Introduction

The Health Care Authority of the City of Anniston (HCACA) has conducted a 2023 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 2023 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 Regional Medical Center Health System, DBA Northeast Alabama Regional Medical Center (RMC) and Stringfellow Campus of Regional Medical Center (RMCHS), delineated as 501(c)(3) tax-exempt status. RMCHS 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.

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.

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 located 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) 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, 2017 and 2020 and relative to the 2017 CHNA, inclusive of, at that time, the RMC-Jacksonville Hospital, which was folded under HCACA's governance and operation in 2018. Since the 2017 CHNA, RMCHS has reverted to a 2-hospital health system with both hospitals domiciled in Anniston. The 2023 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 and its variants (and future pandemics) 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 RMCHS.

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 2023 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 the low-income population, inclusive of racial/ethnic minority populations in correlation with social determinants of health (SDOH);
- Identification of unmet need areas that can be used as the basis of the Implementation Strategy Report to be developed and implemented 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 RMCHS: local greater Calhoun County service area agencies and providers, and community leaders; RMCHS Management; RMCHS Board; RMCHS Medical Staff/community physicians; and
- Preparation, documentation, and completion of 2023 Community Health Needs Assessment (CHNA) report.

CHNA Approach & Methodology

The 2023 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 RMCHS' 2-hospital health system resources regarding current and future healthcare program accessibility; and

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

A range of qualitative and quantitative approaches in conducting the 2023 CHNA was utilized, including the following:

- **Key Informant Interviews:** Interviews were conducted with key individuals, as recommended by the RMCHS Management Team. The interviews were scheduled to be performed at RMC's board room in Anniston and in the community. 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 in person. A list of persons interviewed is included in Attachment A;

- **Secondary Data Analysis:** An extensive amount of currently 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 RMCHS, 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.

- **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 and potential future COVID-19 variants and other pandemics. 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 2023 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 2023 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 variants' continuance, 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 extended the deadline for conducting a CHNA and adopting an implementation strategy for 2020 to meet the community health needs identified through the 2020 CHNA to December 31, 2020. Due to burdens the COVID-19 pandemic had placed on hospitals, the IRS provided this additional relief to hospital organizations so that they could meet their CHNA requirements. The COVID-19 pandemic and its variants has had dire economic consequences throughout all regions and states in the U.S. and Alabama is no exception. This IRS extension does not apply to the 2023 CHNA.

Section 501(r)(3)(B) requires that a CHNA (i) take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and (ii) be made widely available to the public. 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)."

RMCHS' community is the health system's geographic area referred to as the service area in which the majority of its patients reside among factors. RMCHS' 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.

RMCHS periodically assesses 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 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 2022 reporting.

While RMCHS 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. Alabama has 12 metropolitan statistical areas, 13 micropolitan statistical areas, and 7 combined statistical areas. There are 67 counties in Alabama. Each county is governed by a county commission. There are 390 county subdivisions in Alabama. They are all census county divisions (CCDs), which are delineated for statistical purposes, have no legal function, and are not governmental units. CCDs were first established for the 1960 census. Prior to 1960, the minor civil divisions (MCDs) used in the census included election precincts, beats, and land survey townships. 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, not yet updated as of this 2023 CHNA).***

Describing service area by a "drilled down" methodology such as zip code and/or place, which is deployed at RMCHS, 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 (HRSA) 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, RMCHS 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., RMCHS' 2-hospital system) draws at least 75 percent of its inpatients."

To determine the geographic service area, the hospital establishes a reference period such as year ending 12/31/2022, specific for this 2023 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 12/31/2022.

For the reference period, the hospital (i.e., RMCHS' 2-hospital health system) should next determine its total inpatient population, i.e., discharges and multiply 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: DHH's Health Resources and Services Administration's-HRSA 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 it's "geographic service area."

Analyzing the two hospitals' calendar year ending 12/31/2022 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. RMCHS 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. All 15 zip codes in the patient origin study that comprised the minimum 75 percent threshold, were delineated from either Calhoun, Cleburne, or Talladega Counties or combination thereof. Calhoun County zip codes comprise the majority, both in terms of absolute amounts and percentages.

Exhibit 1 - Community Served by the Health System

Zip Code	*Place*	*County*	*RMC Discharges*	*SMH Discharges*	*Combined Discharges*	*Percent*	*Cumulative Percent*
36201	Anniston	CA	2062	465	2527	17.4%	17.4%
36203	Oxford	CA,CL,TA	1329	172	1501	10.3%	27.7%
36207	Anniston	CA	1325	281	1606	11.0%	38.7%
36265	Jacksonville	CA	1015	201	1216	8.4%	47.0%
32606	Anniston	CA	897	156	1053	7.2%	54.3%
36264	Heflin	CL	614	71	685	4.7%	59.0%
36272	Piedmont	CA	525	56	581	4.0%	63.0%
35160	Talladega	TA	478	23	501	3.4%	66.4%
36277	Weaver	CA	376	92	468	3.2%	69.6%
36268	Mumford	CL,TA	309	35	344	2.4%	72.0%
36271	Ohatchee	CA	283	57	340	2.3%	74.3%
36260	Oxford	TA	279	31	310	2.1%	76.5%
36250	Alexandria	CA	271	45	316	2.2%	78.6%
36205	Anniston	CA	110	25	135	0.9%	79.5%
36279	Wellington	CA	106	18	124	0.9%	80.4%
Service Area			9979	1728	11707	80.4%	
All Others			2217	637	2854	19.6%	
Total			12196	2365	14561	100.0%	

Source: RMCHS (RMC & SMC) 2022 hospital discharges; Legend: CA-Calhoun, CL-Cleburne, T-Talladega

Further validation of the zip code service area delineated in the preceding Exhibit, was mapped to RMCHS' 2-hospital system's ED utilization for the same period in time (2022 calendar year). RMC alone and the two hospitals (RMC and SMH) combined, reported 34,550 (63.6% of the total) and 54,319 total ED visits respectively. Of the two hospitals combined total ED visits, 18.4% (10,015) were admitted as inpatients to the hospitals and 8.8% (6,181) were for primary care visits only to the ED (Primary Care Levels 1 and 2). It should be noted that the same service area zip codes for ED visits (75 percent threshold) correspond to the above patient origin study/discharge analysis (75 percent threshold) for the two hospitals combined. Noteworthy is that total ED visits declined significantly between the two CHNA's from 64,990 (2020) to 54,319 (2023). Concurrently, ER admissions were consistent between the two CHNA's 10,176 (2020) to 10,015 (2023), giving rise to chronic disease incidence impact.

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 as demonstrated in Attachment B. Calhoun County's Index of Medical Underservice (IMU) score is 61.9, Cleburne County is 61.1, and Talladega County is 45.2 ***(Source: HRSA Geospatial Website 5/2023***). 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 5/2023***). There has been no MUA designation updating by HRSA since the 2020 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 2023, a detailed map of which, is included in Attachment C along with other maps in Attachment D of this report. The combined fifteen-zip code community (75% service area) constitutes a total population of 163,762 ***(Source: U.S. Census Bureau, 2016-20120 Census ACF)***, including 62,055 (37.9%) low-income population individuals, those having income equal to or less than 200 percent of federal poverty level (FPL).

Exhibit 2 - Community Served by the Health System – Population

Zip Code	*Place*	*County*	*Population: Total (#) 2016-2020*	*Population: Low-Income (#) 2016-2020*	*Population: Low-Income (%) 2016-2020*
	Total		163762	62055	37.9%
36201	Anniston	CA	17431	9280	53.2%
36203	Oxford	CA,CL,TA	17705	5315	30.0%
36207	Anniston	CA	19737	5605	28.4%
36265	Jacksonville	CA	20299	7328	36.1%
36206	Anniston	CA	10539	4130	39.2%
36264	Heflin	CL	8270	3160	38.2%
36272	Piedmont	CA	13012	5368	41.3%
35160	Talladega	TA	25622	11190	43.7%
36277	Weaver	CA	5804	1530	26.4%
36268	Munford	CL,TA	5980	2513	42.0%
36271	Ohatchee	CA	6237	2785	44.7%
36260	Eastaboga	TA	4286	1777	41.5%
36250	Alexandria	CA	5258	769	14.6%
36205	Anniston	CA	718	366	51.0%
36279	Wellington	CA	2864	939	32.8%

Source: UDS Mapper 5/2023, U.S. Census/2016-2020 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, 2022, U.S. Census Bureau population estimates of 115,788, the population density is 192.2 persons per square mile.

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

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

In another section of this report, RMCHS 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. RMCHS 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 qualitative 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):

- Alabama Cancer Facts & Figures;
- Alabama Cancer Statistics (Alabama Statewide Cancer Registry – ASCR);
- Alabama Center for Health Statistics;
- Alabama County Health Statistics;
- Alabama Department of Public Health (ADPH) Selected Health Status Indicators (Calhoun, Cleburne, and Talladega Counties), Vital Statistics;
- Alabama State Health Plan;
- American Community Survey (ACS) 5 Year Estimates Data Files;

- American Hospital Association;
- Association of American Medical Colleges (AAMC);
- Centers for Disease Control and Prevention (CDC) – Behavioral Risk Factor Surveillance System (BRFSS);
- Centers for Disease Control and Prevention (CDC) – National Center for Health Statistics ;
- Federal Register, Vol. 79, No. 250, 12/31/2014;
- HCACA / RMCHS: Regional Medical Center (Anniston) and Stringfellow Memorial Hospital (Anniston) internal and external reporting information;
- Health Resources and Services Administration (HRSA) Geospatial Website;
- Healthy People 2030;
- HRSA HPSA Designations;
- HRSA Uniform Data System (UDS) Mapper 5/2023;
- HRSA/Shortage Designation Branch (SDB);
- Internal Revenue Service (IRS) Notice 2011-52;
- IRS Instructions for Schedule H (Form 990);
- Kaiser State Health Facts, Kaiser Family Foundation ;
- KidsCount.org, Annie E. Casey Foundation ;
- National Cancer Institute, SEER Cancer Statistics ;
- National Cancer Institute, State Cancer Profile;
- Patient Protection and Affordable Care Act (P.L. 111-148) (PPACA /ACA);
- Robert Wood Johnson Foundation, County Health Rankings;
- Substance Abuse and Mental Health Services Administration (SAMSHA);
- U.S Census Bureau, Small Area Health Insurance Rankings (SAHIE);
- U.S. Census Bureau American FactFinder;
- U.S. Census QuickFacts;
- U.S. Council on Graduate Medical Education;
- United Health Foundation, America's Health Rankings Report; and
- USAFacts
- RMC/UAB collaboration discussions/documentation/Letter of Intent (LOI)

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 Family

Foundation-KFF), many of which contain valuable county-level data. 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 2023 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 to 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 2020-21 and beyond, the U.S. has been in unchartered waters relative to healthcare access especially relative to the population, socioeconomic, and demographic profile. The COVID-19 pandemic and its variants have had unprecedented, widespread impacts on individuals, families, and households across the country – urban, rural, and suburban. The CDC published "Risk for COVID-19 Infection, Hospitalization, and Death 2020-22 By Race/Ethnicity" on 4/24/2023 relative to COVID-19 rate ratios compared to Whites are documented to date as follows:

- Black/African American and Hispanic/Latino cases were 1.1 and 1.5 greater respectively;

- Black/African American and Hispanic/Latino hospitalizations were 2.1 and 1.8 greater respectively; and

- Black/African American and Hispanic/Latino deaths were 1.6 and 1.7 greater respectively.

Cleary, race and ethnicity are risk markers for other underlying conditions that affect health, including socioeconomic status, access to healthcare, and exposure regarding the COVID-19 pandemic. The healthcare access problems 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. The COVID-19 pandemic and nationwide racial justice movement over the past several years have heightened the focus on health disparities and their underlying causes and contributed to the increased prioritization of health equity.

An 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 has been a difficult and unprecedented time for all providers and community population of all races, ethnicities, and incomes alike, and Alabama is no exception. The COVID-19 pandemic along with variants 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 2023 CHNA. USAFacts shows that of the 1,659,936 and 21,138 COVID-19 cases and deaths respectively in Alabama through 5/13/2023, Calhoun County has been hardest hit in the RMC service area with 41,931 cases and 683 deaths, followed by Talladega and then Cleburne. 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 ***(Source: American Community Survey and U.S. Census Quick Facts)***, and are summarized below and included as Attachment F.

Exhibit 3 – Population and Population 2021 Estimates

	Calhoun County	*Cleburne County*	*Talladega County*	*Alabama State*
Population Estimates, July 1, 2021, (V2021)	115,677	15,148	80,483	5,049,846
Population estimates base, April 1, 2020, (V2021)	116,444	15,057	82,152	5,024,356
Population, percent change - April 1, 2020 (estimates base) to July 1, 2021, (V2021)	-0.70%	0.60%	-2.00%	0.50%
Persons under 5 years, percent	5.70%	6.00%	5.20%	5.80%
Persons under 18 years, percent	21.70%	23.10%	20.70%	22.30%
Persons 65 years and over, percent	18.50%	19.70%	18.90%	17.60%
Female persons, percent	51.60%	50.70%	51.50%	51.40%

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

It is important to note that the total population in both Calhoun and Talladega Counties in the 3-county service area continues to decline as shown above when comparing 2020 to 2021 and below when comparing the prior CHNAs (population 2010 estimates) to the current CHNA (population 2021 estimate), of which, program and service development may be impacted in the future. Cleburne County's population was relatively static between 2020-21 and also between 2010-20. The overall 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 Estimates Comparison

	Calhoun County	*Cleburne County*	*Talladega County*	*Alabama State*
Population Estimates, July 1, 2021, (V2021)	115,677	15,148	80,483	5,049,846
Population estimates base, April 1, 2020, (V2021)	116,444	15,057	82,152	5,024,356
Population, percent change - April 1, 2020 (estimates base) to July 1, 2022, (V2022)	-0.60%	1.90%	-1.80%	1.00%
Population, percent change - April 1, 2020 (estimates base) to July 1, 2021, (V2021)	-0.70%	0.60%	-2.00%	0.50%
Population, Census, April 1, 2020	116,441	15,056	82,149	5,024,279
Population, Census, April 1, 2010	118,572	14,972	82,291	4,779,736
Population Estimates, July 1, 2021, (V2021)	115,677	15,148	80,483	5,049,846
Population estimates base, April 1, 2020, (V2021)	116,444	15,057	82,152	5,024,356

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

Regarding the need for children's and adolescent programs, the pediatric population, based on American Community Survey 5-Year Estimates 2016-2020 of Calhoun (24.4%), Cleburne (24.7%), and Talladega Counties (23.6%) - all had a similar, but slightly less percentage of the population that is 0 - 19 years old than the State (25.2%) (Exhibit 5). Relative to 2021 U.S. Census Population Estimates (Exhibit 3), Calhoun

County's and Alabama's total population are estimated at 116,425 and 4,997,675 respectively, with the County indicating a slight decrease (.5%) and the State indicating a slight increase (.5%), both from April 1, 2010.

Exhibit 5 – Pediatric Population

	Calhoun County	*Cleburne County*	*Talladega County*	*Alabama State*
Total Population	116,425	15,046	81,850	4,997,675
Under 5 years	6,716	865	4,326	295,632
5 to 9 years	6,632	1,042	4,911	301,814
10 to 14 years	7,469	951	4,786	329,794
15 to 19 years	8,000	860	5,273	329,732
Children 0-19	28,817	3,718	19,296	1,256,972

Source: U.S. Census Bureau, 2021: ACS 5 Year Estimates Data Profiles

The working years' population that is 20 – 64 years old, based on American Community Survey 5-Year Estimates 2016-2020 of Calhoun (56.7%), Cleburne (56.1%), and Talladega Counties (58.0%) – shows that Calhoun and Cleburne had a similar percentage of the population that is 20-64 years to the State percentage (57.9%), with Talladega slightly more than the other two counties.

Exhibit 6 – Working Years Population

	Calhoun County	*Cleburne County*	*Talladega County*	*Alabama State*
Total Population	116,425	15,046	81,850	4,997,675
20 to 24 years	7345	769	5191	326,900
25 to 29 years	7830	924	5336	331,435
30 to 34 years	7174	983	5045	315,812
35 to 39 years	7463	804	4523	309,796
40 to 44 years	6683	841	5322	305,314
45 to 49 years	7031	1052	5372	313,389
50 to 54 years	7369	996	5512	320,542
55 to 59 years	8046	986	4780	337,355
60 to 64 years	7084	1085	6870	335,733
Working Years 20-64	66025	8440	47951	2,896,276

Source: U.S. Census Bureau/2021: 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 2016-2020, Calhoun (16.3%), Cleburne (16.1%), and Talladega (16.5) Counties - all had a higher percentage of the population that are 65 years and older than the State (15.2%). Based on American Community Survey 5-Year Estimates 2016-2020, the State was comparable to the Nation and is projected to have a similar percentage of the population over 65 in 2023, as is that of the overall United States.

Exhibit 7 – Population 65 and Older

	Calhoun County	*Cleburne County*	*Talladega County*	*Alabama State*
Total Population	116,425	15,046	81,850	4,997,675
65 to 69 years	6,922	961	5,056	282,913
70 to 74 years	5,679	739	3,977	228,989
75 to 79 years	4,297	578	2,168	148,131
80 to 84 years	2,023	149	2,306	100,678

Source: U.S. Census Bureau/2021: 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 and beyond. 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 the years 2020-21 of the COVID-19 pandemic and now beyond with different variants, 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, 2021 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 16.3%, 16.1%, and 16.5% respectively, contrasted to 15.2% 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 2016-2020, relative to the need for obstetrical programs (prenatal, postpartum, and delivery), the women of childbearing years 15-44 percentage of the Calhoun County population (19.6%) and Talladega County population (19.2%) is similar to that of the State, whereas Cleburne County (16.8%) had a percentage of the population 15 - 44 years old that is lower than the State, amounting to approximately three percent lower.

Women of childbearing years are expected to continue to decline into future years for both Calhoun, Cleburne and Talladega Counties, 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 5/2023***), 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	116,425	15,046	81,850
Female Population	60,346	7,678	42,253
20 to 24 years	3,707	384	2,642
25 to 29 years	3,949	451	2,587
30 to 34 years	3,728	517	2,611
35 to 39 years	3,793	452	2,428
40 to 44 years	3,636	372	2,728
SELECTED AGE CATEGORIES			
15 to 17 years	2,274	257	1,607
Under 18 years	12,491	1,701	8,658
18 to 24 years	5,406	484	3,787
Childbearing Years 15 to 44 years	22,786	2,533	15,748

Source: U.S. Census Bureau/2021: ACS 5 Year Estimates Data Profiles

Based on American Community Survey 5-Year Estimates 2016-2020, the median age of Calhoun, Cleburne, and Talladega Counties was older than the State. Calhoun (39.7) was more comparable to the State (39.7), followed with Cleburne and Talladega Counties with Cleburne's median age of 41.9 years, over 2 years greater than the State and Talladega's (41.7) also 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	116,425	15,046	81,850	4,997,675
Median age (years)	39.7	41.9	41.7	39.3
Male Population	56,079	7,368	39,597	2,429,703
Female Population	60,346	7,678	42,253	2,567,972

Source: U.S. Census Bureau/2021: ACS 5 Year Estimates Data Profiles

C.2. Population Race and Hispanic Origin

Relative to racial and ethnicity composition, based on American Community Survey 5-Year Estimates 2016-2020, Calhoun and Talladega Counties are more comparable to the State regarding White and Black/African American percentages. Almost three-quarters of the State (68.9%) is White, similar to Calhoun (74.7%) and Talladega (63.9%), whereas Cleburne is 94.7% White, which are all comparable to the 2020 CHNA.

Since 1992 and continuing into 2023, 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/Latino 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 2021 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/Latino population has risen steadily and now represents 4.8% (2021) of the state's population vs. 4.6% in 2023 ***(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 (4.2%) 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 (2017-2021)	74.70%	94.70%	63.90%	68.90%
Black or African American alone, percent (2017-2021)	21.60%	3.00%	33.20%	26.80%
American Indian and Alaska Native alone, percent (2017-2021)	0.50%	0.50%	0.40%	0.70%
Asian alone, percent (2017-2021)	0.90%	0.20%	0.60%	1.60%
Native Hawaiian and Other Pacific Islander alone, percent (2017-2021)	0.10%	0.10%	Z	0.10%
Two or More Races, percent (2017-2021)	2.20%	1.50%	1.90%	1.90%
Hispanic or Latino, percent (2017-2021)	4.20%	2.70%	2.60%	4.80%
White alone, not Hispanic or Latino, percent (2017-2021)	71.10%	92.40%	61.90%	64.90%

Source: U.S. Census Bureau 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 for all category hospitals (including community hospitals such as RMC) per 1,000 population (***Source: KFF, 2019-2021***), all regions, all ages including ages 65-84, 85+) was 104, 95, and 96 for 2019, 2020, and 2021 respectively. For Alabama, it was 20-25% higher than the U.S. rate: 130, 117, and 119 respectively for the same periods of time (***Source: KFF/American Hospital Association, 5/2023***). For all three categories, the highest region of the U.S. relative to hospital admission rate per 1,000 population was in southern states (i.e., AL, KY, MS, TN).

Higher admission use rates generally indicate a sicker population with chronic diseases 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 along with value-based contracting arrangements currently in place as of this 2023 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 2022, it is estimated that there will be a decline in the total population in both Calhoun (-6.4%) and Talladega (-2.3%) 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;
- According to the ADPH, the 2021 Alabama infant mortality rate is 7.6 deaths per 1,000 live births, with 443 infants dying during their first year of life. The state's infant mortality for 2021 is an 8.6 percent increase over the 7.0 rate of 2020. Moreover, Alabama's infant mortality rate remains higher than the U.S. rate for 2021, which is provisionally 5.5. Infant deaths, fetal deaths, live births, and estimated pregnancies all increased in Alabama from 2020 to 2021;
- Black/African American mothers continue to have the highest infant mortality rate in the state. In 2021, the rate increased to 12.1 from the 2020 rate of 10.9. The infant mortality rate for White mothers was 5.8, an increase from 5.2 in 2020. The infant mortality rate declined among Hispanic/Latino mothers from 7.2 (37 infant deaths) in 2020 to 5.2 (29 infant deaths) in 2021 (***Source: ADPH)***;
- Regarding births to Alabama residents, the number of live births overall increased from 57,643 in 2020 to 58,040 in 2021. Although births to mothers in the Black/African American and "Other" racial category

decreased from 20,151 in 2020 to 19,170 in 2021, births to White mothers increased from 37,492 in 2020 to 38,870 in 2021. The 5,598 births to Hispanic/Latino mothers in 2021 were the highest seen among the ethnic category in the past decade. ***(Source: ADPH)***; and

- The Overall Death Rate along with White and Black Death Rates, when comparing Alabama to the U.S., Alabama's rates are 27%, 24%, and 11% 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.

