The Health Care Authority of the City of Anniston

2020 Community Health Needs Assessment

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Executive Summary

The Health Care Authority of the City of Anniston (HCACA) has conducted a 2020 Community Health Needs Assessment (CHNA) mandated by the Patient Protection and Affordable Care Act (ACA). The CHNA is required by all 501(c)(3) providers, mandated by the ACA and regulated by the IRS. The 2020 CHNA includes the two Calhoun County, AL hospitals governed/operated by HCACA: Regional Medical Center (RMC) and Stringfellow Memorial Hospital (SMH). HCACA was restructured in 2016 from a hospital board to a health care authority to allow the multi-hospital health system greater flexibility in meeting the ongoing challenging and changing healthcare environment and to be better prepared for future expansion, quality program and service development, and for recruitment of top medical, clinical, and administrative staff.

The 2020 CHNA considered the challenging external forces on a state and national level, inclusive of the COVID-19 pandemic since there is a need to review, adapt, cease, and commence healthcare programs and services in a changing marketplace as the population ages and the healthcare environment continues to evolve. The 2020 CHNA approach focused on the availability of qualitative and quantitative information, incorporating strategic planning 1) To project need to more appropriately target HCACA's resources regarding current and future healthcare program accessibility and 2) To assist on choosing alternatives to provide additional healthcare program and service access.

The IRS issued Notice 2020-56, extending the 2020 CHNA deadline to December 31, 2020 due to burdens the COVID-19 pandemic has placed on hospitals. As of August 15, 2020, 29.2 million Americans were receiving unemployment insurance benefits, compared with 1.6 million Americans at that point in 2019, thereby severely impacting communities and the health systems that serve them.

With a total of 323 beds at RMC and 125 beds at SMH, along with numerous outpatient facilities and services, HCACA is the premier regional healthcare provider for a 5-county service area that includes a primary service area of Calhoun, Cleburne, and Talladega Counties, along with Clay and Randolph Counties. HCACA provides services to over 16,000 inpatients, 57,000 outpatients, nearly 1,800 newborn deliveries, and over 64,000 emergency room visits each year. Quality, compassionate, state-of-the-art healthcare is provided by more than 2,000 employees, 300 volunteers and over 200 physicians in a full range of specialties, including: cardiac, women's, orthopedics, oncology, and emergency services to our patients with integrity, skill and compassion.

RMC's Cancer Program is accredited by the American College of Surgeons' Commission on Cancer and is an affiliate in the University of Alabama (UAB) Cancer Care Network based out of Birmingham. RMC's Orthopedics program is recognized by Blue Cross and Blue Shield® of Alabama as a Blue Distinction Centers+ for Knee and Hip Replacement®. RMC's OB/maternity program is the first designated *Baby-Friendly* birthing facility in the State of Alabama.

Our 2020 CHNA represents a collaborative, community-based approach to identify, assess and prioritize important health issues affecting our northeast AL community, The CHNA process is the foundation that healthcare providers and the community use to collaboratively plan, develop and foster programs to effectively address health needs in our community. It involves an assessment of health indicators, health status, barriers to care, and other demographic and social issues affecting all residents and organizations in the community. Health improvement plans that address the needs identified in the CHNA ensure that HCACA remains focused on improving the health of the many communities we serve. The CHNA serves as the key tool in delineating the health needs of the community. The qualitative and quantitative data research and analysis, serves as the base for Health Service Priority need areas development.

The qualitative data was obtained through key informant survey monkey interviews and Zoom meeting sessions. The stakeholders involved in providing input, included broad representation from the 3-county service area community served by HCACA and included: Senior Management, Board of Directors, Medical Staff/community physicians, and community organizations. Conducting a CHNA also provides HCACA with the opportunity to promote community "buy-in" and to improve health outcomes 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.

HCACA's community is the health system's geographic service area in which, the majority of its patients reside among factors. HCACA's geographic service area is the area composed of the lowest number of contiguous zip codes from which the health system draws at least 75% of its inpatients.

Zip Code	*Place*	*RMC Discharges*	*SMH Discharges*	*Combined Discharges*	*Percent*
36201	Anniston	2,030	579	2,609	16.3%
36203	Oxford	1,510	202	1,712	10.7%
36207	Anniston	1,384	294	1,678	10.5%
36265	Jacksonville	1,092	224	1,316	8.2%
36206	Anniston	944	208	1,152	7.2%
36264	Heflin	658	107	765	4.8%
35160	Talladega	543	57	600	3.7%
36272	Piedmont	487	65	552	3.4%
36277	Weaver	412	91	503	3.1%
36271	Ohatchee	332	64	396	2.5%
36260	Oxford	318	68	386	2.4%
36268	Munford	336	49	385	2.4%
Service Area		10,046	2,008	12,054	75.2%
All Others		3,210	771	3,981	24.8%
Total		13,256	2,779	16,035	100.0%

The health of a community is largely related to the characteristics of its residents: age, sex, race, ethnicity, education, income level, as well as access to nutritious food, transportation and housing affecting health status and healthcare access. In 2020, the U.S. is in unchartered waters relative to healthcare access. The COVID-19 pandemic has had unprecedented, widespread impacts on households across the country – urban, rural, and suburban. This access problem caused by COVID-19 in serving the need of communities, crosses throughout the entire medical care provider society – inpatient, outpatient, home, and inclusive of hospitals, physicians, ambulatory care providers, home health agencies, etc.

The total population in each of HCACA's service area's three counties continues to decline when comparing 2010 to 2019 and when comparing the prior CHNA (2016 estimate) to the current CHNA (2019 estimate), of which, program/service development may be impacted in the future. The 3-county service area decline in population trend, is indicative of many rural areas throughout the country, not just Alabama.

	Calhoun County	***Cleburne County***	***Talladega County***	***Alabama State***
Population estimates, July 1, 2019	113,605	14,910	79,978	4,903,185
Population estimates, July 1, 2016	114,611	14,924	80,103	4,863,300
Population % change, 2016-2019	-.88%	-.09%	-.16%	.82%

Relative to 2019 U.S. Census Population Estimates, Calhoun County's and Alabama's total population are estimated at 113,605 and 4,903,185 respectively, with all three service area counties showing a slight decrease from 2016-2019, whereas the state is showing a slight increase. Regarding the need for children's and adolescent programs, the pediatric population, based on American Community Survey 5-Year Estimates 2014-2018 of Calhoun (24.6%), Cleburne (25.0%), and Talladega Counties (23.8%) - all had a similar, but slightly less percentage of the population that are ages 0-19 than the State (25.3%).

Nationally, the biggest shift in the population has been and continues to be the aging baby boomer population (along with resultant impact on programs and services). Older people, due to their age and incidence of chronic disease, frequently with co-morbid clinical conditions, require more primary care resources. During this year 2020 of the COVID-19 pandemic, healthcare providers' patients with co-morbid clinical conditions, have been shown to have a greater potential in contracting COVID-19 regarding their own specific COVID-19 "Underlying Conditions," which include but are not limited to Hypertension, Diabetes, and Obesity. COVID-19 discriminates by these and other underlying conditions and by ethnicity. Therefore, in terms of the U.S Census July 1, 2019 population estimates, the 3-county service area is at a higher risk for COVID-19 than the state as the population ages 65+ for Calhoun, Cleburne, and Talladega is 18.1%, 20.2%, and 18.5% respectively, contrasted to 15.7% for the state as a whole.

The younger population, requiring less primary care resources due to their younger age and less impact of incidence of chronic disease (than the elderly), are declining in numbers. Hence, there is a shift of need and intensity of primary care resources due in part to the increase of chronic diseases with a higher percentage of the population being elderly, even prior to the COVID-19 pandemic.

Women of childbearing years is continued expected to decline into future years for both Calhoun County and for Alabama based on U.S. Census Population estimates. The population of women of childbearing age is declining, which is the nationwide trend as many women move past childbearing age and have a need for women's health and other healthcare services. Rural areas, besides having an increasing percentage of the elderly ages 65+, concurrently, have a decrease in the younger population, specifically, women of childbearing years of ages 15-44 and children of ages 0-19, thereby impacting future program and service development. 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 diversity of the population will have a substantial impact on the overall health of the area because of known health disparities by race/ethnicity. The CDC reports there is increasing evidence that some racial and ethnic minority groups are being disproportionately affected by COVID-19 and that inequities in the social determinants of health, such as poverty and healthcare access, affecting these groups are interrelated and influence a wide range of health and quality-of-life outcomes and risks.

Inequities in the social determinants of health, such as poverty, healthcare access, and education, affecting racial and ethnic minority population groups are interrelated and influence a wide range of health and quality-of-life outcomes and risks. This has become more apparent during COVID-19. They suffer the worst status and are also those that have the highest poverty rates and the least education. To achieve health equity, barriers must be removed so that everyone has a fair opportunity to be as healthy as possible. 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. Chronic disease management has become a more apparent issue as our country ages, affecting both urban and rural areas such as HCACA' service area, and all races and ethnicities, specifically Black/African Americans.

HCACA's CHNA sought input form persons who represent the broad interests of the community served by the health system. For the 2020

CHNA, the performance was entirely different contrasted to performance of prior years' CHNAs. Due to COVID-19 travel and social distancing restrictions throughout 2020, the surveys were conducted using a combination of self-survey (Survey Monkey) and virtual survey (Zoom). The process included input from persons who represent the broad interests of the community served by HCACA including four key member groups: 1) Board of Directors, 2) Senior Management, 3) Physicians, and 4) Community Members including local agencies, providers, and community leaders. The CHNA offered the ability to engage and collaborate with HCACA relative to identifying, addressing, and prioritizing community health needs. Key selective results are as follows:

- Senior Management believes HCACA is currently achieving its mission even though it has been "strapped" for capital to invest in technology in recent years, especially since the COVID-19 pandemic.

- In terms of "Meeting the Needs" of the Community, respondents from the Board group, Senior Management group, and Physician group agreed that:
    - HCACA is doing "a good job" meeting the needs of the community.
    - Physicians gave HCACA a 5-STAR rating for meeting community needs.
    - Viewed HCACA as "patient-centered," "compassionate," and "knowledgeable."
    - Community Member group felt that HCACA was <u>not</u> adequately addressing the health needs of the community:
        - COVID-19 incidence, mental health/substance use related issues, and poverty in their communities
        - Community Members believed that access to the certain specialty services was inadequate
    - Community Member and Physician groups indicated that HCACA could do more to provide community education and involvement with community needs.
    - Community Members all agreed that HCACA is vital to the health and welfare of its service area.

- In a post-COVID-19 scenario, respondents indicated that HCACA can differentiate itself in its service area by "Accessibility vs Distance to Birmingham."

- Survey respondents agreed that when given the option to choose 2 out of 3 major objectives for HCACA to achieve, "Widest Access" was selected by both Board Members and Community Members:
    - Board Members chose "Widest Access" + "Highest Quality"
    - Community Members chose "Lowest Cost" + "Widest Access"

- Top 3 Strategic Priorities for HCACA included:

  - Physician recruitment and retention, practice acquisitions;
  - Improved quality of clinical services and patient satisfaction; and
  - Strengthening the hospital's financial position.

- Perceived areas of increased pressure over the next three years for HCACA included:
  - Medicare / Medicaid reimbursements;
  - HMO payment rates, payment denials; and
  - Health reform, conversion of the uninsured market.

HCACA's community healthcare needs identified and prioritized, as derived from the Health Status and Health Indicators sections of this 2020 CHNA, 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. Clearly, 2020 is a "different" year for HCACA, Alabama, the U.S, and the world due to the COVID-19 pandemic that will continue into 2021. The CHNA also considered the challenging and ever-changing marketplace on a state and national level, inclusive of the COVID-19 pandemic since there is a need to review, adapt, cease, and commence healthcare programs and services in a changing marketplace as the population ages and the healthcare environment continues to evolve

The biggest factors driving today's healthcare strategy for all providers, and HCACA is no exception, are the aging population, rising chronic disease rates (co-morbid conditions or in terms of COVID-19, "underlying 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 such as HCACA's hospitals) or other services. These factors are expanding the definition of the provider and requiring all providers to work together in an integrated fashion to improve health outcomes, reduce health disparities, and create health equity for all residents in the community they serve.

Improving healthcare service quality in HCACA's greater 3-county service area by creating an integrated healthcare delivery system, should be high on the priority list. Hospital readmissions is the driving force, as in today's world, hospitals in themselves, and HCACA is no exception, have a limited ability to impact this outcome and must coordinate the continuum of care with other providers in healthcare service delivery.

The priority needs for HCACA's greater 3-county service area were developed from the Health Status and Health Indicators sections of this CHNA and based on the health issues at hand (inclusive of COVID-19) that present a threat to the health of the community in the greater 3-county service area along with the contiguous counties' secondary service area. In developing responses to the needs from the

recommendations identified and prioritized, HCACA needs to consider other criteria including:

1) Consistency with revised mission, vision, and strategic plan;
2) Quality considerations;
3) Governance and organizational structure issues;
4) Financial and operations impacts; and
5) Risk.

In addition to the identification and prioritization of community healthcare needs recommendations, there are three concurrent overarching themes that were apparent from the key informant survey/interview process (Survey Monkey and Zoom):

1) Improve access for all community residents to health and social services;
2) Achieve health equity for all community residents; and
3) Enhance the physical and social environment to support health well-being and reduce unhealthy behaviors.

The following five Health Service Priority need areas were developed:

B.1 Systems to Reduce Socioeconomic Stressors;
B.2 Access to Primary Medical Care and Behavioral Health Care;
B.3 Healthcare Education, Prevention, Wellness, Promotion;
B.4 Healthcare Services for Chronic Conditions; and
B.5 Healthcare Services for the Elderly

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As HCACA continues to position the 2-hospital health system for success in the future relative to health reform and regulatory and reimbursement changes, along with external factors outside its control (i.e. population, socioeconomic and demographic characteristics and determinants, COVID-19 pandemic), many of the CHNA Health Service Priorities objectives and potential activity recommendations delineated for HCACA's community will help support HCACA as the leader in transforming community health, regardless or not of the COVID-19 pandemic.

The goal of this 2020 CHNA, similar to CHNAs performed in prior years, continues to position HCACA as a 2-hospital health system, as the premier regional healthcare provider in the greater Calhoun, Cleburne, and Talladega service area (along with Clay and Randolph Counties) and with critical linkages throughout the community to address community needs as well as to build programs and services within the health system in response to those community needs and in an integrated way.

If the health system can link more closely with the community and other providers and agencies (vertical and horizontal) to even better position the organization as the provider of choice for certain key services in serving the community, HCACA should be able to improve its reputation for quality that will allow HCACA's hospitals 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) HCACA's RMC's Women's and Children's Center, Baby Friendly Hospital.

Of equal importance, health systems such as HCACA 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, regardless of the COVID-19 pandemic. In order to improve healthcare quality in the 3-county real world, the HCACA health system needs to embrace a truly virtual integrated approach (with a combination of direct face-to-face service delivery and telehealth service delivery) with other providers and agencies to reduce fragmentation and duplication. Clearly, as documented in the key informant questionnaire Survey Monkey and Zoom meeting process, HCACA offers its patients personalized, top-rated healthcare, using the most sophisticated equipment and skilled staff and is the key asset to the community it serves.

The Health Service Priorities identified in this CHNA and implemented, 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. In turn, they will reduce healthcare costs while improving health outcomes, which will enable both HCACA and the residents in the communities that HCACA serves to realize the improvement of the health status in these communities.

Introduction

The Health Care Authority of the City of Anniston (HCACA) has conducted a 2020 Community Health Needs Assessment (CHNA) mandated by the Patient Protection and Affordable Care Act (P.L. 111-148) of 201.50 (PPACA and ACA). The CHNA is one of many additional reporting requirements for all 501(c)(3) providers, mandated by the ACA and regulated by the Internal Revenue Service (IRS). The 2020 CHNA is inclusive of the two Calhoun County, Alabama hospitals governed and operated by HCACA. It is consistent with prior years' CHNAs performed for the Northeast Alabama Regional Medical Center (RMC), delineated as 501(c)(3) tax-exempt status. HCACA was restructured in 2016 from a hospital board to a health care authority to allow the multi-hospital health system (RMC and Stringfellow Memorial Hospital-SMH) greater flexibility in meeting the ongoing challenging and changing healthcare environment and to be better prepared for future expansion, quality program and service development, and for recruitment of top medical, clinical, and administrative staff.

A CHNA was required to 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. The Federal Register, Volume 79, No. 250, published on December 31, 2014, finalized regulations for charitable hospitals relative to CHNAs.

On July 14, 2020, the IRS issued Notice 2020-56, which extends the deadline for conducting a CHNA and adopting an implementation strategy to meet the community health needs identified through the CHNA to December 31, 2020. Due to burdens the COVID-19 pandemic has placed on hospitals, the IRS provided this additional relief to hospital organizations so that they could meet their CHNA requirements.

The final CHNA regulations, allow hospital organizations with multiple hospital facilities to collaborate and produce one joint CHNA report and implementation strategy for all its hospital facilities, provided the hospital facilities define their communities to be the same. From prior CHNA reports, the communities are predominantly in three counties: Calhoun, Cleburne, and Talladega. The Treasury Department and the IRS have assumed that hospital facilities operated by hospital organizations with three or fewer hospital facilities (i.e. HCACA with Regional Medical Center and Stringfellow Memorial Hospital) will produce joint CHNA reports, which is the case with this CHNA for HCACA.

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 of persons and organizations with which the hospital consulted, 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 the community health needs identified by the CHNA.

Separate and distinct from this written report engagement 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, i.e. HCACA.

CHNA Project Objective

The objective was to provide a written report relative to documentation of a Community Health Needs Assessment (CHNA) mandated by the Patient Protection and Affordable Care Act (P.L. 111-148) of 201.50 (PPACA and ACA). It was performed in conjunction with final regulations published in the December 31, 2014 Federal Register. A CHNA was performed in 2012, 2015, and 2017, the latter, inclusive of, at that time, Jacksonville Hospital, which was folded under HCACA's governance and operation in 2014. Since the 2017 CHNA, HCACA has reverted back to a 2-hospital health system with both hospitals domiciled in Anniston. The 2020 CHNA has been conducted 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 challenging and ever-changing marketplace on a state and national level, inclusive of the COVID-19 pandemic since there is a need to review, adapt, cease, and commence healthcare programs and services in a changing marketplace as the population ages 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 health in the northeast Alabama service area communities and their residents as well as for the HCACA.

