State rate is higher than the US. The White and Black stroke rates are comparable in Calhoun and Talladega, with White higher in Talladega and Black slightly higher in Calhoun. There is no detailed reporting for Cleburne. Lifecycle changes such as improving blood cholesterol levels, eating a heart-healthy diet, etc. through community education services will have a profound impact on chronic and preventable diseases such as cerebrovascular disease.

- **CHRONIC LOWER RESPIRATORY DISEASE - Problem/Need:** The age adjusted death rate from cancer (all cancers) is higher in Calhoun, Cleburne, and Talladega Counties than the State and the US. The State rate is higher than the US. The White rates are significant higher than Black rates when comparing Calhoun to Talladega. There is no detailed reporting for Cleburne. Relative to Chronic Obstructive Pulmonary Disease (COPD), smoking cessation remains the most effective, and cost-effective way to reduce the risk of COPD and to stop its progression. Pulmonary rehabilitation can reduce symptoms, improve quality of life, and increase physical and emotional participation in everyday activities.

- **CHANGES IN NEGATIVE LIFESTYLE BEHAVIORS: SMOKING CESSATION AND VIOLENCE - Problem/Need**: Tobacco is the major contributing factor to premature deaths from heart disease, stroke, cancer, and chronic obstructive pulmonary disease (COPD). Smoking, as well as other risky behaviors is higher among Alabama's population compared to other states with a ranking of 43 based on United Health Foundation, America's Health Rankings 2011 reporting. Other determinants and their ranking are Obesity (49) and High School Graduation (43), a negative lifestyle that needs to be worked on with the whole community, which contributes to short and long-term health problems.

- **TEEN PREGNANCY PREVENTION, ADOLESCENT RISK REDUCTION - Problem/Need**: The teen birth rate (ages 10-19) is higher for all three service area counties (Calhoun, Cleburne, and Talladega), than the State and the US. According to Healthy People 2010, approximately 77% of births to adolescents, age 15-19 years are unintended. The Healthy People 2010's Objective is to reduce teen pregnancies (15-17 years) to 4.3% of females. Adolescents are more likely to engage in risky behaviors, such as smoking, substance use and abuse, unprotected sex/high chlamydia rate, and driving recklessly.

People are dying from preventable cancers, heart disease, diabetes, cerebrovascular disease, and chronic lower respiratory disease due to lack of screening, lack of primary and preventive care and risky behaviors. This needs to be changed. Part of the impetus will come from the pressures from payors and national health reform to simultaneously reduce cost, improve quality, and implement value-based payment programs which will, in turn, require organizations to examine how to best manage the health of their patient populations. Many of the strategies will be through increasing care coordination and preventive services.

The national Affordable Healthcare Act ("ACA") expands coverage for a wide range of prevention and wellness services, by increasing incentives for employers that establish wellness programs and eliminating copayments for immunizations, screenings, and other clinical preventive services. The health reform is forcing provider systems to be accountable for the full breadth of care, beyond the hospital and physician office. Programs such as the elimination of payment for unnecessary readmissions, the development of delivery payment pilots for bundled

services, medical home demonstrations, coordination grants, and increased financial support for health centers encourage partnerships between hospitals and other community organizations. ACA creates a fund to provide sustained national investment in preventive and public health programs, including those offered by hospitals to increase access to clinical preventive services and create healthier communities.

F. Description of Existing Healthcare Facilities within the Community

Relative to healthcare providers and facilities, it is important to describe the physician complement as to need and/or excess need. As the population ages, the local and national shortage of physicians is expected to increase. As has been documented in the literature, medical schools have been encouraged to expand capacity by the Association of American Medical Colleges and the US Council on Graduate Medical Education.

F.1. Federal Designations and Physician Shortage

Federal criteria relative to healthcare provider need in an area (county of subset) is predicated on two federal designations: 1) Health Professional Shortage Area (HPSA) and Medically Underserved Area/Population (MUA/P). For purposes of this Community Health Needs Assessment, HPSA designations, which are updated on an ongoing basis, is the rationale for demonstrating healthcare provider need and MUA/P in utilized in conjunction with other criteria and methodologies in determining service area, including patient origin studies as the base and incorporating MUA/MUP federal designation and Stark II Phase II rules in final service area determination. Stark II Phase II became effective on July 26, 2004 and the geographic area served by the hospital (geographic service area) is defined in the Phase II rule as "the area composed of the lowest number of contiguous zip codes from which the hospital draws at least 75 percent of its inpatients."

HPSA – Primary Medical Care designation is based on several criteria, the most paramount being the ratio of the population to 1.0 full-time equivalent (FTE) primary care physician. The definition of primary care physician includes internal medicine (primary care versus subspecialty allocation), family/general medicine/practice, obstetrics/gynecology, and general pediatrics. The ratio as set forth by HRSA's Shortage Designation Branch is 3,500:1 (HPSA Geographic Area) and in certain conditions, 3,000:1 (HPSA Population Group). If an area meets one of the ratios, a second pass includes determination that contiguous areas to the area in question, cannot assist in alleviating primary care shortage.

The designation of an area as a HPSA Geographic Area accords physicians (primary care and subspecialty care) for a service site located in the designated area, the ability to realize a 10 percent bonus in payments based on the Medicare Fee Schedule for services rendered to Medicare beneficiaries. HPSA Population Group does not accord 10 percent bonus payments, but does provide for other physician-related recruitment and retention benefits. HPSA – Mental

Health and HPSA – Dental Health designations also delineate provider need in those respective disciplines.