Exhibit 11 – 2020 Deaths/100,000

	U.S.	***Alabama***
Overall Death Rate	835.4	1,057.80
White	831.2	1,028.9
Black	1,101.7	1,221.2
Hispanic	723.6	460.2
Asian or Pacific Islander	470.5	455.9
American Indian or Alaska Native	1,008.4	319.8

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 1999-2020

- Relative to the CDC's COVID-19 dataset reporting (5/10/2023) across the country as to risk of illness case, hospitalization, and death by race and ethnicity:

  - Once COVID-19 infected, racial, and ethnic minorities have shown that on average, they have a significantly greater chance of becoming seriously ill and dying vs. non-Hispanic Whites;

  - Black/African Americans represent 13% of the total population, account for 14% of the seriously ill or have died to date; and

  - Hispanics that represent 18% of the total population, account for 15% of the seriously ill or have died.

More paramount and exemplified during the years 2020-21 of the COVID-19 pandemic and variants, 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) reported at that early time of COVID-19 that 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 (SDOH), 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. The KFF (5/2023) points out that the COVID-19 pandemic and nationwide racial justice movement over the past several years have heightened the focus on health disparities and their underlying causes and contributed to the increased prioritization of health equity. These disparities are not new and reflect longstanding structural and systemic inequities rooted in racism and discrimination.

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 RMCHS' service area, and all races and ethnicities, specifically Black/African Americans.

Based on the American Community Survey 5-Year Estimates 2016-2020, 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 20-25 percent. 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 that of the State. Since COVID-19, as RWJF studies of 2020-21 indicate, 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

	Calhoun County	Cleburne County	Talladega County	Alabama
Median value of owner-occupied housing units, 2017-2021	$123,200	$116,500	$114,800	$157,100
Persons per household, 2017-2021	2.56	2.66	2.46	2.57
Median household income (in 2021 dollars), 2017-2021	$50,977	$48,333	$45,400	$54,943

Source: U.S. Census Bureau QuickFacts

Other selective socioeconomic indicators 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*	*U.S.*
All Ages in Poverty	19.2	15.0	19.1	16.3	12.8
Under Age 18 in Poverty	25.2	22.1	27.1	22.7	16.9
Ages 5 to 17 in Families in Poverty	24.7	21.1	26.4	21.6	16.1
Under Age 5 in Poverty	NA	NA	NA	25.1	18.3
Uninsured Adults Age <65*	13%	13%	12%	12%	10%

*Source: U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE) Program 2021. Statistics for ages under 5 years are available only at the state level. *RWJF County Health Rankings 2020 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, 2 of the 3 counties have percentages of children in poverty comparable to the State with Talladega delineated as higher and having a higher percentage of children in single-parent families.

Exhibit 14 - Education Indicators

Indicator	*Calhoun County*	*Cleburne County*	*Talladega County*	*Alabama State*
High School Graduates (2021)	92.2%	96.4%	93.2%	90.7%
Children in Poverty (2016-2020)	20%	21.5%	24.5%	22.7%
Unemployment	4.1%	2.6%	4.1%	3.4%
Children in Single-Parent Families (2015-2019)	31%	17.5%	36.2%	31.1%
High school Drop Out Rate (2020-2021)	2.5%	1.2%	3.2%	4.3%
Percent of teens(16-19) Not Attending School and Not Working (2016-2020)	6.9%	8.0%	12.3%	8.0%

Source: KidsCount.org, Annie E. Casey Foundation

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 a key COVID-19 underlying condition as we found out in 2021-22. The U.S. rate of 39% is high and all three counties and the State of Alabama are comparable, indicating an unhealthy community in the nation, state, and counties.

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*
Adult Smoking (2020)	21%	22%	22%	20%
Adult Obesity - (age 18 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2 (2020)	37%	38%	42%	39%
Quality of life – Adults reporting poor or fair health (2020)	20%	19%	22%	19%
Physical Inactivity - adults age 18 and over reporting no leisure-time physical activity (2020)	28%	29%	32%	28%
Access to exercise opportunities (2020 & 2022)	65%	42%	50%	61%
Excessive Drinking - adults reporting binge or heavy drinking (2020)	16%	17%	15%	16%
Diabetes Prevalence Adults Aged 20+ (2020)	12%	11%	13%	13%
Female Medicare enrollees ages 65-74 that received an annual mammography screening (2020)	30%	26%	34%	36%
Food insecurity - Percentage of population who lack adequate access to food (2020)	16%	16%	17%	15%
Percent of live births with low birth weight (<2500 grams) (2014-2020)	9%	8%	11%	10%
Infant Mortality Rate/1,000 Live Births (2014-2020)	8	N/A	8	8
Teen Births per 1,000 female population ages 15-19 (2014-2020)	30	31	29	28
Sexually Transmitted Infections (STI) - newly diagnosed chlamydia cases per 100,000 population (2020)	449.8	194.5	507.6	552.2
Air pollution –particulate matter - Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) (2019)	9.7	9.4	10.0	9.3
Preventable hospital stays - Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees (2020)	3,722	3,277	3,722	3,599

Sources: RWJF 2023 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 2023 CHNA.

Exhibit 16 - Additional Selected Behavioral Risk Factors

Indicator	*Alabama*	*U.S.*
Adults 65+ who had a flu shot in past year (2021)	67.0%	68.6%
Children 0-17 who had both medical & dental preventive care visit in the last 12 mos. (2021)	58.8%	59.9%
Adults told by Dr. they have Diabetes (2021)	15.1%	10.9%
Adult women who have been told they have Diabetes (2021)	15.7%	NA
Adults self-reported current Asthma Prevalence Rate (2021)	10.1%	9.8%
Children 10-17 who are obese (2020-2021)	22.1%	17.0%
Adults who visited dentist in past year any reason (2020)	61.4%	66.7%

Sources: kff.org/Centers for Disease Control and Prevention (CDC)'s Behavioral Risk Factor Surveillance System (BRFSS)/National Survey of Children's Health

Likely, as the result of some of the above behaviors, plus other issues, the population in the three counties has poor access to primary care providers (worse in Cleburne and Talladega vs. Calhoun), behavioral health providers (i.e. HPSA Mental Health designations), or other providers in the healthcare delivery 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 (Alabama and the 3 counties – higher than the U.S.) 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*	*U.S. Median*
Poor or fair health - Percentage of adults reporting fair or poor health (age-adjusted) (2020)	20%	19%	22%	19%	12%
Poor physical health days Average number of physically unhealthy days reported in past 30 days (age-adjusted) (2020)	3.8	4.0	4.1	3.5	3.0
Poor mental health days Average number of mentally unhealthy days reported in past 30 days (age-adjusted (2020)	4.9	5.4	5.4	5.1	4.4
Frequent mental distress - Percentage of adults reporting 14 or more days of poor mental health per month (2020)	17%	18%	18%	16%	14%
Excessive drinking - Percentage of adults reporting binge or heavy drinking (2020)	16%	17%	15%	16%	19%
Uninsured adults - Percentage of adults under age 65 without health insurance (2020)	13%	13%	12%	12%	10%
Ratio of Population to PCP (2020)	1670:1	3740:1	3480:1	1520:1	1310:1
Social associations - Number of membership associations per 10,000 population (2020)	13.4	8.0	12.0	11.9	9.1
Food Environment Index – Healthy food 0-10 scoring (2019 & 2020)	6.0	7.3	6.7	5.3	7.0

Source: RWJF 2023 County Health Rankings

The U.S. Census Bureau's 2020 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's rates are comparable to the state and Talladega's rates are lower compared to the state. It should be noted that in prior years' CHNAs, 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 prior CHNA ***(Source: KFF 2019***) relative to uninsured, Alabama vs. the U.S., males/females combined, Whites, Blacks, and Hispanics were 10% vs. 8%, 13% vs. 11%, and 27% vs 20% respectively. For 2023 CHNA ***(Source: KFF 2021***) relative to uninsured, Alabama vs. the U.S., males/females combined, Whites, Blacks, and Hispanics were 10% vs. 7%, 12% vs. 11%, and 31% vs 19% respectively – basically the same other than a rise in the Hispanic rate. This situation is exacerbated relative to women, especially 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. For women <65, all races, Calhoun (11.4%) and Cleburne (12.8%) have higher uninsured rates that Alabama (10.5%).

Exhibit 18 – Uninsured Women All Races

	Calhoun County	*Cleburne County*	*Talladega County*	*Alabama*
Under 65 years All Incomes	11.4%	12.8%	9.6%	10.5%
Under 65 years <=200% of Poverty	17.2%	19.4%	13.3%	17.2%
Under 65 years <=250% of Poverty	16.2%	18.5%	12.8%	16.2%
Under 65 years <138% of Poverty	18.7%	21.0%	14.4%	18.5%
Under 65 years <=400% of Poverty	13.9%	15.5%	14.2%	13.7%
Under 65 years 138% to 400% of Poverty	11.0%	12.4%	9.4%	10.8%

Source: U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE) 2020

Intimate Partner Violence ("IPV") constantly has been linked to long-term as well as short-term health issues. Long-term issues include neurological, gastroenterological, and cardiac as well as other medical and behavioral health (mental health) issues. Over one-third (37.5%) of Alabama women and 29.5% of Alabama men experience intimate partner physical violence, intimate partner sexual violence and/or intimate partner stalking in their lifetimes. Children who witness the violence also have neurological, mental, and physical health issues.

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 significantly higher in the three counties compared to the State. This is especially so in Cleburne (18.3) and Talladega (15.3) as indicated in Kidscount.org in the most current reporting as of the CHNA 2023. 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*
Children with Indication of Abuse or Neglect in Alabama per 1,000 under 18 (2021)	14.3	18.3	15.3	10.8
Children Who Are Subject to an Investigated Report in Alabama per 1,000 under 18 (2020)	NA	NA	NA	33.0
Children Who Are Confirmed by Child Protective Services as Victims of Maltreatment in Alabama per 1,000 under 18 (2020)	NA	NA	NA	11.0

Source: KidsCount.org Annie E. Casey Foundation

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. COVID-19 ranks #3 for the U.S., for Alabama and for each of the three counties. Chronic Lower Respiratory Disease (CLRD) ranks #4 for Alabama and for each of the three counties, whereas for the U.S., it is Accidents. No. 5 for the U.S, it is Stroke, as it is for Alabama and Talladega. Alzheimer's Disease appears in the "top five" for Calhoun and for Cleburne, it is Accidents.

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

Rank	*U.S.*	*Calhoun County*	*Cleburne County*	*Talladega County*	*Alabama*
1	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease
2	Cancer	Cancer	Cancer	Cancer	Cancer
3	COVID	COVID (2019)	COVID (2019)	COVID (2019)	COVID (2019)
4	Accidents	CLRD	CLRD	CLRD	CLRD
5	Stroke	Alzheimer's Disease	Accidents	Stroke	Stroke

Source: Alabama Center for Health Statistics 2020, 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 heart disease, cancer, COVID-19, and CLRD 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 less than Alabama, in the majority of the other death rate indicators, the three counties are generally higher than Alabama (i.e., CLRD in Talladega 87.5 vs. 69.7).

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

Indicator	*Calhoun County*	*Cleburne County*	*Talladega County*	*Alabama*
Heart Disease	459.2	380.8	373.8	299.5
Cancer	245.0	280.6	277.6	212.5
Coronavirus Disease 2019	154.2	167.0	162.5	133.1
Chronic Lower Respiratory Disease	107.5	126.9	87.5	69.7
Cerebral Disease/Stroke	52.9	46.8	72.5	68.9
Influenza/Pneumonia	30.8	33.4	36.3	22.6
Accidents	56.4	80.2	57.5	61.1
Suicide	24.7	13.4	8.8	16.1
Diabetes	20.3	6.7	27.5	29.5
HIV Disease	0.9	0.0	0.0	1.7
Alzheimer's Disease	77.6	53.5	26.3	62.9

Source: Alabama Center for Health Statistics 2020, 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 (459.2), Cleburne (380.8), and Talladega (373.8) are all considerably higher than Alabama (299.5), 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 Talladega 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*
Total Population	6,721	911	4,628	261,947
Males	569.2	559.0	547.9	532.6
Females	404.0	385.1	391.0	401.3
Black Males	588.4	640.9	566.5	562.4
Black Females	377.7	557.6	335.4	383.0
White Males	566.9	548.2	536.9	517.8
White Females	411.4	378.9	413.0	406.6

Source: Alabama Cancer Statistics (Alabama Statewide Cancer Registry (ASCR), 2021. Data Years: 2008-2018

Exhibit 23 - Cancer Mortality Frequencies in Alabama and by County

Cancer Mortality: All Cancers	*Calhoun County*	*Cleburne County*	*Talladega County*	*Total Alabama*
Total Population	273	34	205	10,437
Males	142	19	116	5,695
Females	132	15	89	4,742
Males Black	21	3 or fewer	30	1,249
Females Black	21	3 or fewer	22	1,139
White Male	119	19	85	4,373
White Females	109	13	66	3,540

Source: National Cancer Institute, State Cancer Profile, 5 Year Average 2016-2020

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. 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.

Exhibit 24 - Selected Cancer Incidence and Mortality per 100,000 Population

Indicator	*Calhoun County*	*Cleburne County*	*Talladega County*	*Alabama*	*U.S.*
Breast Cancer Incidence Female*	117.1	107.1	122.5	122.8	128.1
Breast Cancer Mortality**	18.6	***	24.4	20.9	19.6
Lung and Bronchus Incidence*	76.0	65.0	70.3	62.5	56.3
Lung Cancer Mortality **	54.4	48.0	51.9	44.6	35.0
Colorectal Incidence*	49.3	53.3	46.8	42.4	37.7
Colorectal Mortality**	17.2	18.6	19.0	14.7	13.1
Prostate Incidence Male*	138.7	105.1	102.4	124.0	109.9
Prostate Mortality**	21.5	***	24.9	20.2	18.8
Pancreas Mortality**	12.4	***	12.7	11.8	11.1
Non-Hodgkin Lymphoma Mortality**	5.5	***	4.4	4.9	5.1

*Sources: National Cancer Institute – Surveillance, Epidemiology, and End Results Program (SEER), 5 Year Age-Adjusted Incidence Rates, *2015-2019, **2016-2020*
*** Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).*

The State appears to have similar behavior to the U.S., albeit 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, All Races, Both Sexes Adults 50+

Screening	*Alabama*	*U.S.*
Sigmoidoscopy/Colonoscopy	77.41%	74.4%
Home-Based Fecal Occult Blood Test (FOBT) in Past 2 Years	15.25%	14.3%
Home-Based FOBT in the Past 2 Years or Ever Had a Colorectal Endoscopy	80.82%	79.9%

Source: National Cancer Institute, 2020 BRFSS Data

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**: According to Alabama Public Health, the age-adjusted death rate from heart disease is higher in Calhoun (459.2), Cleburne (380.8), and Talladega (373.8) Counties relative to the State and the U.S. rates. The State rate of 299.5/100,000 is higher than the U.S. rate of 211.5/100,000. 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 2022 report, Alabama ranked 47th of all states relative to obesity (39.9% of all adults) and 49th relative to physical activity (31.5% 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 Most Recent Data: 92.8 coronary health disease deaths/100,000 (2021). (Healthy People 2030 Target = 71.1. Status: Getting Worse; Desired Direction: Decrease desired***

- **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 2022 report, Alabama ranked 40th of all states relative to smoking (17.2% of all adults) and 48th relative to cancer deaths per 100,000 population. Cancer is the second leading cause of death in the United States. Strategies to help people quit smoking, eat healthy, and get more physical activity can help reduce deaths from different types of cancer. Vaccines, screening procedures, and new treatments can also help reduce cancer deaths. ***Healthy People Most Recent Data: 146.6 cancer deaths/100,000 (2021). (Healthy People 2030 Target = 122.7). Status: Improving; Desired Direction: Decrease desired***

- **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 2022 report, Alabama ranked 47th of all states relative to diabetes (15.1% of all adults), which also is a key COVID-19 underlying condition. Adults diagnosed with diabetes are at an increased risk of early death. Complications like heart disease and kidney disease are among the leading causes of death in people with diabetes. Improving diabetes treatments can help reduce the risk of these complications and lower the death rate in people with diabetes. ***Healthy People Most Recent Data: 15.2 diabetes deaths/100,000 (2010-2015). (Healthy People 2030 Target = 13.7). Status: Baseline Only; Desired Direction: Decrease desired***

- **CEREBROVASCULAR DISEASE - Problem/Need:** The age-adjusted death rate from cerebrovascular disease is higher in Talladega (72.5/100,000) County relative to the State and the U.S. rates. The State rate of 68.9/100,000 is higher than the U.S. rate of 48.6/100,00. Based on the United Health Foundation, America's Health Rankings 2022 report, Alabama ranked 38 of all states relative to all behaviors. Stroke is the fifth leading cause of death in the United States and a leading cause of long-term disability. Low-income populations, some racial/ethnic groups, and people

who live in certain geographic regions are more likely to have a stroke and to die of a stroke. Interventions to lower people's risk for stroke by improving blood pressure, diet, and physical activity are critical for reducing stroke deaths. Raising awareness of stroke signs and symptoms and improving stroke management can also help reduce death and disability related to stroke. ***Healthy People Most Recent Data: 41.1 stroke deaths/100,000 (2021). (Healthy People 2030 Target = 33.4). Status: Getting Worse; Desired Direction: Decrease desired***

- **CHRONIC LOWER RESPIRATORY DISEASE - Problem/Need:** Alabama Public Health County Profiles show the age-adjusted death rate/100,000 from chronic lower respiratory disease is higher in Calhoun (107.5), Cleburne (126.9), and Talladega (87.5) counties relative to the State rate. The State rate of 69.7 is higher than the U.S. rate of 46.3. COPD (chronic obstructive pulmonary disease) is a group of diseases — including emphysema, chronic bronchitis, and non-reversible asthma — that make it hard to breathe and can cause death. COPD is a major cause of disability and one of the leading causes of death in the United States — and many people who have COPD may not know it. Strategies to reduce deaths from COPD include reducing smoking and exposure to air pollution, teaching people with COPD how to manage it, and promoting tests that can find it earlier**.** ***Healthy People Most Recent Data: 95.7 COPD deaths per 100,000 adults (2021). (Healthy People 2030 Target = 107.2). Status: Target Met or Exceeded; Desired Direction: Decrease Desired***

- **BEHAVIORAL HEALTH (MENTAL HEALTH, SUBSTANCE USE DISORDER, OPIOID USE DISORDER): Problem/Need**: Based on the United Health Foundation, America's Health Rankings 2022 report, Alabama has the dubious distinction of ranking 50th of all states relative to number of mental health providers 128.8/100,000 population, and 47th relative to adults in frequent mental distress (18.4%). Adults with both 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 touches a wide range of the population, including people with stable lives, jobs and families, and workplaces too. According to the Alabama Department of Public Health (ADPH), in 2018, there were 11,081 visits to hospital emergency departments in Alabama related to overdoses, with 2,180 involving opioids. There was a total of 20,353 overdose-related 911 runs in 2018, with 4,373 involving opioids. In 2017, the rate of drug overdose deaths in Alabama was 17.1 per 100,000 population. In 2019, Governor Ivey secured funding in the state's operating budget to improve the Prescription Drug Monitoring Program to, in part, make it easier to use for both physicians and pharmacists. Also, Governor Ivey

signed a law making it a crime to traffic in either fentanyl or carfentanil, which are synthetic opioids with a higher potency than heroin. The new law makes it a felony to knowingly possess more than a half gram of fentanyl or a related synthetic opioid or to possess, sell, or deliver a mixture containing fentanyl or a related synthetic opioid. Both Acts were directly recommended by the Alabama Opioid Overdose and Addiction Council. Opioid overdoses are the leading cause of injury deaths in the United States, and they have increased dramatically in recent years. Interventions to change health care providers' opioid prescribing behaviors and teach patients about the risks and benefits of prescription opioids can help reduce opioid-related deaths. Distributing naloxone to reverse overdoses and providing access to medications for opioid use disorder can also help reduce overdose deaths. ***Healthy People Most Recent Data: 24.7 overdose deaths involving opioids deaths/100,000 (2021). (Healthy People 2030 Target = 13.1). Status: Getting Worse; Direction: Decrease desired***

The COVID-19 2020-21 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 CHNA reports for RMC and currently, 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 what COVID-19 showed us. Part of the impetus has been coming from payor pressures, i.e., value based contracting 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 expanded 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 has forced 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 created 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 has been 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 2023 CHNA, Alabama has not expanded Medicaid, so the poorest residents in the state continue to 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 have not qualified for Medicaid coverage through 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 has been losing out on $14.4 billion in federal spending and state hospitals have been losing $7.0 billion in reimbursement over the same period. Noteworthy though is that Democrats and Republicans offer the same message on Obamacare: The landmark healthcare law is here to stay with the Supreme Court's 7-2 decision in June 2021 affirming the law for the third time ***(Source: Politico 6/17/2021).***

As of May 24, 2023, 7 of the 10 states which have not expanded Medicaid to cover more of the poor, low-income residents are located in the south and includes Alabama and its 4 neighboring states of Georgia, Mississippi, Tennessee, and Florida. Prior to ACA/Obamacare, Alabama's rate of uninsured was at 14% and currently, 10.0% of Alabamians still remain without insurance, whereas the rate for the U.S. is 8.6% inclusive of the 10 states that have not expanded and the 40 that have expanded ***(Source: KFF 5/2023, 2021).*** 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 Alabamians covered by Medicaid are the working poor, either self-employed or working in small businesses which do not provide coverage (48%).

It has been projected that under Medicaid expansion, the rate of uninsured would drop to 6% and many of the uninsured would be covered. 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 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's poor, low-income residents, goes to the other 38 states which decided to expand their Medicaid programs ***(Source: AL.com article, 9/2020)***. Alabama and the other 9 states that have not yet adopted Medicaid expansion, equates to over 2.1 million people in the "coverage gap" — meaning they fall into the income level that would make them eligible for Medicaid but cannot access it because their state has not adopted it. 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 continue to increase as it has for years. 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 2023 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 HRSA 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 HRSA update, and Talladega County is wholly designated HPSA Primary Care – High Needs Geographic Area as of the 12/31/2018 last HRSA update. Validating mental health need based on the United Health Foundation, America's Health Rankings 2022 report, "Alabama has the dubious distinction of ranking 50 of all states relative to number of mental health providers per 100,000 population, and 47 relative to adults in frequent mental distress (18.4%)," 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* (2021)	115,972	15,103	79,828
Primary Care Physicians Per Population* (2020)	59.9	26.7	28.8
Dentists Per Population*(2021)	65.5	***	34.3
Mental Health Providers Per Population* (2022)	149.2	53.0	31.9
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 2023 County Health Rankings;*
*** HRSA Shortage Designation Branch 5.3.2023;*

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 2022 report, "Alabama has the dubious distinction of ranking 50 of all states relative to number of mental health providers per 100,000 population, and 47 relative to adults in frequent mental distress (18.4%)." RWJF's 2023 county health 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 59.9, 26.7, and 28.8 respectively.