CHNA Project Scope

The CHNA, which must be conducted by the end of the hospital's first fiscal year starting after March 23, 2012, and at least once every three years thereafter, provides the foundation for HCACA's submission of IRS Form 990 Schedule H. For the 2020 CHNA, the project included the following scope:

- Determination of "community served by the hospital facility," i.e. geographic area, target population, service area thereby giving HCACA 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 healthcare needs of the community, including those specific to low-income and minority populations in correlation with social determinants of health;
- Identification of unmet need areas that can be used as the basis of the Implementation Strategy Report to be developed by HCACA;
- 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 HCACA: HCACA Management, HCACA Board, HCACA Medical Staff/community physicians, local greater Calhoun County service area agencies and providers, and community leaders; and
- Preparation, documentation, and completion of 2020 CHNA report.

CHNA Approach & Methodology

The 2020 CHNA development approach was to focus on the availability of qualitative and quantitative information, incorporating strategic planning as follows:

- To project need to more appropriately target HCACA's 2-hospital health system resources regarding current and future healthcare program accessibility; and

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

A range of qualitative and quantitative approaches in conducting the 2020 CHNA was utilized, including the following:

- **Key Informant Interviews:** Interviews were conducted with key individuals, as recommended by the HCACA Management Team. The interviews were scheduled to be performed at RMC and in the community, including at governmental entities, private and public organizations, and providers' offices. The purpose was to provide indications of healthcare service and program need in the communities, access issues for various population segments, apparent gaps in services, challenges posed by community residents and the healthcare community, and potential strategic areas of opportunity for the hospital. Interviews were conducted primarily by Zoom video, email, and/or telephone communication due to the COVID-19 pandemic, depending on interviewee preference. A list of persons interviewed is included in Attachment A;

- **Secondary Data Analysis:** An extensive amount of current existing reports and data available was reviewed specific to the U.S.; Alabama; and Calhoun, Cleburne; and Talladega Counties relative to 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: 1) Population and demographic information from the U.S. Census Bureau, American Community Survey, and the Alabama Department of Public Health (ADPH); 2) Provider information from internet resources, Health Resources and Services Administration's (HRSA) geospatial website, and hospital/health system provider directories and websites; and 3) Utilization and healthcare indicators and statistical information from HCACA, 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. Descriptive data has been indicated regarding population and population subsets, i.e. total general, civilian 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 specific services offered; and

- **Literary Research:** A literary research was conducted regarding medical care issues that were applicable to the project including healthcare delivery programs and services and also pandemics that continue to emerge, i.e., COVID-19. The literary research yielded many of the reports and other documents used in the secondary data analysis.

CHNA Project Limitations

The project was to provide HCACA and community-interested parties with a 2020 CHNA as required since 2012, CHNA's are required every three years. The CHNA was performed relative to medical care provision and accessibility in primarily Calhoun County, but included Cleburne and Talladega Counties as well, since the latter two counties are contiguous to Calhoun County. The 2-hospital health system also serves residents from these counties, but to a lesser extent than it does for residents from Calhoun County. No consideration was given to other counties, cities, and towns outside these three counties, which were not viewed as the health system's primary service area for the CHNA and therefore, not within the scope of the project.

The analysis, findings, and conclusions in this 2020 CHNA are based solely on the application of various quantitative and qualitative analytical techniques and methodologies generally accepted in the healthcare industry. Regarding the ever-changing national, state, and local landscape as to healthcare program policy development, funding, etc., i.e., COVID-19 pandemic, and if some of the facts that have been assumed are incorrect, or there are other material facts not disclosed to during the project, the analysis and conclusions herein may be affected and may require revision.

CHNA Detailed Findings

A. Description of Community Served by a Hospital

IRS Notice 2011-52 CHNA requirements in 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.

On July 14, 2020, the IRS issued Notice 2020-56, which extends the deadline for conducting a CHNA and adopting an implementation strategy to meet the community health needs identified through the CHNA to December 31, 2020. Due to burdens the COVID-19 pandemic has placed on hospitals, the IRS provided this additional relief to hospital organizations so that they could meet their CHNA requirements. The COVID-19 pandemic has had dire economic consequences throughout all regions and states in the U.S. and Alabama is no exception. As of August 15, 2020, 29.2 million Americans were receiving unemployment insurance benefits, compared with 1.6 million Americans at that point in 2019 (***Source: RWJF 9/2020***), thereby severely impacting communities and the health systems that serve them.

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. Further and 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)."

HCACA's community is the health system's geographic area referred to as the service area in which the majority of its patients reside among factors. HCACA's 2-hospital health system, through its 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 health system 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 health system, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation.

HCACA periodically assess its service area to ensure that the service area description adequately reflects the health system's current activities in providing programs and services to the community. Patient origin analyses are routinely performed of inpatient and outpatient services (for example, delineating zip codes of inpatient patient discharge records on file of the two hospitals and emergency department (ED) 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 hospitals draw the majority of its patients. The hospitals' discharge record information and ED visit information is derived from the two hospitals' calendar year 2019 reporting.

While HCACA 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 by 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 HCACA, is typically necessary to enable analysis of service area demographics. The service area is also analyzed relative to being federally-designated by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration's (HRSA) Shortage Designation Branch (SDB) as a Medically Underserved Area (MUA) i.e. county, or in part, or contains 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, HCACA utilizes a combination of different methodologies in determining its service area, including patient origin studies as the base and incorporating provider shortage federal designations (MUA/MUP, HPSA) 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 HCACA 2-hospital health system (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 (i.e., HCACA's 2-hospital system: RMC and SMH) draws at least 75 percent of its inpatients."

To determine the geographic service area, the hospital establishes a reference period such as year ending 12/31/2019, specific for this 2020 CHNA. 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., hospital discharge information for calendar year ending 12/31/2019.

For the reference period, the hospital (i.e., HCACA's 2-hospital health system) 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 the two hospitals' calendar year ending 12/31/2019 reporting relative to hospital inpatient discharge records, along with ED visits, including ED visits resulting in admissions to the hospitals – Regional Medical Center-RMC and Stringfellow Memorial Hospital-SMH), a patient origin study of inpatient patient discharges was performed to ensure that the determined service area is accurate. HCACA identified all zip codes in which those inpatients reside as determined from the patient origin study/discharge analysis from the two hospitals individually and then combined for CHNA reporting and then 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 Exhibit, which has been determined to be the community (primary service area) served by the health system.

Exhibit 1 - Community Served by the Health System

Zip Code	*Place*	*County*	*RMC Discharges*	*SMH Discharges*	*Combined Discharges*	*Percent*	*Cumulative Percent*
36201	Anniston	CA	2,030	579	2,609	16.3%	16.3%
36203	Oxford	CA,TA	1,510	202	1,712	10.7%	26.9%
36207	Anniston	CA	1,384	294	1,678	10.5%	37.4%
36265	Jacksonville	CA	1,092	224	1,316	8.2%	45.6%
36206	Anniston	CA	944	208	1,152	7.2%	52.8%
36264	Heflin	CL	658	107	765	4.8%	57.6%
35160	Talladega	TA	543	57	600	3.7%	61.3%
36272	Piedmont	CA	487	65	552	3.4%	64.8%
36277	Weaver	CA	412	91	503	3.1%	67.9%
36271	Ohatchee	CA	332	64	396	2.5%	70.4%
36260	Oxford	CA,TA	318	68	386	2.4%	72.8%
36268	Munford	CA,TA	336	49	385	2.4%	75.2%
Service Area			10,046	2,008	12,054	75.2%	
All Others			3,210	771	3,981	24.8%	
Total			13,256	2,779	16,035	100.0%	

Source: HCACA (RMC & SMH) 2019 hospital discharges; Legend: CA-Calhoun, CL-Cleburne, TA-Talladega

Further validation of the zip code service area delineated in the preceding Exhibit, was mapped to HCACA's 2-hospital system's ED utilization for the same period in time (2019 calendar year). RMC alone and the two hospitals (RMC and SMH) combined, reported 43,114 (66.3% of the total) and 64,990 total ED visits respectively. Of the two hospitals' combined total ED visits, 15.7% (10,176) were admitted as inpatients to the hospitals and 9.6% (6,181, vs. 7,905 for CHNA 2017) were for primary care visits only to the ED (Primary Care Levels 1 and 2). It should be noted that the same twelve service area zip codes for ED visits (75%) correspond to the above patient origin study/discharge analysis for the two hospitals combined.

The three counties delineated as the Community Served by the Health System in the above Exhibit, of which Calhoun County is the "dominant" county and where the two hospitals are 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 61.10, and Talladega County is 45.20 ***(Source: HRSA Geospatial Website 9/2020***). 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 9/2020***). There has been no MUA designations updating by HRSA since the 2017 CHNA.

The community (primary service area) served by the health system, which includes predominantly zip codes of Calhoun County, but inclusive of Cleburne and Talladega Counties as well (albeit to a lesser extent), has been mapped to HRSA's Uniform Data System (UDS) Mapper, a detailed map of which, is included in Attachment C along with other maps in Attachment D of this report. The combined twelve-zip code community (75% service area) constitutes a total population of 157,418 ***(Source: U.S. Census Bureau, 2014-2018 Census ACF)***, including 64,829 (41.2%) low-income population individuals, those having income equal to or less than 200 percent of federal poverty level.

Exhibit 2 - Community Served by the Health System – Population

Zip Code	*Place*	*County*	*Total Population # 2014-2018*	*Low-Income Population # 2014-2018*	*Low-Income Population % 2014-2018*
36201	Anniston	CA	18052	10161	56.3%
36203	Oxford	CA, TA	18033	6019	33.4%
36207	Anniston	CA	19746	6866	34.8%
36265	Jacksonville	CA	20694	7635	36.9%
36206	Anniston	CA	11541	4913	42.6%
36264	Heflin	CL	8523	3715	43.6%
35160	Talladega	TA	26312	11719	44.5%
36272	Piedmont	CA	13221	5941	44.9%
36277	Weaver	CA	5529	1856	33.6%
36271	Ohatchee	CA	5952	2010	33.8%
36260	Oxford	CA, TA	4001	2022	50.5%
36268	Munford	CA, TA	5814	1972	33.9%
	Service Area		157418	64829	41.2%

Source: UDS Mapper 9/2020, U.S. Census/2014-2018 American Community Survey

Calhoun County is bounded by Etowah and Cherokee Counties to the north/northwest, Talladega and Clay Counties to the south, Cleburne County to the east, and St. Clair County to the west. Calhoun County encompasses 606 square miles and based on the July 1, 2019 U.S. Census Bureau population estimates of 113,605, the population density is 187.5 persons per square mile.

B. Description of Process/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, HCACA will detail the description of the process used by the health system to take into account input from persons who represent the broad interests of the community served by the 2-hospital health system. HCACA will detail the description of the process and methods used by the health system 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 community health and to facilitate access to health, preventive, and wellness resources in the community. The process involves getting a pulse on the community regarding 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 (Also included as ATTACHMENT E – Data Sources):

- Internal Revenue Service (IRS) Notice 2011-52;
- IRS Instructions for Schedule H (Form 990);
- Federal Register, Vol. 79, No. 250, 12/31/2014;
- HCACA: Regional Medical Center (RMC in Anniston) and Stringfellow Memorial Hospital (SMH in Anniston) internal and external reporting information;
- U.S. Census Bureau;
- U.S. Census Bureau American FactFinder;

- U.S. Census QuickFacts;
- American Community Survey (ACS) 5 Year Estimates Data Files;
- National Cancer Institute, SEER Cancer Statistics 2010-2014;
- Health Resources and Services Administration (HRSA) Geospatial Website (9/2020) – www.hrsa.gov;
- HRSA Community Fact Sheets (Calhoun, Cleburne, and Talladega Counties);
- HRSA Uniform Data System (UDS) Mapper 9/2020 - www.udsmapper.org;
- HRSA/Shortage Designation Branch (SDB);
- Alabama Department of Public Health (ADPH) Selected Health Status Indicators (Calhoun, Cleburne, and Talladega Counties), Vital Statistics;
    - HRSA Community Health Status Reports;
- Centers for Disease Control and Prevention (CDC) – Behavioral Risk Factor Surveillance System (BRFSS) – www.cdc.gov 2013-2018 and Healthy People 2030;
- Centers for Disease Control and Prevention (CDC) – National Center for Health Statistics 1999-2016 Underlying Causes of Death
- Kaiser State Health Facts, Kaiser Family Foundation - kff.org, 2018;
- Alabama Cancer Facts & Figures, 2018-2019;
- Alabama Center for Health Statistics, 2017;
- Alabama County Health Statistics, 2017;
- Alabama County Health Profiles, 2017;
- KidsCount.org, Annie E. Casey Foundation 2015;
- Robert Wood Johnson Foundation, County Health Rankings 2020; and
- Patient Protection and Affordable Care Act (P.L. 111-148) of 201.50 (PPACA and ACA).

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 regarding 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/American Community Survey, 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 (i.e. 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 important agency sources, especially regarding projects that involve health needs and health disparities. HRSA is an agency within the U.S. Department of Health and Human Services (HHS). 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 and Federally-funded community health centers (FQHC). It includes community health, health indicators and health disparities drilled down to the county level.

The CDC is also an agency within the HHS. 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, Healthy People 2030, 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. Regarding access to healthcare, in 2020, the U.S. is in unchartered waters relative to healthcare access. The COVID-19 pandemic has had unprecedented, widespread impacts on households across the country – urban, rural, and suburban. The Robert Wood Johnson Foundation, and Harvard T.H. Chan School of Public Health multi-faceted study, ***The Impact of Coronavirus on Households***, identified areas, problems, and vulnerable populations in urgent need, including certain major findings related to healthcare access as follows:

- One in five of all race/ethnicity households (20%) report anyone in their household has been unable to get medical care for a serious problem when they needed it during the coronavirus outbreak, with a majority of those unable to get care (57%) reporting negative health consequences as a result.

- One in five of all Black/African American households (18%) report anyone in their household has been unable to get medical care for a serious problem when they needed it during the coronavirus outbreak, with a majority of those unable to get care (73%) reporting negative health consequences as a result.

- One in four of all Hispanic/Latino households (25%) report anyone in their household has been unable to get medical care for a serious problem when they needed it during the coronavirus outbreak, with a majority of those unable to get care (47%) reporting negative health consequences as a result.

This medical care access problem caused by COVID-19 in serving the need of communities crosses throughout the entire medical care provider society – inpatient, outpatient, home, and inclusive of hospitals, physicians, ambulatory care providers i.e. FQHCs, home health agencies, etc. Another May 2017 RWJF report mentions hospitals and health systems have a tradition of serving the need of their communities—of not only improving community health by providing healthcare services, but also of bolstering the local economy and quality of life, which supports their charitable purpose and mission of providing community benefit in addressing unmet need in the community. Clearly, this is a difficult and unprecedented time for all providers and community population of all races, ethnicities, and incomes alike. The COVID-19 pandemic raises concern relative to the ability to weather long-term healthcare issues (i.e., global pandemics) and including, but not limited to those delineated in this 2020 CHNA. The following report sections take into consideration some of these characteristics and met/unmet needs for Calhoun, Cleburne, and Talladega Counties.

C.1 Population Age Subgroups and Estimates

The ages of a population impact the prevalence and severity of disease as well as program needs. Therefore, it is paramount to examine the population age composition and age changes over time. Population figures were derived from the U.S Census Bureau, along with HRSA and ADPH statistics and population estimates and projections, that were obtained from the U.S. Census Bureau (American Community Survey and U.S. Census Quick Facts), and are summarized below and included as Attachment F.

Exhibit 3 – Population and Population 2019 Estimates

	Calhoun County	*Cleburne County*	*Talladega County*	*Alabama State*
Population estimates, July 1, 2019 (V2019)	113,605	14,910	79,978	4,903,185
Population estimates base, April 1, 2010 (V2019)	118,526	14,972	82,353	4,780,125
Population, percent change - April 1, 2010 (estimates base) to July 1, 2019 (V2019)	-4.20%	-0.40%	-2.90%	2.60%
Persons under 5 years, percent	5.80%	6.00%	5.30%	6.00%
Persons under 18 years, percent	21.50%	22.50%	20.90%	22.20%
Persons 65 years and over, percent	18.10%	20.20%	18.50%	15.70%
Female persons, percent	52.00%	50.80%	51.90%	51.70%

Source: U.S. Census Bureau/U.S. Census Quick Facts

It is important to note that the total population in each of the counties in the 3-county service area continues to decline as shown above when comparing 2010 to 2019 and below when comparing the prior CHNA (population 2016 estimate) to the current CHNA (population 2019 estimate), of which, program and service development may be impacted in the future. The 3-county service area decline in population trend, is indicative of many rural areas throughout the country, not just Alabama.

Exhibit 4 – Population and Population 2016/2019 Estimates Comparison

	Calhoun County	*Cleburne County*	*Talladega County*	*Alabama State*
Population estimates, July 1, 2019 (V2019)	113,605	14,910	79,978	4,903,185
Population estimates, July 1, 2016	114,611	14,924	80,103	4,863,300
Population % change, 2016-2019	-.88%	-.09%	-.16%	.82%

Source: U.S. Census Bureau/U.S. Census Quick Facts, 2019

Regarding the need for children's and adolescent programs, the pediatric population, based on American Community Survey 5-Year Estimates 2014-2018 of Calhoun (24.6%), Cleburne (25.0%), and Talladega Counties (23.8%) - all had a similar, but slightly less percentage of the population that is 0 - 19 years old than the State (25.3%) (Exhibit 5). Relative to 2019 U.S. Census Population Estimates (Exhibit 3), Calhoun County's and Alabama's total population are estimated at 113,605 and 4,903,185 respectively, with the County indicating a 4.2% decrease and the State indicating a 2.6% increase, both from April 1, 2010.