The only HPSA – Primary Medical Care designation in Calhoun County is the minor civil division of Piedmont. The county has no designation (Geographic Area or Population Group). Cleburne County is wholly designated HPSA (Geographic Area) and Talladega County is wholly designated HPSA (Population Group – Low Income). All three counties are HPSA Dental Health-designated (Population Group – Low Income). All three counties are HPSA Mental Health-designated (Geographic Area for Catchment Areas 7 and 9).

In summary, the greatest primary medical care need for the general, civilian population is in Cleburne County, but recognizing the significant primary medical care need and lack of access for same relative to the low-income population, HPSA Population Group – Low Income has been achieved. Clearly, the lack of Mental Health and Dental Health providers, specifically for the low income population is apparent in all three counties as demonstrated by HPSA designations.

Figure 25 – Primary Care Indicators

Primary Care Indicator	Calhoun County	Cleburne County	Talladega County
Primary Care Physicians per 100,000 Population	79.4	6.8	41.4
Dentists per 100,000 Population	40.6	6.8	17.4
Health Professional Shortage Area (HPSA) – Primary Medical Care	No	Yes	Yes
Health Professional Shortage Area (HPSA) – Mental Health	Yes	Yes	Yes
Health Professional Shortage Area (HPSA) – Dental Health	Yes	Yes	Yes
Medically Underserved Area/Population (MUA/P)	Yes	Yes	Yes

Reports from most specialty associations or workgroups project shortages including the following:

- Primary Care: Expected 20 to 27% shortfall by 2025 due to aging of population and chronic diseases since those over 65 seek care from PCPs at twice the rate of those under 65. The number of primary care residency graduates declined each year since 1998. The practice of primary care needs to be made more lucrative and require less administrative work in order to attract new physicians. Larger group practices and employment options help to alleviate these concerns somewhat;

- Cardiology: Expected increase in need with almost 50% of existing cardiologists nearing retirement age; over 800% increase in shortage nationwide by 2025;

- Critical Care: Demand will exceed supply through 2020;

- Dermatology: Expected increase in demand with aging population and increasing incidence of skin diseases with a shortage of providers. Dermatologists increased their use of midlevel providers by 43% between 2003 and 2008;

- Emergency Medicine: Demand increased 32% and supply dropped 7%; crowding due to aging of population, lack of on-call specialists and greater use of ED for non-emergency issues;

- Endocrinology: Current demand exceeds supply by 15% which will increase with aging of population, increased incidence of diabetes and retirement of physicians;

- General Surgery: Decreased interest in general surgery among medical students; supply dropped from 7.68 MDs per 100,000 in 1981to 5.69 in 2005;

- Geriatric Medicine: There are few departments and few physicians choose this specialty due to long, expensive training and low pay. As with other primary care in general, more incentives are needed;

- Oncology: Demand expected to increase 48% from 2007 to 2020 if current rates and practices continue but supply will only increase by 14%; and

- Psychiatry: Expected shortages due to retiring physicians and reduced work load per provider

These gaps in supply require health systems to be more efficient, make better use of all types of providers in integrated teams that enable each provider to work "at the top of their license" and continue to reshape the delivery options, including higher use of home care services.

There have been expectations that once national health reform has progressed such that more people have health insurance, physician need will increase which will exacerbate any shortages. According to a study by the Advisory Board Company on the impact of state health reform in Massachusetts, in 2010 compared to 2006, non-elderly adults were 4.7% more likely to have a usual source for healthcare or advice and were more likely to have had a preventive care visit or specialist visit within the previous year.

The proportion of family medicine physician offices accepting new patients declined from 70% in 2007 to 60% in 2009. Internal medicine physicians accepting new patients declined from 66% in 2005 to 44% in 2009. The impact on Emergency Room and Inpatient utilization is not well understood yet.

Lack of access is especially apparent for the low-income population (income equal to or less than 200% of federal poverty level) of the Calhoun, Cleburne, and Talladega Counties combined service area. Even with the presence of one satellite site Federally Qualified Health Center, Quality of Life Health Services, Inc. in Anniston, there remains a significant void in primary medical care capacity in the three counties combined.

As previously indicated, he community (service area) served by RMC, which includes predominantly zip codes of Calhoun County, but inclusive of Cleburne County and Talladega County as well, albeit to a lesser extent, has been mapped to UDS Mapper, a detailed map of which is included in the Attachment C as well as other maps in Attachment D of this report. The combined nine-zip code community (service area) constitutes 138,167 total population ***(Source: U.S. Census Bureau, 2010 Census)***, which includes 54,819 (39.7%) low-income individuals, those having income equal to or less than 200 percent of federal poverty level.

Figure 26 - Community Served by the Hospital – Low-Population

Zip Code	Place	Total Pop	Low-Income	Percent
36201	Anniston	20,156	11,835	58.7%
36207	Anniston	19,801	5,575	28.2%
36203	Oxford	18,799	6,452	34.3%
36264	Heflin	8,659	3,845	44.4%
36206	Saks	11,427	3,896	34.1%
36265	Jacksonville	21,060	7,790	37.0%
36277	Weaver	5,420	2,036	37.6%
36271	Ohatchee	6,023	2,141	35.5%
35160	Talladega	26,822	11,246	41.9%
Total Zip Codes		138,167	54,816	39.7%

Source: UDS Mapper, UDSmapper.org, 2012

Less than one-quarter (23%) of the total zip codes' low-income population is being served by all FQHC organizations, the predominant FQHC being Quality of Life Health Services, Inc. The remainder, which is approximately 43,000 low-income individuals, is not currently served by any FQHC organization and consequently, there remains approximately 77 percent primary medical care capacity for the low-income population relative to the combined three-county service area of Calhoun, Cleburne, and Talladega Counties.