Further and based on 2020 data, in 2021 Alabama needs an additional 196 primary care physicians (PCP). Alabama has one Full Time Equivalent (FTE) PCP for every *2,226* residents. This ratio globally suggests that Alabama has adequate numbers of PCPs available for its 4,864,573 residents, but in Alabama the PCP shortage is the result of the current distribution of PCPs and the lack of PCP access it creates. ***(Source: Status Report of the Alabama Primary Care Physician Workforce, 2020).***

On 4/25/2023, the Alabama House of Representatives passed the Physician Workforce Act that aims to address the state's physician shortage to boost recruitment of out-of-state physicians to Alabama and creates an apprenticeship-like program for medical school graduates who are waiting to get placed into residency programs.

New physician workforce projections indicate that the physician shortage remains significant throughout the U.S. 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 sharply. 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 under ACA when 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 dynamic nature of projected assumptions, projected shortfalls of physicians in 2025 are less than shortfalls projected in earlier studies with projected demand for physicians in 2025 exceeding supply by 46,100 to 90,400 versus a 130,600-shortfall projected in a 2010 study; and

- 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 2022 report, Alabama ranked 46 and 45 relative to Preventable Hospitalizations and availability of Primary Care Physicians respectively of all states, while RWJF's County Health Rankings 2023 (using 2020 data) AL delineated that there were 3,599 preventable hospital stays per 100,000 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 the 2020's;

- Dermatology: Medical specialties, such as dermatology, are expected to see a shortage ranging from 3,800 to 13,400 physicians. These recent figures are consistent with the AAMC's previous physician workforce reports;

- 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 2021 reporting shows AL (411) ranked as the 31st highest state in the U.S. (383) regarding hospital ED visits per 1,000 population. 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: A 2021 report released by the American Association of Medical Colleges projects shortages of 15,800-30,200 in all surgical specialties by 2034;

- 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 primary care in general, more incentives are needed;

- Oncology: According to the American Society of Clinical Oncologists (ASCO), there were 13,146 oncologists engaged in active patient care in the United States in 2021. Some cities are flush with oncologists; however, 32 million Americans live in a county with *no* oncologists. ASCO projects a shortage for more than 2,200 oncologists by 2025; and

- Psychiatry: Expected shortages due to retiring physicians and reduced workload per provider – United Health Foundation's 2022 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 2020 CHNA, continues to be apparent for the low-income population (income equal to or less than 200% of federal poverty level) in the 2023

CHNA with 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. (QLHS) (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 in 2020-2021 COVID-19 pandemic years. Yet, unmet need for the low-income medically underserved and vulnerable populations, not provided by all FQHCs combined, has significantly increased.

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 15-zip code community (service area) constitutes 163,762 total population ***(Source: U.S. Census Bureau)***, which includes 62,055 (37.9%) 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 half of the total population is low-income.

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

Zip Code	*Place*	*County*	*Population: Total (#) 2016-2020*	*Population: Low-Income (#) 2016-2020*	*Population: Low-Income (%) 2016-2020*
	Total		163762	62055	37.9%
36201	Anniston	CA	17431	9280	53.2%
36203	Oxford	CA,CL,TA	17705	5315	30.0%
36207	Anniston	CA	19737	5605	28.4%
36265	Jacksonville	CA	20299	7328	36.1%
36206	Anniston	CA	10539	4130	39.2%
36264	Heflin	CL	8270	3160	38.2%
36272	Piedmont	CA	13012	5368	41.3%
35160	Talladega	TA	25622	11190	43.7%
36277	Weaver	CA	5804	1530	26.4%
36268	Munford	CL,TA	5980	2513	42.0%
36271	Ohatchee	CA	6237	2785	44.7%
36260	Eastaboga	TA	4286	1777	41.5%
36250	Alexandria	CA	5258	769	14.6%
36205	Anniston	CA	718	366	51.0%
36279	Wellington	CA	2864	939	32.8%

Source: UDS Mapper, 5/2023

Based on HRSA's UDS Mapper 5/2023 reporting required of all FQHCs, less than one-fifth (8,558 - 13.8%) of the total zip codes' low-income population (62,055) is being served by all FQHCs of which, the dominant FQHC is QLHS The remainder, which totals 53,497 low-income individuals (income less than or equal to 200% of federal poverty level), is not currently served by any FQHC and consequently, there remains 86.2% primary medical care capacity or "unmet need" for the low-income population in the combined 15-zip code service area and in a state with no Medicaid expansion. This is even greater when consideration is given to the three-county service area of Calhoun, Cleburne, and Talladega Counties (all zip codes). Noteworthy that the low-income unmet need has increased significantly even with HRSA funding mechanisms, as the low-income unmet need was 49,367 - 76.1% three years ago in the 2020 CHNA.

QLHS, basically "the only shown in town," has been the recipient of significant U.S. Public Health Service Section 330/HRSA grant funding with no funding reported/allocated directly to Calhoun County. QLHS has increased comprehensive preventive/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). QLHS 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*	*County*	*Population: Low-Income (#) 2016-2020*	*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*
	Total		62055	8558	13.8%	53497	86.2%
36201	Anniston	CA	9280	1909	20.6%	7371	79.4%
36203	Oxford	CA,CL,TA	5315	677	12.7%	4638	87.3%
36207	Anniston	CA	5605	873	15.6%	4732	84.4%
36265	Jacksonville	CA	7328	590	8.1%	6738	91.9%
36206	Anniston	CA	4130	550	13.3%	3580	86.7%
36264	Heflin	CL	3160	1116	35.3%	2044	64.7%
36272	Piedmont	CA	5368	586	10.9%	4782	89.1%
35160	Talladega	TA	11190	1241	11.1%	9949	88.9%
36277	Weaver	CA	1530	162	10.6%	1368	89.4%
36268	Munford	CL,TA	2513	217	8.6%	2296	91.4%
36271	Ohatchee	CA	2785	208	7.5%	2577	92.5%
36260	Eastaboga	TA	1777	152	8.6%	1625	91.4%
36250	Alexandria	CA	769	109	14.2%	660	85.8%
36205	Anniston	CA	366	47	12.8%	319	87.2%
36279	Wellington	CA	939	121	12.9%	818	87.1%

Source: UDS Mapper, 5/2023

F.2. Existing Healthcare Facilities

The CHNA offers providers such as RMCHS 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 (164 beds)	1 (39 beds)	2 (52 beds)
Assisted Living Facilities (Specialty Care)	4 (163 beds)	1 (16 beds)	1 (16 beds)
Community Mental Health Centers	0	0	0
End Stage Renal Treatment Centers	6 (79 stations)	0	4 (73 stations)
Federally Qualified Health Centers (Core/Satellite)	1	0	0
Home Health Agencies	2	0	3
Hospices	4	0	3
Hospitals – General Acute	2 (463 beds)	0	2 (290 beds)
Hospitals – Specialized	1 (38 beds)	0	0
Independent Clinical Laboratories	15	0	8
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	1	0	8

Source: Alabama Department of Public Health (ADPH), Health Care Facilities Directories, 5.3.2023

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
Anniston, AL 36202-2208
338 bed General Hospital
Authorized bed capacity: 338
Licensee Type: Public Corporation

HCACA - Stringfellow Memorial Hospital
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 took into account input from persons who represent the broad interests of the community served by the hospital (RMC and Stringfellow), including those with special knowledge of or expertise in public health. To accomplish this task, EXEC developed survey instruments (example and summary in Attachment G), which were used in a direct person-to-person interview survey process. A particular survey

instrument was used with community physicians in an effort to ascertain additional insight with regard to perception of HCACA meeting community needs by the physician community practicing in the primary service area of RMCHS.

In order to be compliant with IRS Notice 2011-52, the process that EXEC utilized, encompassed conducting interviews with key individuals representing the greater Calhoun/Cleburne/Talladega Counties community, as recommended by the HCACA Management Team, and of which were performed primarily at the hospital; and at governmental; private, and public organizations; physician offices, school boards, and elsewhere in the community during August 2023. 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 EXEC'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 primarily, direct face-to-face and to a lesser extent, on the telephone, depending on the preference of the interviewee. A list of persons interviewed is included in Attachment A.

Conducting a CHNA 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. It also

involved a discussion relative to the potential affiliation between RMC and the University of Alabama-Birmingham (UAB) and the projected impact on healthcare at RMC and throughout the community.

Interviews were conducted by EXEC'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 findings of the survey process.

H. Community Member Interview Results Summary

Executive Resources, LLC (EXEC) conducted direct face-to-face informant interviews with community members in August 2023. The interviews were designed to obtain input on health needs from people who represent the broad interests of the community served by RMC, including those with special knowledge of or expertise in public health. Twenty members of the community were interviewed, including: persons with special knowledge of or expertise in public health; health and other public departments or agencies with data or information relevant to the health needs of the community; and leaders, representatives, and members of medically underserved, low-income, and minority populations, and of populations with chronic disease needs; and representatives of the education and business communities.

An annotated list of individuals providing community input is included in the following section of this report. Interviews were conducted using a structured questionnaire. Informants were asked to discuss community health issues and encouraged to think broadly about the social, behavioral, and other determinants of health. Interviewees were asked about issues related to health status, health care access and services, chronic health conditions, populations with special needs, and health disparities. The frequency with which specific issues were mentioned and interviewees' perceptions of the severity (how serious or significant) and scope (how widespread) of each concern were assessed.

The following health status issues and contributing factors were reported to be of greatest concern. The items in each list are presented in order of stated importance, although the differences in some cases are relatively minor.

Nine community members (eight organizations) participated in direct face-to-face informant interviews during the CHNA process. These community members represented a wide array of community organizations/resources including the following;

- Interfaith Ministries of Calhoun County

- Saint Michaels Medical Clinic
- Carillion Oaks
- Calhoun County Health Department
- East AL Regional Planning Commission
- Community Enabler Developer
- ARC of Calhoun County
- Quality of Life Health Services

The organizations/agencies represent thousands of community residents and interviewees were asked to not only provide their individual perspective when responding to the questions, but as much as able, to also provide the response from the perspective of users (clients/patients) of their respective organizations/agencies. It is the opinion of Executive Resources, LLC (EXEC) that these direct face-to-face interviews provide a "broad and deep" community perspective and thus very adequately meet the requirement of community participation in the CHNA survey process.

Health Status Issues

1. **Substance Abuse Disorder (SUD)-Drug, Alcohol, Substance Abuse**

   Substance abuse was mentioned most frequently as a major health status issue and was portrayed as both growing and serious throughout the region. SUD (along with opioid use disorder-OUD) services was indicated as the number one healthcare priority in the community and associated with underlying chronic mental health disease services and that there continues to be a lack of adequate drug and alcohol treatment programs, especially for the low-income/poor population in which services are essentially not available. As with prior CHNAs, respondents reported that greater emphasis of drug & alcohol education programs – particularly directed at youth as a "strategy" should be of paramount focus.

2. **Mental and Behavioral health**

   Mental and behavioral health was frequently mentioned as a major health issue in the community. Interviewees reported that the community's mental health needs have risen, while mental health service capacity has not. The respondents described a wide range of mental health issues, including bullying among youth, autism spectrum symptoms and diagnoses, depression among senior citizens, adult and family stress and coping difficulties, lack of affordable outpatient mental

health professionals, and a lack of local inpatient treatment facilities. Interviewees also noted frequent dual diagnoses of mental health problems and substance abuse. Mental health services lack of accessibility was indicated as the number two healthcare priority in the community regardless of income level and income status. Hospital (RMC) emergency departments are routinely impacted with patients experiencing psychiatric/mental health crises. Meeting these patients care needs is difficult and lack of adequate referral opportunities for these patients contributes to inefficiency in emergency service delivery.

3. **Transportation Services**

Lack of adequate transportation services was a recurring theme among the respondents and the number three healthcare priority in the community. Rurality, in all three counties, and especially outside Anniston city limits and where there is no public transportation, is a real problem for residents to receive healthcare. Lack of multiple cars in a family is also a problem especially when one family member works and travels to work by car, leaving a void of vehicles for other family members. Income and cost of transportation was also cited several times.

4. **Navigating the Healthcare System**

Navigating the healthcare system was echoed throughout by the respondents as the number four healthcare priority in the community. This includes a wide range of related systematic area, including but not limited to the following: 1) Linkage with RMC's emergency room and other hospital systems and medical records, 2) Linkage with referral systems, 3) Connectivity/WiFi/Phones/reception all related to communications, 4) Processes in place to admit patients.

5. **Chronic Illness (i.e., Cholesterol, Diabetes, and Hypertension)**

Diabetes was the most frequently mentioned chronic disease in the interviews and was often paired with discussions about obesity and overweight. This was true for all ages, but these health issues were noted to be rising among children and youth. Interview participants mentioned nutrition and diet, low physical activity and exercise levels, and food insecurity and hunger. Access to healthy foods was mentioned as a barrier, including that some do not have money to purchase fresh produce. There was widespread recognition of the toll a chronic illness has on health, its impact on the health care system, and the importance of not only treatment but also behavioral change in addressing the chronic disease.

6. **Cancer**

   Cancer was mentioned frequently during the interview process.

In addition to direct face-to-face informant interviews conducted with community members in August 2023, twenty community members responded to survey questions. The actual survey questions with responses follow this summary section of survey questions and responses.

Contributing Factors

1. **Access to health care (physicians/specialists):** Interviewed participants cited a wide range of difficulties regarding access to care, including availability of providers (physicians/specialists), cost and affordability of care, significant transportation barriers for low-income and elderly populations, and language or cultural barriers for some members of the community. Some interviewees mentioned that there are community residents that do not seek medical care due to their immigration status in the country.

2. **Financial insecurities and poverty**: It was frequently stated that issues related to income and financial resources limit access to care, contribute to poor diet and nutrition, and create stresses that negatively impact health.

3. **Education/Awareness**: Several interviewees mentioned that education and awareness about services were barriers to care. Factors linked generally to educational attainment and specifically to health education were noted by interview participants as impeding both the ability to effectively seek and manage health care, and to adopt and practice healthy behaviors. Many noted that the community is not aware of services available to them, and that finding services is not easily managed. It was also mentioned that those coming out of prison have limited access to resources.

4. **Poor nutrition and diet**: Among healthy behaviors, dietary habits and nutrition were mentioned most frequently as major factors in obesity, diabetes, heart disease and related conditions, and chronic diseases. Interview participants mentioned this is due to a lack of access to affordable healthy foods for lower income families.

5. **Lack of physical activity and exercise**: Among health behaviors that contribute to or inhibit good health, a lack of physical activity and exercise was mentioned as a concern for all age groups. Interview participants recognized that reasons for limited activity and strategies to increase activity differ across the life span.

6. **Affordable Housing/Assisted Living**: Interview participants frequently mentioned the need for affordable housing and assisted home care for senior citizens. Some interview participants highlighted the health risks experienced by older residents in the community. Seniors have lower incomes, transportation barriers, advanced chronic diseases, and social isolation that can negatively impact health status.

7. **Homelessness**: Homelessness is a risk factor for poor health, and creates stress and challenges to maintaining one's health and seeking or obtaining needed health care

Community Member Survey Results:

As indicated, twenty community members responded to fifteen survey questions. The actual survey questions with responses follow this summary section of survey questions and responses.

Question 1: Inquires about how long respondent has lived in the area

Responses clearly illustrate that the interviewees in total have hundreds of years of experience living in the RMCHS service area.

Question 2: Asks respondent number of hours they are involved in community

Responses demonstrate involvement in the community – the people interviewed participate in community, civic, religious and or political activities.

Question 3: Responses to this question illustrate the types of community engagement by the respondents

Clearly the respondents represent a broad range of community engagement.

Question 4: : Intends to determine the perceived level at which most members of the community attend to their health needs

The majority (three-quarters) of the community members indicated that they were some degree of being attentive in taking care of their health needs.

Question 5: Inquires about specific health related issues and requires respondents to prioritize the issues

Key issues are mental stress, drug/alcohol/substance abuse, heart disease, respiratory disease, cancer, poverty, vision and/or dental, health disparities, diabetes.

Question 6: Seeks to determine the interviewees perspective on the adequacy of healthcare services in the community

The consensus (65-70%) of the respondents as to adequate access were in physical rehab, dental and primary care physicians; whereas the least adequate access (20%) were in mental health, drug and alcohol, and geriatrics.

Question 7: Asks the respondents to choose two of three major objectives of a health care organization such as RMCHS. The choices were Highest Quality, Widest Access, and Lowest Cost.

Respondents concluded that Highest Quality and Widest Access were most important.

Question 8: Determines the respondent's familiarity with RMCHS locations/facilities, community involvement, mission, programs and services, and leadership including board of directors

Responses indicate a great knowledge of location and facilities with 90% of respondents being very familiar with location and facilities. And respondents were either "very" or "somewhat" familiar with the other factors.

Question 9: Respondents graded on a scale of 1-5 with 1 being inadequate, 3 being incomplete and 5 meeting the total needs of the community fourteen factors associated with hospital or medical center services

Not surprisingly, respondents found that most services are not being completely met.

Question 10: Survey's respondents' perception regarding how vital RMCHS is to the health and welfare of the service area

Respondents unanimously stated that RMCHS is vital to the community.

Question 11: Asks the respondents if community healthcare needs would be met if RMA ceased to exist

Response was unanimous, no.

Question 12: Inquires about the adequacy of RMCHS in improving health indicators, reducing health disparities, and addressing the social determinants of health

About 85% of the respondents stated they somewhat agree, agree or neither agree nor disagree.

Question 13: Asks respondents "do you think there is a need for more primary care physicians in the community"

Surprisingly only 55% thought that more primary care physicians are needed. This seems inconsistent with other data and should be further evaluated.

Question 14: Asks about the adequacy of specialty care physicians in the community

85% of the respondents stated that there is a need for more specialty care.

Question 15: "Open ended" opportunity for respondents to suggest how RMCHS can better meet community needs

A general theme in responses emphasizes the need of the community for improved access to emergency services, mental health services, and greater community outreach. It should also be noted that discussions relative to the potential affiliation between RMC and the University of Alabama-Birmingham (UAB) and the projected impact on healthcare at RMC and throughout the community were positively received by all community respondents.

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

Q1 How many years have you lived in the Calhoun/Cleburne/Talladega County area?

Answered: 20 Skipped: 0

#	RESPONSES	DATE
1	25	7/24/2023 7:07 PM
2	66	7/14/2023 10:47 AM
3	67	7/12/2023 1:14 AM
4	67	7/6/2023 10:53 AM
5	61	7/5/2023 12:27 PM
6	25	7/5/2023 10:16 AM
7	45	7/5/2023 10:02 AM
8	55	7/3/2023 2:41 PM
9	64	6/29/2023 10:43 AM
10	20	6/29/2023 10:09 AM
11	34	6/28/2023 4:36 PM
12	41	6/27/2023 6:38 PM
13	35 plus years	6/27/2023 2:13 PM
14	31	6/27/2023 5:51 AM
15	54	6/26/2023 7:19 PM
16	58 years	6/26/2023 6:42 PM
17	41 years	6/26/2023 4:29 PM
18	65	6/26/2023 11:53 AM
19	10	6/26/2023 10:53 AM
20	14	6/26/2023 10:43 AM

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

Q2 How many hours per month do you spend working with or in support of community, civic, religious and/or political activities?

Answered: 20 Skipped: 0

#	RESPONSES	DATE
1	20	7/24/2023 7:07 PM
2	150	7/14/2023 10:47 AM
3	40	7/12/2023 1:14 AM
4	8	7/6/2023 10:53 AM
5	2	7/5/2023 12:27 PM
6	50	7/5/2023 10:16 AM
7	5	7/5/2023 10:02 AM
8	30	7/3/2023 2:41 PM
9	0	6/29/2023 10:43 AM
10	40	6/29/2023 10:09 AM
11	120	6/28/2023 4:36 PM
12	4	6/27/2023 6:38 PM
13	15 plus	6/27/2023 2:13 PM
14	2	6/27/2023 5:51 AM
15	4	6/26/2023 7:19 PM
16	10 hours	6/26/2023 6:42 PM
17	6hours	6/26/2023 4:29 PM
18	40	6/26/2023 11:53 AM
19	10	6/26/2023 10:53 AM
20	3	6/26/2023 10:43 AM

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

Q3 In what role do you experience most of your contact with the community?

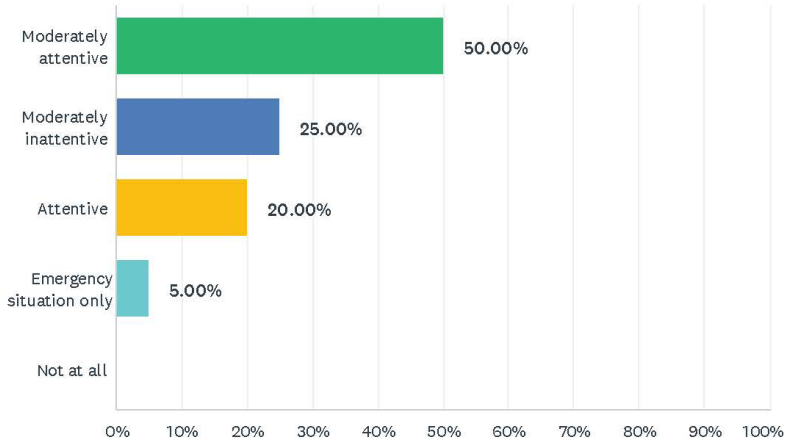
Answered: 20 Skipped: 0

#	RESPONSES	DATE
1	Serving on various community/civic boards	7/24/2023 7:07 PM
2	Social Services	7/14/2023 10:47 AM
3	County Commissioner	7/12/2023 1:14 AM
4	Church	7/6/2023 10:53 AM
5	volunteer	7/5/2023 12:27 PM
6	job	7/5/2023 10:16 AM
7	Retail store owner	7/5/2023 10:02 AM
8	volunteer with food insecure and people with disabilities	7/3/2023 2:41 PM
9	Consumer	6/29/2023 10:43 AM
10	Health Department Administrator	6/29/2023 10:09 AM
11	As an executive director of a non-profit	6/28/2023 4:36 PM
12	nurse	6/27/2023 6:38 PM
13	In my professional role	6/27/2023 2:13 PM
14	Shopping	6/27/2023 5:51 AM
15	Participant in various activities	6/26/2023 7:19 PM
16	Volunteering	6/26/2023 6:42 PM
17	Hospital volunteer	6/26/2023 4:29 PM
18	Volunteer	6/26/2023 11:53 AM
19	church	6/26/2023 10:53 AM
20	volunteer	6/26/2023 10:43 AM

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

Q4 What is your perception regarding health-related issues in the community. Please indicate what you think the level at which most members of the community attend to their health needs.