Exhibit 5 – Pediatric Population

	Calhoun County	*Cleburne County*	*Talladega County*	*Alabama State*
Total population	115,098	14,938	80,565	4,864,680
Under 5 years	6,562	821	4,301	292,125
5 to 9 years	6,844	1,055	5,040	302,174
10 to 14 years	7,158	962	4,796	312,093
15 to 19 years	7,773	895	5,044	323,914
Children 0-19	28,337	3,733	19,181	1,230,306

Source: U.S. Census Bureau, 2018: ACS 5 Year Estimates Data Profiles

The working years' population that is 20 – 64 years old, based on American Community Survey 5-Year Estimates 2014-2018 of Calhoun (58.19%), Cleburne (56.25%), and Talladega Counties (59.12%) – shows that Calhoun and Talladega had a similar percentage of the population that is 20-64 years to the State percentage (58.60%), with Cleburne slightly less than the other counties.

Exhibit 6 – Working Years Population

	Calhoun County	*Cleburne County*	*Talladega County*	*Alabama State*
Total population	115,098	14,938	80,565	4,864,680
20 to 24 years	7,226	760	5,262	334,416
25 to 34 years	15,017	1,706	9,849	632,660
35 to 44 years	13,845	1,824	10,058	599,382
45 to 54 years	14,958	2,110	11,046	641,069
55 to 59 years	7,851	966	5,609	334,011
60 to 64 years	8,078	1,036	5,803	309,004
Working Years 20-64	66,975	8,402	47,627	2,850,542

Source: U.S. Census Bureau/2018: ACS 5 Year Estimates Data Profiles

Nationally, the biggest shift in the population has been and continues to be the aging baby boomer population (along with resultant impact on programs and services). The first baby boomers reached 65 years of age in 2011. For 2014-2018, Calhoun (16.84%), Cleburne (18.76%), and Talladega (17.08%) Counties - all had a higher percentage of the population that are 65 years and older than the State (16.11%). Based on American Community Survey 5-Year Estimates 2014-2018, the State was comparable to the Nation and is projected to have a similar percentage of the population over 65 in 2019, as is the overall United States.

Exhibit 7 – Population 65 and Older

	Calhoun County	*Cleburne County*	*Talladega County*	*Alabama State*
Total population	115,098	14,938	80,565	4,864,680
65 to 74 years	11,489	1,618	8,317	463,057
75 to 84 years	5,847	773	4,037	237,339
85 years and over	2,050	412	1,403	83,436
Elderly 65+	19,386	2,803	13,757	783,832

Source: U.S. Census Bureau/2018: ACS 5 Year Estimates Data Profiles

The population is still aging quickly (ages 65-74, the "old," and ages 85+, the "old, old") and, in many areas, the growth is continued to occur through 2019. The large increase in the average annual growth in the 65+ population between 2000 and 2010, compared to the same between 2010 and 2019 and beyond, clearly demonstrates the aging.

Like other parts of the United States, the pediatric population is projected to decline while the 65 and older population is projected to increase; of which is even more apparent in rural areas. Older people, due to their age and incidence of chronic disease, frequently with co-morbid clinical conditions, are requiring more primary care resources. During this year 2020 of the COVID-19 pandemic, healthcare providers' patients with co-morbid clinical conditions, have been shown to have a greater potential in contracting COVID-19 regarding their own specific COVID-19 "Underlying Conditions," which include but are not limited to Hypertension, Diabetes, and Obesity. COVID-19 discriminates by these and other underlying conditions and by ethnicity. The CDC reports, "As you get older, your risk of being hospitalized for COVID-19 increases." Eight out of 10 COVID-19-related deaths reported in the U.S. (9/2020) have been people at or above age 65 and those 85+ have the highest risk for severe COVID-19. Therefore, in terms of the U.S Census July 1, 2019 population estimates, the 3-county service area is at a higher risk for COVID-19 than the state as the population 65+ for Calhoun, Cleburne, and Talladega is 18.1%, 20.2%, and 18.5% respectively, contrasted to 15.7% for the state as a whole.

The younger population, requiring less primary care resources due to their younger age and less impact of incidence of chronic disease (than the elderly), are declining in numbers. Hence, there is a shift of need and intensity of primary care resources due in part to the increase of chronic diseases with a higher percentage of the population being elderly, even prior to the COVID-19 pandemic.

Based on American Community Survey 5-Year Estimates 2014-2018, relative to the need for obstetrical programs (prenatal, postpartum, and delivery), the women of childbearing years' percentage of the Calhoun County population (19.4%) and Talladega County population (19.1%) is similar to that of the State, whereas Cleburne County (16.7%) had a percentage of the population 15 - 44 years old that is lower than the State (19.6%), amounting to approximately three percent lower.

Women of childbearing years is continued expected to decline into future years for both Calhoun County and for Alabama based on U.S. Census Population estimates. The population of women of childbearing age is declining, which is the nationwide trend as many women move past childbearing age and have a need for women's health and other healthcare services. Rural areas (i.e., Cleburne and Talladega in total and Calhoun in part, ***Source HRSA HPSA Designations 9/2020***), besides having an increasing percentage of the elderly ages 65 and older, concurrently, have a decrease in the younger population, specifically, women of childbearing years of ages 15-44 and children of ages 0-19, thereby impacting future program and service development.

Exhibit 8 – Women of Childbearing Years

	Calhoun County	*Cleburne County*	*Talladega County*
Total Population	114,331	15,010	80,137
Female Population	59,390	7,600	41,648
15 to 19 years	3,783	385	2,667
20 to 24 years	3,667	356	2,628
25 to 29 years	4,134	457	2,742
30 to 34 years	3,570	425	2,396
35 to 39 years	3,625	436	2,494
40 to 44 years	3,430	446	2,376
Childbearing Years 15-44	22,179	2,505	15,303

Source: U.S. Census Bureau, Population Division, June, 2020;7/1/2018 Population Estimates

Based on American Community Survey 5-Year Estimates 2014-2018, the median age of Calhoun, Cleburne, and Talladega Counties was older than the State. Calhoun (39.8) was more comparable to the State (39.1), followed with Cleburne and Talladega Counties with Cleburne's median age of 42.3 years, over 3 years greater than the State and Talladega's (42.3) being over 2 years greater. The male/female percentages split of roughly 48/52%% of all three counties is comparable to the same percentage split of the State with males in the minority.

Exhibit 9 – Median Age and Male/Female

	Calhoun County	*Cleburne County*	*Talladega County*	*Alabama State*
Total Population	115,098	14,938	80,565	4,864,680
Median Age (years)*	39.8	42.3	41.3	39.1
Male Population	55,315	7,281	39,156	2,355,799
Female Population	59,783	7,657	41,409	2,508,881

Source: U.S. Census Bureau/2018: ACS 5 Year Estimates Data Profiles;
**County Health Profile (2017)*

C.2. Population Race and Hispanic Origin

Relative to racial and ethnicity composition, based on American Community Survey 5-Year Estimates 2014-2018, Calhoun and Talladega Counties are more comparable to the State regarding White and Black/African American percentages. Almost three-quarters of the State (69.1%) is White, similar to Calhoun (75.1%) and Talladega (64.7%), whereas Cleburne is 95.1% White, which are all comparable to the 2017 CHNA.

Since 1992, Alabama has experienced an ongoing increase in 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% between the 1990 and 2000 Censuses - the seventh greatest increase among all 50 states and this trend has continued into the 2016 census estimates. 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 risen steadily and now represents 4.6% (2019) of the state's population vs. 4.2% in 2015 ***(Source: U.S. Census QuickFacts***). This increase in Alabama's Hispanic/Latino population has posed a challenge in counties where growth has been the greatest. Calhoun County (4.1%) is similar to the state, whereas Cleburne and Talladega are each about one-half of the state's percentage. 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 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 assist in providing care for Hispanic/Latino Alabamians by securing training in medical Spanish for RMC's ED staff.

Exhibit 10 – Race and Hispanic Origin

	Calhoun County	*Cleburne County*	*Talladega County*	*Alabama State*
White alone, percent, July 1, 2019 (V2019)	75.1%	95.1%	64.1%	69.1%
Black or African American alone, July 1, 2019	21.3%	2.8%	33.0%	26.8%
American Indian and Alaska Native alone, percent, July 1, 2019	0.5%	0.5%	0.4%	0.7%
Asian alone, percent, July 1, 2019	0.9%	0.2%	0.7%	1.5%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2019	0.1%	0.1%	Z	0.1%
Two or More Races, percent, July 1, 2019	2.0%	1.3%	1.8%	1.8%
Hispanic or Latino, percent, July 1,2019	4.1%	2.6%	2.4%	4.6%
White alone, not Hispanic or Latino, percent, July 1, 2019	71.7%	92.85	62.35	65.3%

Z - Value greater than zero but less than half unit of measure shown

Source: U.S. Census Bureau/ACS Quick Facts.

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 (ages 65-84, 85+). The U.S. hospital admission rate per 1,000 population (all regions, all ages) in 2016 was 104.2 and for ages 65-84 and 85+ was 232.5 and 455.7 respectively (Source: HHS Agency for Healthcare Research and Quality, 12/2018). For all three categories, the highest region of the U.S. relative to hospital admission rate per 1,000 population was East South Central Division (AL, KY, MS, and TN) with rates of 121.3, 272.4, and 500.9 respectively. Higher use rates generally indicate a sicker population and can indicate differences in delivery choices and options as well as patient and physician behavior. Downward pressures on utilization from payors and healthcare reform currently in place as of this 2020 CHNA 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. Just as alarming is the fact that between 2010 and 2019, is the decline in the total population in both Calhoun (-4.9%) and Talladega (-2.9%) Counties.

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 include:

- 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 Exhibit below from the Kaiser Family Foundation, which also shows that Hispanics and Asian/Pacific Islanders have lower death rates;
- ADPH Center for Health Statistics 2017 reports continue to show an overall improvement in AL Infant Mortality Rate (IMR); and while, the Alabama statewide IMR discrepancy gap between Black/Other (11.0) and White (5.5) babies continues to grow, the IMR in the 3-county service area is relatively comparable between Black/Other and White without an apparent IMR discrepancy gap. Further, AL overall state IMR remains high at 7.4 as one of the highest in the U.S;
- The Overall Death Rate along with White and Black Death Rates, when comparing Alabama to the U.S., Alabama's rates are 27%, 25%, and 16% higher respectively and while the overall death rates have declined in the U.S., they have been demonstrated to be continually increasing in Alabama in recent years; and

Exhibit 11 - 2018 Deaths/100,000

	U.S.	*Alabama State*
Overall Death Rate	723.6	918.1
White	725.4	902.8
Black	852.9	987.2
Other	420.2	370.4

Source: Kaiser State Health Facts, Kaiser Family Foundation – kff.org/Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2018

- Relative to the CDC's COVID-19 reporting (7/2020) across the country as to risk of illness and death by race and ethnicity:

  - Once COVID-19 infected, racial and ethnic minorities have on average, twice the chance of becoming seriously ill and dying vs. non-Hispanic whites;
  - Black/African Americans that represent 13% of the total population, account for 22% of the seriously or have died;
  - Hispanics that represent 18% of the total population, account for 33% of the seriously or have died.

More paramount and exemplified during this year 2020 of the COVID-19 pandemic, is that patients with co-morbid clinical conditions, have been shown to have a greater potential in contracting COVID-19 regarding their own specific COVID-19 "Underlying Conditions," which include but is not limited to Hypertension, Diabetes, and Obesity. COVID-19 discriminates by these and other underlying conditions and by ethnicity. The CDC (July 2020) reports there is increasing evidence that some racial and ethnic minority groups are being disproportionately affected by COVID-19 and that inequities in the social determinants of health, such as poverty and healthcare access, affecting these groups are interrelated and influence a wide range of health and quality-of-life outcomes and risks

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

Inequities in the social determinants of health, such as poverty, healthcare access, and education, affecting racial and ethnic minority population groups are interrelated and influence a wide range of health and quality-of-life outcomes and risks. They suffer the worst status and are also those that have the highest poverty rates and the least education. To achieve health equity, barriers must be removed so that everyone has a fair opportunity to be as healthy as possible. 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. Chronic disease management has become a more apparent issue as our country ages, affecting both urban and rural areas such as HCACA' service area, and all races and ethnicities, specifically Black/African Americans.

Based on the American Community Survey 5-Year Estimates 2014-2018, Median Household Income and Median Value of Housing Units for Calhoun, Cleburne, and Talladega Counties are all lower than that for the State. Talladega is significantly less than the State in both indicators by approximately ¼ to one-third. The absolute amounts are consistent from prior years and not projected to change drastically over time. However, even pre-COVID-19, the unemployment rate was higher in all three counties compared to the that of the State. Since COVID-19, as the RWJF 9/2020 study indicates, all races and ethnicities have been negatively impacted relative to losing jobs, being furloughed, or having wages or hours reduced due to the pandemic.

Exhibit 12 - Median Household Income

	Med HHD Income (2018 $) 2014-2018	*Med Value Housing Units 2014-2018*	*Persons Per Household 2014-2018*
Calhoun County	45,197	113,800	2.49
Cleburne County	40,188	112,000	2.58
Talladega County	41,012	101,800	2.46
Alabama – Statewide	48,486	137,200	2.55

Source: U.S. Census Bureau/ACS QuickFacts

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. Specifically, relative to Calhoun and Talladega Counties in the following Exhibit, there are more 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. These are all indicators of potentially worse access to healthcare.

Exhibit 13 – Selective Socioeconomic Indicators

Indicator	*Calhoun County*	*Cleburne County*	*Talladega County*	*Alabama State*	*U.S.*
All Ages in Poverty	19.5	16.0	19.3	16.8	13.1
Under Age 18 in Poverty	26.5	22.9	26.4	23.9	18.0
Ages 5 to 17 in Families in Poverty	24.1	22.9	24.1	22.8	17.0
Under Age 5 in Poverty	NA	NA	NA	26.0	19.5
Uninsured Adults Age <65*	12%	13%	10%	11%	NA

*Source: U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE) Program 2018;*RWJF 2020 County Health Rankings 2017 Data*

Educational issues further compound the income disparities, particularly among children. In two key indicators below (percent of population ages who have graduated from high school and percent of teen population who are not at school and not working), Calhoun, Cleburne, and Talladega Counties' children are shown to be at a disadvantage compared to the State overall. Further, all three counties have higher percentages of children in poverty compared to the State and both Calhoun and Talladega have higher percentages of children in single-parent families.

Exhibit 14 - Education Indicators

Indicator	*Calhoun County*	*Cleburne County*	*Talladega County*	*Alabama State*
High School Graduates	92%	98%	93%	89%
Children in Poverty	27%	23%	26%	24%
Unemployment	4.7%	4.2%	4.3%	3.9%
Children in Single-Parent Families	40%	25%	46%	37%
High school Drop Out Rate (2015-2016)*	4.1%	0.6%	3.5%	4.5%
Percent of teens Not Attending School and Not Working (2011-2015)*	8.8%	6.4%	14.0%	8.8%

*Source: *KidsCount.org, Annie E. Casey Foundation 2015/RWJF 2020 County Health Rankings Data 2016-2017*

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 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 Exhibit, which include some of those relative to COVID-19 underlying conditions (i.e., diabetes, obesity) if reversed, would lead to improved health. In all indicators, Alabama's rates and percentages are poor compared to the U.S. (based on the 90th percentile). The three counties also perform poorly with Cleburne sometimes better than the other two counties and, in some cases, better than the State. Obesity has become a problem nationwide leading to many health problems and chronic disease – also COVID-19. The U.S. rate of 25% is high and all three counties and the State of Alabama are even higher, indicating an unhealthy community.

High hospitalization rates for ambulatory sensitive conditions (ASC) show lack of access to primary and preventive services, either through choice, lack of insurance payment, or lack of understanding on how to access services. As evidenced by teen pregnancy rates, teens are engaging in risky behaviors too, which also parallels higher chlamydia rates also shown in the Exhibit below.

Exhibit 15 - Selected Behavioral Risk Factors

Indicator	*Calhoun County*	*Cleburne County*	*Talladega County*	*Alabama State*
Adult Smoking (2017)	21%	18%	23%	21%
Adult Obesity - (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2 (2016)	39%	37%	39%	36%
Quality of life – Adults reporting poor or fair health (2017)	23%	19%	23%	22%
Physical Inactivity - adults age 20 and over reporting no leisure-time physical activity (2016)	32%	31%	35%	30%
Access to exercise opportunities (2010 & 2019)	32%	31%	35%	61%
Excessive Drinking - adults reporting binge or heavy drinking (2017)	14%	14%	14%	14%
Diabetes Prevalence Adults Aged 20+ (2016)	18%	13%	16%	14%
Female Medicare enrollees ages 65-74 that received an annual mammography screening (2017)	32%	26%	36%	40%
Food insecurity - Percentage of population who lack adequate access to food (2017)	16%	15%	17%	17%
Percent of live births with low birth weight (<2500 grams) (2012-2018)	9%	9%	12%	10%
Infant Mortality Rate/1,000 Live Births (2012-2018)	8	N/A	8	8
Teen Births per 1,000 female population ages 15-19 (2012-2018)	34	39	34	31
Sexually Transmitted Infections (STI) - newly diagnosed chlamydia cases per 100,000 population (2017)	654.6	187.9	729.4	614.1
Air pollution –particulate matter - Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) (2014)	11.8	11.0	11.5	11.0
Preventable hospital stays - Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees (2017)	6,581	6,416	5,467	5,805

Sources: RWJF 2020 County Health Rankings

Despite these indicators, and the relatively high rates shown below, screening indicators are similar in Alabama and the U.S., but slightly higher for the state. The exceptions are for both dental indicators, including "adults who visited dentist in past year any reason," in which Alabama's rate is less than that of the U.S. County level data was not available for these indicators for the 2020 CHNA.