F.2. Existing Healthcare Facilities

The CHNA offers providers such as RMC the ability to engage their communities in their service area in identifying, addressing, and prioritizing community health needs. The description by facility type, number, and licensed capacity of existing healthcare facilities within the Calhoun, Cleburne, and Talladega service area community available to meet the community health needs identified in this CHNA are presented in the following figure.

Besides RMC's three-county service area and the existing healthcare facilities delineated within, it should be noted that RMC purchased a Rural Health Clinic (RHC) in Roanoke, Randolph County when Randolph Medical Center closed the RHC in the summer of 2011. Four nurse practitioners provide primary medical care and mental health services at the RHC location. In addition, RMC has a primary care practice with one FP and one nurse practitioner at a separate location in Roanoke. Further, several physician subspecialists provide part time services at these locations, specifically OB/GYN and cardiology. Randolph County (including Roanoke) is a federally-designated MUA (as well as an HPSA) and has been identified by RMC as an area with unmet needs. RMC has received increased inpatient and outpatient utilization since establishing the services and the medical center plans to add a diagnostic center with urgent care services to be complete by the summer of 2013.

Figure 27 – Existing Healthcare Facilities

Facility Type - Description	Calhoun County	Cleburne County	Talladega County
Ambulatory Surgical Centers	1	0	0
Assisted Living Facilities	3 (84 beds)	0	3 (82 beds)
Assisted Living Facilities (Specialty Care)	3 (123 beds)	0	2 (32 beds)
Community Mental Health Centers	1	0	5
End Stage Renal Treatment Centers	3 (58 stations)	0	4 (67 stations)
Federally Qualified Health Centers (Core/Satellite)	1	0	0
Home Health Agencies	2	0	4
Hospices	6	0	5
Hospitals – General Acute	3 (552 beds)	0	2 (185 beds)
Hospitals – Specialized	1 (38 beds)	0	0

Independent Clinical Laboratories	12	0	6
Independent Physiological Laboratories	3	0	1
Nursing Homes	5 (667 beds)	1 (82 beds)	3 (468 beds)
Portable X-Ray Suppliers	1	0	0
Rehabilitation Centers	1	0	0
Rural Health Clinics	0	0	6

The Calhoun, Cleburne, and Talladega service area hospitals constitute four in Calhoun, two in Talladega, and none in Cleburne. They are identified as follows:

Jacksonville Medical Center
Jacksonville, AL 36265
89 bed General Hospital
Authorized bed capacity: 63

Stringfellow Memorial Hospital
Anniston, AL 36201
125 bed General Hospital
Authorized bed capacity: 125

Northeast Alabama Regional Medical Center
Anniston, AL 36202-2208
338 bed General Hospital
Authorized bed capacity: 338

Noland Hospital Anniston, LLC
Anniston, AL 36202-1578
38 bed Specialized Long Term Care Hospital
Authorized bed capacity: 38
Licensee Type: Limited Liability

Citizens Baptist Medical Center
Talladega, AL 35161
122 bed General Hospital
Authorized bed capacity: 103

Coosa Valley Medical Center
Sylacauga, AL 35150
163 bed General Hospital
Authorized bed capacity: 163

G. Input from the Community

Based on IRS Notice 2011-52, "Treasury and the IRS intend to provide that a the Community Health Needs Assessment (CHNA) will satisfy CHNA requirements with respect to a hospital facility, i.e. RMC only if it identifies and assesses the health needs of, and takes into account input from persons who represent the broad interests of, the community served by that specific hospital facility. RMC's CHNA took into account input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of or expertise in public health. In order to accomplish this task EXEC developed survey instruments (example and summary in Attachment H), which were used in a personal interview survey process. A particular survey instrument was used with community physicians in an effort to ascertain additional insight with regard to perception of RMC meeting community needs by the physician community practicing in the primary service area of RMC.

In order to be compliant with IRS Notice 2011-52, the process that EXEC utilized encompassed conducting interviews with key individuals, as recommended by the RMC Management Team, which were performed at the hospital; at governmental; private, and public organizations; and in the community. The process included delineation of persons and organizations with which RMC has consulted with relative to conducting the CHNA. Community involvement through an interview process (including interview development) to take into account input from persons who represent the broad interests of the community served by RMC including RMC Management, RMC Board, RMC Medical Staff/community physicians, local agencies and providers, and community leaders.

The objective of the interview process was to take into account input from persons who represent the broad interests of the community served by RMC and included representation from Calhoun, Cleburne, and Talladega Counties – RMC's service area. It is EXEC's opinion and supported by RMC, that the CHNA offers providers and other organizations to engage and collaborate with RMC relative to their communities in the Calhoun, Cleburne, and Talladega Counties service area as to identifying, addressing, and prioritizing community health needs.

The interview process was anticipated to provide an indication of the healthcare services and programs in the communities, access issues for various population segments, apparent gaps in services, challenges posed by the resident and healthcare community and, generally, strategic areas of opportunity for the hospital. Interviews were conducted primarily, direct face-to-face

and to a lesser extent, on the telephone, depending on the preference of the interviewee. A list of persons interviewed is included in Attachment A.