Answered: 20 Skipped: 0

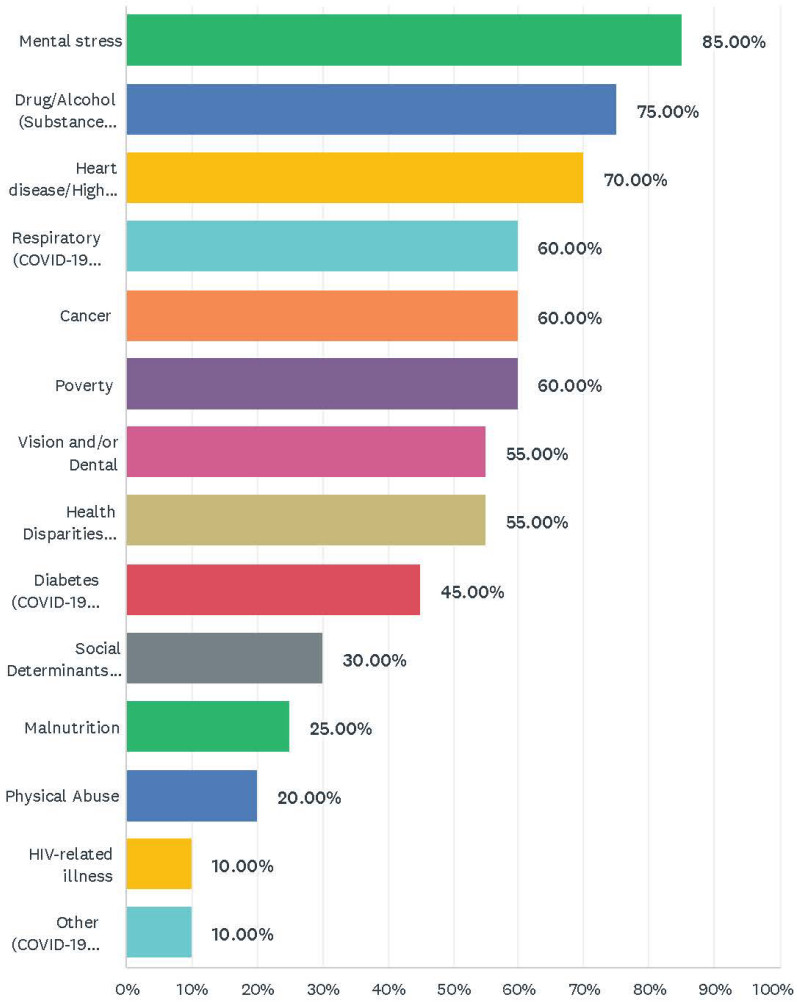


ANSWER CHOICES	RESPONSES	
Moderately attentive	50.00%	10
Moderately inattentive	25.00%	5
Attentive	20.00%	4
Emergency situation only	5.00%	1
Not at all	0.00%	0
Total Respondents: 20		

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

Q5 Since 2020, which of the following health-related issues have you observed or encountered within the community: (Select all that apply)

Answered: 20 Skipped: 0



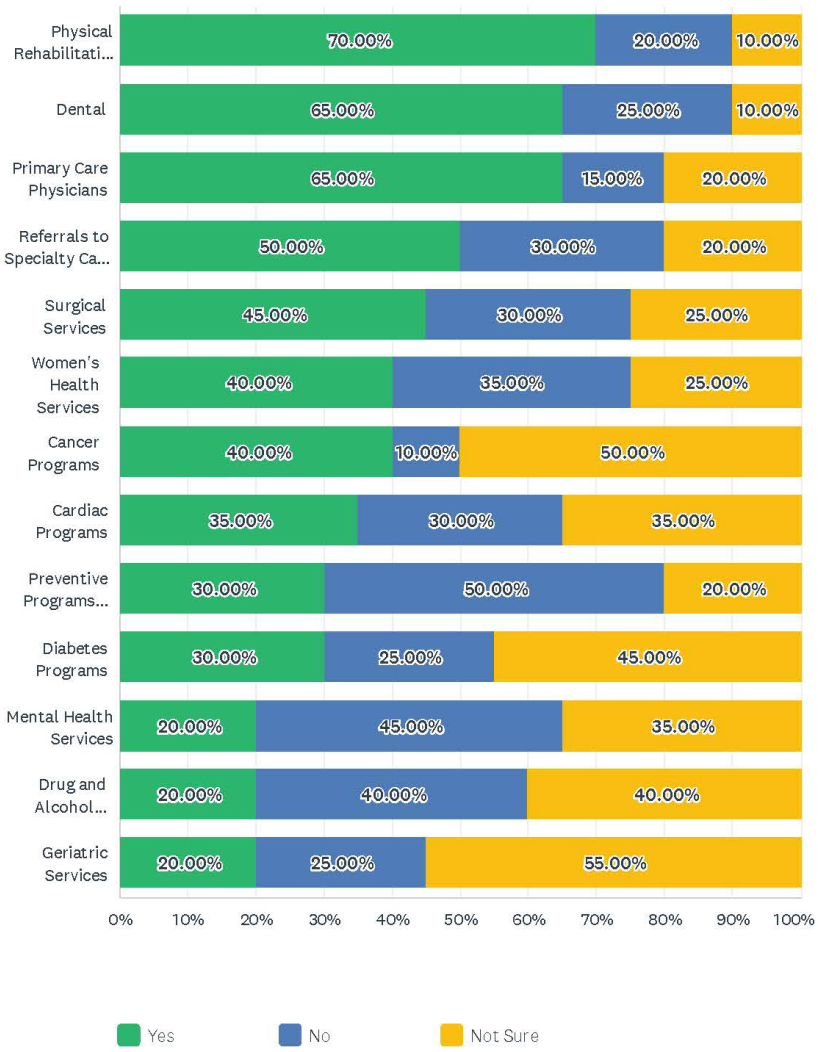
Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

ANSWER CHOICES	RESPONSES	
Mental stress	85.00%	17
Drug/Alcohol (Substance Abuse)	75.00%	15
Heart disease/High Blood Pressure (COVID-19 Underlying Condition)	70.00%	14
Respiratory (COVID-19 Underlying Condition)	60.00%	12
Cancer	60.00%	12
Poverty	60.00%	12
Vision and/or Dental	55.00%	11
Health Disparities (i.e., Race, Ethnicity, Religion, Gender, Age)	55.00%	11
Diabetes (COVID-19 Underlying Condition)	45.00%	9
Social Determinants of Health	30.00%	6
Malnutrition	25.00%	5
Physical Abuse	20.00%	4
HIV-related illness	10.00%	2
Other (COVID-19 Underlying Condition)	10.00%	2
Total Respondents: 20		

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

Q6 Do you believe the community has adequate access to the following healthcare services?

Answered: 20 Skipped: 0



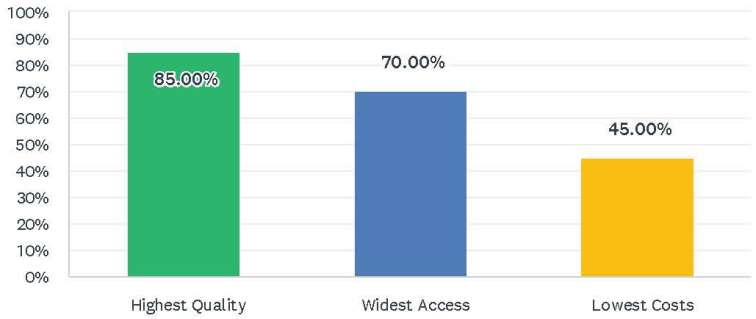
Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

	YES	NO	NOT SURE	TOTAL
Physical Rehabilitation Services	70.00% 14	20.00% 4	10.00% 2	20
Dental	65.00% 13	25.00% 5	10.00% 2	20
Primary Care Physicians	65.00% 13	15.00% 3	20.00% 4	20
Referrals to Specialty Care Physicians	50.00% 10	30.00% 6	20.00% 4	20
Surgical Services	45.00% 9	30.00% 6	25.00% 5	20
Women's Health Services	40.00% 8	35.00% 7	25.00% 5	20
Cancer Programs	40.00% 8	10.00% 2	50.00% 10	20
Cardiac Programs	35.00% 7	30.00% 6	35.00% 7	20
Preventive Programs (Screenings, Education)	30.00% 6	50.00% 10	20.00% 4	20
Diabetes Programs	30.00% 6	25.00% 5	45.00% 9	20
Mental Health Services	20.00% 4	45.00% 9	35.00% 7	20
Drug and Alcohol Treatment	20.00% 4	40.00% 8	40.00% 8	20
Geriatric Services	20.00% 4	25.00% 5	55.00% 11	20

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

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?

Answered: 20 Skipped: 0



ANSWER CHOICES	RESPONSES	
Highest Quality	85.00%	17
Widest Access	70.00%	14
Lowest Costs	45.00%	9
Total Respondents: 20		

#	WHY? (PLEASE DETAIL)	DATE
1	I think there is a perception that you need to leave town for high quality health care. I also think there is a belief that healthcare is expensive anywhere you go and cutting cost won't necessarily drive more business.	7/24/2023 7:07 PM
2	Residents in rural areas have very limited access. The limited number of annual Medicaid visits. Transportation	7/14/2023 10:47 AM
3	Most important to me.	7/12/2023 1:14 AM
4	We have older people that don't get treatment needed due to their Medicare coverage not covering a lot of things	7/5/2023 12:27 PM
5	Costs and insurance coverage should be addressed in order to provide for the other 2 objectives.	7/5/2023 10:02 AM
6	The only thing the recipient of the services can have any control over is getting themselves to services. The others fall solely on the provider.	7/3/2023 2:41 PM
7	If the wealthy are forced to pay their fair share in taxes it is achievable.	6/29/2023 10:43 AM
8	Because people need access to healthcare at an affordable cost	6/28/2023 4:36 PM
9	Quality Healthcare is important and all citizens should have access to quality healthcare.	6/27/2023 2:13 PM
10	Everyone needs access to high quality health care.	6/27/2023 5:51 AM

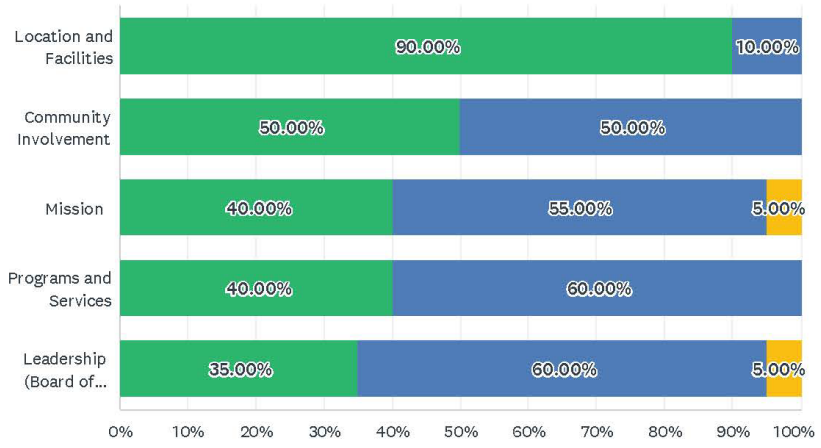
Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

11	When someone seeks medical care, they expect quality care and easily accessible services	6/26/2023 7:19 PM
12	It is important to have the highest quality healthcare which will cover several counties. The best physicians and nurses is imperative.	6/26/2023 4:29 PM
13	Times are financially difficult for majority of people now and highest quality ensures strong healthcare	6/26/2023 11:53 AM
14	People dont usually choose health care based on cost-- If they need it they need it	6/26/2023 10:53 AM
15	Health care is essential to maintaining a healthy, viable community. Low-quality or health care or limited access would negatively impact the entire community. I admit I'm having a little trouble separating "wide access" and "low cost." At some point, those overlap.	6/26/2023 10:43 AM

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

Q8 How familiar are you with the following characteristics of RMCHS?

Answered: 20 Skipped: 0

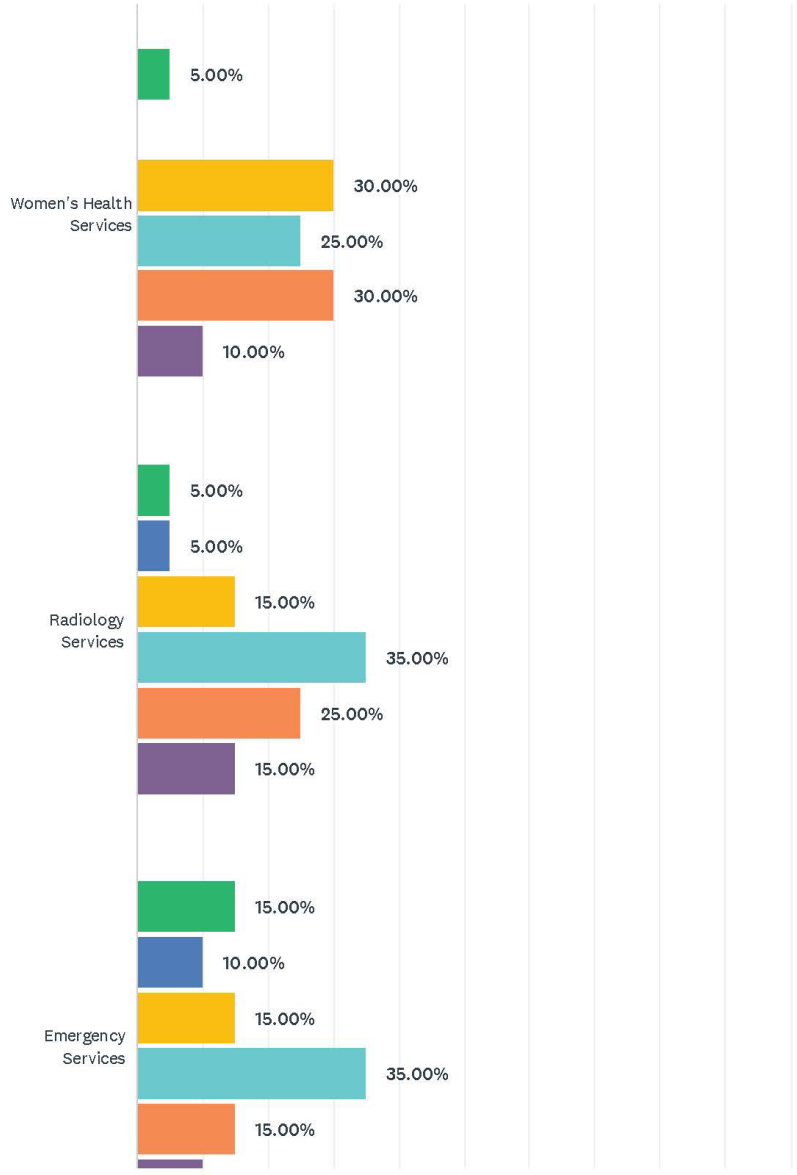


	VERY	SOMEWHAT	NOT FAMILIAR	TOTAL	WEIGHTED AVERAGE
Location and Facilities	90.00% 18	10.00% 2	0.00% 0	20	1.10
Community Involvement	50.00% 10	50.00% 10	0.00% 0	20	1.50
Mission	40.00% 8	55.00% 11	5.00% 1	20	1.65
Programs and Services	40.00% 8	60.00% 12	0.00% 0	20	1.60
Leadership (Board of Directors, CEO/Management Team)	35.00% 7	60.00% 12	5.00% 1	20	1.70

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

Q9 We would like to know and understand your perception of RMCHS. On a scale of 1 to 5, with 1 representing inadequate programs and services, 3 representing incomplete programs and services, and 5 meeting the total needs of the community, please rate the following seervices:

Answered: 20 Skipped: 0



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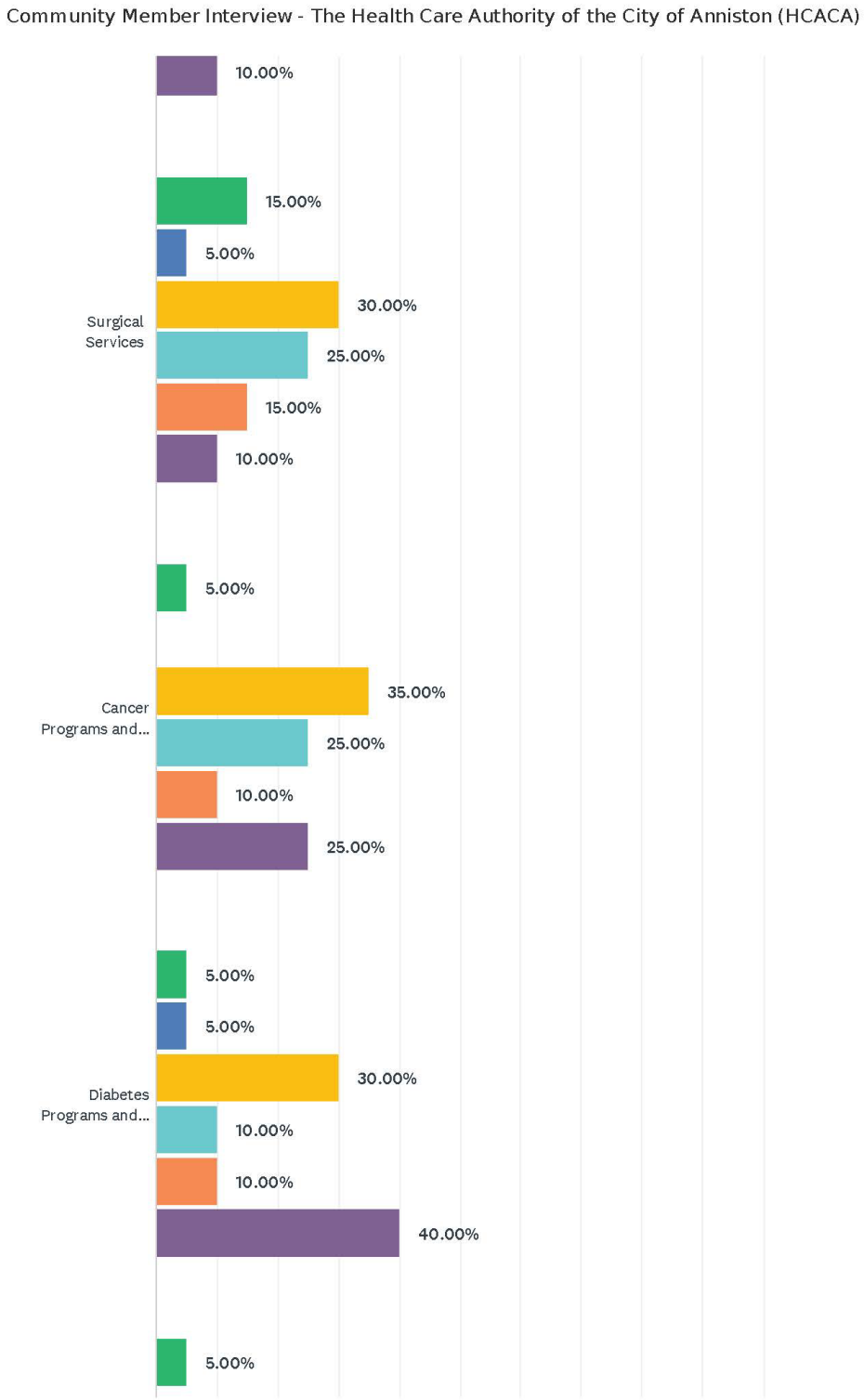
Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)
10.00%
15.00%
5.00%
Surgical Services
30.00%
25.00%
15.00%
10.00%
5.00%
Cancer Programs and...
35.00%
25.00%
10.00%
25.00%
5.00%
5.00%
Diabetes Programs and...
30.00%
10.00%
10.00%
40.00%
5.00%

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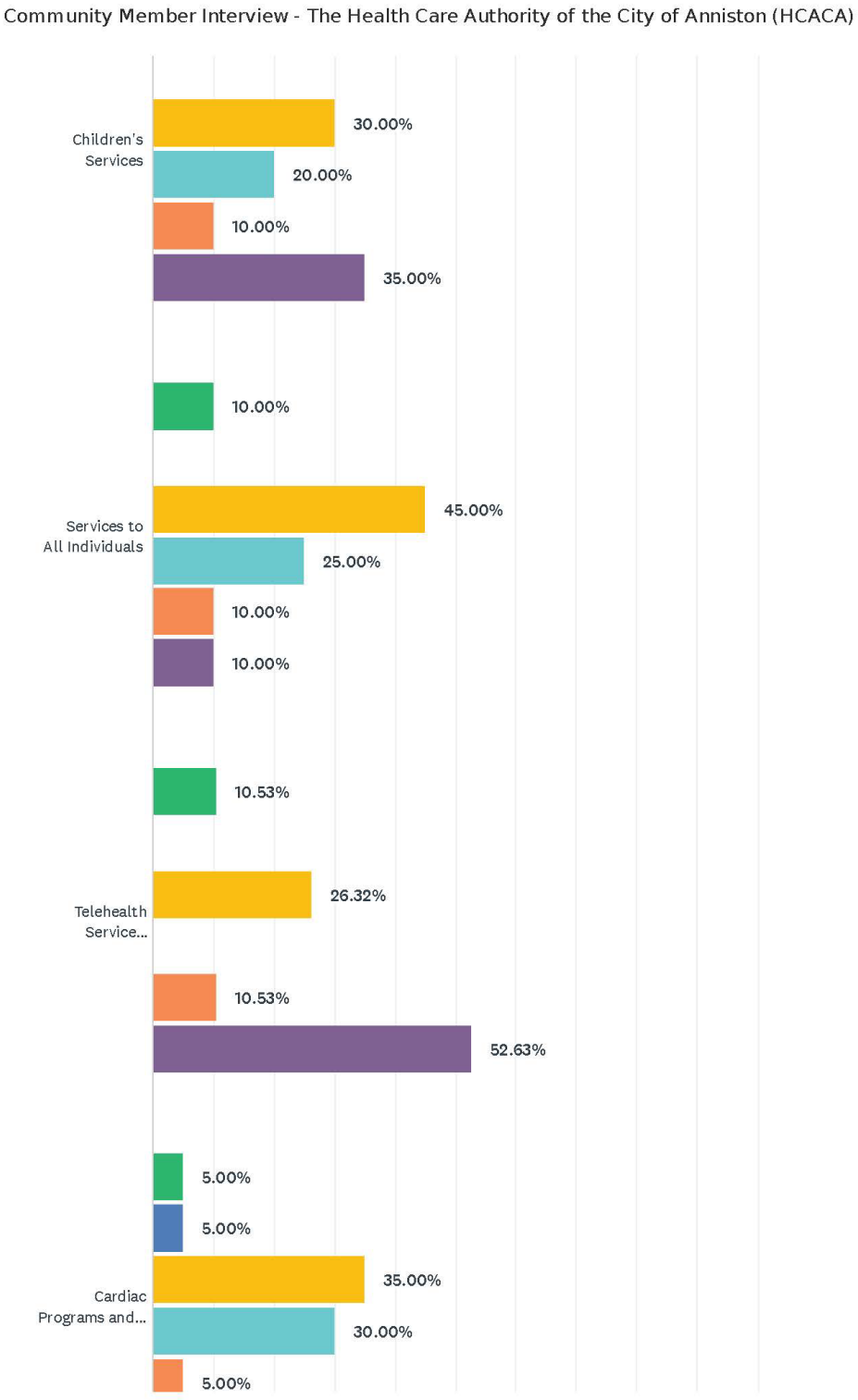
Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)
Children's Services
30.00%
20.00%
10.00%
35.00%
10.00%
Services to All Individuals
45.00%
25.00%
10.00%
10.00%
10.53%
Telehealth Service...
26.32%
10.53%
52.63%
5.00%
5.00%
Cardiac Programs and...
35.00%
30.00%
5.00%

