Approved by the Regional Medical Center Board August 22, 2016

2015 COMMUNITY HEALTH NEEDS ASSESSMENT

IMPLEMENTATION STRATEGY

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 of which, 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 (co-morbid conditions), gaps in supply and demand of physicians (especially in rural areas), the delivery options that technological advances enable, more information on evidence-based care and the change in the payment system relative to ACA which is requiring collaboration along the care continuum and continuing to reduce payment for unnecessary admissions (readmissions to hospitals) or other services. These factors are expanding the definition of the 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, along with the acute care hospital.

Within this context, the priority needs for RMC's three-county primary service area (Calhoun, Cleburne, and Talladega Counties) were developed based on the specific issues in three-county service area environment, along with certain Randolph County consideration. 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 (in process);
2) Quality considerations;
3) Governance and organizational structure issues;
4) Financial and operations impacts; and
5) Risk.

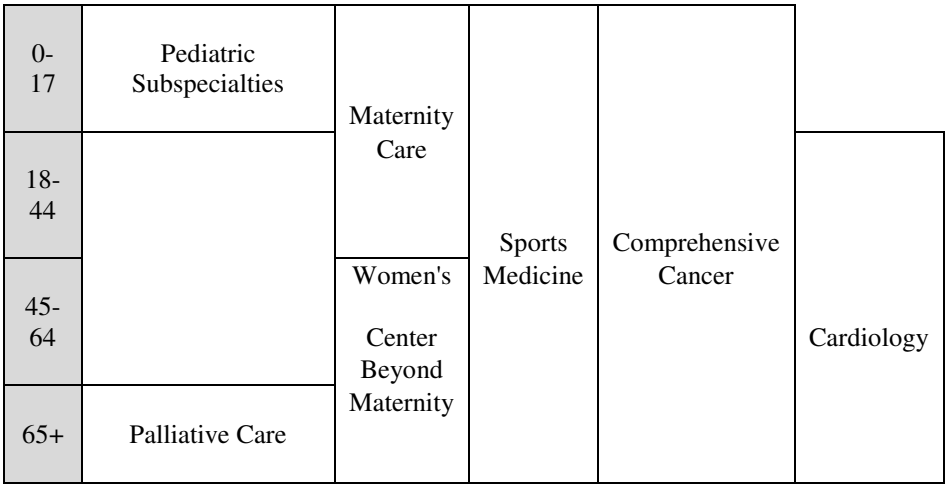
As RMC continues to position the medical center for success in the future, in light of health reform and many regulatory and reimbursement changes, many of the recommendations for the Priority areas will help in this regard concurrent with continuing its recent healthcare advancements such as but not limited to the following:

1) UAB Cancer Center continued affiliation in the 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 continue to both address community need and position RMC for success – for all Life Cycles – Prenatal, Children, Adolescent, Adult, and Elderly.

These advancements should also help to keep more of the population able and interested in obtaining healthcare services close to home in Calhoun County, and contiguous Cleburne and Talladega Counties in the quality-driven RMC, which is based on improving health outcomes throughout the medical center's service area. Because of the relative large population and age distribution in its service area (even though the population growth is static at best and is actually declining in Calhoun County based on 2014 US Census estimates), 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 reform and ongoing, evolving payment systems since they focus on healthier individuals (thru preventive and primary medical care) 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 the 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 and clearly, in health reform, 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 works and will continue to need to work together with other community providers, both private and public (i.e. FQHC network organizations), and community organizations to come up with solutions for resolving these among the population in the community as well as those accessing care in FQHC and RHC sites, physician offices, and the medical center.

Objectives:

- To continue existing programs and 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 (vertical and horizontal) in the community in these efforts.

Recommendations:

- Research implementation of transportation assistance services for indigent patients via grant funding.

- Join statewide efforts to expand Medicaid in Alabama

- Develop community health clinic in West Anniston community. Provide preventive health services, education materials and education sessions.

- Work with area organizations to provide medical-related scholarships to economically disadvantaged students who excel academically.

- Engage social service agencies to teach adults and children to deal with poverty-related stress factors

B. Access to Primary Medical Care and Mental Health Care

Access to comprehensive preventive and 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.

In 2015, the presence of OB service delivery continues to remain 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, Alabama's First and Only Baby Friendly Hospital. RMC's Women's and Children's Center is staffed with specially trained nurses and the latest in Labor, Delivery, and Recovery Care to ensure new moms of the safest and most comfortable surroundings for the birth experience. Proper care and medical attention for newborns and infants are top priority at the Center.