Conducting a CHNA provides the opportunity to garner community "buy-in" and to improve health and to facilitate access to health, preventive, and wellness resources in the community. The process involves getting a pulse on the community relative to its population base, health indicators, health disparities, and basic well-being by analyzing quantitative and quantitative information such as leading causes of death, illness, and disability.

The CHNA process involved comparing the community, i.e. service area, which is predominantly Calhoun County, and to a lesser amount, Cleburne and Talladega Counties to each other as well as to the State of Alabama and where applicable, to the Nation relative to health indicators. If communities, i.e. counties, such as Calhoun, Cleburne, and Talladega work collaboratively, they can derive innovative solutions for improving the overall health of the community.

Interviews were conducted by a Board-Certified Health Care Executive (Fellow American College of Healthcare Executives-FACHCE), a healthcare professional with knowledge of the health indicators of the RMC primary service area, a background in healthcare delivery with specific knowledge of hospital/medical center delivery systems, and experience in conducting personal interviews. The following sections provide the detailed findings of the survey process.

H. Physician (Medical Staff) Interview Questions and Results Summary

The initial section of the physician interview inquired about the physician practice description; e.g. Family Practice, Internal Medicine, Surgery, Pediatrics, etc. The physicians interviewed included family practice and pediatrics. The following characteristics describe the physicians surveyed:

- Active in women's and minority health issues
- On Alabama state health committees
- Active practice in RMC service area for greater than 10 years
- Routinely provide services to low income minority population groups

The physicians viewed their respective practice primary services areas to be similar to or the same as the RMC primary service area although the physicians interviewed were not familiar with the definition of primary service area. In response to an inquiry about RMC supporting their practices in the primary service area they indicated RMC has been active in community outreach activities and included their practices in these efforts. Efforts included such things as community education programs, immunization awareness, and screening for chronic disease.

When asked if they thought RMC has met community needs with respect to health education and awareness response varied from yes to no response.

The physicians included in the survey felt unique and distinguished themselves from other members of the RMC medical staff by offering "free clinics", being active in "environmental health issues," and being "understanding and sensitive to" the health needs of the low-income minority population.

In response to an inquiry about the "worst health indicators or disparities" in the community responses included lack of treatment options for chronic disease conditions, e.g. obesity (and its co-morbidity), hypertension, cardiac disease, asthma and the inability of low income patients to access prescription pharmaceuticals. They felt access to cancer treatment was routinely available even to the low-income uninsured population.

When asked about the quality measures used in their individual practices typical quality indicators of evidenced based practice were referenced. These included indicators concentrated on the following:

- Immunization rates
- Cancer screenings
- Blood pressure control of hypertensive patients
- Screening for other chronic disease conditions.

Although the physicians interviewed stated they felt they had mature well-developed practices, it was represented that the practices offered readily accessible care (new appointment available within 24 - 72 hours). One physician stated that uninsured low income patients that lacked the ability to pay were referred to the local FQHC and that it offered "same or next day appointments". The ability to offer "new patient" appointments within 24-72 hours is not a characteristic of most "mature" practices; waiting times for this patient category in mature practices routinely exceed weeks if appointments are available at all.

The physicians indicated that their respective practices grew from "word of mouth" awareness in the community and referrals from other physicians.

When asked about use of electronic health records the physicians indicated some to moderate use of EHR and stated that the link to RMC for results reporting was important. Awareness of "meaningful use" issues and requirements was rudimentary but present.

When asked about practice growth opportunities, the geographical area south of RMC and Calhoun County was felt to present the most opportunity. From a business development perspective; physicians interviewed did not indicate use of usual and customary analytical tools

to assist in market analysis and determination of best opportunities for targeted practice development efforts.

When asked about the need for more primary care or specialty care physicians in the service area a common theme of lack of access to some limited specialty care was the response. It was stated that low-income/uninsured patients routinely lack access to physician care regardless of specialty need. It was the consensus that Medicaid coverage was insufficient with respect to affording access to most specialty care.

The physicians surveyed felt RMC's involvement in their individual practice expansion efforts would be welcome. The physicians did not demonstrate knowledge of the constraints RMC must contend with under current fraud and abuse and Stark regulatory limitations in assisting existing practices with business development.

The physicians did state that if RMC were to initiate a "growth effort" that they would be willing to participate; particularly in "win – win" (not defined) situations. Physicians indicated a willingness to participate in such activities as "speaker's bureau," willingness to lease or occupy space in another medically underserved area with RMC, willing to work with tele-med development efforts.

When asked about "competitors" in Calhoun County or the greater service area, the physicians surveyed responses varied from not considering there to be competition to being in a very competitive situation. Physicians interviewed felt little or no competition to provide services to low-income uninsured patients.

When asked to define success factors for practice expansion in the near and long term, physician responses varied from lack of ability to define these factors to expressing that success factors for either practice or RMC expansion included the attracting of more "insured" patients.

When asked about the "patient centered medical home" designation, interviewed physicians indicated it was their intent to seek such designation and felt it would improve their opportunity to further expand their practices.

When asked about the value that RMC affiliation adds to their practice; physicians responded that RMC's reputation for high quality care by the general public transferred to them as a result of them being on the medical staff of and practicing at RMC.

In response to the question "what would motivate you to change your existing referral pattern and use a hospital other than RMC" responses included such aspects as the quality of hospital based physicians, and respect for the autonomy of the individual patient choice regarding choice of hospital. Physicians were asked "how do you measure patient satisfaction" within your

practice; responses included, call backs, patient referrals, and word of mouth. Physicians interviewed did not use standardized methods to measure "patient satisfaction."