Exhibit 16 - Additional Selected Behavioral Risk Factors

Indicator	*Alabama State*	*U.S.*
Adults 65+ who had a flu shot in past year	58.0%	54.1%
Children 0-17 who had both medical & dental preventive care visit in the last 12 mos.	65.4%	68.3%
Adults told by Dr. they have Diabetes	14.5%	11.4%
Adult women who have been told they have Diabetes	14.7%	11.0%
Adults self-reported current Asthma Prevalence Rate	10.5%	9.2%
Children 0-17 who are overweight or obese	33.2%	30.7%
Adults who visited dentist in past year any reason	60.8%	66.5%

Sources: kff.org/Centers for Disease Control and Prevention (CDC)'s Behavioral Risk Factor Surveillance System (BRFSS) 2013-2018 Survey Results

Likely, as the result of some of the above behaviors, plus other issues, the population in the three counties has worse access to primary care providers (more so in Cleburne and Talladega vs. Calhoun), behavioral health providers (i.e., HPSA Mental Health designations), or other providers in the healthcare system, and 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 U.S. The number of poor mental health days per month (AL and the 3 counties) is a predictor of future health, forecasting office visits, and hospitalizations. Poor mental health can lead to suicide.

Exhibit 17 - Reported Indicators in Calhoun, Cleburne, and Talladega Counties

Indicator	*Calhoun County*	*Cleburne County*	*Talladega County*	*Alabama State*	*U.S. Median*
Poor or fair health - Percentage of adults reporting fair or poor health (age-adjusted) (2017)	23%	19%	23%	22%	12%
Poor physical health days Average number of physically unhealthy days reported in past 30 days (age-adjusted) (2017)	4.9	4.5	4.8	4.9	3.1
Poor mental health days Average number of mentally unhealthy days reported in past 30 days (age-adjusted (2017)	4.8	4.9	5.0	4.9	3.4
Frequent mental distress - Percentage of adults reporting 14 or more days of poor mental health per month (2017)	15	15	16	16	N/A
Excessive drinking - Percentage of adults reporting binge or heavy drinking (2017)	14%	14%	14%	14%	13%
Uninsured adults - Percentage of adults under age 65 without health insurance (2017)	15%	17%	13%	14%	N/A
Ratio of Population to PCP (2017)	1,570:1	3,730:1	3,200:1	1,540:1	1,030:1
Social associations - Number of membership associations per 10,000 population (2017)	14.5	8.1	12.4	12.4	18.4
Food Environment Index – Healthy food 0-10 scoring (2017)	6.9	8.0	7.0	5.8	8.6

Source: RWJF 2020 County Health Rankings

The U.S. Census Bureau's 2018 estimates for uninsured women of all races relative to poverty level, shows Cleburne County (all poverty levels) with higher rates across the board than Alabama, whereas, Calhoun and Talladega Counties have lower rates across the board. It should be noted that in the 2017 CHNA, Kaiser Family Foundation's (KFF) reports and briefs show that people of color have been more likely to be uninsured and to face more barriers in accessing healthcare than whites, often resulting in lower use of healthcare services and worse healthcare outcomes. For the 2017 CHNA, Alabama vs. the U.S., males/females combined, Whites, Blacks, and Hispanics were 11% vs. 8%, 14% vs. 12%, and 28% vs 17% respectively. This situation is exacerbated relative to women of color, regardless of the CHNA reporting year. This likely contributes to poorer health among the uninsured groups, particularly if there is not a strong community of caring for them.

Exhibit 18 – Uninsured Women All Races

	Calhoun County	*Cleburne County*	*Talladega County*	*Alabama State*
Under 65 years All Incomes	9.7	12.3	10.4	10.8
Under 65 years <=200% of Poverty	14.6	19.1	15.6	17.9
Under 65 years <=250% of Poverty	13.8	17.8	14.8	16.8
Under 65 years <138% of Poverty	15.8	20.4	16.9	19.2
Under 65 years <=400% of Poverty	11.8	15.0	12.5	14.0
Under 65 years 138% to 400% of Poverty	9.1	11.7	9.5	10.6

Source: U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE) 2018

Intimate Partner Violence ("IPV") constantly has been linked to long-term as well as short-term health issues. COVID-19 is the "perfect storm" as early reports indicate the perpetuation of abuse and violence in spousal, children, and family relationships ***(Source: Family Violence and COVID-19, https://doi.org/10.1111/inm.12735***). Long-term issues include neurological, gastroenterological, cardiac as well as other medical and behavioral health (mental health) 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. Further regarding violence, in United Health Foundation, America's Health Rankings 2019 report, Alabama ranked 44 of all states throughout the U.S. relative to violent crime offenses (520) per 100,000 population.

Only a small percentage of primary care physicians indicate that they routinely inquire about IPV; 6% of internists, 10% of family practitioners and 17% of OBGYNs. There is no specific data on IPV in the three counties against adults but the level of abuse against children is higher in the counties compared to the State. This is especially so in Cleburne (17.0) and Talladega (16.2) as indicated in Kidscount.org in 2015, the most current reporting. The indicator is a measurement that involves instances of child abuse or neglect where both credible evidence and the professional judgment of the social worker substantiate that an alleged perpetrator is responsible for harming the child.

Exhibit 19 - Indicators of Abuse Among County Children

Indicator	*Calhoun County*	*Cleburne County*	*Talladega County*	*Alabama State*
Child Abuse/Neglect Investigations per 1,000 children <18 (2015)	11.2	17.0	16.2	7.8
Investigations Substantiated	NA	NA	NA	NA

Source: KidsCount.org Annie E. Casey Foundation 2015

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 needs to be coordinated with both other provider and non-provider members of the community relative to the 3-county service area.

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 U.S., AL, and each of the three service area counties have similar leading causes of death, but in slightly different orders. Heart Disease and Cancer rank #1 and #2 for Alabama and all three counties. Chronic Lower Respiratory Disease (CLRD) ranks #3 for Alabama and Calhoun County and #4 and #5 in Cleburne and Talladega respectively. Alzheimer's Disease appears in the "top five" for Calhoun and Cleburne at #4 and #6 respectively.

Exhibit 20 - Top 5 Leading Causes of Death, U.S., Alabama and 3 Counties

Rank	*U.S.*	*Alabama State*	*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	CLRD	Accidents	Stroke
4	Cerebrovascular Diseases (Stroke)	Stroke	Alzheimer's Disease	CLRD	Accidents
5	Accidents	Accidents	Stroke*	Stroke*	CLRD
5			Accidents*	Alzheimer's*	

**Tied in ranking.*
Source: Alabama Center for Health Statistics 2017, County Health Statistics

The Exhibit below summarizes the death rate per 100,000 population for the leading causes of death. In almost all areas, Alabama and the three counties have higher death rates than the U.S., in some cases significantly higher. Further, all three counties are higher than Alabama. Other than Diabetes in which, all three counties are all significantly less than Alabama, in the majority of the other areas, the three counties area, are higher than Alabama (i.e. HIV in Talladega 5.0 vs. 1.9). Regarding Accidents and Alzheimer's Disease, the three counties are particularly higher than Alabama.

Exhibit 21 - Mortality Data (Deaths per 100,000 Age-Adjusted Population)

Indicator	*Calhoun County*	*Cleburne County*	*Talladega County*	*Alabama State*
Heart Disease	400.0	389.3	344.7	268.8
Cancer	229.2	187.9	258.5	213.7
Chronic Lower Respiratory Disease	96.8	80.5	77.4	71.5
Cerebral Disease/Stroke	61.9	67.1	86.2	60.1
Influenza/Pneumonia	37.5	26.8	36.2	24.1
Accidents	61.9	94.0	81.2	55.4
Suicide	24.4	13.4	22.5	17.1
Diabetes	13.1	13.4	23.7	24.0
HIV Disease	1.7	0.0	5.0	1.9
Alzheimer's Disease	63.6	67.1	33.7	52.6

Source: Alabama Center for Health Statistics 2017, County Health Profiles

As it has throughout our CHNAs' reporting, heart disease continues to affect every segment of the population. It is the leading cause of death among all segments of the population and significantly so in all three counties compared to AL and the U.S. as delineated in the above Exhibit. Calhoun (400.0), Cleburne (389.3), and Talladega (344.7) are all considerably higher than Alabama (268.8), relative to the age-adjusted heart disease mortality rate. 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 (prevalent in southern states) and poor primary care and prevention can lead to heart disease; all these behaviors are present in the area as shown previously. To reduce the mortality from heart disease heightened as an underlying condition during the COVID-19 pandemic, changes continue to need to be made on all fronts of the healthcare delivery system (direct care and telehealth care): prevention, treatment, control and rehabilitation.

Calhoun, Cleburne, and Talladega Counties all have an overall higher incidence rate of cancer (all cancers) compared to both AL and the U.S. In Calhoun County especially, it is the male cohort with a substantially higher incidence rate that is pushing the overall

rate up since the female incidence is more similar to the U.S. and less than the state. Cleburne County's incidence rate for the black population (both males and females) has a higher incidence than the U.S. and the state. In all three counties, black males have a higher incidence than white males, along with higher incidence for black males compared to the state. Black females in Cleburne and Talladega both have a higher incidence than white female counterparts, in addition to higher than the state.

The cancer (all cancers) mortality rates in all three counties and the state are higher than the U.S. Even in Cleburne and Talladega Counties where the incidence is lower, the mortality is higher. The higher mortality is applicable to overall rates (both sexes and all races) and for whites more than for blacks. This indicates that patients are not getting timely treatment and, possibly, not getting timely screenings where appropriate. Similarly, relative to cancer incidence rates for the total population, the cancer mortality rates are also closely aligned with the state rate; however, all three counties and the state are higher than the U.S.

Exhibit 22 – Cancer Incidence In Alabama and by County

Cancer Incidence: All Cancer	*Calhoun County*	*Cleburne County*	*Talladega County*	*Alabama State*
Total Population	467.1	468.7	464.6	461.6
Males	573.4	547.3	560.9	545.5
Females	394.9	407.5	393.3	401.2
Black Males	594.6	693.6	693.6	581.3
Black Females	358.4	449.0	449.0	382.8
White Males	574.2	543.1	543.1	530.9
White Females	405.0	404.8	412.1	406.7

Source: Alabama Cancer Facts & Figures 2018-2019 (Alabama Statewide Cancer Registry (ASCR), 2019. Data Years: 2007-2016

Exhibit 23 - Cancer Mortality Frequencies in Alabama and by County

Cancer Mortality: All Cancers	*Calhoun County*	*Cleburne County*	*Talladega County*	*Alabama State*
Total Population	302	29	197	10,630
Males	155	16	109	5,759
Males – Other	0	0	1	37
Females	147	13	88	4,871
Females – Other	1	0	0	44
Males Black	26	0	29	1,238
Females Black	31	0	20	1,138
White Male	129	16	79	4,484
White Females	115	13	68	3,689

Source: Alabama Department of Public Health, Center for Health Statistics 2018, Mortality Statistical Query System

The Cancers where the incidence is relatively higher in all three counties compared to the State and U.S. are Lung/Bronchus incidence and Lung Cancer mortality along with Colorectal incidence and Colorectal cancer. Overall, mortality for Colorectal Cancer is similar to the State and U.S. other than Cleburne. Prostate incidence from males in all three counties is less than the State; however, prostate mortality is higher than the State relative to Talladega, but not Calhoun and Cleburne. Breast Cancer incidence for women in all three counties is less than the State; however, Breast Cancer mortality is higher than the State once again relative to Talladega, but not Calhoun and Cleburne.

Exhibit 24 - Selected Cancer Incidence and Mortality per 100,000 Population (Age Adjusted to the U.S. 2000) 2007-2016

Indicator	*Calhoun County*	*Cleburne County*	*Talladega County*	*Alabama State*	*U.S. (SEER)***
Breast Cancer Incidence Female	107.0	98.7	115.4	120.8	128.5
Breast Cancer Mortality	13.1	6.7	21.2	14.4	20.1
Lung and Bronchus Incidence	80.2	79.2	76.2	70.3	54.2
Lung Cancer Mortality	77.6	67.1	77.4	60.5	32.0
Colorectal Incidence*	50.7	55.8	48.4	45.1	38.2
Colorectal Mortality	27.0	26.8	23.7	19.8	11.5
Prostate Incidence Male	131.9	102.5	132.8	136.4	109.8
Prostate Mortality	7.0	6.7	11.2	9.5	19.0
Pancreas Mortality	12.2	0.0	16.2	14.6	11.0
Non-Hodgkin Lymphoma Mortality	7.8	6.7	1.2	6.2	4.1

*Sources: Alabama Department of Public Health, Center for Health Statistics, Division of Statistical Analysis – 113 Causes of Death by County of Residence, Race and Sex, Vital Statistics, 2017; *Alabama Cancer Facts & Figures 2018-2019; Alabama Statewide Cancer Registry (ASCR), 2019. Data Years: 2007-2016; **National Cancer Institute – Surveillance, Epidemiology, and End Results Program (SEER), 5 Year Age-Adjusted Incidence Rates 2013-2017, 2014-2018*

The State appears to have similar behavior to the U.S., albeit it slightly higher, in following the guidelines for screening (sigmoidoscopy/colonoscopy) for Colorectal Cancer, as shown in the screening below, which is consistent with the State being slightly higher relative to mortality and incidence as well. County data is not available for these screenings.

Exhibit 25 - Colorectal Cancer Screening, Adults 50 and Older, 2016

Screening	*Alabama State*	*U.S.*
Sigmoidoscopy/Colonoscopy	71.7%	69.4%
Fecal Occult Blood Test in Past 3 Years	15.0%	17.5%

Source: Alabama Cancer Facts & Figures 2018-2019, Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention

Derived from the Health Status and Health Indicators sections, the following, while not necessarily all-inclusive, demonstrates potential, ***selective*** goal areas to be considered in a healthcare plan specific to HCACA'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 relative to the State and the U.S. rates. The State rate is higher than the U.S. rate. The Counties' and State rates are higher than the Healthy People 2020 target rate of 103.4/100.000 population. Hypertension, smoking, high blood cholesterol levels and obesity are all risk factors in chronic heart disease – COVID-19 also. Based on the United Health Foundation, America's Health Rankings 2019 report, Alabama ranked 45 of all states relative to obesity (36.2% of all adults) and to physical activity (30.7% of all adults). Most of the behaviors of the service area population show elevated levels for all risk factors, including limited physical activity. Diet and lifestyle interventions should be the treatment focus. ***Healthy People 2020 overall coronary health disease target death rate objective is 103.4 deaths per 100,000 population (Healthy People 2030 = 71.1).***

- **CANCER - Problem/Need**: The incidence rate from cancer (all cancers) is higher in Calhoun, Cleburne, and Talladega Counties relative to the State and the U.S. rates. The State rate is higher than the U.S. rate. Based on the United Health Foundation, America's Health Rankings 2019 report, Alabama ranked 40 of all states relative to smoking (19.2% of all adults) and 42 relative to cancer deaths per 100,000 population. In addition to community education services such as smoking cessation 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 cancer-related diseases. ***Healthy People 2020 overall cancer target death rate objective is 161.4 deaths per 100,000 population (Healthy People 2030 = 122.7).***

- **DIABETES - Problem/Need:** The-age adjusted death rate from diabetes is less in Calhoun and Cleburne Counties and Talladega is consistent relative to the State rate. Based on the United Health Foundation, America's Health Rankings 2019 report, Alabama ranked 49 of all states relative to diabetes (14.5% of all adults),

which also is a key COVID-19 underlying condition. Even though the diabetes incidence, as measured by diagnosed diabetics, was less in the three counties to the State and U.S., the situation still may exist that people don't not get appropriate treatment and education in a timely manner. It continues to be indicated during the key informant surveys that diabetic treatment is adequate. ***Healthy People 2030 overall diabetes target death rate objective is 13.7 deaths per 1,000 person years.***

- **CEREBROVASCULAR DISEASE - Problem/Need:** The age-adjusted death rate from cerebrovascular disease is higher in Calhoun, Cleburne, and Talladega Counties relative to the State and the U.S. rates. The State rate is higher than the U.S. rate. Based on the United Health Foundation, America's Health Rankings 2019 report, Alabama ranked 35 of all states relative to all behaviors. 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.Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment. ***Healthy People 2020 overall stroke target death rate objective is 34.8 deaths per 100,000 population (Health People 2030 = 33.4).***

- **CHRONIC LOWER RESPIRATORY DISEASE - Problem/Need:** The age-adjusted death rate from chronic lower respiratory disease is higher in Calhoun, Cleburne, and Talladega Counties relative to the State rate. The State rate is higher than the U.S. rate. 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. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. ***Healthy People 2020 overall COPD target death rate objective is 102.6 deaths per 100,000 population (Health People 2030 = 107.2).***

- **BEHAVIORAL HEALTH (MENTAL HEALTH, SUBSTANCE USE DISORDER, OPIOID USE DISORDER): Problem/Need**: Based on the United Health Foundation, America's Health Rankings 2019 report, Alabama has the dubious distinction of ranking 50 of all states relative to number of mental health providers per 100,000 population, and 45 relative to adults in frequent mental distress (15.6%). Adults with both a mental health (MH) and substance use disorder (SUD) often get treated for one or the other but not both. An approach that treats both diagnoses together is critical for getting people the care they need in Alabama. With 4.9 million+ residents, Alabama struggles with its fair share of MH, SUD, and opioid use disorder (OUD) issues. Depression and other MH diagnoses are as common as alcoholism, heroin addiction, and prescription painkillers i.e. opioids. A main reason for failure to

address need has been separation between care for the SUD diagnosis and the rest of the healthcare system. Despite the stigma surrounding SUD, the rampant opioid crisis (i.e. Tom Petty death in 2017) touches a wide range of the population, including people with stable lives, jobs and families, and workplaces too. In 2017, half of the 775 reported drug overdose deaths in Alabama involved opioids. And in 2018, Alabama providers wrote 97.5 opioid prescriptions for every 100 persons – highest in the U.S. The need to start/expand MH and SUD services and to integrate with primary care services is critical with a specific focus on treatment, prevention, and awareness of opioid abuse. Since depression is a common problem among Alabama adults, treatment plans that connect primary care providers, patients, and mental health specialists can help adults get the care they need. ***Relative to OUD objectives, a paramount Healthy People objective is to reduce overdose deaths involving opioids, of which the Healthy People 2030 target is 13.1 deaths per 100,000 population.***

The COVID-19 pandemic has led to an increase in anxiety, depression, and other mental health issues worldwide. In the July 2020 issue of the Journal of Psychosocial Nursing and Mental Health Services (***Source: Action Steps Toward a Culture of Moral Resilience in the Face of COVID-19***), recommended interventions regarding COVID-19, includes professionals in helping those who are experiencing mental health, develop a large-scale support system and intervention hotlines that caters to the needs of people who are experiencing anxiety, psychological stress, and posttraumatic stress disorder (PTSD).