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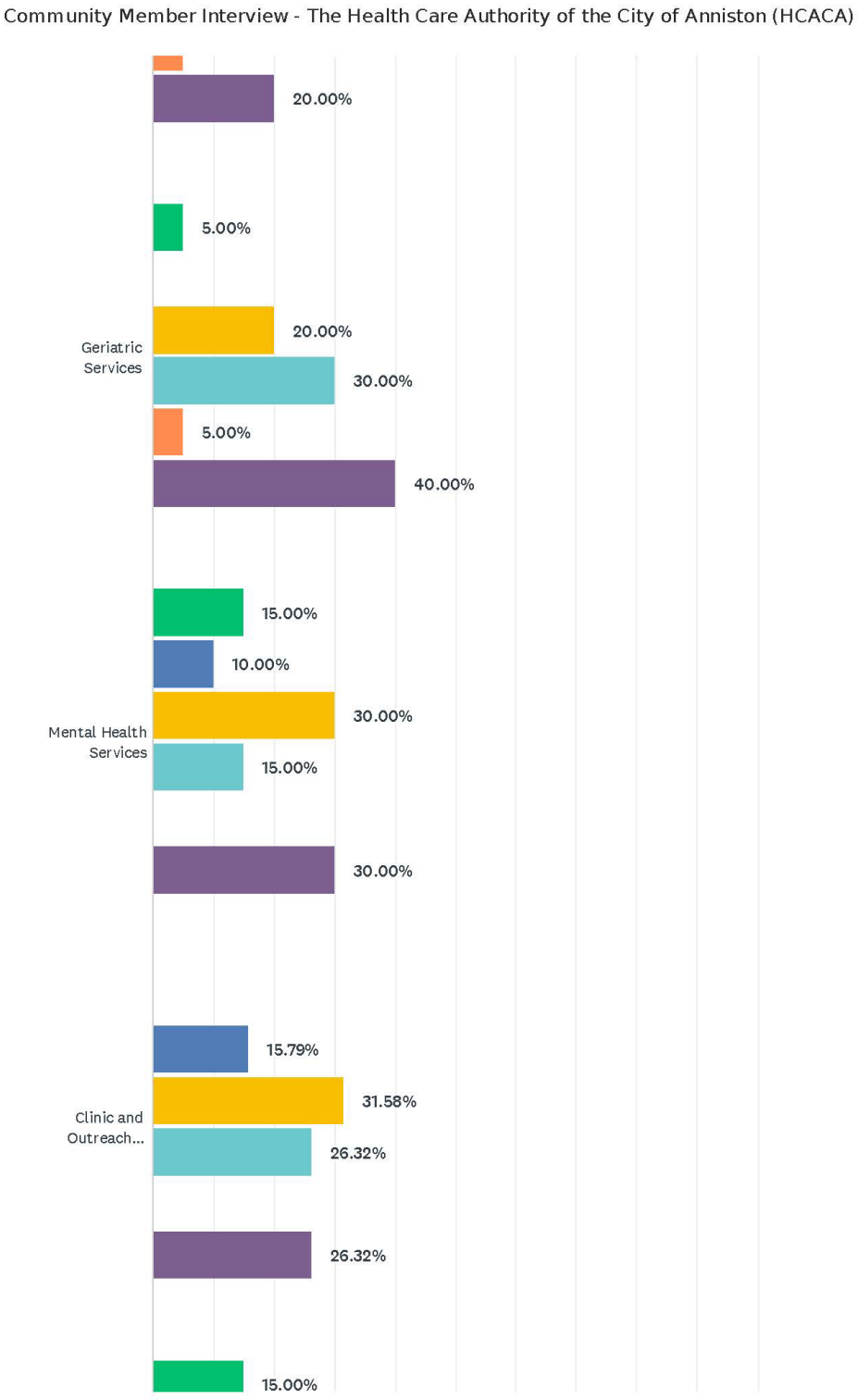
Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)
20.00%
5.00%
Geriatric Services
20.00%
30.00%
5.00%
40.00%
15.00%
10.00%
Mental Health Services
30.00%
15.00%
30.00%
15.79%
Clinic and Outreach...
31.58%
26.32%
26.32%
15.00%

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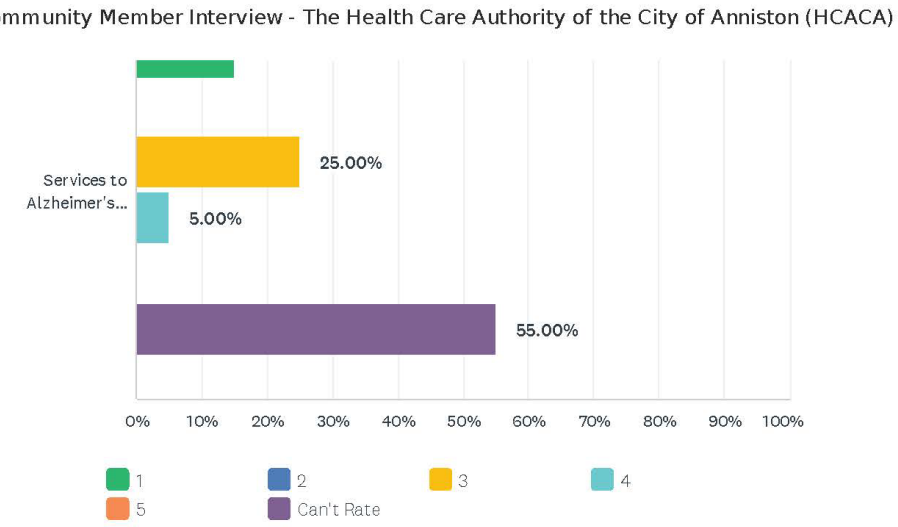
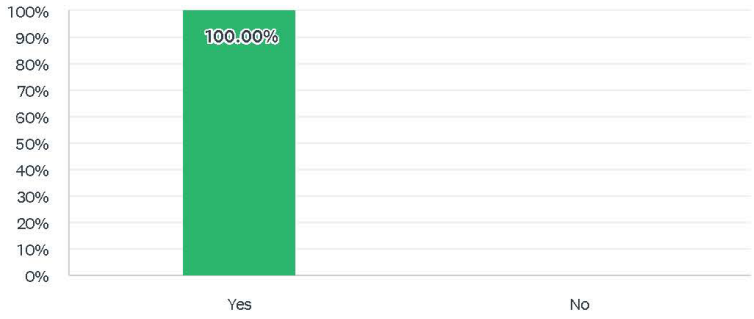


	1	2	3	4	5	CAN'T RATE	TOTAL	WEIGHTED AVERAGE
Women's Health Services	5.00% 1	0.00% 0	30.00% 6	25.00% 5	30.00% 6	10.00% 2	20	4.05
Radiology Services	5.00% 1	5.00% 1	15.00% 3	35.00% 7	25.00% 5	15.00% 3	20	4.15
Emergency Services	15.00% 3	10.00% 2	15.00% 3	35.00% 7	15.00% 3	10.00% 2	20	3.55
Surgical Services	15.00% 3	5.00% 1	30.00% 6	25.00% 5	15.00% 3	10.00% 2	20	3.50
Cancer Programs and Services	5.00% 1	0.00% 0	35.00% 7	25.00% 5	10.00% 2	25.00% 5	20	4.10
Diabetes Programs and Services	5.00% 1	5.00% 1	30.00% 6	10.00% 2	10.00% 2	40.00% 8	20	4.35
Children's Services	5.00% 1	0.00% 0	30.00% 6	20.00% 4	10.00% 2	35.00% 7	20	4.35
Services to All Individuals	10.00% 2	0.00% 0	45.00% 9	25.00% 5	10.00% 2	10.00% 2	20	3.55
Telehealth Service Delivery	10.53% 2	0.00% 0	26.32% 5	0.00% 0	10.53% 2	52.63% 10	19	4.58
Cardiac Programs and Services	5.00% 1	5.00% 1	35.00% 7	30.00% 6	5.00% 1	20.00% 4	20	3.85
Geriatric Services	5.00% 1	0.00% 0	20.00% 4	30.00% 6	5.00% 1	40.00% 8	20	4.50
Mental Health Services	15.00% 3	10.00% 2	30.00% 6	15.00% 3	0.00% 0	30.00% 6	20	3.65
Clinic and Outreach Programs	0.00% 0	15.79% 3	31.58% 6	26.32% 5	0.00% 0	26.32% 5	19	3.89
Services to Alzheimer's Patients	15.00% 3	0.00% 0	25.00% 5	5.00% 1	0.00% 0	55.00% 11	20	4.40

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

Q10 Do you believe that the continuation of RMCHS is vital to the health and welfare of the service area, including all served counties?

Answered: 20 Skipped: 0

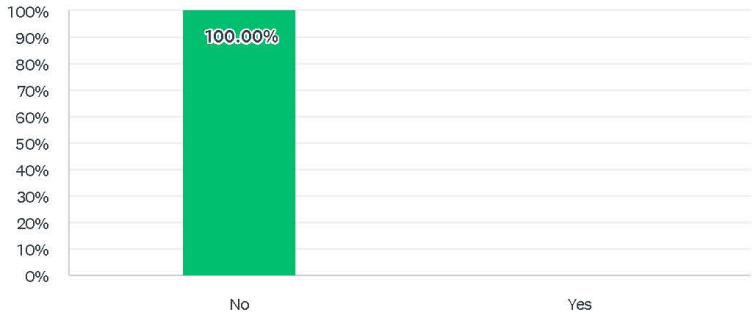


ANSWER CHOICES	RESPONSES	
Yes	100.00%	20
No	0.00%	0
TOTAL		20

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

Q11 If RMCHS did not exist, do you believe the community's healthcare needs would be met?

Answered: 20 Skipped: 0



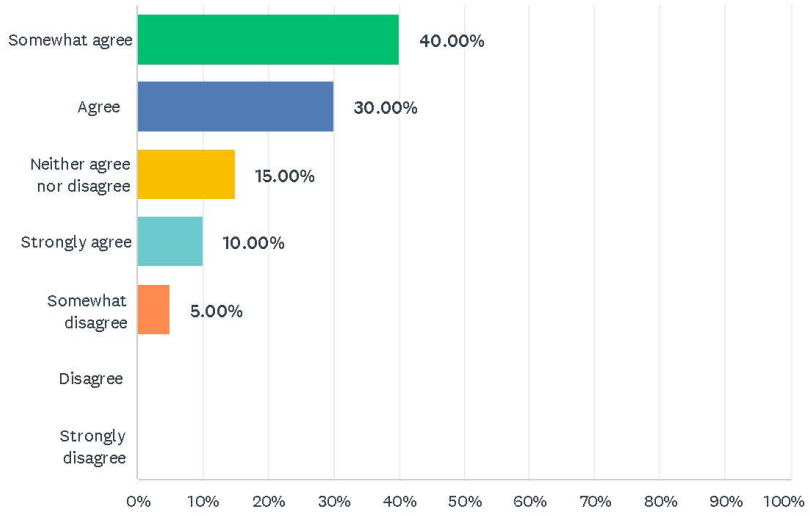
ANSWER CHOICES	RESPONSES	
No	100.00%	20
Yes	0.00%	0
TOTAL		20

#	COMMENT:	DATE
1	We need RMC in our community. Better communication and coordination between staff and departments could be better.	7/5/2023 10:02 AM
2	Alabama's loss of hospitals is already resulting in an increase of avoidable deaths. I think RMC could improve its services tremendously, especially in quality of attending physicians. But standard health care is better than no health care at all.	7/3/2023 2:41 PM
3	I can't imagine the loss of life and degradation in the quality of life that would result.	6/29/2023 10:43 AM
4	Birmingham or Georgia system hospitals are too far away. We need services in our own community.	6/28/2023 4:36 PM
5	Citizens would have to travel to receive adequate healthcare	6/27/2023 2:13 PM
6	Not everyone has the necessary transportation and economic resources to go outside of the community for care. Also a good many people would have the necessary skills to locate the services that they need elsewhere.	6/26/2023 7:19 PM

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

Q12 Do you think that RMCHS adequately addresses the needs of the community and is successful in improving health indicators, reducing health disparities, and eliminating social determinants of health?

Answered: 20 Skipped: 0



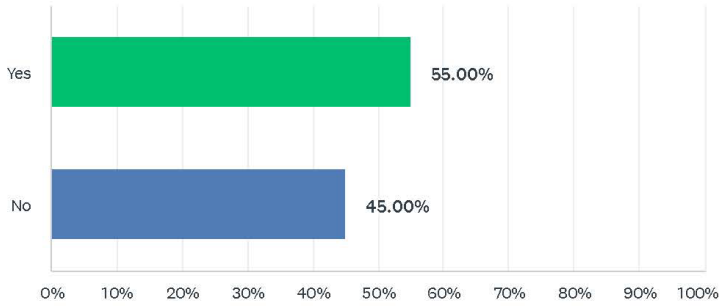
ANSWER CHOICES	RESPONSES	
Somewhat agree	40.00%	8
Agree	30.00%	6
Neither agree nor disagree	15.00%	3
Strongly agree	10.00%	2
Somewhat disagree	5.00%	1
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		20

#	COMMENT:	DATE
1	I think valiant efforts are being made but the State needs to expand Medicaid and there are other challenges in healthcare that will impede RMC's efforts	6/28/2023 4:36 PM

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

Q13 Do you think there is a need for more primary care physicians in the community?

Answered: 20 Skipped: 0



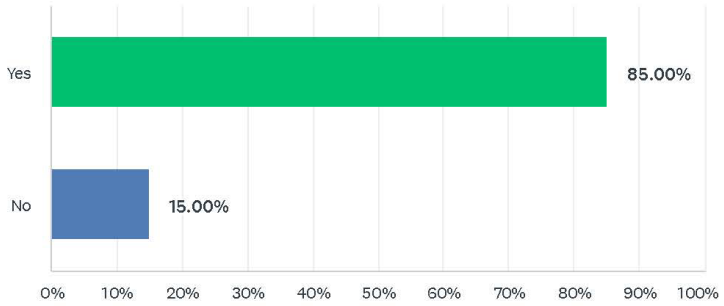
ANSWER CHOICES	RESPONSES	
Yes	55.00%	11
No	45.00%	9
Total Respondents: 20		

#	COMMENT:	DATE
1	I don't know. I work in Birmingham and my doctor is in St. Clair County, but it seems like anytime I change insurance, there are only a handful of doctors in any system who will accept new patients. This makes me think there will be demand anywhere for more primary care options.	6/26/2023 10:43 AM

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

Q14 Do you think there is a need for more specialty care physicians in the community?

Answered: 20 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	85.00%	17
No	15.00%	3
Total Respondents: 20		

#	IF YES, SPECIFY SPECIALTY(IES):	DATE
1	Women's Health, Mental Health	7/24/2023 7:07 PM
2	Cancer	7/14/2023 10:47 AM
3	Cardiac, ortho, nephro, neuro,	6/28/2023 4:36 PM
4	Many have to travel for specialty care.	6/27/2023 5:51 AM
5	Neurosurgeons, psychiatrist,	6/26/2023 4:29 PM
6	Cardio, cancer	6/26/2023 11:53 AM
7	Dermatology, gastro surgery, heart surgery	6/26/2023 10:53 AM
8	See above. When someone requires specialty care, they're often at the mercy of whatever is available and covered by their insurance.	6/26/2023 10:43 AM

Community Member Interview - The Health Care Authority of the City of Anniston (HCACA)

Q15 How can RMCHS better meet the needs of the community?

Answered: 20 Skipped: 0

#	RESPONSES	DATE
1	RMCHS needs to be better at communicating with the public. The hospital system has a long standing PR problem that needs to be addressed with better marketing and communication.	7/24/2023 7:07 PM
2	Establish mobile clinics in remote areas.	7/14/2023 10:47 AM
3	More availability of services	7/12/2023 1:14 AM
4	Reduce the wait time when going to the emergency room.	7/6/2023 10:53 AM
5	more OBGYN that treat women health after child bearing age.	7/5/2023 12:27 PM
6	x	7/5/2023 10:16 AM
7	Communicate better...between patient, staff and departments.	7/5/2023 10:02 AM
8	Perhaps more clinics, and better advertising of the ones that they do have. My general interaction with RMC has been negative in regards to the care of my immediate family, and that is almost totally on the level of poor diagnosis by the physicians treating them. This has happened on multiple occasions.	7/3/2023 2:41 PM
9	I believe they are on the right track and should continue their present mission.	6/29/2023 10:43 AM
10	Mental health	6/29/2023 10:09 AM
11	Improve its Emergency care services! Wait times are excessive and quality care is lacking.	6/28/2023 4:36 PM
12	better pay for staff to recruit better staff	6/27/2023 6:38 PM
13	Continue to meet the needs of the community by listening to the feedback of the services provided.	6/27/2023 2:13 PM
14	Additional specialty physicians	6/27/2023 5:51 AM
15	Continue to make resources publically known through free events and varied media resources.	6/26/2023 7:19 PM
16	By continuing to keep doing all the things they are doing now to improve things.	6/26/2023 6:42 PM
17	We need more doctors to plug into the emergency area . Generally, we need more specialized physicians.	6/26/2023 4:29 PM
18	Reach out to community	6/26/2023 11:53 AM
19	My sense is that establishing a relationship with UAB will provide better connections for specialty services we are currently short of. Emergency rooms need improvement. Waiting times can be crazy.	6/26/2023 10:53 AM
20	I don't know.	6/26/2023 10:43 AM

I. Board of Directors Survey Results

Six members of the RMCHS Board of Directors responded to survey questions. The actual survey questions with responses follow this summary section of survey questions and responses.

Question 1: Inquired of the BOD "is the hospital achieving its mission and vision"

Most members, five of six, responded that yes, the hospital is meeting its mission and vision.

Question 2: Asked "does the mission need to be revised/expanded, changed"

Three of the respondents replied that no revision is needed at this time, three of the respondents stated yes revision needed.

Question 3: Asked board members "what are the barriers/risks that threaten RMCHS' ability to achieve its mission"

Five of the six respondents stated that finances, funds, and reimbursement were the major threat. One member stated that there is "no money. No definitive plan to change".

Question 4: Inquired of board members "do you think RMCHS … is key in the marketplace in meeting needs of the community"

Yes, is the unanimous consensus of board members with an additional statement "they are doing the best they can with the shortage of nurses and other essential workers".

Question 5: This question asked, "in your opinion, do you think that RMCHS is doing a good job in meeting the needs of the community"

Five of the six respondents opined that yes, one member stated no.

Question 6: Asked "how did the impact of COVID-19 affect RMCHS's ability to meet its mission"

Responses to this question elicited the following, "we excelled during this period', "gave them an infusion of cash that delayed the need for buyout also point out some holes in the overall system that needed to be addressed", "Terrible, we had employees that didn't return. For a while the community rallied during COVID and then most things tried to get back to normal, we were faced with less employees & drained emotionally for the ones that stayed".

Question 7: Respondents were asked to choose two of three objectives – highest quality, widest access, or lowest

All respondents ranked highest quality first. Respondents then were equally divided between widest access and lowest cost. "All should strive for the highest quality of care at the lowest cost" and "quality is top" were statements that respondents offered.

Question 8: Asked respondents "what are the strengths of RMCHS"

The following responses were given, "community engagement and service", "top medical services", "the staff and nurses", "the heroic effort put forth by our physicians and staff during difficult times is our greatest strength".

Question 9: Asked respondents "what external factors pose the greatest challenge to the viability of RMCHS over the next three years"

Sixty Six percent of respondents choose cutbacks in reimbursement and inability to recruit staff as the greatest challenges. Competition and aging population were also considered great challenges.

Question 10: Asked respondents about "internal factors" that pose the greatest challenge

Employee retention, physician retention and recruitment are considered the greatest challenges.

Question 11: When asked to consider the top THREE strategic priorities for RMCHS

Physician recruitment/retention and facility capital needs were selected by two thirds of the respondents as top strategies. Respondents did not select program expansion or service area expansion as top strategies.

Question 12: Asked respondents "do you expect increased or decreased pressure" from a number of health care issues

There was unanimous consensus that pressure will increase in all areas of inquiry with Medicare/Medicaid reimbursement, outpatient services volume and mergers affiliations as major pressure points.

Question 13: Asked respondents "should RMCHS get involved in addressing the following, health disparities, health indicators, social determinants, special populations, chronic diseases, public health issues"

Most respondents replied that RMCHS should address all of these issues, with health disparities being the primary issue to address.

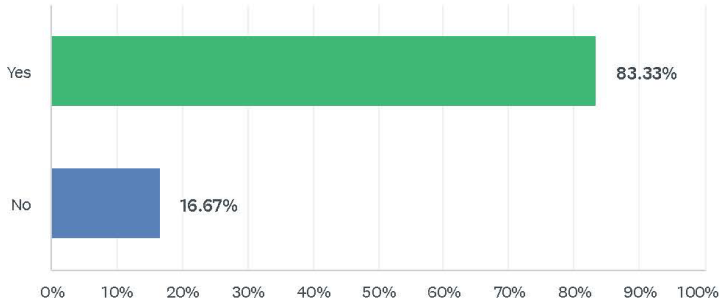
Question 14: This question asked respondents "how can RMCHS better meet the needs of the community"

Continuing the mission, reaching out, better reimbursement rates were offered as responses, with one respondent stating, "it needs a new playbook, the current one is failing the community".

Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

Q1 Is the Hospital achieving its mission and vision?

Answered: 6 Skipped: 0

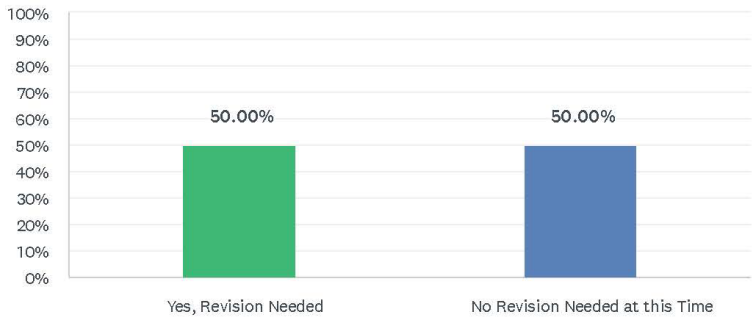


ANSWER CHOICES	RESPONSES	
Yes	83.33%	5
No	16.67%	1
TOTAL		6

Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

Q2 Does the mission need to be revised/expanded, changed?

Answered: 6 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes, Revision Needed	50.00%	3
No Revision Needed at this Time	50.00%	3
TOTAL		6

Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

Q3 What are the barrier/risks that threaten RMCHS' ability to achieve its mission, vision?

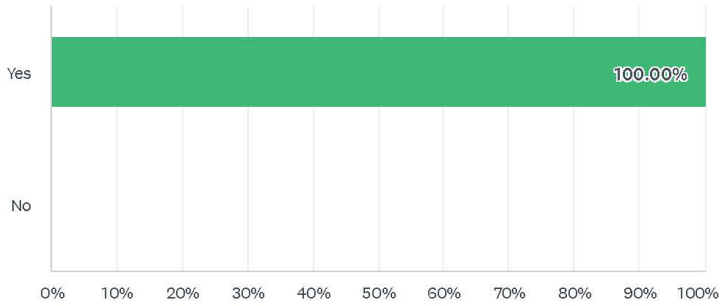
Answered: 6 Skipped: 0

#	RESPONSES	DATE
1	Finances	6/29/2023 9:04 PM
2	Reimbursement	6/29/2023 1:35 PM
3	Funds	6/29/2023 11:29 AM
4	no money. No definitive plan to change	6/29/2023 11:03 AM
5	I believe our community has to get a handle on the mental health issue. We have so many that come to the ER and it doesn't leave room for patients that are there for emergency issues .	6/27/2023 1:27 AM
6	Insufficient reimbursement by insurance providers	6/26/2023 2:41 PM

Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

Q4 In your opinion, do you think that RMCHS as a local hospital system is key in the marketplace in meeting the needs of the community?

Answered: 6 Skipped: 0



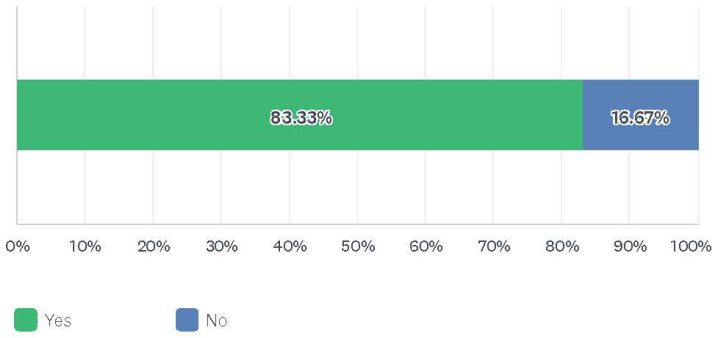
ANSWER CHOICES	RESPONSES	
Yes	100.00%	6
No	0.00%	0
TOTAL		6

#	COMMENT:	DATE
1	I feel they are doing the best they can with the shortage of nurses and other essential workers.	6/27/2023 1:27 AM
2	Retirement community needs good health care	6/26/2023 2:41 PM

Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

Q5 In your opinion, do you think that RMCHS is doing a good job in meeting the needs of the community?

Answered: 6 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	83.33%	5
No	16.67%	1
TOTAL		6

#	COMMENT	DATE
1	They are trying to. It doesn't always work out.	6/27/2023 1:27 AM
2	?????	6/26/2023 2:41 PM

Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

Q6 How did the impact of COVID-19 affect RMCHS's ability to meet its mission?

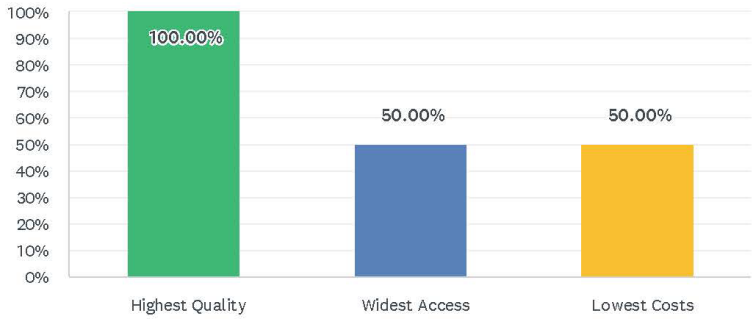
Answered: 6 Skipped: 0

#	RESPONSES	DATE
1	We excelled during that period	6/29/2023 9:04 PM
2	Huge asset providing vaccines and treatments	6/29/2023 1:35 PM
3	It affected our operations revenue.	6/29/2023 11:29 AM
4	gave them an infusion of cash that delayed the need for buy out. also pointed out some holes in the overall system that needed to be addressed	6/29/2023 11:03 AM
5	Terrible. We had employees that didn't return. For a while the community rallied during COVID and then after most things tried to get back to normal , we were faced with less employees & drained emotionally for the ones that stayed.	6/27/2023 1:27 AM
6	Staff reduction stymied delivery of vital medical care	6/26/2023 2:41 PM

Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

Q7 If a healthcare organization could only achieve two of the three major objectives: 1) Highest Quality, 2) Widest Access, or 3) Lowest Cost, which TWO would you select? WHY?

Answered: 6 Skipped: 0



ANSWER CHOICES	RESPONSES	
Highest Quality	100.00%	6
Widest Access	50.00%	3
Lowest Costs	50.00%	3
Total Respondents: 6		

#	WHY? (PLEASE SPECIFY)	DATE
1	Quality and range outweigh costs	6/29/2023 9:04 PM
2	Quality is top	6/29/2023 1:35 PM
3	It serving our patients.	6/29/2023 11:29 AM
4	All healthcare systems need to have the best /highest quality for the community it serves. Our community deserves it. You want your community members to take advantage of their local hospital. But we have to look at lowest cost in order to survive.	6/27/2023 1:27 AM
5	All should strive for the highest quality of care at the lowest cost	6/26/2023 2:41 PM

Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

Q8 In your opinion, what are the strengths of RMCHS? Have they changed in the last 3 years since the last CHNA (2020)? Describe changes, if any.

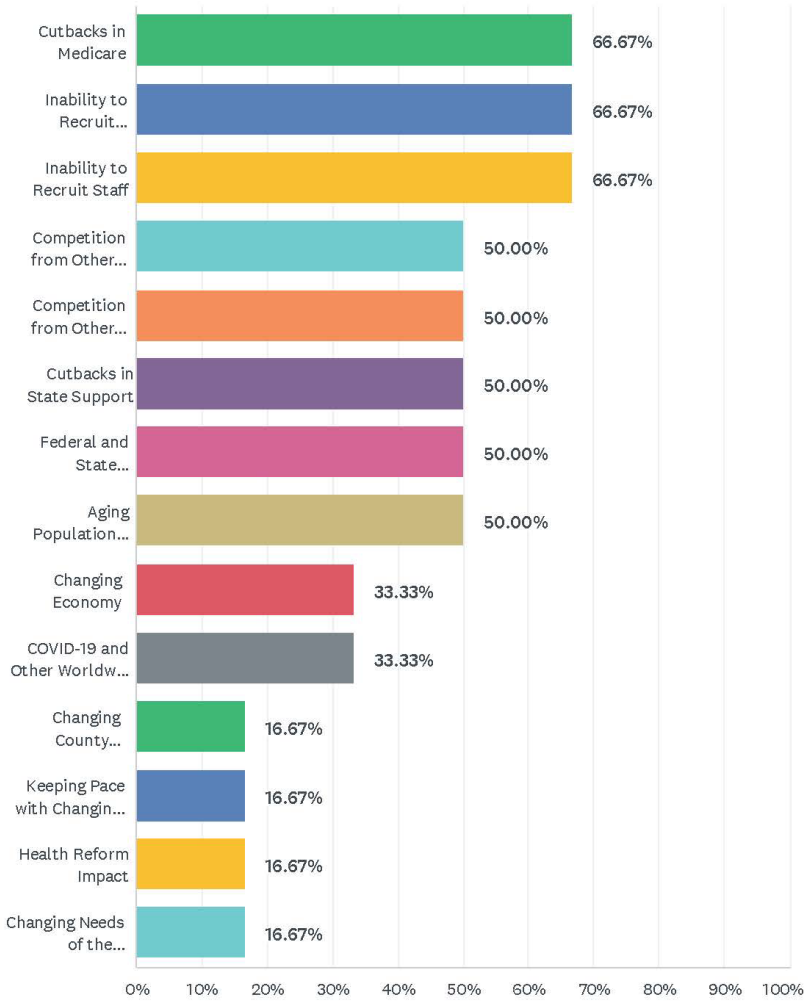
Answered: 6 Skipped: 0

#	RESPONSES	DATE
1	Community engagement and service	6/29/2023 9:04 PM
2	Top medical services Serves the community No changes	6/29/2023 1:35 PM
3	The Staff and nurses.	6/29/2023 11:29 AM
4	none	6/29/2023 11:03 AM
5	Kind employees. Work well together. We have lots of programs. We have great volunteers. We have a teen program. I think COVID did a number on us! It slowed up so many of our programs.	6/27/2023 1:27 AM
6	The heroic effort put forth by our physicians and staff during difficult times is our greatest strength	6/26/2023 2:41 PM

Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

Q9 What external factor or factors pose the greatest challenge to the viability of RMCHS over the next three years? (Select all that apply)

Answered: 6 Skipped: 0



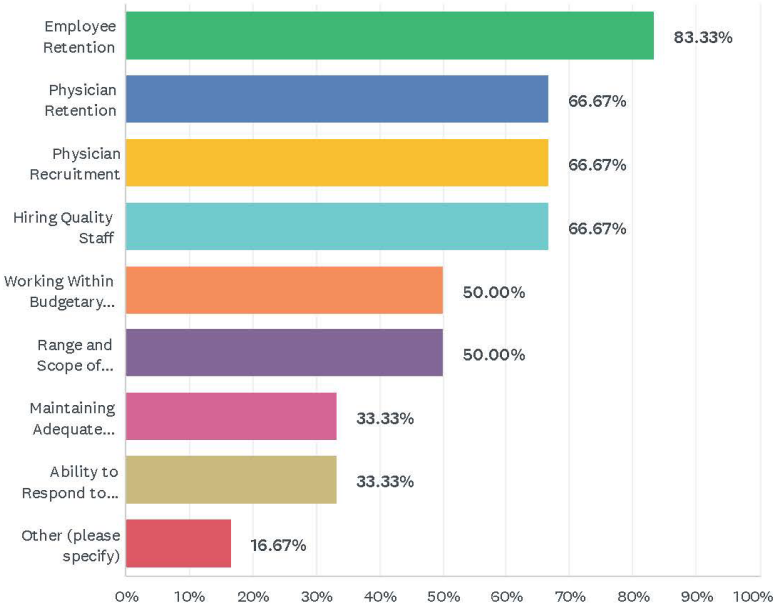
Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

ANSWER CHOICES	RESPONSES	
Cutbacks in Medicare	66.67%	4
Inability to Recruit Providers	66.67%	4
Inability to Recruit Staff	66.67%	4
Competition from Other Hospitals	50.00%	3
Competition from Other Non-Hospital Providers	50.00%	3
Cutbacks in State Support	50.00%	3
Federal and State Regulations	50.00%	3
Aging Population (Growth in Safety Net Cost - uninsured/underinsured)	50.00%	3
Changing Economy	33.33%	2
COVID-19 and Other Worldwide Pandemics	33.33%	2
Changing County Demographics that Predict Changing Services Demand	16.67%	1
Keeping Pace with Changing Technology and Adequate Facilities	16.67%	1
Health Reform Impact	16.67%	1
Changing Needs of the Community (i.e., Chronic Disease)	16.67%	1
Total Respondents: 6		

Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

Q10 In your opinion, what internal factors pose the greatest challenges to the visibility of RMCHS over the next 3 years? (Select all that apply)

Answered: 6 Skipped: 0



ANSWER CHOICES	RESPONSES	
Employee Retention	83.33%	5
Physician Retention	66.67%	4
Physician Recruitment	66.67%	4
Hiring Quality Staff	66.67%	4
Working Within Budgetary Constraints	50.00%	3
Range and Scope of Services	50.00%	3
Maintaining Adequate Staffing	33.33%	2
Ability to Respond to Changing Environment	33.33%	2
Other (please specify)	16.67%	1
Total Respondents: 6		

#	OTHER (PLEASE SPECIFY)	DATE

11 / 18

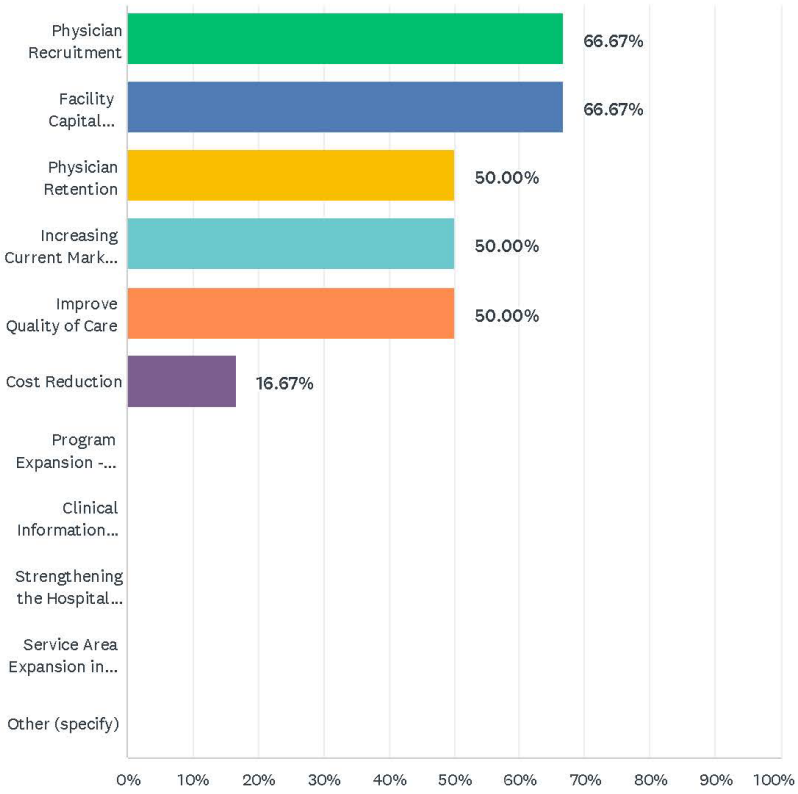
Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

1	poor change management	6/29/2023 11:03 AM

Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

Q11 What do you consider the top THREE strategic priorities for RMCHS?

Answered: 6 Skipped: 0



Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

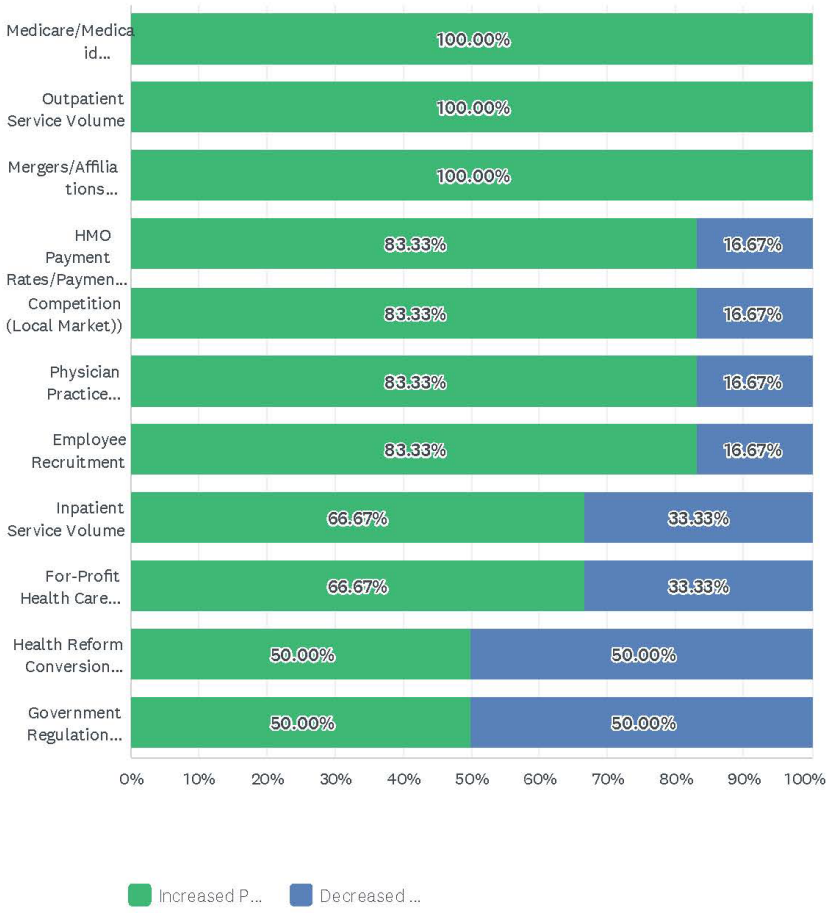
ANSWER CHOICES	RESPONSES	
Physician Recruitment	66.67%	4
Facility Capital Improvement	66.67%	4
Physician Retention	50.00%	3
Increasing Current Market Penetration	50.00%	3
Improve Quality of Care	50.00%	3
Cost Reduction	16.67%	1
Program Expansion - Inpatient and/or Outpatient	0.00%	0
Clinical Information Systems	0.00%	0
Strengthening the Hospital Mission	0.00%	0
Service Area Expansion in Other Counties	0.00%	0
Other (specify)	0.00%	0
Total Respondents: 6		

#	OTHER (SPECIFY)	DATE
	There are no responses.	

Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

Q12 Based on your perception of the healthcare industry, do you expect RMCHS to experience increased pressure or decreased pressure from the following issues over the next three years?

Answered: 6 Skipped: 0



Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

	INCREASED PRESSURE (OVER NEXT 3 YEARS)	DECREASED PRESSURE (OVER NEXT 3 YEARS)	TOTAL	WEIGHTED AVERAGE
Medicare/Medicaid Reimbursement	100.00% 6	0.00% 0	6	1.00
Outpatient Service Volume	100.00% 6	0.00% 0	6	1.00
Mergers/Affiliations (Regional)	100.00% 6	0.00% 0	6	1.00
HMO Payment Rates/Payment Denials	83.33% 5	16.67% 1	6	1.17
Competition (Local Market))	83.33% 5	16.67% 1	6	1.17
Physician Practice Penetration	83.33% 5	16.67% 1	6	1.17
Employee Recruitment	83.33% 5	16.67% 1	6	1.17
Inpatient Service Volume	66.67% 4	33.33% 2	6	1.33
For-Profit Health Care Penetration	66.67% 4	33.33% 2	6	1.33
Health Reform Conversion (i.e., Value-Based Contracting)	50.00% 3	50.00% 3	6	1.50
Government Regulation (Federal and State)	50.00% 3	50.00% 3	6	1.50

Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

Q13 Do you think RMCHS should get more involved in addressing the following? (Select all that apply)

Answered: 6 Skipped: 0

	YES	NO	TOTAL	WEIGHTED AVERAGE
Health Disparities	83.33% 5	16.67% 1	6	1.17
Health Indicators	66.67% 4	33.33% 2	6	1.33
Social Determinants of Health	66.67% 4	33.33% 2	6	1.33
Special Population Groups	66.67% 4	33.33% 2	6	1.33
Chronic Diseases	66.67% 4	33.33% 2	6	1.33
Public Health Issues	50.00% 3	50.00% 3	6	1.50

Board of Directors Interview - The Health Care Authority of the City of Anniston (HCACA)

Q14 How can RMCHS better meet the needs of the community?

Answered: 6 Skipped: 0

#	RESPONSES	DATE
1	Continuing our mission of expanding service to underserved segments of our society while maintaining and expanding services for those who can afford to pay	6/29/2023 9:04 PM
2	So involved now	6/29/2023 1:35 PM
3	I believe by hearing the concerns of the citizens of our local community.	6/29/2023 11:29 AM
4	it needs a new playbook . The current one is failing the community.	6/29/2023 11:03 AM
5	Reaching out. Speaking to civic clubs. More health fairs.	6/27/2023 1:27 AM
6	Better insurance reimbursement rates will enable RMC to	6/26/2023 2:41 PM

J. Senior Management Survey Results

Although often not a component of a community health needs assessments, (CHNA) Executive Resources, LLC (EXEC) and RMCHS agreed that conducting a survey of RMCHS senior management would contribute to a more complete understanding of community needs. Consequently, senior management (as determined by RMCHS) were asked to complete a survey instrument and then participated in a collective in-person interview process. The interviews allowed EXEC an opportunity to present a summary survey response from both the community surveys as well as management survey responses. The survey consisted of fourteen survey questions. The actual survey questions with responses follow this summary section of survey questions and responses.

Question 1: Asked members of senior management if they believed that RMCHS is achieving its mission

Eighty-three percent of management responded affirmatively.

Question 2: Asked management if the mission needs to be revised/expanded changed and why

More than eighty percent of management state that no change in mission is necessary currently. The present financial constraints result in a feeling that "we would be hard-pressed to increase our expansion efforts at this time" even if expansion of services is warranted by community need.

Question 3: Asked about barriers that threaten RMCHS ability to achieve its mission

A recurring theme of financial pressures resulting from low reimbursement from payers presents an existential threat to RMCHS.

Question 4: Asked management to envision the impact the COVID-19 and other external forces has on RMCHS's ability to meet its mission

COVID created workforce challenges (professional and non-professional workers exiting the workforce) and post-pandemic has resulted in increased competition for all staff but particularly key staff (physicians, nurses, other clinical and technical staff).