In response to a question about describing practice experience at RMC, the respondents indicated RMC to be a physician-friendly hospital and one that welcomes new patients. When asked "how can RMC better meet the needs of the community," there was a recurring theme that assisting low income, uninsured patient with acquiring prescription drugs would be a tremendous aid to the community and would have a significant impact on the health status of that segment of the population.

I. Community Member (non – provider) Interview Results

Fourteen members of the community were interviewed during the CHNA process. These fourteen individuals represented a cross section of the communities of the primary service area of RMC. Members of this group of interviewees were instructed, where appropriate, to respond to the Community Member Interview Guide questions on behalf of the element of the community with which they primarily identified, e.g. a church pastor was requested to consider the consensus of the church members the pastor identified with when responding to the question. Consequently even though only fourteen individuals were interviewed, their responses reflect the views of literally hundreds of residents of RMC's primary service area.

Collectively, the community members surveyed represent hundreds of years of living experience in the primary service area of RMC and therefore provide high probability that respondents know and understand the community dynamics and issues of the primary service area.

When asked how many hours do you spend per month working with or in support of community, civic, religious and / or political activities; an indicator of community leadership and involvement and consequently likely to provide an accurate perspective on community issues, the responses varied from a few hours per month to full time. Obviously the more involved in community issues the higher the probability that a respondent will understand and can thus provide valid assessment of the community's position on a respective issue.

PRIORITIZATION OF HEALTH CARE NEEDS

Health service priority needs identified are based on the health issues at hand that present a threat to the health of the community and have the potential to be modifiable with appropriate healthcare delivery interventions.

The biggest factors driving today's healthcare strategy for all providers, and RMC is no exception, are the aging population, rising chronic disease rates, gaps in supply and demand of

physicians, the delivery options that technological advances enable, more information on evidence-based care and the change in the payment system which is requiring collaboration along the care continuum and continuing to reduce payment for unnecessary admissions or other services. These factors are expanding the definition of provider and requiring all providers to work together in an integrated fashion. Provider includes physician, other clinicians, post-acute care provider, social and community service workers and public health workers.

Within this context, the priority needs for RMC's service area (Calhoun, Cleburne, and Talladega Counties) were developed based on the specific issues in its environment. In developing responses to the needs from the recommendations identified, RMC needs to consider other criteria including:

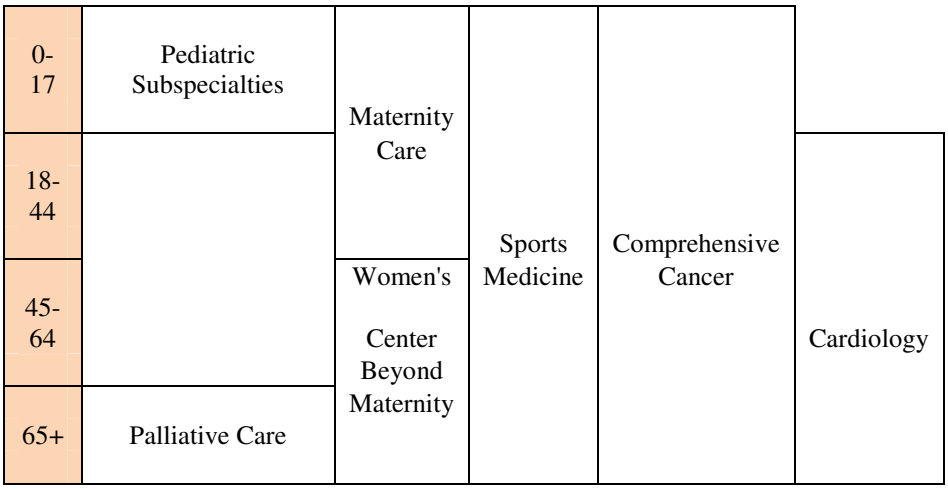
1) Consistency with the organization's mission and strategic plan;
2) Quality considerations;
3) Governance and organizational structure issues;
4) Financial and operations impacts; and
5) Risk.

As RMC begins to position the medical center for success in the future, many of the recommendations for the Priority areas will help in this regard concurrent with continuing its recent healthcare advancements such as but not limited to the following: 1) UAB Cancer Center affiliation in the new UAB Cancer Care Network programs, 2) Center for Balance Disorders relative to problems associated with dizziness or imbalances especially for those age 55+, and 3) RMC's Women's and Children's Center, Baby Friendly Hospital. These developments can both address community need and position RMC for success. They should also help to keep more of the population able and interested in obtaining health care services close to home in Calhoun County, and contiguous Cleburne and Talladega Counties.

Because of the relative large population and age distribution in its service area (even though the population growth is static at best), RMC needs to consider specific services for each age segment of its population, in addition to the health priority areas mentioned in this report for community need.

Many services cross all age groups but some are more specifically targeted as shown by example in the following figure. In many cases, the older half of the 18-44 and the 45-64 ages groups, represent working, well-insured individuals who will often be the most aggressive in seeking quality care and the most informed in their decision process. Studies have shown that, in many cases, the women are making many of these decisions.

Figure 28 - Examples of Service Distribution Across the Age Segments



The recommendations in this section are also consistent with the tenets of national health care reform and the evolving payment system since they focus on healthier individuals and communities, integration among a full range of providers and managing awareness and prevention to reduce longer-term costs. Given the healthcare environment trends and the specific information contained in this report the following five Health Service Priority needs were developed. The following sections outline recommendations for meeting the challenge of these Priorities. Many of the recommendations across Priorities are linked since they are all highly related.