Throughout our prior and current CHNA reports for the HCACA, people continue to die 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. Clearly, this needs to be changed and more so now with COVID-19. Part of the impetus has been coming from payor pressures and from states as well (regardless or not if they chose 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.

ACA/Obamacare 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. 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 hospital readmissions, the development of delivery payment pilots for bundled services, medical home demonstrations, coordination grants, and increased financial support for health centers (FQHCs) 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. A central goal of the ACA is to significantly reduce the number of uninsured by providing a continuum of affordable coverage options through Medicaid and the Health Insurance Marketplaces, hence the national investment in preventive and public health programs.

As of this 2020 CHNA, Alabama has not expanded Medicaid, so the poorest residents in the state have not benefited from the ACA. An August 2014 Urban Institute study shows the impact of not expanding Medicaid. In AL, based on that study, approximately 254,000 people will not qualify for Medicaid coverage through 2016 into 2017. In terms of financial impact, Urban Institute calculated that while AL would spend $1.08 billion to expand Medicaid over a ten-year period, the State is losing out on $14.4 billion in federal spending and state hospitals are losing $7.0 billion in reimbursement over the same period.

Eight of the 12 states which have not expanded Medicaid to cover more of the poor, low-income residents are located in the south and includes Alabama and 4 neighboring states of Georgia, Mississippi, Tennessee, and Florida. Prior to ACA/Obamacare, Alabama's rate of uninsured was at 14% and currently, 10% of Alabamians still remain without insurance, whereas the rate for the U.S. is 9% inclusive of the 12 states that have not expanded and the 38 that have expanded. This included 483,400 residents of all races and ethnicities who are uninsured Alabamians residing throughout rural, suburban and urban areas such as the 3-county service area. Many are the working poor, either self-employed or working in small businesses which do not provide coverage. It has been projected that under Medicaid expansion, the rate of uninsured would drop to 6% and many of the uninsured would be covered (Source: AL.com article, 9/2020).. In addition to helping these needy individuals, the Alabama Hospital Association has stated that Medicaid expansion would also stop the closure of more small, rural hospitals, several of which have closed in recent years. Gov. Kay Ivey has opted to submit a Medicaid Waiver to CMS/DHHS which would include work requirements. the feds and is unlikely to ever be approved. By not expanding Medicaid with the majority of it (approximately 90%) paid for by the Federal government) to cover the maximum number allowed under federal law approximately 4.8 billion in federal tax money that could go to Alabama poor, low-income residents, goes to the other 38 states which decided to expand their Medicaid programs (Source: AL.com article, 9/2020).

In states where Medicaid has been expanded, premium subsidies start at 138 percent of the poverty level, as enrollees below that level qualify for Medicaid instead. Since there's a correlation between poverty and poorer health status, Medicaid expansion helps to strengthen the risk pools in the individual market, and AL's exchange has not yet benefitted from this.

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 (AAMC) and the U.S. Council on Graduate Medical Education.

F.1. Federal Designations and Physician Shortage

Federal criteria relative to healthcare provider need in an area (county or county subset) continues to be predicated on two federal designations: 1) Health Professional Shortage Area (HPSA) and Medically Underserved Area/Population (MUA/P). For purposes of this 2020 CHNA, HPSA designations, which are updated on an ongoing basis, are the rationale for demonstrating healthcare provider need and MUA/P designations are utilized in conjunction with other criteria and methodologies in determining a health center's (FQHC) service area, along with obtaining grants. This includes 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 (SDB) is 3,500:1 (HPSA Geographic Area) and in certain conditions, 3,000:1 (HPSA Population Group, i.e. Low-Income). 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 current HPSA – Primary Medical Care designation in Calhoun County is based on the 12/31/2018 last update. The "whole county" of Calhoun is designated as HPSA Primary Care – Low-Income Population Group. Cleburne County is wholly designated

HPSA Primary Care - Geographic Area as of the 10/28/2017 last update and Talladega County is wholly designated HPSA Primary Care – High Needs Geographic Area as of the 12/31/2018 last update. Validating mental health need based on the United Health Foundation, America's Health Rankings 2019 report, "Alabama has the dubious distinction of ranking 50 of all states relative to number of mental health providers per 100,000 population, and 45 relative to adults in frequent mental distress (15.6%)," All three counties are HPSA Mental Health – Geographic Area-designated ("single county"), last updated in 2017/2018 and with Talladega as "High Needs." All three counties ("single county") are HPSA Dental Health – Low-Income Population Group-designated.

In summary, the greatest primary medical care "High Needs" for the general, civilian population is in Talladega 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.

Exhibit 26 – Primary Care Indicators

Primary Care Indicator	*Calhoun County*	*Cleburne County*	*Talladega County*
Total Population*	114,277	14,987	79,828
Primary Care Physicians Per Population*	72.8	4.0	24.9
Dentists Per Population*	66.8	***	21.3
Mental Health Providers Per Population*	131.4	6.0	15.0
Health Professional Shortage Area (HPSA) – Primary Medical Care**	Yes	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

*Source: * RWJF 2020 County Health Rankings 2017/2018 Data;*
*** HRSA Shortage Designation Branch 9.23.2020;*
****Missing or Unreliable Data*

It should be noted that the above Exhibit is based on calculating the population divided by number of health professionals and determining a ratio. The measures have been modified as follows: *1) Primary care physicians include non-federal, practicing physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics; *2) Dentists are measured as the ratio of the county population to total dentists in the county; and *3) Mental Health Providers is the ratio of the county population to the number of mental health providers including psychiatrists, psychologists, licensed clinical social workers, counselors,

marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care. Once again, validating mental health need is based on the United Health Foundation, America's Health Rankings 2019 report, "Alabama has the dubious distinction of ranking 50 of all states relative to number of mental health providers per 100,000 population, and 45 relative to adults in frequent mental distress (15.6%)." RWJF's county rankings show Primary Care Physicians as a ratio of the population to primary care physicians (non-federal MDs and DOs of which the ratios for Calhoun, Talladega, and Cleburne Counties are 72.8, 24.9 and 4.0 respectively.

New physician workforce projections indicate that the physician shortage remains significant. A March 2015 report for 2025 projections relative to physician supply and demand released by the Association of American Medical Colleges (AAMC) shows that the demand for physicians continues to grow faster than supply, leading to a projected shortfall of between 46,100 and 90,400 physicians by 2025, with major findings as follows:

- Although physician supply is projected to increase modestly between 2013 and 2025, demand will grow more steeply. Total physician demand is projected to grow by 86,700 to 133,200.

- Projected shortfalls in primary care will range between 12,500 and 31,100 physicians by 2025, while demand for non-primary care physicians will exceed supply by 28,200 to 63,700 physicians.

- Expanded medical coverage achieved under ACA when it was fully implemented, has been projected to increase demand by about 16,000 to 17,000 physicians over the increased demand resulting from changing demographics.

- Due to new data and the dynamic nature of projected assumptions, the projected shortfalls of physicians in 2025 are smaller than shortfalls projected in earlier studies with projected demand for physicians in 2025 exceeding supply by 46,100 to 90,400, compared to a 130,600 shortfall projected in a 2010 study.

- The demand for physicians in medical subspecialties is growing rapidly i.e. internal medicine, pediatric subspecialties, and the supply of surgeons is not projected to grow based on current trends; yet there continues to be strong projected growth in demand with a shortfall of between 23,100 and 31,600 surgeons projected by 2025.

Reports from most specialty associations or workgroups project shortages and generally support the AAMC report, 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 has declined each year since 1998. The practice of primary care needs to be made more lucrative and require less administrative work to attract new physicians. Larger group practices and employment options help to alleviate these concerns somewhat. Further, Alabama, has not chosen to expand Medicaid, which could further impact a shortage of physicians in rural areas in the future, thereby disproportionately affecting already overburdened healthcare resources;

- Preventable Hospitalization: Based on United Health Foundation, America's Health Rankings 2014 report, Alabama ranked 43 and 40 relative to Preventable Hospitalizations and availability of Primary Care Physicians respectively of all states and RWJF's County Health Rankings 2017: AL delineated that there were 61 preventable hospital stays per 1,000 Medicare enrollees relative to Ambulatory Care Sensitive Conditions;

- Cardiology: Expected increase in need with almost 50% of existing cardiologists nearing retirement age; there is 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 relative to co-morbidity arising from chronic disease management, lack of on-call specialists and greater use of ED for non-emergency issues. This is critical as KFF 2018 reporting shows AL (479) ranked as the 19th highest state in the U.S. (439) regarding hospital ED visits per 1,000 population – considerable improvement from the 2017 CHNA 262 versus 63 for the U.S. More FQHC collaboration and/or site/service develop, however, in which collaboration with FQHCs and other ambulatory care providers could stem the tide in a more appropriate and less costly setting than hospital EDs;

- 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 1981 to 5.69 in 2005;

- Geriatric Medicine: There are few departments in medical schools 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 – United Health Foundation's 2019 report shows Alabama as 50th in ranking relative to mental health providers per 100,000 population.

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, especially regarding ACA/Obamacare and the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess hospital readmissions within 30 days of a discharge, effective for Medicare discharges beginning on October 1, 2012.

Lack of access, as with the 2017 CHNA, continues to be apparent for the low-income population (income equal to or less than 200% of federal poverty level) in the 2020 CHNA with f the Calhoun, Cleburne, and Talladega Counties combined service area. Even with the presence of now Federally Qualified Health Center (FQHC) satellite sites in the three-county service area by Quality of Life Health Services, Inc. (Calhoun/Anniston-2, Cleburne/Heflin-1, Talladega/Talladega-1), there remains a significant void in primary medical care capacity in the three counties combined and it should be noted that that this Gadsden-based FQHC network organization has received additional U.S. Public Health Service section 330 dollars for HRSA New Access Point (NAP) satellite site expansion during ACA health reform, plus COVID-19, capital, and other HRSA grant funding.

As previously indicated, the community (service area) served by HCACA, 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 HRSA's 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 twelve-zip code community (service area) constitutes 157,418 total population ***(Source: U.S. Census Bureau)***, which includes 64,829 (43.1%) low-income individuals, those having income equal to or less

than 200 percent of federal poverty level. The low-income percentage is comparable to prior CHNAs, but clearly, almost one-half of the total population is low-income.

Exhibit 27 - Community Served by the Hospital – Low-Income Population

Zip Code	*Place*	*County*	*Total Population 2011-2015*	*Low-Income Population 2011-2015*	*Low-Income % Total Population 2011-2015*
Summary:			157,418	64,829	42.74%
36201	Anniston	CA	18,052	10,161	57.77%
36203	Oxford	CA,TA	18,033	6,019	33.81%
36207	Anniston	CA	19,746	6,866	35.25%
36265	Jacksonville	CA	20,694	7,635	40.11%
36206	Anniston	CA	11,541	4,913	42.99%
36264	Heflin	CL	8,523	3,715	44.91%
35160	Talladega	TA	26,312	11,719	49.47%
36272	Piedmont	CA	13,221	5,941	45.16%
36277	Weaver	CA	5,529	1,856	33.77%
36271	Ohatchee	CA	5,952	2,010	33.77%
36260	Oxford	CA,TA	4,001	2,022	50.64%
36268	Munford	CA,TA	5,814	1,972	33.95%

Source: UDS Mapper September 25, 2020

Based on HRSA's Uniform Data System (UDS) Mapper 2020 reporting required of all FQHCs, less than one-quarter (15,462 – 23.9%) of the total zip codes' low-income population (64,829) is being served by all FQHC organizations of which, the dominant FQHC is Quality of Life Health Services, Inc. The remainder, which totals 49,367 low-income individuals (with income less than or equal to 200% of federal poverty level), is not currently served by any FQHC organization and consequently, there remains 76.1% primary medical care capacity or "unmet need" for the low-income population relative to the combined twelve-zip code service area. This is even greater when consideration is given to total three-county service area of Calhoun, Cleburne, and Talladega Counties (all zip codes). The unmet need percentage has declined slightly with HRSA funding mechanisms, but still the number of low-income individuals unserved (49,367) is significant.

Quality of Life Health Services, Inc. has been the recipient of such funding, but no Federal U.S. Public Health Service Section 330/HRSA grant funding has been reported directly to Calhoun County. Quality of Life Health Services, Inc. has increased comprehensive preventive and primary medical care access for the predominantly low-income population in the three-county service area, as well as in Randolph County. With assistance in part from NAP Section 330/HRSA funding, QLHS service delivery sites

are as follows: 1) 1316 Noble Street, Anniston (Calhoun); 2) 601 Leighton Avenue, Anniston (Calhoun); 3) 64 Giles Street, Heflin (Cleburne – 14 miles from Anniston); and 4) 110 Spring Street N., Talladega (Talladega – 22 miles from Anniston). Quality of Life Health Services, Inc. is based corporately in Gadsden in contiguous Etowah County to the northwest of Calhoun County.

Exhibit 28 - Low- Income Population Served/Unserved by Existing FQHCs

Zip Code	Place		Low-Income Population 2014-2018	Low-Income Population # Served by Existing FQHCs	Low-Income Population % Served by Existing FQHCs	Low-Income Population # Unserved by Existing FQHCs	Low-Income Population % Unserved by Existing FQHCs
Summary:			64,829	15,462	23.9%	49,367	76.1%
36201	Anniston	CA	10,161	4,102	40.4%	6,059	59.6%
36203	Oxford	CA,TA	6,019	1,486	24.7%	4,533	75.3%
36207	Anniston	CA	6,866	1,299	18.9%	5,567	81.1%
36265	Jacksonville	CA	7,635	678	8.9%	6,957	91.1%
36206	Anniston	CA	4,913	1,034	21.0%	3,879	79.0%
36264	Heflin	CL	3,715	2,335	62.9%	1,380	37.1%
35160	Talladega	TA	11,719	2,421	20.7%	9,298	79.3%
36272	Piedmont	CA	5,941	1,086	18.3%	4,855	81.7%
36277	Weaver	CA	1,856	194	10.5%	1,662	89.5%
36271	Ohatchee	CA	2,010	283	14.1%	1,727	85.9%
36260	Oxford	CA,TA	2,022	267	13.2%	1,755	86.8%
36268	Munford	CA,TA	1,972	277	14.0%	1,695	86.0%

Source: UDS Mapper September 25, 2020

F.2. Existing Healthcare Facilities

The CHNA offers providers such as the HCACA 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 Exhibit.

Exhibit 29 – Existing Healthcare Facilities

Facility Type - Description	*Calhoun County*	*Cleburne County*	*Talladega County*
Ambulatory Surgical Centers	1	0	0
Assisted Living Facilities	4 (205 beds)	0	3 (68 beds)
Assisted Living Facilities (Specialty Care)	4 (140 beds)	0	1 (16 beds)
Community Mental Health Centers	0	0	0
End Stage Renal Treatment Centers	7 (89 stations)	0	4 (73 stations)
Federally Qualified Health Centers (Core/Satellite)	2	1	1
Home Health Agencies	2	0	4
Hospices	5	0	5
Hospitals – General Acute	2 (448 beds)	0	2 (290 beds)
Hospitals – Specialized	1 (38 beds)	0	0
Independent Clinical Laboratories	12	0	7
Independent Physiological Laboratories	1	0	0
Nursing Homes	5 (667 beds)	1 (82 beds)	5 (494 beds)
Rehabilitation Centers	2	0	0
Rural Health Clinics	0	0	6

Source: Alabama Department of Public Health (ADPH), Health Care Facilities Directories, 9/17/2020

The Calhoun, Cleburne, and Talladega service area hospitals still constitute three in Calhoun (one of which is long-term care), two in Talladega, and none in Cleburne. They are identified as follows:

HCACA - Northeast Alabama Regional Medical Center
400 East 10th Street, Anniston, AL 36207
323 bed General Hospital
Authorized bed capacity: 323
Licensee Type: Public Corporation

HCACA - Stringfellow Memorial Hospital
301 East 18th Street, Anniston, AL 36207
125 bed General Hospital
Authorized bed capacity: 125
Licensee Type: Public Corporation

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

Citizens Baptist Medical Center
Talladega, AL 35161
122 bed General Hospital
Authorized bed capacity: 103
Licensee Type: Limited Liability Company

Coosa Valley Medical Center
Sylacauga, AL 35150
168 bed General Hospital
Authorized bed capacity: 168
Licensee Type: Healthcare Authority

G. Input from the Community

Based on IRS Notice 2011-52, "Treasury and the IRS intend to provide that a Community Health Needs Assessment (CHNA) will satisfy CHNA requirements with respect to a hospital facility, i.e., HCACA, 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. Federal Register, Volume 79, No. 250, which was published on December 31, 2014, finalized regulations for charitable hospitals relative to CHNAs.

HCACA's CHNA sought input form persons who represent the broad interests of the community served by the hospital, including those with special knowledge and expertise in public health and community organizations and governance. This input task was accomplished with the use of survey instruments and process developed by Executive Resources, LLC (example and summary in Attachment H), which were used in a personal interview survey process. For the 2020 CHNA, the performance was entirely different contrasted to performance of prior years' CHNAs. Due to COVID-19 travel and social distancing restrictions throughout 2020, the surveys were conducted using a combination of self-survey (Survey Monkey) and virtual survey (Zoom).

In order to be compliant with IRS Notice 2011-52, the process that Executive Resources, LLC utilized, encompassed conducting interviews with key individuals, as recommended by the HCACA Management Team, which were performed during November of 2020. The process included delineation of persons and organizations with which HCACA 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 HCACA including HCACA Management, HCACA Board, HCACA Medical Staff/community physicians, local agencies and providers, and community leaders.