Question 5: Asked as a two-hospital system, what do you think in 2023 is RMCHS's service area for inpatient outpatient service area?

The pandemic exasperated existing workforce shortages and increased financial pressure on RMCHS. Prior to the pandemic RMCHS management was aware of the harsh reality of operating a "stand-alone" two-hospital system serving a five-county area and that reality became even more focused with the pandemic experiences. Senior management is aware that, notwithstanding major change in health system/hospital reimbursement, a "stand-alone" hospital system is unlikely to be viable in the long term; hence collaboration and letter of intent re; affiliation between RMCHS and UAB.

Question 6: Asked about RMCHS performance, "doing a good job of providing inpatient and outpatient programs and services to its service area and meeting the needs of the community"

Senior management unanimously agreed that RMCHS is doing a "good job". Management is clearly aware of the unmet community needs but without more resources (funding) and the aforementioned collaboration, it is unlikely that major new programs will be developed.

Question 7: Asked senior management it they think RMCHS's service area for its inpatient and outpatient service area should be expanded

Management overall understands the hospital service area population (declining, static at best) demographics, and is aware of patient outmigration in the northern part of the service area. it is unlikely that major new programs can be developed, and that existing pain management, psychiatry, and detox programs should be expanded.

Question 8: Due to technology and service delivery changes post-pandemic Management was asked how RMCHS differentiates itself in its service area

Accessibility, service, patient satisfaction, and quality were the underlying characteristics that Management expressed as being essential.

Question 9*: *When asked about doing "an adequate job on improving upon health indicators, reducing health disparities, and addressing social determinants of health"

Management included the following responses, "… is plugged into a number of community-wide efforts to improve health disparities. We have relationships with free clinics, offer numerous support groups and wellness programs for the community, participate in charity events that are geared towards improving health-related issues and assist numerous patients with establishing contacting social services organizations post-discharge".

Question 10: This question asked Management "what external threats pose the greatest challenge(s) to RMCHS's future"

One hundred percent of Management concurred that decreased payments and hospital finances presented the greatest challenges. The ability to recruit and increased regulations were also stated as great challenges.

Question 11: This question asked Management about "internal factors pose the greatest challenge(s) to RMCHS's future"

Management's response to this question was unanimous – employee retention with physician recruitment being second.

Question 12: Management was asked to select from a series of statements "what do you consider the top THREE strategic priorities for RMCHS

Management's top three is strengthening hospital's bottom line, increase market share, and merger/affiliation.

Question 13: This question asks Management "do you expect … increased or decreased pressure from the following issues over the next three years" and Management then select from a set of "pressures"

Although there were several selections to choose from the top three from Management's perspective are fundamentally related to healthcare/hospital financing, they include Medicare and Medicaid payment, healthcare reform/conversion and employee recruitment.

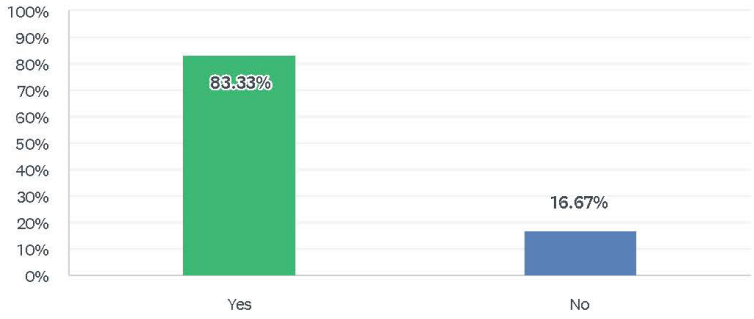
Question 14: Management was asked "do you think RMCHS should get more involved in addressing the following" and then selected from choices that included health disparities, chronic diseases, public health issues, health indicators, social determinants of health and special populations

Management concurred, indicating nearly seventy percent with health disparities and chronic diseases being at the top of the list.

Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

Q1 Since the last CHNA (2020), do you think RMCHS is currently achieving its mission?

Answered: 6 Skipped: 0

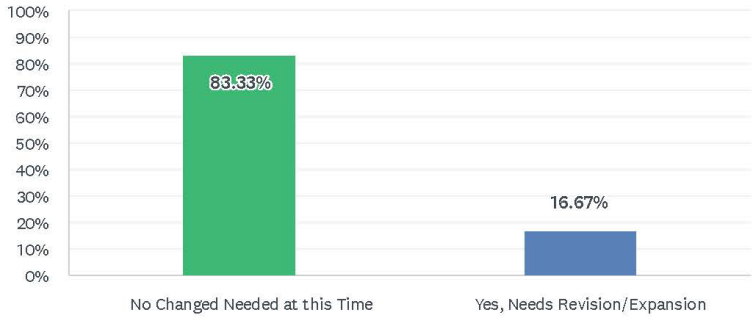


ANSWER CHOICES	RESPONSES	
Yes	83.33%	5
No	16.67%	1
Total Respondents: 6		

Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

Q2 Do you think the mission needs to be revised/expanded changed, and why?

Answered: 6 Skipped: 0



ANSWER CHOICES	RESPONSES	
No Changed Needed at this Time	83.33%	5
Yes, Needs Revision/Expansion	16.67%	1
TOTAL		6

#	WHY?	DATE
1	Changes are very slow, needs more communication and unity	8/1/2023 3:13 PM
2	The system is already treating a disproportionate number of patients across a broad spectrum of illnesses and financial issues. We would be hard-pressed to increase our expansion efforts at this time.	7/18/2023 11:11 AM

Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

Q3 What are the barriers/risks that threaten RMCHS's ability to achieve its mission, vision?

Answered: 6 Skipped: 0

#	RESPONSES	DATE
1	access to capital and financial pressures	8/4/2023 8:38 AM
2	Challenges with staffing and resources such as supplies, equipment in good repair, and access to physicians.	8/3/2023 5:25 PM
3	Attitudes	8/1/2023 3:13 PM
4	Low payment rates, citizens in our service area leaving the market to access healthcare, limited access to capital, changing labor market	7/26/2023 10:37 AM
5	On-going reimbursement issues with current payors. The lack of Medicaid expansion in our state combined with a high poverty rate in our service area. The inability to attract primary care physicians to replace an aging medical staff.	7/18/2023 11:11 AM
6	Competition, market competitive wages increasing, governmental funding potentially.	6/26/2023 2:24 PM

Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

Q4 How do you envision the impact of COVID-19 and other external forces will affect RMCHS's ability to meet its mission? What steps has management taken to address these issues?

Answered: 6 Skipped: 0

#	RESPONSES	DATE
1	the pandemic created workforce challenges that we are still dealing with; competition for staff and wage growth has made it difficult to staff some departments as needed	8/4/2023 8:38 AM
2	No, we maintained our ability to provide care to the community during COVID 19 and went above and beyond for our patients. There were ample staff brought in to help staffing issues, and we never went without the supplies necessary to provide safe care.	8/3/2023 5:25 PM
3	Covid 19 was hard on everyone. It will take time to get over this. We need to return to pre-Covid if at all possible. Management is trying hard to change things to make it all better, some harder than others.	8/1/2023 3:13 PM
4	COVID has limited, and will continue to limit our ability to meet our mission. Seeking a larger organization to partner with is a top priority. Wage rates have been increased, physician recruitment has been a priority,	7/26/2023 10:37 AM
5	COVID-19 wreaked havoc on our financials, but just as importantly, caused a major upheaval in our workforce. Very difficult to hire and\or retain staff given the numerous non-healthcare-related job openings that have pulled staff away from our system.	7/18/2023 11:11 AM
6	COVID shook everyone in every industry. It definitely provided a challenge in both funding, logistical issues and mental health of the staff.	6/26/2023 2:24 PM

Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

Q5 As a two-hospital system, what do you think in 2023 is RMCHS's service area for inpatient and outpatient programs and services?

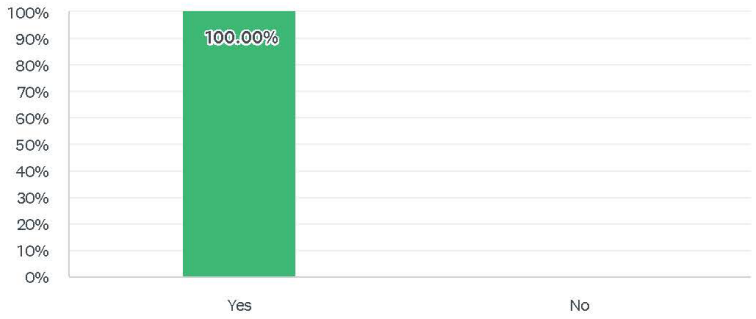
Answered: 6 Skipped: 0

#	RESPONSES	DATE
1	5 county area, 250K people	8/4/2023 8:38 AM
2	I do not feel that our 5 county service area has changed with the addition of the Stringfellow campus.	8/3/2023 5:25 PM
3	Area could be joined or one inpatient and one total outpatient.	8/1/2023 3:13 PM
4	Primary Svc Area: Calhoun, Cleburne, and Talladega Counties Secondary Svc Area: Clay and Randolph Counties	7/26/2023 10:37 AM
5	Our primary service area has not changed; however, the lack of a large presence in the northern part of our service area has somewhat diluted our market penetration.	7/18/2023 11:11 AM
6	It would be the same service area with only 1 hospital in the system.	6/26/2023 2:24 PM

Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

Q6 Do you think RMCHS does a good job of providing inpatient and outpatient programs and services to its service area and meeting the needs of the community?

Answered: 6 Skipped: 0



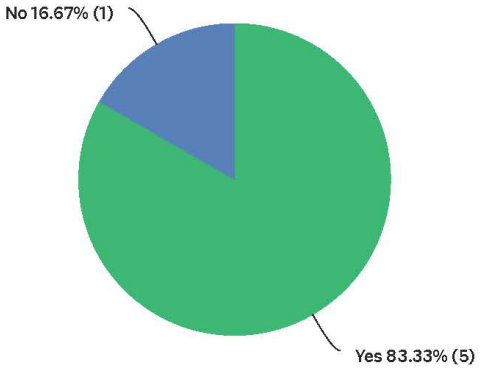
ANSWER CHOICES	RESPONSES	
Yes	100.00%	6
No	0.00%	0
TOTAL		6

#	COMMENT:	DATE
1	The primary inpatient program that is in demand is behavioral health.	8/3/2023 5:25 PM
2	Yes but needs more available times for outpatients.	8/1/2023 3:13 PM
3	There is always room for improvement, but generally speaking, RMC has the reputation for making sure that as many of the community's needs as possible are met.s	7/18/2023 11:11 AM

Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

Q7 Do you think RMCHS's service area for its inpatient and outpatient programs should be expanded?

Answered: 6 Skipped: 0



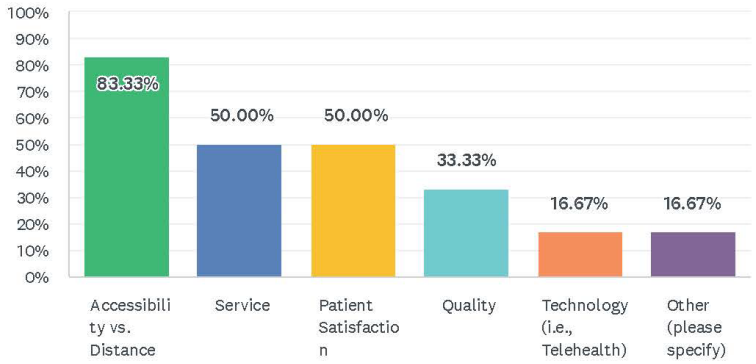
ANSWER CHOICES	RESPONSES	
Yes	83.33%	5
No	16.67%	1
TOTAL		6

#	IF YES, WHERE AND WHAT PROGRAMS SHOULD BE EXPANDED?	DATE
1	Pain management, epidurals	8/3/2023 5:25 PM
2	All of the programs, especially Psych and Detox	8/1/2023 3:13 PM
3	Cancer services, expand surgical capabilities	7/26/2023 10:37 AM
4	We would benefit from expanding the reaches of our geriatric psych program beyond the 5-county area that we define as primary.	7/18/2023 11:11 AM

Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

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

Answered: 6 Skipped: 0



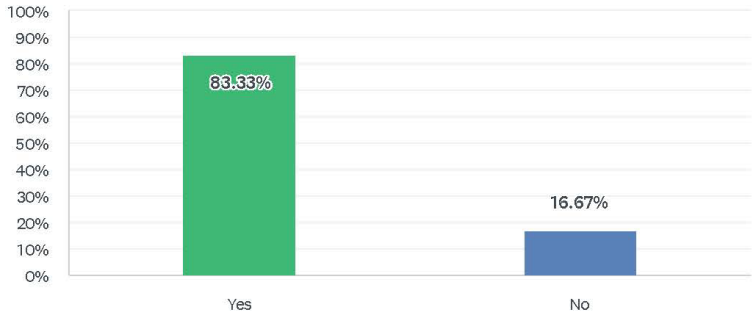
ANSWER CHOICES	RESPONSES	
Accessibility vs. Distance	83.33%	5
Service	50.00%	3
Patient Satisfaction	50.00%	3
Quality	33.33%	2
Technology (i.e., Telehealth)	16.67%	1
Other (please specify)	16.67%	1
Total Respondents: 6		

#	OTHER (PLEASE SPECIFY)	DATE
1	community feel and personal attention	8/4/2023 8:38 AM

Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

Q9 Does RMCHS do an adequate job on improving upon health indicators, reducing health disparities, and eliminating social determinants of health?

Answered: 6 Skipped: 0



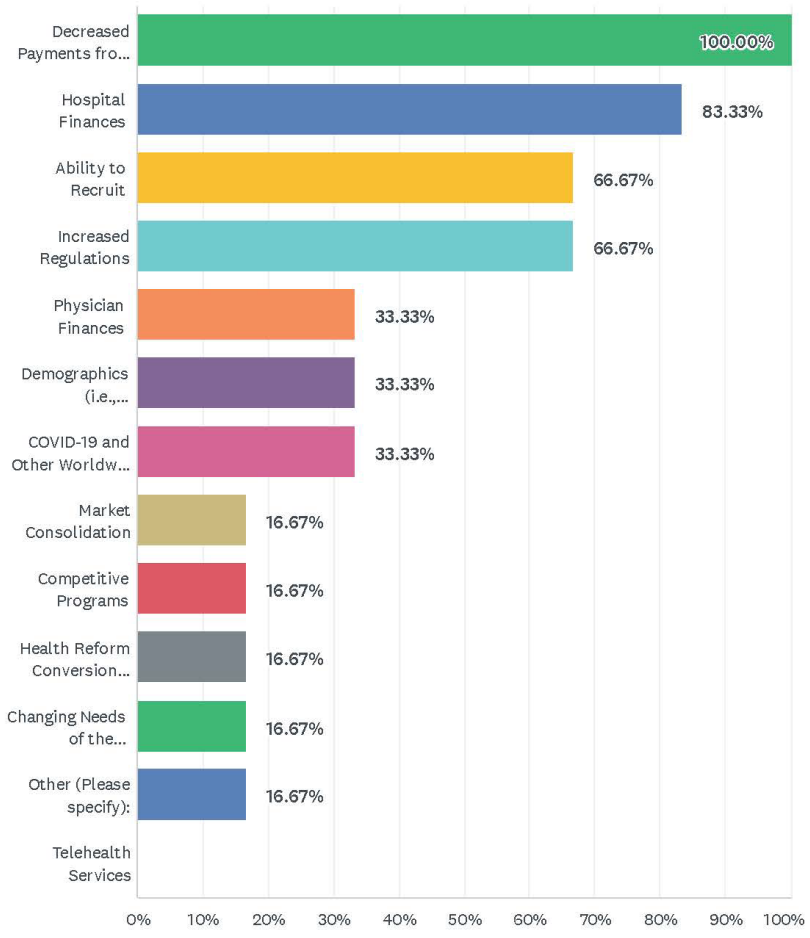
ANSWER CHOICES	RESPONSES	
Yes	83.33%	5
No	16.67%	1
TOTAL		6

#	OTHER (PLEASE SPECIFY)	DATE
1	this is a challenge without financial assistance	8/4/2023 8:38 AM
2	But like anything else this could be improved or stressed more.	8/1/2023 3:13 PM
3	RMCHS is plugged into a number of community-wide efforts to improve health disparities. We have relationships with free clinics, offer numerous support groups and wellness programs for the community, participate in charity events that are geared towards improving health-related issues and assist numerous patients with establishing contacting socail services organizations post-discharge.	7/18/2023 11:11 AM

Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

Q10 In your opinion, what external threats pose the greatest challenges to RMCHS's future? (Select all that apply)

Answered: 6 Skipped: 0



Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

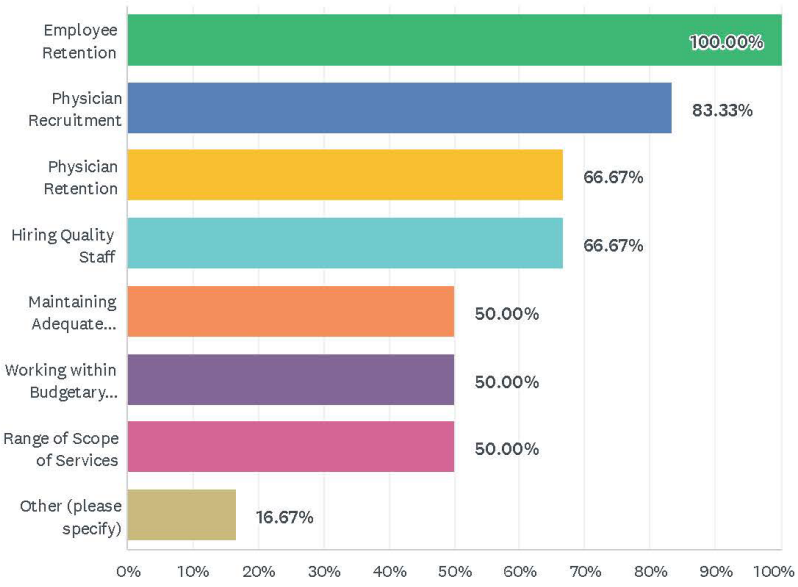
ANSWER CHOICES	RESPONSES	
Decreased Payments from Medicare/Medicaid	100.00%	6
Hospital Finances	83.33%	5
Ability to Recruit	66.67%	4
Increased Regulations	66.67%	4
Physician Finances	33.33%	2
Demographics (i.e., Population Changes)	33.33%	2
COVID-19 and Other Worldwide Pandemics	33.33%	2
Market Consolidation	16.67%	1
Competitive Programs	16.67%	1
Health Reform Conversion (Value-Based Contracting)	16.67%	1
Changing Needs of the Community	16.67%	1
Other (Please specify):	16.67%	1
Telehealth Services	0.00%	0
Total Respondents: 6		

#	OTHER (PLEASE SPECIFY):	DATE
1	low reimbursement from managed care	8/4/2023 8:38 AM

Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

Q11 In your opinion, what internal factors pose the greatest challenges to RMCHS's future? (Select all that apply)

Answered: 6 Skipped: 0



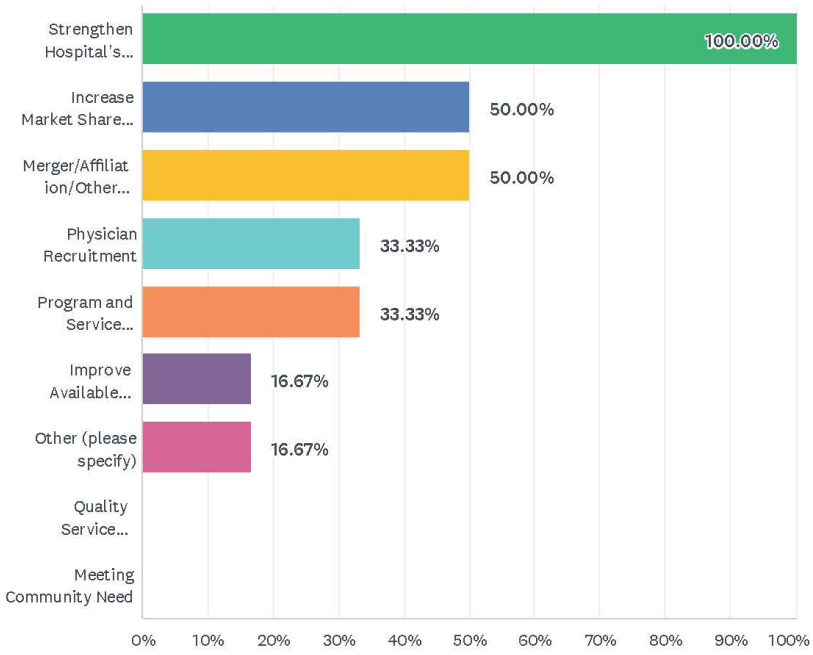
ANSWER CHOICES	RESPONSES	
Employee Retention	100.00%	6
Physician Recruitment	83.33%	5
Physician Retention	66.67%	4
Hiring Quality Staff	66.67%	4
Maintaining Adequate Providers and Support Staff	50.00%	3
Working within Budgetary Constraints	50.00%	3
Range of Scope of Services	50.00%	3
Other (please specify)	16.67%	1
Total Respondents: 6		

#	OTHER (PLEASE SPECIFY)	DATE
1	deferred maintenance and capital needs	8/4/2023 8:38 AM

Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

Q12 What do you consider the top THREE strategic priorities for RMCHS?