A. Systems to Reduce Socioeconomic Stressors
B. Access to Primary Medical and Mental Health Care
C. Healthcare Education, Prevention, Wellness, Promotion;
D. Healthcare Services for Chronic Conditions; and
E. Healthcare Services for the Elderly

A. Systems to Reduce Socioeconomic Stressors

As noted in other sections of this report, "The health of a community is largely related to the characteristics of its residents; it has been well documented that an individual's age, sex, race, ethnicity, education, income level, as well as access to nutritious food, transportation and housing affects health status and access to healthcare." Clearly, socioeconomic stressors on the individuals, families and children in service area are significant in their homes, their neighborhoods and their schools. Given the increasing amount of information in the literature on the impact these stressors have on health, the community health cannot be improved without changes to these stressors. The relatively higher percentage of adults who feel unhealthy and

have a lack of social support further emphasizes this. Nationwide, solutions to these issues are just in the developmental stages as the healthcare system has become more aware of their impact and is beginning to respond. RMC needs to work together with other community providers and community organizations to come up with solutions for resolving these among the population in the community as well as those accessing care in physician offices and the medical center.

Objectives:

- To develop programs within RMC and throughout the community that will alleviate socioeconomic stressors and, thus, their impact on health;
- To improve the health of the community by alleviating these stressors; and
- To work collaboratively with all levels of providers in the community in these efforts.

Recommendations:

- Commence a three-county socioeconomic resources card for the service area and distribute to provider practices so they are able to ask their patients the appropriate questions and provide the necessary resources based on the responses they receive;
- Rethink outreach activities to enable more of the population (especially Cleburne County) to be reached. Appoint a champion to lead this effort. They should assemble a task force with key individuals throughout the community to develop an Action Plan. As part of the Action Plan specific financial analyses can be completed to evaluate the relative cost and benefit of a range of proposals;
- The task force should include members of the payor community since it is important to include them in the dialogue of resolving these stressors;
- Implement the Patient-Centered Medical Home (PCMH) model and incorporate community health workers or volunteers to help patients navigate their socioeconomic stressors. Determine options for expanding these resources into the private practice community;
- Integrate behavioral health services (both mental health and substance abuse) within the PCMH;

- Consider working with the State food programs to be able to write prescriptions for children and families for obtaining food at a farmer's market or other healthy venue – (The Food Assistance Division administers the Supplemental Nutrition Assistance Program (SNAP) in Alabama. The Food Assistance Program's purpose is to end hunger and improve nutrition by providing monthly benefits to eligible low income households to help them buy the food they need for good health);

- Create an understanding within the provider community about the multi-faceted nature of health and its relationship with socioeconomic factors. Have cultural competency training for PCPs, hospital workers and other providers that addresses the pervasive barriers to a consistently healthy lifestyle;

- Until the payors are more involved or the payment system changes, this will need to be supported by internal or external funding. Consider grant options through the new agencies set up by the ACA, Robert Wood Johnson Foundation, and the Value Driven Health Disparities Collaboration Project;

- Reach out to and collaborate with others who are working on these initiatives in their specific market areas (in and out of Alabama); and

- Monitor progress on each Action item chosen to see the cost and benefit of each and adjust subsequent steps based on outcomes.

B. Access to Primary Medical Care and Mental Health Care

Access to primary medical care is a critical issue throughout the three-county service area, especially for the low-income population and where financial and non-financial barriers prevent patients from receiving timely and appropriate diagnosis, assessment, and treatment of their condition. The presence of OB service is a luxury in many of Alabama's counties. Only 24 of the 55 rural counties have hospitals that deliver babies today. Calhoun County is fortunate in having RMC's Women's and Children's Center, Baby Friendly Hospital. The void of OB service in so many of Alabama's rural counties contributes in creating a challenge for rural residents relative to receipt of adequate prenatal care during their pregnancies. There is a recognized relationship between the presence of a hospital providing OB service and the receiving of adequate prenatal care by local women. Lack of prenatal care is a real problem in our secondary service area. Teen mothers are less likely to obtain adequate prenatal care and to complete high school or attend college. Children of teenage mothers are at greater risk for preterm birth, low birth weight,

poverty and welfare dependence. Lack of access has been documented throughout this project relative to the following:

- Need for primary care providers internists, family practitioners, obstetricians, pediatricians) especially for the low-income population (witness HPSA – Population Group Low-Income designations);
- High level of uninsured; with unknown state and impact of the soon to be formed healthcare exchanges;
- Low level of subspecialty availability/accessibility for the low-income population uninsured or underinsured;
- Accessing FQHCs – only one satellite site in the three-county service area, Quality of Life Health Services, Inc. in Anniston (Calhoun County);
- Noted high primary care utilization in RMC emergency rooms (EXEC's analysis performed in 2009/2010), particularly among low-income groups;
- High level of Medicare admissions for ambulatory sensitive conditions;
- High level of mortality relative to incidence of disease;
- Low level of mental health providers relative to the population, especially for the low-income population (HPSA Mental Health designations in place);
- Relatively high level among the population feeling a lack of emotional support;
- Relatively high level of alcohol consumptions and emergency room visits for alcohol related issues;
- Noted presentation of patients with advanced disease; and
- Aging of population may exacerbate the problem.