The objective of the interview process was to allow input from persons who represent the broad interests of the community served by HCACA and included representation from Calhoun, Cleburne, and Talladega Counties – HCACA's primary service area. It is Executive Resources LLC's opinion and supported by HCACA, that the CHNA offers providers and other organizations to engage and collaborate with HCACA 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 confronting health care delivery, and strategic areas of opportunity for the hospital. Interviews were conducted using a combination of self-survey (Survey Monkey) and virtual survey (Zoom). A list of persons interviewed is included in Attachment A.

Conducting a CHNA also provides the opportunity to promote community "buy-in" and to improve health outcomes 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., HCACA 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 rest of 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.

Virtual survey (Zoom) interviews were conducted by Executive Resources, LLC's President and by a Board-Certified Health Care Executive (Fellow American College of Healthcare Executives-FACHE), of which both healthcare professionals have considerable knowledge of the health indicators of the HCACA primary service area, and they both possess backgrounds 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.

Four distinct survey instruments were used and focused on representatives from areas who represent broad interests of the community served by HCACA as follows:

1) Community Members
2) Physicians
3) Board of Directors
4) Senior Management.

Due to COVID-19 travel and social distancing restrictions throughout 2020, the surveys were conducted using a combination of self-survey (Survey Monkey) and virtual survey (Zoom). Self-surveys were sent to 15 board members, 11 members of senior management, 5 physicians and 7 community members. The results of these surveys are included in Attachment H. Virtual surveys were conducted with a board member and 4 members of senior management.

H. Survey Interview Process Summary

Senior Management Survey:

The following four senior management officials participated in a virtual survey:

1) Louis Bass, CEO
2) Mark North, CFO
3) Trip Johnson, AVP Operations
4) Elaine Davis, VP CNO

The results of Senior Management Survey are as follows:

- Senior management does believe that the HCACA is currently achieving its mission even though it has been "strapped" for capital to invest in technology in recent years, especially since the COVID crisis.

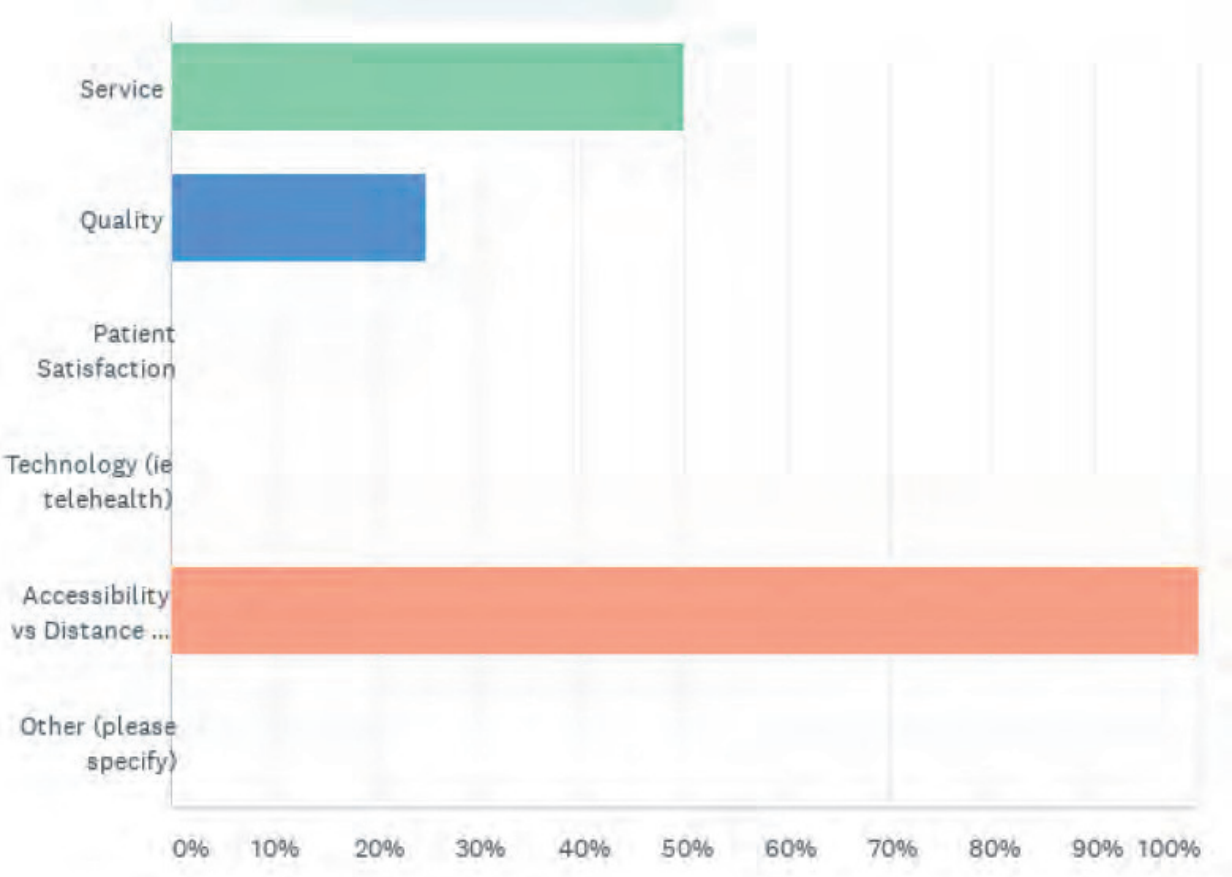
- There is a consensus of senior management that the mission statement is adequate.

- In response to the question about barriers/risks that threaten RMCHC ability to achieve its mission vision senior executives echoed the physician and nursing shortages as the major threat.

- Questions **6**, **7**, and **8** inquire about service area issues. Senior management feels that HCACA does a good job providing inpatient and outpatient programs to its service area and meeting the needs of the community. This group does not think the service area for inpatient and outpatient programs needs to be expanded; it is currently adequate. When asked about technology and service delivery changes due to COVID-19, senior executives stated that the ability of HCACA to provide access points throughout the service area were and are a major strength. When asked about issues of telehealth senior executives stated

that most telehealth initiatives are "piecemeal" and the majority of the medical staff are not advanced with the use of telehealth.

Q8 With technology and service delivery changes due to COVID-19, how does HCACA differentiate itself in its service area? (Select all that apply)



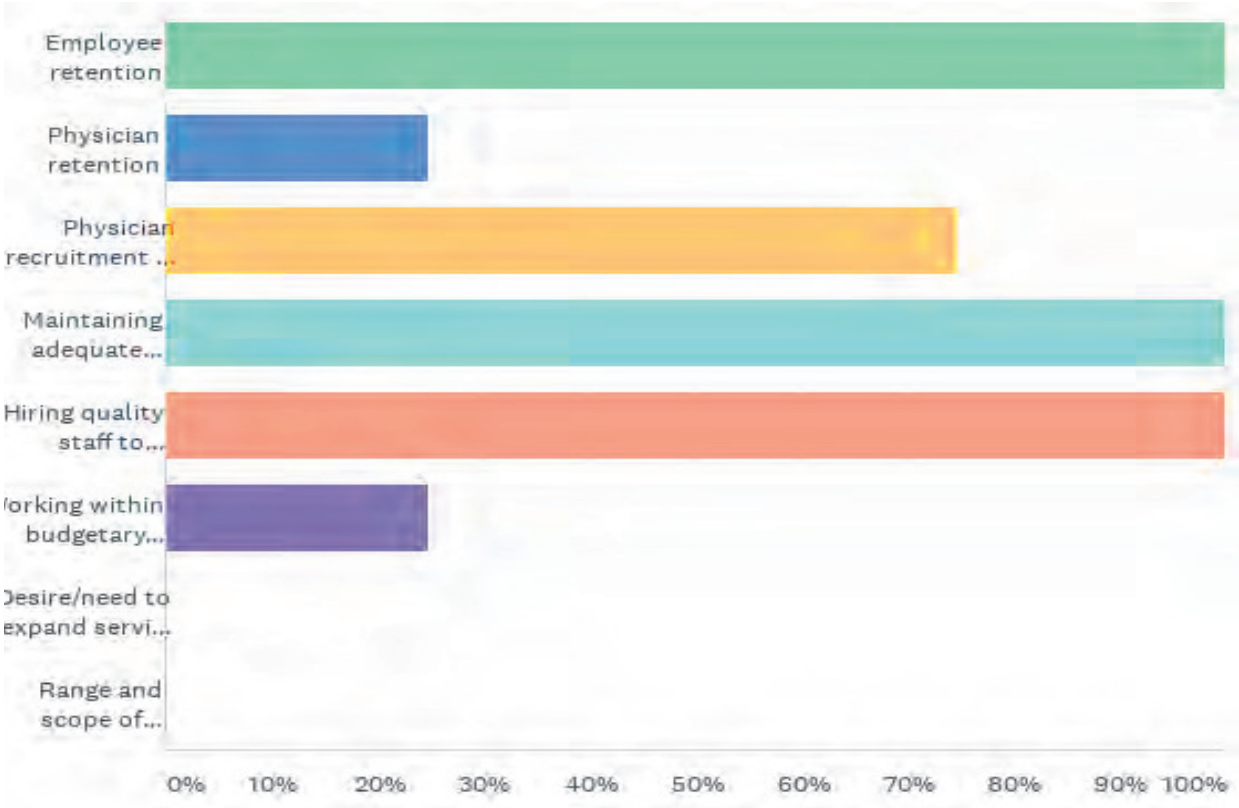
Source: Senior Management Survey, Q8, page 11.

- The purpose of question number **9** is to determine the senior executives' position as to if HCACA is doing an adequate job improving health indicators, reducing health disparities and how does it address the social determinants of health. The group expressed that HCACA efforts to coordinate and support the Anniston City low-income indigent care clinic is an example of addressing this issue.

- Question **11** asks the executives opinion of internal factors that pose the greatest challenges to HCACA future. Those factors were ranked as follows, (1) Employee retention, (2) Maintaining adequate staffing levels, (3) Physician recruitment, (4) Physician retention, and (5) Hiring quality staff to support physician staff & programs. Executives stated that HCACA was able to increase wages through a combination of market rate adjustments and merit increases.

During years 2019 and 2020, the merit increases totaled 4.5 percent. Senior executives understand that competitive compensation is essential and rely on Alabama Hospital Association wage information and other types of compensation surveys to determine HCACA competitive position with respect to compensation. Executives realize that major urban hospitals are financially better prepared to offer higher wage and salary benefits, but they nevertheless position HCACA competitively. It was mentioned that a HCACA strategy to qualify or be categorized as urban will improve the hospital systems financial position and allow it to improve employee compensation.

Q11 In your opinion, what internal factors pose the greatest future? (Select all that apply)



Source: Senior Management Interview, Q11, page 14.

- The top three strategic priorities of senior executives are determined by question **12**; they are (1) Strengthen hospital's financial position, (2) Quality service delivery and (3) Meeting community need.

- Question **13** asks the senior executives about increased and decreased pressure from a number of issues over the next three years. There was a consensus that

there may be opportunities in Medicare and Medicaid reimbursement as a result of the reclassification to urban status from rural. It was unclear as to whether other issues will impose positive
for negative pressure.

- Question **14** responses indicate that senior executives are aware of the public health issues, health indicators, health disparities, social determinants, special population health issues and chronic disease increase. All of these issues present unique challenges that are very costly; system executives understand that collaboration and identification of new and more resources are essential to make progress in these areas.

Survey Results:

HCACA wished to identify and rank the priorities of their stakeholders. In order to do so, HCACA provided input to Executive Resources, LLC on the various member groups that would best represent the perspectives of their broader service base. A total of four key member groups were identified: 1) Board of Directors, 2) Senior Management 3) Physicians 4) Community Members. Once key member groups were identified, Executive Resources drafted four complementary versions of the CHNA in collaboration with HCACA to solicit input and responses via an electronic, web-based survey format. The survey instruments can be found in Attachment H . The survey platform selected was SurveyMonkey.com. Contact information for key members to be surveyed were provided by HCACA to Executive Resources, LLC. The web survey was open from October 28th through November 18th, 2020 for a total of 22 days. Reminder emails were sent after each week-long interval.

Response Rates:

The response rate for the survey was as follows:

- Board of Directors Survey – 4 respondents completed the survey on their own, 1 respondent completed the survey via Zoom Meeting. That individual response was incorporated with the remainder of the responses for a total of 5 responses out of 15 distributed. BOD members typically spent about 10 minutes completing the survey.

- Senior Management Survey – 4 members out of the 11 Senior Management team completed the survey. Sr Management typically spent about 22 minutes completing the survey.

- Physician Survey – 2 of the 4 physicians solicited responded to the CHNA. Physicians spent 23 minutes completing the survey.

- Community Member Survey – 5 of the 7 targeted Community Members completed the survey. Community Members typically spent 22 minutes completing the survey.

Survey Limitations:

Challenges experienced with the survey implementation included: a power outage across the survey region due to Hurricane Eta at the onset of the survey launch period, and Information Technology (IT) email filters which may have blocked recipients from receiving the survey link via email.

Key Findings:

- Overwhelmingly, **100%** of respondents indicated that the hospital is achieving its mission and vision. However, it is worth noting that while Community Members stated that they are ***very familiar*** with the sites, locations, programs and services of HCACA, they also indicated that they are ***less familiar*** with the hospital's "mission and vision" and "leadership".

- 8 out of 9 respondents did *not* feel that the mission needed to be revised, expanded, or changed at this time.

- **Threats / Barriers to achieving the mission** -- Members of Sr. Management and the Board expressed similar concerns pertaining to the workforce recruitment and retention – in that the ***ability to attract and retain physicians and staff*** poses a great challenge given HCACA's rural market rate due to competition from providers in higher reimbursement markets to be able to offer higher wages. Other common concerns included: an aging physician workforce/staff and the ability to access capital for investment in infrastructure and equipment.

- **Impact of COVID-19 on achieving the mission** – Survey respondents reported that COVID-19 has had both positive and negative impacts on HCACA' ability to meet its mission, such as:

    - Decreased ED utilization rates which impacts cash
    - Staff shortages due to infection
    - A positive view was that COVID-19 shed a light on how active HCACA is in the community
    - COVID-19 forced hospital leadership to think through solutions and processes to move patients through the system

- The majority of HCACA's employed provider groups have utilized telemedicine as a result

- In terms of **"Meeting the Needs**" of the Community, respondents from the BOD group, Sr. Management group, and Physician group agreed that:

  - HCACA is doing "a good job" meeting the needs of the community.
  - The physicians surveyed gave HCACA a **5-STAR** rating for meeting the needs of the community.
  - Survey respondents viewed HCACA as ***"patient-centered", "compassionate", and "knowledgeable".***
  - However, respondents from the **Community Member** group disagreed in that 3 out of 5 respondents felt that HCACA was ***not*** adequately addressing the health needs of the community:
    - Community Members indicated that since the last CHNA, they had witnessed incidences of COVID-19, mental health/substance use related issues, and poverty in their communities
    - Community Members believed that access to the following services were inadequate:
      - Services for all individuals – this was congruent with the physician respondent group who indicated that not all offices accept Medicaid patients
      - Mental Health services
      - Drug and Alcohol treatment services
      - Geriatric services
      - Cancer + prevention services
      - Referrals to specialist physicians – cost / upfront fees were cited as barriers to specialty services
      - Dental
      - Diabetes Education – this aligns with the perspectives of the physician survey respondents who cited "Obesity" as a major health indicator in the service area
    - Both Community Member and Physician survey groups indicated that HCACA could do more to provide **community education and involvement with community needs**. Some recommendations included: increased outreach for free cancer and health screenings, health education / life coaching, and coordination with the continuum of care in the community with partners.
    - Community Members **100%** agreed that HCACA is vital to the health and welfare of its service area.

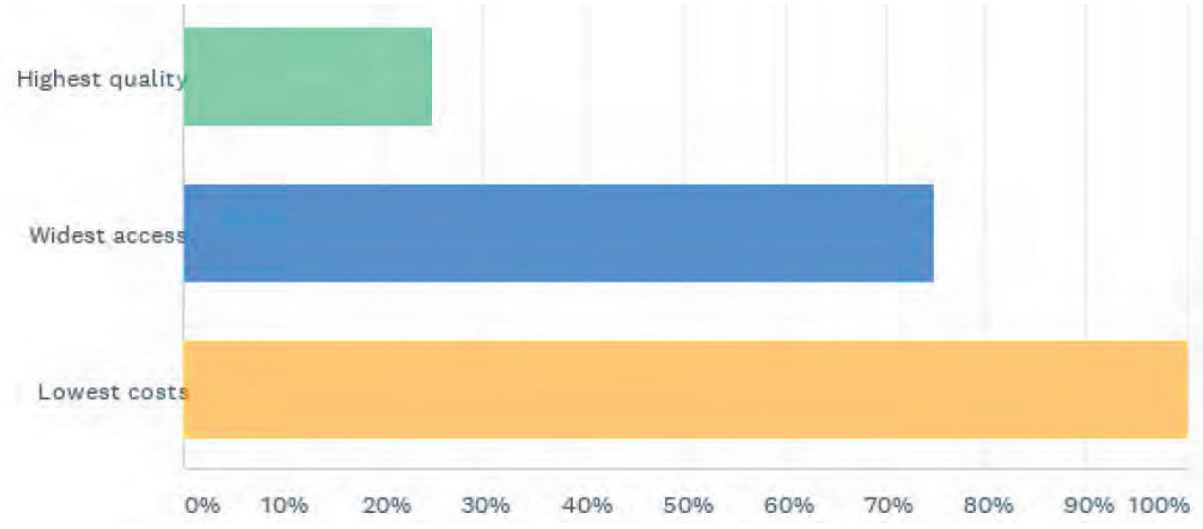
- **Adequacy of Service Area:** Survey responses from Senior Management team members and Community Members indicated that the current service area for inpatient and outpatient programs and services is adequate and does not need to be expanded, but rather better marketed to patients.

- In a post COVID-19 scenario, survey respondents indicated that HCACA can differentiate itself in its service area by "Accessibility vs Distance to Birmingham".