Answered: 6 Skipped: 0



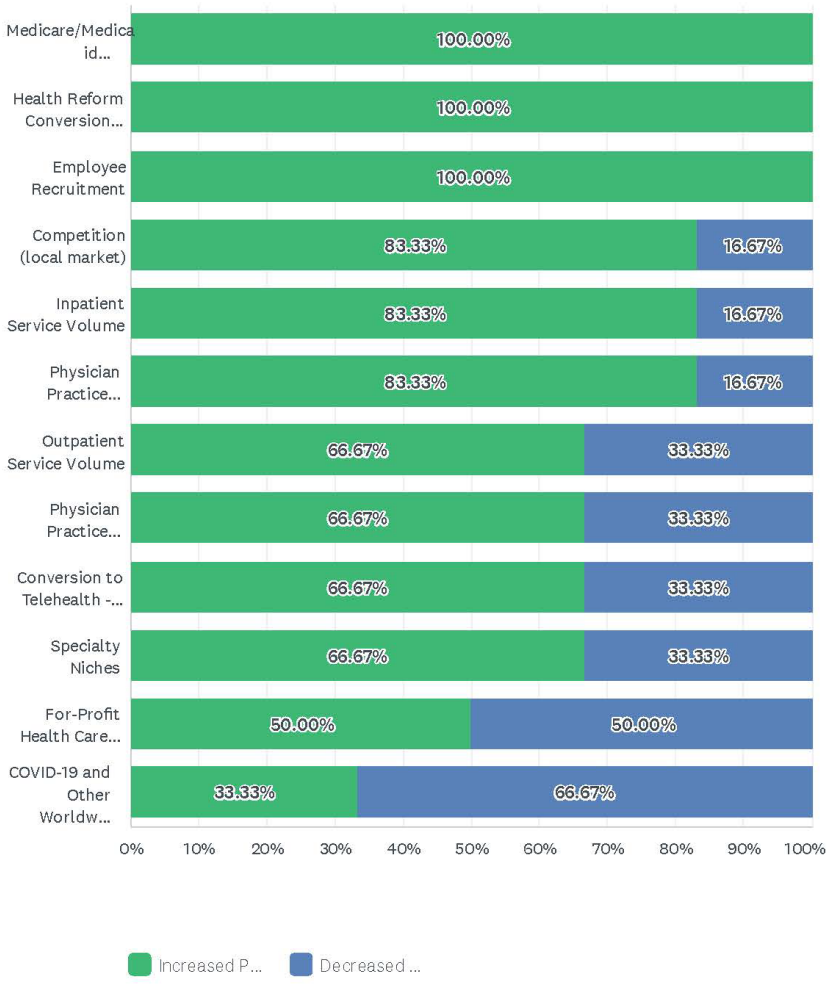
ANSWER CHOICES	RESPONSES	
Strengthen Hospital's Bottom Line	100.00%	6
Increase Market Share Penetration (Current Service Area, New Service Area)	50.00%	3
Merger/Affiliation/Other Corporate Structure Development	50.00%	3
Physician Recruitment	33.33%	2
Program and Service Development	33.33%	2
Improve Available Medical Technology, i.e., Telehealth	16.67%	1
Other (please specify)	16.67%	1
Quality Service Delivery	0.00%	0
Meeting Community Need	0.00%	0
Total Respondents: 6		

#	OTHER (PLEASE SPECIFY)	DATE
1	Medical Staff Development	8/4/2023 8:38 AM

Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

Q13 Based on your perception of the healthcare industry, do you expect RMCHS to experience increased or decreased pressure from the following issues over the next 3 years?

Answered: 6 Skipped: 0



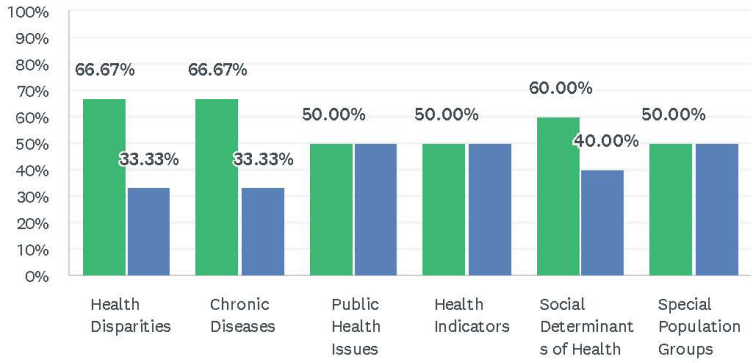
Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

	INCREASED PRESSURE	DECREASED PRESSURE	TOTAL	WEIGHTED AVERAGE
Medicare/Medicaid Reimbursement	100.00% 6	0.00% 0	6	1.00
Health Reform Conversion (i.e., Value-Based Contracting)	100.00% 6	0.00% 0	6	1.00
Employee Recruitment	100.00% 6	0.00% 0	6	1.00
Competition (local market)	83.33% 5	16.67% 1	6	1.17
Inpatient Service Volume	83.33% 5	16.67% 1	6	1.17
Physician Practice Acquisitions/Consolidations	83.33% 5	16.67% 1	6	1.17
Outpatient Service Volume	66.67% 4	33.33% 2	6	1.33
Physician Practice Penetration	66.67% 4	33.33% 2	6	1.33
Conversion to Telehealth - RMCHS' Readiness?	66.67% 4	33.33% 2	6	1.33
Specialty Niches	66.67% 4	33.33% 2	6	1.33
For-Profit Health Care Penetration	50.00% 3	50.00% 3	6	1.50
COVID-19 and Other Worldwide Health Issues	33.33% 2	66.67% 4	6	1.67

Senior Management Interview - The Health Care Authority of the City of Anniston (HCACA)

Q14 Do you think that RMCHS should get more involved in addressing the following? (Select all that apply)

Answered: 6 Skipped: 0



	YES	NO	TOTAL	WEIGHTED AVERAGE
Health Disparities	66.67% 4	33.33% 2	6	1.33
Chronic Diseases	66.67% 4	33.33% 2	6	1.33
Public Health Issues	50.00% 3	50.00% 3	6	1.50
Health Indicators	50.00% 3	50.00% 3	6	1.50
Social Determinants of Health	60.00% 3	40.00% 2	5	1.40
Special Population Groups	50.00% 3	50.00% 3	6	1.50

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

The physician survey process of RMCHS' medical staff included insight from both primary care provision (pediatrics) and subspecialty care provision (infectious diseases). However, since the survey response was limited in number of responses, in which conclusions might not represent the consensus of medical staff membership, the results and findings tallied and noted represent only major findings for this CHNA. All responses are shown in the attachments. They should not be interpreted to represent the majority of RMCHS' medical staff. The following characteristics describe the two physicians surveyed:

- Understanding of healthcare access-related issues, including the low-income population
- Understanding of the RMCHS service area "landscape" and the need for collaboration among the level of providers – both horizontal and vertical
- Active practice in RMCHS service area for number of years
- Understanding of health indicators, health outcomes, and health disparities and with an eye to the future

- ***Question 4: To what extent would you say that RMCHS has been able to meet the needs of the communities (served)?***

- The respondents indicated that RMCHS was doing between a moderate and good extent on meeting the needs of the communities.

- ***Question 5: What do you see as the #1 priority unmet healthcare need in the community and its primary cause?***

- Mental healthcare on both in-patient and outpatient levels is viewed by the respondents as the #1 priority unmet healthcare need in the community, echoing same results from community respondents. Following COVID-19, it was stated that we (the community) should have been better prepared (the primary cause) to brace for the emotional, mental, social, and financial fall-out. These issues have resulted in increases in SUD, domestic violence, unwanted/unplanned pregnancies, isolation, and feelings of alienation from family/school/society.

- ***Question 16: What do you think is the #1 worst health indicator, #1 worst health disparity, and #1 worst social determinant of health in the service area?***

- The respondents indicated Obesity and High Blood Pressure as the worse health indicator in the service area. Lack of access to healthcare is the worst social determinant of health. With the advent of COVID-19, misinformation is now competing with illegitimacy in becoming the worst social determinant of health.

Prioritization of Community Healthcare Needs

A. Overview

RMCHS' community health care 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.

The largest factors, excepting consideration of COVID and other worldwide pandemics, in driving today's healthcare strategy for all providers, and RMCHS is no exception, continues to be the following:

- Aging population,
- Rising chronic disease rates (co-morbid conditions),
- Gaps in supply and demand of physicians (especially in rural areas),
- Delivery options that technological advances enable i.e., telemedicine,
- Evidence-based care, and
- Change in the payment system relative to ACA which has required 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, acute, post-acute) 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 (RMC and Stringfellow) community is the health system's geographic area referred to as the service area in which the majority of its patients reside – three-counties. HCACA's two-hospital health system, 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.

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 three-county service area by creating an integrated healthcare delivery system, should be high on the priority list. Notwithstanding the COVID-19 pandemic, 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 2-hospital health system).

B. Identification and Prioritization of Community Healthcare Needs

Within this context, the priority needs for HCACA's three-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 that present a threat to the health of the community in the three-county primary service area along with the contiguous counties' secondary service area. In developing responses to

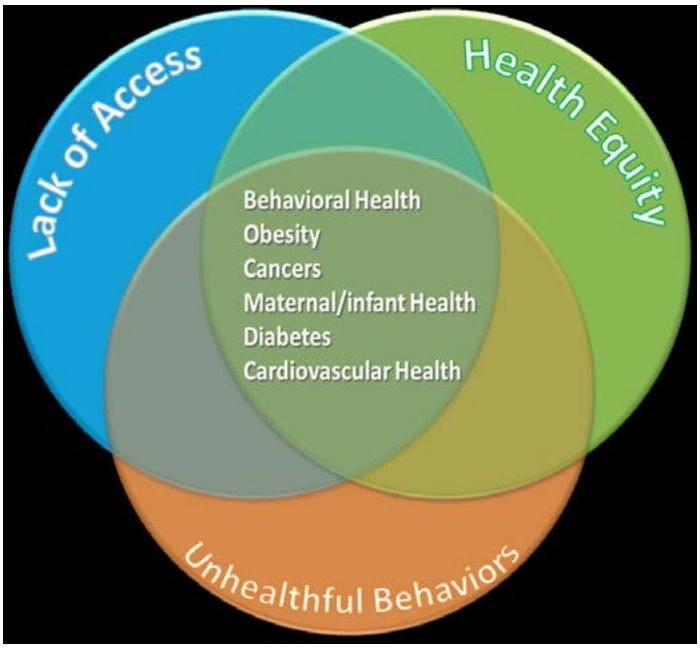
the needs from the recommendations identified and prioritized, HCACA needs to consider other criteria including:

1) Consistency with 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 through 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. Given the healthcare environment trends 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 Access to Primary Medical Care and Behavioral Health Care
B.2 Systems to Reduce Socioeconomic Stressors
B.3 Healthcare Education, Prevention, Wellness, Promotion
B.4 Healthcare Services for Chronic Conditions
B.5 Healthcare Services for the Elderly

B.1. 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 abuse), especially substance abuse, remains a critical issue throughout the three-county service area, especially for the low-income population and where financial and non-financial barriers prevent patients from receiving timely and appropriate diagnosis, assessment, and treatment of their condition. The key informant interview/survey process delineated the increasing and resounding need and lack of access to behavioral health care services (mental health and substance abuse – all age groups) and the increasing opioid epidemic throughout the service area.

The presence of OB service delivery continues to remain a luxury in many of Alabama's counties. Only two dozen of the 55 rural counties have hospitals that deliver babies today. Calhoun County and the contiguous service area is fortunate to have RMC's Women's and Children's Center, Alabama's First Baby Friendly Hospital. 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, 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 (RMC also has Blue Distinction® Center designation for knee and hip replacement). This designation is an expansion of the national Blue Distinction Specialty Care program. Even considering the new "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 HPSA – Population Group Low-Income designations for Primary Medical Care and "Single County" for Dental and Mental);

- High level of uninsured throughout the three-county primary service area validated by HRSA UDS Mapper; with a negative access and reimbursement impact based on the state's decision not to implement Medicaid expansion;

- 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 other HRSA-related grants and benefits; and while the key informant interview/survey 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 – it should be noted that HRSA is scheduled to announce a new NAP grant cycle on 12/12/2023, calling for 230 new sites nationwide;

- Historical high primary care utilization in HCACA's hospitals' emergency rooms, specifically RMC with the most paramount utilization (EXEC's analysis performed for prior years; however, for 2022, it was less than 10%), particularly among low-income groups and the potential need for HCACA to establish, develop, and implement a "free clinic" or FQHC-type model on Anniston's "west" side along with further collaboration with QLHS;

- 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 and relative to the

hospitals' emergency rooms, while overall, total volume has decreased but the amount and percentage of admissions has increased significantly;

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

- Low level of mental health providers relative to the population, especially for the low-income population (HPSA "Single County" Mental Health designations), thereby creating the behavioral health need – both mental health and substance abuse, 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 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.1.a. Objectives:

- To develop structures to improve the ability to recruit primary care physicians throughout the community to serve the low-income population – one consideration based on the key informant interview process was future development of an FQHC-type "homegrown" model and to recruit and staff the site with MD/DO and/or NP providers, thereby creating access and stemming the tide of inappropriate primary care in HCACA's emergency rooms, along with mitigating hospital readmissions;

- To integrate the full range of primary care services, medical, behavioral, and dental, into the primary care setting – FQHC being an appropriate setting – prior to, during, and post-health reform, especially since significant section 330 NAP dollars have been accorded to QLHS during health reform and there remains significant low-income unmet need in the 3-county service area;

- To collaborate with QLHS and other providers/agencies on expansion of primary medical care and urgent care services to be more conducive based on community needs (need to schedule based on community need – 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 (Martin Luther King Drive), which could potentially develop as an FQHC "Look-Alike" provider and take advantage of FQHC benefits, i.e. enhanced reimbursement, 340B Drug Pricing Program;

- 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 and outreach and education to the population, so they understand the health risks of not accessing services; and

- To reduce the mortality in cancer, diabetes, and heart disease in Calhoun, Cleburne, and Talladega Counties – these same high mortality rates continue in the 2023 CHNA similar to prior years' CHNAs.

B.1.b. RMCHS CHNA Implementation Plan 2021-23 Actions/Strategies:

Strategy Statement	Affordable primary care is essential to the establishment of a healthcare system that promotes well-being. More primary care in a community equates to lower mortality, better preventive care and fewer hospitalizations and ER visits

- Leverage technology to expand access to care through telehealth and other platforms that do not require travel/transportation;

- Continue to expand both the number and roles of nurse practitioners and physician assistants in our service area;

- Create multidisciplinary care teams (physician\nurse practitioner, nutritionist, exercise physiologist, etc.) in community health clinics in order to provide patients with a comprehensive understanding of medical conditions and the appropriate way to treat them;

- Incorporate and integrate electronic health records across delivery system in order to share information in real time and thus reduce duplication of services and lowers cost;

- Continue efforts to expand Medicaid in the State of Alabama;

- Establish stronger relationships with community-based clinics and federally qualified health clinics to establish referral source for low-to- moderate income patients who are unnecessarily visiting high-cost emergency rooms;

- Partner with local municipalities and other stakeholders to establish and support health clinics for low income and underserved populations;

- Offer supplements to National Health Service Corps (NHSC) physicians willing to relocate to rural communities within our service area;

- Increase social work and case management resources to ensure consistent access and availability of their services; and

- Explore the creation of a navigator program for the uninsured and underinsured to assist in the reduction and\or prevention of non-compliant events that result in emergency room visits or hospitalizations..

- Publicize health screenings related to heart disease, colorectal and prostate cancer, and promote Breast Cancer Awareness Month.

- Offer community-based wellness programs at the Tyler Center in order to promote the importance of physical activity.

- Provide support groups to address a variety of community-related issues (diabetes, obesity, cardiac, nutrition, ostomy, hypertension, etc.).

- Promote community-based free clinics as a source of attaining health care without concerns of the ability to pay.

- Publish a listing of available social services agencies and post to RMC's website

B.2. 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 (derived from key informant survey/interview process with Superintendent of Schools and community-based agencies/organizations along with a service area tour of Anniston's "east" and "west" sides).

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 and will continue to need to work together with other community providers, both private and public (i.e., FQHC network organizations, school systems), 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 RHC sites, physician offices, and the health system's hospitals.

B.2.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 improve 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.2.b. RMCHS CHNA Implementation Plan 2021-23 Actions/Strategies:

Strategy Statement	Reduce barriers to accessing healthcare due to demographic, environmental or financial factors

- Partner with health professions advisors at high school level to emphasize high demand for healthcare workers;
- Continue Volunteens Program to increase exposure of high school students to the healthcare environment;
- Offer health-care related scholarships to high achieving low-income students as an encouragement to further education;
- Offer health-care related scholarships and reimbursement assistance options to our own employees and their dependents;
- As part of community-based health fairs, engage nutritionists and diabetic educators to participate in discussions pertaining to healthy eating;
- Utilize contracted resources to sign up Medicaid eligible patients to obtain insurance benefits;
- Expand and strengthen community outreach efforts around stroke, cardiovascular disease, diabetes, and hypertension;
- Continue Meals on Wheels Program;
- Continue reduced payment and in-kind ancillary services for local ministries; and
- Participate in community health fairs and provide free health screenings for common community-related diseases.

B.3. Healthcare Education, Prevention, Wellness

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).

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

Recommendations for this Priority will be linked to those for 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 develop 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 coordinate and integrate 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;

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

- 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. RMCHS CHNA Implementation Plan 2021-23 Actions/Strategies:

Strategy Statement	The risk factors of smoking, obesity, hypertension, diabetes, and limited physical activity contribute to a wide range of preventable health conditions. Wellness programs need to be designed and geared towards hard-to-reach, lower income, and culturally diverse groups in order to both educate them regarding risk and stress the importance of early detection of disease onset

- Partner with medical staff and other healthcare professionals to develop educational programs focused on health and wellness and combat stigmas that may exist in certain communities and patient populations;

- Take a more active role in promoting and encouraging wellness and healthy living with our own employees and their dependents;

- Conduct more frequent screenings in low-to-moderate income neighborhoods;

- Target outreach to underserved women through the National Breast and Cervical Cancer Early Detection Program;

- Work with local medical and nursing schools in an effort to expand coursework in areas such as communication, cultural competency, and health disparities, and ensure that they receive "hands-on" experiences with culturally diverse patients;

- Assess the viability of a navigator program in underserved communities;

- Tout the benefits of nicotine patches at community health fairs as a

possible means of smoking cessation;

- Work with local churches and civic organizations to advertise and promote screening exams and programs provided by the health system; and

- Utilize social media and other electronic marketing channels to further spread the news about events and educational and wellness programs currently offered.

B.4. Healthcare Services for Chronic Conditions

The high level of mortality from chronic disease (i.e., heart disease, cancer) in Calhoun, Cleburne, and Talladega Counties makes it imperative to improve management of these chronic disease conditions. 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 and substance abuse) 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. 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 develop 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 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. RMCHS CHNA Implementation Plan 2021-23 Actions/Strategies:

Strategy Statement	The high prevalence of citizens living with chronic diseases such as diabetes, hypertension, obesity, and heart disease makes it imperative to assist in the management of these conditions in order to avoid acute and costly hospital visits

- Utilize existing resources to establish chronic care programs for individuals with heart disease and other chronic conditions;

- Continue and expand the Transition of Care program to follow more chronically ill patients in an effort to improve medication adherence and health compliance;

- Ensure access to a full range of health services for the chronically ill patients

;

- Support legislative measures that increase the number of people with health coverage;

- Work to amend licensure laws in order to make it easier for health centers to care for the chronically ill;

- Offer reduced-cost programs for low-income chronically ill patients seeking health care;

- Provide access to electronic health records so that conditions can be reviewed in real time and thereby speed up the care process;

- Assist in the location of programs that will provide low-cost or no-cost medications to patients with chronic conditions;

- Continue to provide assistance to low income, chronically ill patients in helping them register and get approved for programs that may provide healthcare coverage at little to no out of pocket expense;

- Coordinate follow-up access to outpatient provider services for patients prior to being discharged from the acute care setting with chronic conditions to help ensure seamless access and coordination of care.

B.5. Healthcare Services for the Elderly

The fact remains that RMCHS' three-county service area population growth is static at best, and actually declining and getting older. Even the Calhoun, Cleburne, and Talladega Counties' service area, similar to the state and nation, continue to realize 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 departing to other areas, it is cause for alarm from a healthcare service delivery provision with the elderly as the base. 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 improve the accessibility of healthcare and social services along with pharmaceuticals for the elderly in close proximity to their homes;

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

- To improve 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; and

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

- To improve healthcare quality in RMCHS' immediate three-county service area by exploring and developing a virtual, integrated healthcare delivery system aimed at reducing fragmentation and duplication.

B.5.b. RMCHS CHNA Implementation Plan 2021-23 Actions/Strategies:

Strategy Statement	The population of our service area is getting older. With the closest major city being 60 miles away, it is imperative that we provide as many healthcare and social services as possible at the local level

- Continue to work to change scope of practice laws that enable non-physician providers to work at the top of their licenses, thereby creating more appointment slots and "capacity";

- Develop coordinated care models via the creation of patient centered medical homes (PCMHs) to improve access and efficiency while decreasing complications;

- Extend or stagger clinic hours for patients who are not able to make appointments during regular business hours due to transportation or other social issues;

- Utilize telehealth and virtual care platforms to provide basic primary care and chronic care access for established patients;

- Continue workforce investment at high school and college level to insure that an adequate number of healthcare workers are being trained to meet the demands of an increasingly aged population;

- Utilize navigators to monitor compliance with medications and physician office visits;

- Develop community-based, mobile and telehealth clinics and to assist with access issues;

- Partner with academic medical centers or larger tertiary referral hospitals (i.e., UAB) to bring sub-specialty access to care to our communities through the use of telehealth platforms and outreach clinics;

- Advocate shared appointments among the elderly with similar health

concerns\conditions;

- Support the repeal of the physician payment formula that threatens steep cuts to physician pay, and any other reform that preserves the physician\patient relationship; and

- Conduct a comprehensive provider needs assessment and develop a recruitment plan to ensure appropriate and timely access to care.

C. HCACA as Leader in Transforming Community Health

As HCACA continues to position the health system for success in the future relative to health reform and regulatory and reimbursement changes, and potential affiliation between RMCHS and UAB (witness Letter of Intent), along with external factors outside its control (i.e., population, socioeconomic and demographic characteristics, and determinants), 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. This needs to be accomplished concurrent with HCACA continuing its recent healthcare advancements, such as, but not limited to the following:

- Continued affiliation in the UAB Cancer Care Network programs;

- Center for Balance Disorders relative to problems associated with dizziness or imbalances especially for those age 55+;

- RMC's Women's and Children's Center, Baby Friendly Hospital. These developments can continue to both address community need and position RMC for success – for all Life Cycles – Prenatal, Children, Adolescent, Adult, and Elderly; 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 health system, which is based on improving health outcomes throughout RMC'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 in Calhoun/Talladega Counties based on 2021 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 (i.e., UAB) and Atlanta as indicated during the key informant questionnaire/survey process.

Exhibit 31- Examples of Service Distribution Across the Age Segments

<table>
<tr><td rowspan="2">0-17</td><td rowspan="2">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 rowspan="3">18-44
45-64
65+</td><td rowspan="3">Women's Center Beyond Maternity</td></tr>
<tr><td rowspan="2">Palliative Care</td></tr>
</table>

The goal of the 2023 CHNA, similar to prior years' CHNAs, is to position HCACA 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) RMC's Women's and Children's Center (Baby Friendly Hospital).

Of equal importance, hospitals, and 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. 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 other providers and agencies to reduce fragmentation and duplication. Clearly, as documented in the key informant questionnaire/survey 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, will reduce healthcare costs while improving outcomes which will enable both HCACA and the community to succeed.