The void of OB service delivery 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 RMC's secondary service area (predominantly rural). Teen mothers are less likely to obtain adequate prenatal care early in their trimesters 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 for Primary Medical Care and "Single County" for Dental and Mental);

- High level of uninsured throughout the three-county primary service area validated by HRSA UDS Mapper; with unknown impact of health exchanges and current state decision not to implement Medicaid expansion ;

- Low level of subspecialty availability/accessibility for the low-income population uninsured or underinsured;

- Accessing FQHCs – Quality of Life Health Services, Inc. (QLHS) now has 2 sites in Anniston (Calhoun County) and 1 site each in Cleburne, Talladega and Randolph Counties, while being based in Etowah County to the northwest of Calhoun and along with sites, has received considerable U.S. Public Health Service (PHS) section 330 grant funding for New Access Point (NAP) sites ;

- 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 and the problems confronted by hospitals relative to re-admissions and non-reimbursement;

- 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 "Single County" 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 – prior to, during, and post health reform, especially since significant section 330 NAP dollars have been accorded to QLHS during health reform;

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

- 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 – these mortality rates continue in the CHNA in 2015 and from the CHNA performed in 2012.

Recommendations:

- Partner with the City of Anniston to open a primary care clinic in low-income neighborhood.

- Collaborate with Morehouse Medical School to provide clinical and program support.

- Partner with Jacksonville State University to provide nursing, social work and nutritional support.

- Coordinate care efforts with local agencies (Saint Michaels and Etowah Quality of Life) to ensure that sufficient coverage exists.

- Evaluate self-pay discount policies to ensure that financial stresses are kept to a minimum.

- Engage local physicians to perform "mission work" in the local community.
- Increase physician awareness of stress points that lead to mental issues.
- Work with local providers to initiate depression screenings during the examination process.

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 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 (the latter relative to chronic disease management with significant co-morbid clinical conditions).

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, including and especially Quality of Life Health Services, Inc. (QLHS) 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 – this is paramount in an integrated approach across all provider levels;

- 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 (major problem throughout the country – the future of our country is in our children and child obesity is a rampant issue that needs to be dealt with at the current time);
- Reduce the level of alcohol consumption in the service area;
- Increase exercise, physical activities levels in the service area (need to have facilities available);
- Reduce the level of teen pregnancy in the service area; and
- Increase the percentage of mothers who obtain prenatal care.

Recommendations:

- Partner with City of Anniston Department of Recreation to host community walks.
- Implement "Know Your Numbers" program to increase control of high blood pressure, obesity and diabetes.
- Implement community wide weight loss challenges and reward success.
- Emphasize a way of outdoor activities (bike trails, hiking, walking tracks available to the community.
- Engage Jacksonville State University in community outreach and use students to conduct health assessment surveys and provide education.
- Implement Peer Support Groups for blood pressure, diabetes and obesity.

D. Health Services for Chronic Conditions

The high level of mortality from chronic disease (i.e. heart disease, cancer) 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 and co-morbidity will increase, particularly if the underlying risk factors are not addressed.

Chronic medical conditions such as diabetes, high blood pressure, high cholesterol, COPD, asthma, and behavioral health conditions along with co-morbidity in combinations thereof, respond well to careful chronic disease 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, along with availability to all persons; and
- To involve the patients in the success of their treatment.

Recommendations:

- Establish chronic care clinic for patients suffering from heart failure and pulmonary disease.
- Support the adoption and implementation of smoke-free policies in the community.
- Incorporate education initiatives to reduce tobacco use among young people.

- Work with City of Anniston Parks and Recreation Department to incorporate non-smoking education into its wellness programs.

- Utilize facility-based healthcare professionals to design exercise programs that are conducive to patients with chronic conditions.

- Assist in the creation of support groups and provide space for group meetings.

- Assist patients in locating agencies that will provide financial assistance for prescription drug medicines.

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 fact remains that Calhoun County's population has actually declined from the CHNA performed in 2012. 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:

- Make resources available to assist in ensuring that insurance benefits are up to date and available (Medicare and Medicaid).

- Work with social agencies to assure that the appropriate level of support exists to meet home-based needs.

- Increase primary care presence via physicians and mid-level professionals.

- Increase availability of transportation via public and private sources.

The goal of this Community Health Needs Assessment in 2015 continues to position RMC as the premier medical center in the Calhoun, Cleburne, and Talladega primary 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 (ambulatory/FQHC, vertical, and horizontal) 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 continue to attract patients to its Centers of Excellence such as 1) UAB Cancer Center affiliation in the 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 will need to have programs and services in place to succeed under the rules of health reform and beyond, regardless of the administration in place at the national level. Clearly, as documented in the survey and result process, RMC offers patients personalized, top-rated health care using the most sophisticated equipment and skilled staff.

The Priorities identified in this report, which will continue to 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.