- Survey respondents agreed that when given the option to choose 2 out of 3 major objectives for HCACA to achieve, **"Widest Access"** was selected by both Board Members and Community Members:

    - Board Members chose "Widest Access" + "Highest Quality"
    - Community Members chose "Lowest Cost" + "Widest Access"
        - Being "Low Cost" was echoed by Community Members throughout the survey as 'COSTS' and 'upfront fees' (especially those related to transportation) were cited as the main barrier to accessing care.

Q7 It is commonly accepted that healthcare organizations have three major objectives: 1) Highest quality, 2) Widest access, and 3) Lowest costs. Most healthcare economists believe that only two of the three are achievable at any one time. Which two would you advise to be pursued? Why? Do you think that HCACA should get more involved in addressing the following? (Select all that apply)



Source: Community Member Interview, Q7, page 10.

- Access issues were highlighted in the physician survey where neither physician's office had appointment availability for NEW patients less than 2 weeks out.

Q7 Comments

"I believe this because I work with low-income, uninsured patients. With high rates of poverty, low costs are vital to access care. As rates of the uninsured in Calhoun County of approximately 15,000 individuals, access to healthcare is vital to mitigate health disparities and poor health outcomes."

"Because if we can provide access (which lower costs do) then we can diagnose issues or prevent issues – if they need further care (which could be a higher quality care), we can connect them. You can't provide any care if the barriers are so that no one even attempts."

"The location of healthcare is primarily in centralized locations and transportation to those locations is almost impossible for the elderly on a monthly income. There are situations where an ambulance is required for transportation, which requires an upfront fee – which the client is unable to pay. The cost of services on the front end for most revolves around transportation."

- **Top 3 Strategic Priorities** for HCACA included:
  - Physician recruitment and retention, practice acquisitions
  - Improved quality of clinical services and patient satisfaction
  - Strengthening the hospital's financial position

- Perceived areas of ***increased pressure*** over the next three years for HCACA included:
  - Medicare / Medicaid reimbursements
  - HMO payment rates, payment denials
  - Health reform, conversion of the uninsured market

- Survey respondents felt that HCACA should get more involved in addressing:
  1. Public Health issues
  2. Chronic Diseases
  3. Health indicators

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Prioritization of Community Healthcare Needs

A. Overview

HCACA's community healthcare needs identified and prioritized. as derived from the Health Status and Health Indicators sections of this CHNA, 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.

Clearly, 2020 is a "different" year for HCACA, Alabama, the U.S, and the world due to the COVID-19 pandemic that will continue into 2021. The CHNA also considered the challenging and ever-changing marketplace on a state and national level, inclusive of the COVID-19 pandemic since there is a need to review, adapt, cease, and commence healthcare programs and services in a changing marketplace as the population ages and the healthcare environment continues to evolve. A literary research was conducted regarding medical care issues that were applicable to the CHNA project including healthcare delivery programs and services and also pandemics that continue to emerge, i.e., COVID-19.

The biggest factors driving today's healthcare strategy for all providers, and HCACA is no exception, are the aging population, rising chronic disease rates (co-morbid conditions or in terms of COVID-19, "underlying 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 such as HCACA's hospitals) or other services. These factors are expanding the definition of the provider and requiring all providers (i.e., primary care, acute care, post-acute care) to work together in an integrated fashion to improve health outcomes, reduce health disparities, and create health equity for all residents in the community they serve.

HCACA's community is the health system's geographic area referred to as the service area in which the majority of its patients reside. HCACA's 2-hospital health system comprised of Regional Medical Center (RMC) and Stringfellow Memorial Hospital (SMH), through its strategic planning process, reviews its service area to ensure that the service area description adequately reflects the health system's current activities in providing programs and services to the community, along with being consistent with its mission, vision, and values**.** **"**Our mission, our vision and our values are more than just words or a statement; it's what we believe in, strive for and aspire to provide within our community. We hope everyone experiences this each time they encounter our staff, physicians and ambassadors in the community."

At HCACA, our mission, vision and values are more than just words or a statement, it's what we believe in, strive for and aspire to provide within our community.

Our Mission

Providing state of the art health care with integrity, to the people we serve

Our Vision

At HCACA, we strive to:
Remain the Region's premier choice for health care
Deliver advanced medical care
Provide multiple choice of medical specialties
Employ a skilled and compassionate set of professionals
Maintain upscale and convenient facilities and services
Provide programs and services necessary to promote and protect the health of the community
Identify and minimize health disparities

Our Values

Compassion
Accountability
Respect
Excellence

Clearly, improving healthcare service quality in HCACA's primary 3-county service area by creating an integrated healthcare delivery system, should be high on the priority list. Hospital readmissions is the driving force, as in today's world, hospitals in themselves, and HCACA is no exception, have a limited ability to impact this outcome and must coordinate the continuum of care with other providers in healthcare service delivery. Providers include primary care and subspecialty care physicians, other clinicians, post-acute care providers such as home health agencies, social and community service workers and health coaches, and public health workers, along with the acute care hospital – HCACA's 3-hospital health system.

B. Identification and Prioritization of Community Healthcare Needs

Within this context, the priority needs for HCACA's 3-county primary service area (Calhoun, Cleburne, and Talladega Counties) were developed from the Health Status and Health Indicators sections of this CHNA and based on the health issues at hand (inclusive of COVID-19) that present a threat to the health of the community in the 3-county primary service area along with the contiguous counties' secondary service area.

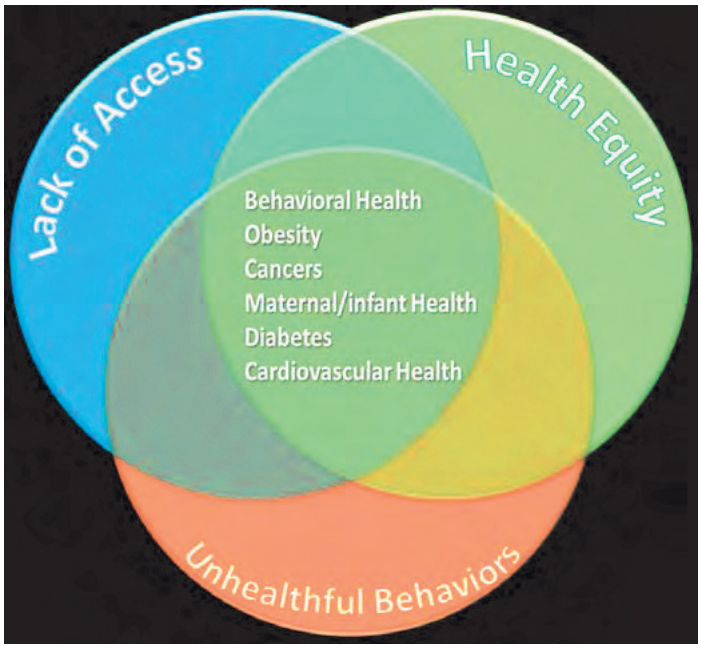
In developing responses to the needs from the recommendations identified and prioritized, HCACA needs to consider other criteria including:

1) Consistency with revised mission, vision, and strategic plan;
2) Quality considerations;
3) Governance and organizational structure issues;
4) Financial and operations impacts; and
5) Risk.

In addition to the identification and prioritization of community healthcare needs recommendations, there are three concurrent overarching themes that were apparent from the key informant survey/interview process:

1) Improve access for all community residents to health and social services;
2) Achieve health equity for all community residents; and
3) Enhance the physical and social environment to support health well-being and reduce unhealthy behaviors,

Exhibit 30 – Overarching Themes: Healthcare Access, Health Equity, Unhealthy Behaviors



The recommendations in this section are also consistent with the tenets of health reform and ongoing, evolving payment systems since they focus on healthier individuals (thru preventive, wellness, and primary medical care) and communities, integration among a full range of providers and managing awareness and prevention to reduce longer-term costs. These recommendations are also a parallel in response to COVID-19 and

"underlying conditions." Given the healthcare environment trends, inclusive of the current COVID-19 pandemic in 2020 that will be with us in 2021 and the specific information contained in this CHNA, the following five Health Service Priority need areas were developed. The following sections outline objectives and potential activity recommendations for meeting the challenge of these Health Service Priorities. Many of these potential activity recommendations across the Health Service Priorities that follow are linked since they are all highly inter-related.

B.1 Systems to Reduce Socioeconomic Stressors
B.2 Access to Primary Medical Care and Behavioral Health Care
B.3 Healthcare Education, Prevention, Wellness, Promotion;
B.4 Healthcare Services for Chronic Conditions; and
B.5 Healthcare Services for the Elderly

B.1. Systems to Reduce Socioeconomic Stressors

As noted in other sections of this CHNA, "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 HCACA service area are significant in their homes, their neighborhoods and their schools (especially during this time of COVID-19 in which community member survey respondents indicated that relative to witnessing COVID-19 incidents, mental health/substance use disorder-SUD, and poverty were more prevalent in the community).

Socioeconomic factors such as income, education, and ethnicity directly contribute to the development of disease. Increased obesity has been linked to poverty level, receipt of food stamps, and lower income. Lower income levels equated to poorer food quality and less consumption of healthy foods like fruits and vegetables. Paramount to addressing the social determinants of health is recognizing that the biologic differences that cause health disparities are largely determined by a complex interplay of socio-economic, cultural, and environmental factors. Given the increasing amount of information in the literature on the impact these socioeconomic determinants have on health, the community's 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 situation. Nationwide and clearly, in health reform, solutions to these issues are maturing in the developmental stages as the healthcare system has become more aware of their impact and is beginning to respond. HCACA works with and will continue to need to work together with other community providers, both private and public (i.e., FQHC network organizations, school systems, public and private providers), and community organizations to come up with solutions for resolving these socioeconomic determinants among the population in the community as well as

those accessing care in FQHC, HIV/AIDS, and HCACA sites, physician offices, and the health system's two hospitals: RMC and SMC.

B.1.a. Objectives:

- To continue/expand existing programs and develop new programs within HCACA and throughout the community (community partnerships) that will alleviate socioeconomic stressors and, thus, their impact on health, thereby, improving health outcomes and reducing health disparities;

- To continue improvement relative to the health of the community by alleviating these socioeconomic stressors; and

- To work collaboratively with all levels of healthcare providers (vertical and horizontal) in the community in these efforts.

B.1.b. Potential Activity Recommendations:

- HCACA, as an "economic engine" and paramount employer in the service area, to assume an innovative and leadership role in addressing the social determinants of health by way of cultivating health equity through collaboration, policy development, advocacy and education;

- Within HCACA and with community partnerships, conduct research involving social, behavioral, biological, and genetic research to improve knowledge of the causes of health disparities and continue to devise effective methods of preventing, diagnosing, and treating disease and promoting health;

- Based on the key informant survey monkey interview process, review/rethink outreach activities to enable more of the service area population (especially Cleburne County) to be reached, along with contiguous counties to Calhoun, Cleburne, and Talladega. It was indicated that HCACA is patient-centered, compassionate, and knowledgeable, but some felt not adequately addressing the health needs of the community.

- Appoint a champion to lead this effort. This person should assemble a task force with key individuals throughout the community to develop an Action Plan. Collaborate more with public school systems and other low-

income providers (critical during COVID-19 with increased mental health and substance use disorder-SUD issues) and the local FQHC network – one of the largest in the state of Alabama (Quality of Life Health Services-QLHS) as outreach is an FQHC required service, and of which, QLHS has received significant federal grant dollars relative to COVID-19 during 2020 in order to respond to the community's COVID-19 needs.

- As part of the Action Plan, specific financial analyses can be completed to evaluate the relative cost and benefit of a range of proposals – QLHS has a site in all three counties and Randolph as well, being one of the largest FQHC organizations in the state of Alabama and that organization is required by the federal oversight agency (HRSA) to collaborate with the local hospital/health system (i.e., HCACA) in the community it serves and has multiple primary care sites;

- The task force should include members of the payor community i.e., Blue Cross Blue Shield of Alabama since it is important to include the payors in the dialogue of resolving these stressors, the end result of which, can lead to positive health outcomes and improvement of clinical performance measures leading to financial incentives to HCACA;

- Continue development and implementation of the Patient-Centered Medical Home (PCMH) model and incorporate community health workers and/or health coaches to help patients navigate their socioeconomic stressors. Determine options for expanding these resources into the private practice community of the 3-county service area;

- Based on the key informant survey monkey interview process, concentrate on the integration of behavioral health services (both mental health and substance use disorder-SUD) and primary medical care within the PCMH;

- Create an understanding within the HCACA service area provider community about the multi-faceted nature of health and its relationship with socioeconomic determinants of health. Provide cultural competency training for PCPs, HCACA health system employees and other

collaborative providers and agencies that addresses the pervasive barriers to a consistently healthy lifestyle;

- As the payors continue to become more involved in new payment systems, i.e. bundled payments, risk-sharing, value-based contracting, HCACA should consider and evaluate each of these alternatives, which has at its core, improving health outcomes and improving the health of the greater Calhoun County service area communities – leading to financial incentives;

- Reach out to and collaborate with other providers, agencies, and organizations that are working on these new payment initiatives in their specific market areas (in and out of Alabama, especially Birmingham and Atlanta marketplaces); and

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

B.2. Access to Primary Medical Care and Behavioral Health Care

Access to comprehensive preventive and primary medical care, along with access to behavioral health care (mental health and substance use disorder-SUD continues to be a critical issue throughout the 3-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. This scenario has been exacerbated in 2020. The key informant survey monkey interview process delineated the increasing and resounding need and lack of access to behavioral health care services and the increasing opioid epidemic throughout the service area, and more so now with COVID-19 throughout 2020 and continuing into 2021.

In 2019, the presence of OB service delivery continues to remain a luxury in many of Alabama's counties as, in total, only one-half of rural counties have hospitals that deliver babies today. Calhoun County and the contiguous service area is fortunate in having HCACA's RMC's Women's and Children's Center, Baby Friendly Hospital – the first such designation in Alabama. HCACA's 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 the top priority at the Center.

On March 28, 2016, HCACA's RMC became the first hospital in Alabama to receive the Blue Distinction® Center for Maternity Care designation by Blue Cross and Blue Shield of Alabama and this designation continues to this day. This designation is an expansion of the national Blue Distinction Specialty Care program. Even considering the "Blue Distinction" designation, the void of OB service delivery in many of Alabama's rural counties continues to contribute to 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 HCACA'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 HRSA's Health Professional Shortage Area (HPSA) designations for Primary Medical Care, Dental Health and Mental Health);

- High level of uninsured throughout the 3-county primary service area validated by HRSA's Uniform Data System (UDS) Mapper 2020 reports; with a negative access and reimbursement impact of based on the state's decision not to implement Medicaid expansion as of this writing;

- Low level of subspecialty availability/accessibility for the low-income population uninsured or underinsured (not applicable for the insured population), which carries over to behavioral health (mental health and substance abuse) services and the continuum of care;

- Accessing FQHCs – Quality of Life Health Services, Inc. (QLHS) now has 2 satellite sites in Anniston (Calhoun County) and 1 satellite site each in Cleburne, Talladega and Randolph Counties, while being based in Etowah County and along with sites, has received considerable U.S. Public Health Service (PHS) section 330 grant funding for New Access Point (NAP) sites along with 3 iterations of COVID-19 grants in 2020, plus other HRSA-related grants and benefits (these grants need to reach HCACA's 3-county service area's QLHS sites, not just Etowah); and while the key informant interview survey monkey process indicated that community agencies and organizations collaborated with QLHS to some extent, there remains significant unmet need for the low-income population throughout the service area (UDS Mapper has the 12-zip code service area with 64,829 persons, 43.1% of the total population);

- Increased emergency room care utilization in the service area along with higher cost primary care utilization in HCACA's hospitals' emergency rooms, specifically RMC with the most paramount utilization (analysis performed for 2019), particularly among low-income groups and the potential need for HCACA to establish, develop, and implement a clinic on Anniston's "west" side, which was indicated in the Zoom meetings with HCACA's Senior Management;

- High level of Medicare admissions for ambulatory sensitive conditions and the problems confronted by hospitals relative to re-admissions and non-reimbursement from subsequent denials – HCACA's hospitals have excess admission ratios in several clinical measures;

- High level of mortality relative to incidence of disease continues throughout the service area, i.e., heart disease, cancer;

- Low level of mental health providers relative to the population, especially for the low-income population (HPSA Mental Health designations), thereby creating the behavioral health need – both mental health and substance use disorder-SUD, including opioid abuse relative to access;

- Relatively high level of alcohol consumption and emergency room visits for alcohol-related issues;

- Noted presentation of patients with advanced disease with limited wellness and preventive care along with co-morbid clinical conditions (COVID-19 "underlying conditions" such as hypertension, heart disease, diabetes) leading to chronic disease management issues; and

- Aging of population continues to exacerbate the chronic disease management problem as other age groups in the service area decline in percentage and absolute numbers.

B.2.a. Objectives:

- To continue development of structures to improve the ability to recruit primary care physicians throughout the community to serve the low-income population – one consideration based on the Zoom meeting process with HCACA's Senior Management was development of a clinic on Anniston's "west" side and to recruit and staff the site with primary care providers, thereby creating access and stemming the tide of inappropriate, higher cost primary care in HCACA's hospitals' emergency room, along with mitigating hospital readmissions;

- To continue integration of 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 and COVID-19, especially since significant section 330 NAP dollars have been accorded to QLHS during health reform and there remains low-income unmet need in the 3-county service area;

- To collaborate on expansion of primary medical care and urgent care services (it was indicated in the survey interview process that there was increased competition in the service area from for-profit urgent care center providers) to be more conducive based on community needs (need to schedule based on community need – hours and days of week) along with integration of primary medical care with behavioral health care, and further development of referral mechanisms for the HIV/AIDS population with the Health Services Center, which that organization could potentially develop as an FQHC "Look-Alike" provider;

- To further develop systems (including interfacing of hospital EMRs with those of private practice physicians) 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 (both more susceptible to COVID-19 "underlying conditions") and outreach and education to the population, so they understand the health risks of not accessing services; and

- To continue reduction of the mortality in cancer, diabetes, and heart disease in Calhoun, Cleburne, and Talladega Counties – these mortality rates continue in the CHNA in 2020 and from the CHNAs performed in 2012, 2015, and 2017.