Objectives:

- To develop structures to improve the ability to recruit primary care physicians throughout the community to serve the low-income population;

- To integrate the full range of primary care services, medical, behavioral and dental, into the primary care setting – FQHC being an appropriate setting;

- To collaborate on expansion of primary medical care and urgent care services to be more conducive based on community needs;

- To develop systems so that the patient population can access the services that are available with an expansion of support services such as transportation for low-income and elderly populations and outreach and education to the population so they understand the health risks of not accessing services; and

- To reduce the mortality in cancer, diabetes and heart disease in Calhoun, Cleburne, and Talladega Counties.

Recommendations:

- Create a medical staff development plan that summarizes provider need and identifies options and opportunities for filling those needs. As part of this plan a provider group practice, whether system owned or independent, should be fully developed;

- Focus on the more FQHC sites of service as sources of new primary care providers, especially for the low-income population. If retention is difficult, conduct interviews to determine their barriers to staying in the community;

- Work with aging providers to transition their practices in the most seamless manner;

- Develop a structure to enable the use midlevel providers (NP, PA, CNMW) in a wider capacity in the community;

- Establish the Patient Centered Medical Home (PCMH) model at Quality of Life Health Services, Inc. – FQHC in Anniston;

- Explore expanding Quality of Life Health Services, Inc.'s sites in Talladega and Cleburne Counties - structure the hours of operation at each site to meet the needs of the patient population; this will likely include evening hours and possibly weekend hours;

- The PCMH should include mental health workers to treat the behavioral and medical health needs of the patient population in an integrative way;

- If feasible, dental health should be included in any PCMH development;

- Develop systems to improve communication and coordination among community agencies so primary healthcare is delivered in most appropriate setting and the various components of care are integrated;

- Further development of RMC's Women's and Children's Services for issues for all women both related to maternity and unrelated to maternity such as breast health, menopause, Urogynecology, GynOncology, bone, joint and osteoporosis and mental health. If it can be developed in such a way that it is attractive to the various components of the area population it could be used for primary care, education and prevention for these women as well. This Center should attract women from all income categories; and

- Require that the medical record from the postpartum visit for all women gets transferred to a primary care physician so that issues that developed during pregnancy can be tracked through the women's life cycle since they may be indicators of future health issues.

C. Healthcare Education, Prevention, Wellness

Many of the healthcare incidence and mortality problems in the Calhoun, Cleburne, and Talladega service area are reversible through prevention services, early treatment or intervention to reduce risk. The risk factors of smoking, poor diet, obesity, asthma, and limited physical activity lead to feeling unhealthy and higher incidence and, ultimately, mortality from preventable conditions.

Reducing the prevalence of modifiable risk factors requires s a more comprehensive approach that improves and strengthens the linkages among the provider community and the patients. It also requires the active engagement of the patient/resident community in their own care. Activities should be geared to the hard to reach populations: lower income, the uninsured, ethnically diverse groups and the elderly.

Initiatives tend to be more successful among the middle to high-income group, as this population is more likely to be informed and to take advantage of new and improved services and policies to be healthier.

Recommendations for this Priority will be linked to those for A and B since work in one can promote work in the others. Because of the currently high level of non-compliance among the patient population groups (which is customary with low-income population groups), resolution of this Priority must be accomplished on a grass roots level, with all providers and organizations working together.

Objectives:

- To develop an effective RMC program to educate the service area population, and particularly the high-risk and vulnerable populations, on the long-term importance of health management and prevention;
- To integrate with a range of other providers and community leaders as well as programs already in place in the State to develop a model system for engaging the population in reaching compliance;
- Prevent and/or reduce tobacco use in the service area;
- Improve healthy eating behaviors in the service area;
- Reduce the number of overweight and obese individuals in the service area;
- Reduce the level of alcohol consumption in the service area;
- Increase exercise, physical activities levels in the service area;
- Reduce the level of teen pregnancy in the service area; and
- Increase the percentage of mothers who obtain prenatal care.

Recommendations:

- Develop a plan with community providers and leaders, including clergy, for the population who are younger and have not yet had any healthcare episode as the result of their risky behaviors; they need to be contacted where they live, work or

otherwise congregate. The plan needs to be more grassroots oriented and different than what is being done now;

- Consider block by block programs for door-to-door screenings and education, as well as disease management;

- For patients with identified chronic conditions identify options to reach them where they get medical care, where they are employed, and through community programs that they are likely to use. This also requires educating the providers of these patients in effective ways of communicating and inspiring them to change their behaviors. Some of these efforts are underway;

- Partner with community leaders within the largest diverse racial and ethnic groups to develop strategies to motivate the population to care about keeping themselves healthy. Identify potential grant money to assist with the development of programs and monitoring of advice;

- Partner with a fitness center(s) to develop and integrate comprehensive preventive, wellness, fitness and nutrition center;

- Collaborate with public prevention programs of local, regional or state agencies and the payors to develop local approaches to addressing smoking, obesity, alcoholism and physical activities in the at-risk populations;

- Partner with employee wellness programs to include education on risky behaviors and work-place assistance in changing those behaviors, such as smoking cessation assistance;

- Set up formal meetings with leadership within the AL Department of Education to identify ways to improve health education, awareness and screening in the schools. Use the students to also identify opportunities to reach their parents.

- Partner with area groceries to provide recipes for healthy eating in a way that makes it easy and affordable for the population to provide healthier choices for their families; and

- Link with national organizations that are developing programs for the Surgeon General's Get Moving! initiative.