B.2.b. Potential Activity Recommendations:

- Create a "roll up your sleeves" realistic, working physician needs assessment plan that summarizes primary care and specialty care physician need in the service area, along with other key criteria, i.e. age, medical staff status, admissions, loyalty factors; and identifies options and opportunities for filling those needs that are desperately needed in both rural and urban areas and especially for a health system such as HCACA in between Atlanta and Birmingham that competes with those areas for the same physician specialties. As part of this plan, develop innovative recruitment and retention strategies, while concurrently, remaining competitive in order to attract physician candidates;

- Focus on more FQHC sites of service (full sites or specific services based on community need) or collaboration with the existing FQHC (Quality of Life Health Services) as sources of new primary care providers, especially for the low-income population, in addition to HCACA clinic consideration as low-income unmet need in service area is significant. If retention is difficult, conduct prospective physician and spouse interviews to determine their barriers to remaining in the community;

- Work with aging and/or retiring physicians (solo and group practice) 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 – consideration for clinic development on Anniston's "west" side;

- Further continuance of developing the Patient Centered Medical Home (PCMH) model at Quality of Life Health Services, Inc. FQHC sites in the 3-county service area, especially to stem the tide of inappropriate and more costly healthcare in HCACA's hospitals' EDs, along with offering the FQHC as an alternative to mitigate hospital readmissions at HCACA's hospitals;

- Continue to explore expanding Quality of Life Health Services, Inc.'s sites relative to additional FQHC-related services in Talladega and Cleburne Counties (since first CHNA performed in 2012 – new sites) - structure the hours of operation at each site to meet the needs of the community and patient population; this will likely include evening hours and possibly weekend hours to provide more sorely needed access;

- The PCMH should include behavioral health providers and support staff (i.e. LCSW, LPC) to treat the behavioral health needs integrated with the primary medical care needs of the patient population in a "warm hand-off" approach during the same patient encounter;

- If feasible relative to operational, staffing, and fiscal considerations, dental health should be included in any PCMH development to complement physical healthcare and behavioral healthcare;

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

- Further development of HCACA's RMC's Women's and Children's Services for issues for all women of all ages. HCACA offers women an exceptional team of physicians, nurses and midwives, all dedicated to women's health at any stage of like. As a 2-hospital health system HCACA offers at RMC and SMH campuses, an array of women's services including Breast Health/Mammography, Bone Health/Osteoporosis, Well-woman Care, Maternity Care, Breast Health Navigator, OB/GYN Services, Cancer Surgery, Robotic Surgery, and Gynecologic Oncology. Women's health services can be developed in such a way that it is attractive to the various components of the service area population and the promotion/marketing effort to attract these services could be used for primary medical care, education, and prevention for these women as well. The women's health services center should attract women from all income categories to provide much-needed access across all ages and incomes.

B.3. Healthcare Education, Prevention, Wellness

Regardless of COVID-19 occurring or not occurring throughout 2020, many of the healthcare incidence and mortality problems in the Calhoun, Cleburne, and Talladega service area are reversible through wellness and prevention services, early treatment or intervention to reduce risk. The risk factors of smoking, poor diet, obesity, asthma, and limited physical activity previously delineated, lead to feeling unhealthy and higher incidence and, ultimately, mortality from preventable conditions. The goal of Affordable Care Act (ACA) wellness regulations, which were finalized in 2013 and became effective in 2014, is to ensure that wellness programs are designed to improve health and prevent disease.

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 regarding his or her own care. Wellness and prevention activities should be geared to the hard to reach populations: lower income, the uninsured, ethnically and culturally diverse groups which may have language and other barriers, special population groups i.e. HIV/AIDS, and the elderly (the latter relative to chronic disease management with significant co-morbid clinical conditions) – all are prone to COVID-19 "underlying conditions."

Initiatives tend to be more successful among the middle income to the 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, in addition to having the financial resources to pay for them.

Recommendations for this Priority will be linked to those for B.1 and B.2 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 Health Service Priority must be accomplished on a grass roots level, with all providers and organizations working together collaboratively.

B.3.a. Objectives:

- To continue the development of an effective HCACA program system wide to educate the service area population, and particularly the high-risk and vulnerable populations, relative to the long-term importance of health management, wellness, and prevention;

- To continue coordination and integration with a range of other community providers, including and especially Quality of Life Health Services, Inc. (QLHS) – FQHC, other service area providers to the low-income population, and community leaders as well as programs already in place in the Region and State to develop a model system for engaging the population in reaching compliance – this is paramount in an integrated approach across all provider levels – whether it be direct face-to-face service delivery, telehealth service delivery, or a combination of both;

- To prevent and/or to reduce tobacco use in the service area's population;

- To improve healthy eating behaviors in the service area's population;

- To reduce the number of overweight and obese individuals in the service area (major problem, not only in the service area and in Alabama but 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);

- To reduce the level of alcohol consumption in the service area's population;

- To increase exercise, physical activities levels in the service area's population (need to have facilities available in Anniston and other communities and to provide transportation for access);

- To reduce the level of teen pregnancy in the service area's teen population, ages 14-19 and in some cases, ages 10-14; and

- To increase the percentage of mothers who obtain prenatal care in the first trimester.

B.3.b. Potential Activity Recommendations:

- Continue development of plans with community providers and leaders, including religious organizations, i.e., St. Michael's and All Angel's Church, Interfaith Ministries for the younger population and who may or may not have 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 to reach this population;

- Consider block-by-block programs for door-to-door screenings and education in the three-county service area and in Anniston's "east" and "west" sides, as well as chronic disease management – low-income and the elderly in light of COVID-19 and "underlying conditions";

- 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. These efforts, while underway, need to be furthered;

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

- Partner with a local fitness center(s) in Anniston and other towns to develop and integrate comprehensive preventive, wellness, fitness and nutrition center;

- Continue collaboration with public prevention programs of local, regional or state agencies i.e. Calhoun County Health Dept./East AL Planning Commission and the payors to develop local approaches to addressing smoking, obesity, alcoholism and physical activities in the at-risk populations;

- Partner HCACA's RMC corporate wellness program with area businesses to include education on risky behaviors and work-place assistance in changing those behaviors, such as smoking cessation assistance – including for cardiology rehab a tie-in to HCACA's RMC cardio rehab wellness services, which include a full-service gym with locker rooms, exercise/swim sessions in an Aquatic Therapy pool, and Massage Therapy;

- Set up formal meetings with leadership within the Anniston City School System and other local school systems to identify ways to improve health education, awareness and screening in the schools (possibly consider telehealth linkage for students in need of physical health, mental health and substance use disorder-SUD issues that have accelerated during COVID-19) – consider individual school linkage with QLHS, the local FQHC regarding school-based health center (SBHC) development and collaboration with them relative to their federal COVID-19 grant funding. Use students to also identify opportunities to reach their parents; and

- Partner with service area grocery stores (i.e., Winn Dixie, Save A Lot, Walmart) 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 – especially for lower income levels, which generally equates to poorer food quality and less consumption of healthy foods like fruits and vegetables.

B.4. Health Services for Chronic Disease 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 disease conditions – all of which is critical during COVID-19, as well as non-pandemic times. As the population ages, which is the case in all three of the counties, the prevalence of these chronic disease 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 (both mental health, i.e. depression and substance abuse i.e. alcohol, painkillers) 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 health coaches, transportation, and proven complementary alternative medicine services, follow-up care and communication among providers and between providers and patients. Further, there has been a boost in reimbursement for telehealth (Medicare and Medicaid) that has been spearheaded by COVID-19 and that service delivery modality should be accelerated and promoted. Therefore, the recommendations in Health Service Priorities B.1 through B.3 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 disease management.

B.4.a. Objectives

- To continue development of a HCACA system-wide approach to the improvement of healthcare management and the health status of patients with chronic health and co-morbid conditions;

- To reduce in the long-term, the mortality rates from heart disease, diabetes and cancer;

- To continue to effectively use the services set up in the prior Health Service Priorities to treat chronic disease conditions;

- To improve the availability of subspecialty care, including behavioral health (mental health and substance abuse) in the community to patients with chronic medical conditions, along with availability to all persons, regardless of the ability to pay; and

- To actively involve the patients in the success of their treatment through health coaches and enabling services.

B.4.b. Potential Activity Recommendations:

- Continue development of a physician and community provider task force to develop plans for optimum treatment of each chronic condition, starting with heart disease and diabetes (large need areas), based on a review of the literature and best practices and create an Action Plan to implement them throughout the HCACA health system. Plans could involve disease health coaches (i.e., cardiology), protocol-based planning and multidisciplinary care in an integrated approach;

- Work with payors and employers to further refine the plans as they apply to the payment methodologies (face-to-face service delivery and telehealth service delivery) and workplace issues (MCO and ACO development and continued collaboration with Blue Cross and Blue Shield of Alabama, the largest payor in the state;

- Develop employer-based wellness program throughout the service area 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 chronic disease management program;

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

- Develop a comprehensive HCACA Diabetes Center of Excellence with subspecialties of Endocrinology, Cardiology, Ophthalmology, Podiatry, Nutrition, Diabetes Education and any others needed to serve the population as well as help primary care providers to provide better coordinated care for their patient base. The management of these patients could all be coordinated through this Center and with HCACA's RMC's Wound Health Center, part of the National Healing Corporation that has a 94% success rate relative to wounds healed within 12-16 weeks. 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 or SMC but connected virtually, either through telehealth (which continues to work well during COVID-19 with payors paying) or another means, to other locations. The key to access is that the Center should attract patients from all income categories;

- Once the Diabetes Center of Excellence is complete, the impetus should continue and to build upon the success of HCACA's and to consider Centers of Excellence for Cardiology and Cancer, especially relative to the latter since RMC is accredited by the Commission on Cancer of the American College of Surgeons (COC) for its comprehensive, multidisciplinary and quality patient care and one of only 22 in the state,

- Address physician subspecialty service needs where necessary through the Physician Needs Assessment and Medical Staff Development Plan, especially relative to chronic disease management, now and in the future with an aging population. Ensure that there is a team of physician subspecialists working in conjunction with the patient's primary care provider to manage and treat the chronic disease conditions;

- Continue further development of the 340B Drug Pricing Program (for which HCACA is a "covered entity") through its own inhouse pharmacy program onsite for employees and registered outpatients of HCACA's hospitals – if deemed appropriate, evaluate pharmacy management firms thru RFP process to provide technical assistance to assure success;

- Consider options for providing EMR linkages between providers to more easily share data and manage patients – it has been indicated in the key informant surveys that not all physicians have EMRs and that EMR linkages are lacking; and

- Collaborate with home care agencies (all three counties have HHAs) so that the message to and care of chronic disease patients is consistent and to reduce hospital readmissions by having strategic partnerships with post-acute providers relative to a hospital readmission reduction program.

B.5. Healthcare Services for the Elderly

The fact remains that HCA's 3-county service area population growth is static at best, and actually declining and concurrently, getting older. Even the Calhoun, Cleburne, and Talladega Counties' service area, similar to the State of Alabama and nation, have realized a growing percentage of the population to be over 65 years of age, and more 75 years and older ("old old"). Based on the declining population overall as indicated in this CHNA, and "working age" groups comprising younger age groups, departing to other areas, it is cause for alarm from a healthcare service delivery provision with the elderly as the base – witness the COVID-19 pandemic and the high at-risk populations including the elderly with their chronic diseases and "underlying conditions." The healthcare challenges that this population will face, combined with a diminished supply of workers to provide healthcare services, must be addressed before a crisis has been reached. In addition, if the Health Service Priorities identified in B.1 through B.4 are not addressed, this elderly population will be quite sick with many co-morbid chronic disease conditions.

B.5.a. Objectives

- To continue improvement of the accessibility of healthcare and social services along with pharmaceuticals for the elderly in close proximity to their homes;

- To continue improvement of the quality of healthcare and social services for the elderly;

- To continue improvement of the functional health of elderly patients, especially those with co-morbid chronic disease conditions (including mental health and substance abuse);

- To improve the availability of behavioral health services for the elderly i.e. mental health – depression, substance abuse – pain killers;

- To reduce the use of multiple medications concurrently among the elderly and the high, documented risk of prescription misuse; and

- To continue improvement of healthcare quality in HCACA's immediate 3-county service area by exploring and developing a virtual, integrated

healthcare delivery system aimed at reducing fragmentation and duplication.

B.5.b. Potential Activity Recommendations:

- Expand geriatric services in the community, where the older patients reside at their home, through physician and nurse practitioner availability and through strategic partnerships with home health agencies in the service area – especially critical during the COVID-19 pandemic;

- Improve the efficiency of caring for age 65 and older, and age 75 and older "old old" medical and surgical patients in HCACA's 2-hospital health system based on their healthcare diagnoses;

- Link with home health agencies electronically in order to optimally manage patients post-acute discharge to reduce hospital readmission rates and to keep them healthy in their homes – develop a Preferred Provider List based on their programs and services, IT capabilities, telemedicine capabilities, executive team and support staff, quality health outcomes, and ability to minimize hospital readmissions among factors;

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

- Continue integration mental health services with medical services in order to treat the whole individual, inclusive of capitalizing on existing behavioral health services and expansion thereof in treating older individuals that experience serious behavioral or emotional problems.

- Evaluate the development of a Palliative Care program within HCACA's RMC or SMC campus in order to improve quality of life and the end of life as well as to avoid significant unnecessary cost to the patient, his/her family, and the healthcare delivery system as a whole – possibly explore with a service area home health agency;

- Increase of elderly population indicates further development of physician subspecialty services and related subspecialty programs and services as part of the Physician Needs Assessment and Medical Staff Development Plan in correlation with healthcare status indicators, analytics, and trends;

- Invest in on-demand transportation services for the elderly from their homes for medical and social service needs in conjunction with any service area transportation service already in existence – critical during this time of the COVID-19 pandemic; and

- Continue to explore and further develop a virtual integrated healthcare delivery system by bringing in key stakeholders, developing incentive-based reimbursement by participation, community wide coalition for healthcare quality with HCACA at the helm, among factors.

C. HCACA as Leader in Transforming Community Health

As HCACA continues to position the 2-hospital health system for success in the future relative to health reform and regulatory and reimbursement changes, along with external factors outside its control (i.e. population, socioeconomic and demographic characteristics and determinants, COVID-19 pandemic), many of the CHNA Health Service Priorities objectives and potential activity recommendations delineated for HCACA's community will help support HCACA as the leader in transforming community health, regardless or not of the COVID-19 pandemic. This needs to be accomplished concurrent with HCACA continuing its recent healthcare advancements, such as, but not limited to the following:

- UAB Cancer Center continued affiliation in the UAB Cancer Care Network programs – HCACA's is an affiliate with the University of Alabama (UAB) Cancer Community Network and has been accredited by the Commission on Cancer (CoC) since 1991 and is one of only two hospitals in the state to currently hold the CoC's Outstanding Achievement Award (OAA).

- Center for Balance Disorders relative to problems associated with dizziness or imbalances especially for those age 55+ - As home to one of the most comprehensive designated Balance Disorders Centers, HCACA is able to provide patients with the most comprehensive diagnostic testing and treatment for balance disorders in the state of Alabama. The Center utilizes the same equipment used for balance testing for astronauts training with NASA.

- HCACA's RMC's Women's and Children's Center, Baby Friendly Hospital. These developments can continue to both address community need and position HCACA for success – for all Life Cycles – Prenatal, Children, Adolescent, Adult, and Elderly; and

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 HCACA 2-hospital health system, which is based on improving health outcomes throughout the health system's service area. Because of the relatively large population and age distribution in its service area (even though the population growth is static at best and is actually declining for each of the three primary service area counties based on 2019 U.S. Census estimates), HCACA needs to consider specific services for each age segment

of its population, in addition to the Health Service Priorities in this CHNA relative to community need.

Many services cross all age groups, but some are more specifically targeted as shown by example in the following Exhibit. In many cases, the older half of the 18-44 and the 45-64 ages groups, continue to represent working, well-insured individuals who will often be the most aggressive in seeking quality care and the most informed in their decision process. It is also a potential reason for outmigration of hospital-related services by these individuals to hospitals/health systems in Birmingham and Atlanta as indicated during the key informant questionnaire survey monkey and Zoom meeting process.

Exhibit 31- Examples of Service Distribution Across the Age Segments

<table>
<tr><td>0-17</td><td>Pediatric Subspecialties</td><td rowspan="2">Maternity Care</td><td rowspan="4">Behavioral Health</td><td rowspan="4">Comprehensive Cancer</td><td rowspan="4">Cardiology</td></tr>
<tr><td>18-44</td><td rowspan="2"></td></tr>
<tr><td>45-64</td><td rowspan="2">Women's Center Beyond Maternity</td></tr>
<tr><td>65+</td><td>Palliative Care</td></tr>
</table>

The goal of this Community Health Needs Assessment (CHNA) in 2020, similar to the CHNAs performed in prior years, continues to position HCACA as a 2-hospital health system, as the premier medical center and health system 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 and services within the health system in response to those community needs and in an integrated way. If the health system can link more closely with the community and other providers and agencies (ambulatory/FQHC - vertical, and horizontal) to even better position the organization as the provider of choice for certain key services in serving the community, HCACA should be able to improve its reputation for quality that will allow HCACA's hospitals 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) HCACA's RMC's Women's and Children's Center, Baby Friendly Hospital.

Of equal importance, health systems such as HCACA 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, regardless of the COVID-19 pandemic. In order to improve healthcare quality in the three-county real world, the HCACA health

system needs to embrace a truly virtual integrated approach (with a combination of direct face-to-face service delivery and telehealth service delivery) with other providers and agencies to reduce fragmentation and duplication. Clearly, as documented in the key informant questionnaire survey monkey and Zoom meeting process, HCACA offers its patients personalized, top-rated healthcare using the most sophisticated equipment and skilled staff and is the key asset to the community it serves.

The Health Service Priorities identified in this CHNA, 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. In turn, they will reduce healthcare costs while improving outcomes, which will enable both HCACA and the residents in the communities that HCACA serves to realize the improvement of the health status in these communities.