D. Health Services for Chronic Conditions

The high level of mortality from chronic disease in Calhoun, Cleburne, and Talladega Counties makes it imperative to improve management of these chronic conditions. As the population ages, the prevalence of these chronic conditions will increase, particularly if the underlying risk factors are not addressed.

Chronic medical conditions like diabetes, high blood pressure, high cholesterol, COPD, asthma, and behavioral health conditions respond well to careful management. Barriers to the appropriate management of chronic care include the lack of reimbursement to providers for secondary prevention services, patient self-management education, patient support services such as transportation and proven complementary alternative medicine services, follow-up care and communication among providers and between providers and patients. Therefore, the recommendations in Priorities A through C should help this Priority since improvement in socioeconomic stressors, access to primary medical care and an increased emphasis on wellness and promotion and a decrease in risky behaviors results in best practice for chronic care management.

Objectives

- To develop a system wide approach to the improvement of healthcare management and the health status of patients with chronic health conditions;
- To reduce the death rates from heart disease, diabetes and cancer;
- To effectively use the services set up in the prior Priorities to treat chronic disease conditions;
- To improve the availability of subspecialty care in the community to patients with chronic medical conditions; and
- To involve the patients in the success of their treatment.

Recommendations:

- Convene a physician and community provider task force to develop plans for optimum treatment of each chronic condition, starting with heart disease and diabetes, based on a review of the literature and best practices and create an Action Plan to implement them throughout the medical center. Plans could involve disease coaches, protocol-based planning and multidisciplinary care;

- Work with payors and employers to further refine the plans as they apply to the payment methodologies and work place issues;

- Develop employer-based wellness program throughout the city addressing employee risk factors, self-management education needs, and to provide the support necessary to motivate patients to take a more active role in their health and healthcare decisions;

- Enroll all patients in a disease-specific chronic disease registry and disease management program;

- Begin to distribute key data points to primary care and other physicians on the team to monitor patient status and compliance. Disease coaches should step in when patient is out of compliance;

- Make patient-specific report cards;

- Track progress and obstacles to successful management in order to continually refine the program;

- Develop a comprehensive Diabetes Center of Excellence with Endocrinology, Cardiology, Ophthalmology, Podiatry, Nutrition, Diabetes Education and any other needed specialties to serve the population as well as help primary care providers to better care for their patient base. The management of these patients could all be coordinated through this Center. In addition the Center could work to attract patients for screenings and other prevention and early detection activities. The Center could be physically located at RMC but connected virtually, either through telehealth or another means, to other locations. This Center should attract patients from all income categories;

- Once the Diabetes Center of Excellence is complete consider Centers for Cardiology and Cancer;

- Address physician subspecialty service needs where necessary through the Medical Staff Development Plan. Ensure that there is a team of specialists working in conjunction with the patient's primary care provider to manage and treat the conditions;

- Consider options for providing EMR linkages between providers to more easily share data and manage patients; and

- Collaborate with home care agencies (all three counties have HHAs) so that the message to and care of these patients is consistent.

E. Healthcare Services for the Elderly

Even areas of the Calhoun, Cleburne, and Talladega Counties' service area with lower elderly populations will find a growing percentage of the population to be over 65 years of age. The healthcare challenges that this population will face, combined with a diminished supply of workers to provide service, must be addressed before a crisis has been reached. In addition, if the Priorities identified in A through D are not addressed, this elderly population will be quite sick with many chronic conditions.

Objectives

- To improve the accessibility of healthcare and social services for the elderly;
- To improve the quality of healthcare and social services for the elderly;
- To improve the functional health of elderly patients, especially those with chronic disease;
- To improve the availability of behavioral health services for the elderly; and
- To reduce the use of multiple medications among the elderly and the risk of prescription misuse.

Recommendations:

- Expand geriatric services in the community through physician and nurse practitioner availability;
- Improve the efficiency of caring for medical and surgical patients in RMC;
- Link with home care agencies electronically in order to optimally manage patients post discharge to reduce readmission rates and to keep them healthy in their homes;

- Link with physician practices and community organizations in order for the patient's medical record be consistent through the continuum;

- Integrate mental health services with medical services in order to treat the whole individual;

- Evaluate the development of a Palliative Care program within RMC in order to improve quality of life and the end of life as well as to avoid significant unnecessary cost to the patient and health care system;

- Increase indicated physician subspecialty services and related programs as a result of the Medical Staff Development Plan and healthcare status indicators; and

- Invest in on-demand transportation services for the elderly for medical and social service needs in conjunction with any area transportation service already in existence.

The goal of this Community Health Needs Assessment is to position RMC as the premier medical center in the Calhoun, Cleburne, and Talladega service area with critical linkages throughout the community to address community needs as well as to build programs at the medical center in response to those community needs. If the medical center can link closely with the community and other providers to even better position the organization as the provider of choice for certain key services, it should improve its reputation for quality that will allow RMC to also attract patients to its Centers of Excellence such as 1) UAB Cancer Center affiliation in the new UAB Cancer Care Network programs, 2) Center for Balance Disorders relative to problems associated with dizziness or imbalances especially for those age 55+, and 3) RMC's Women's and Children's Center, Baby Friendly Hospital.

Of equal importance, hospitals such as RMC are going to need to have the programs in place to succeed under the new rules of healthcare reform. The Priorities identified in this report, which will make the community healthier and have the linkages in place to deliver care in the most appropriate setting with the most appropriate provider, will reduce healthcare costs while improving outcomes which will enable both RMC and the community to succeed.