THE HEALTH CARE AUTHORITY OF THE CITY OF ANNISTON

Community Health Needs Assessment

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EXECUTIVE SUMMARY

The Health Care Authority of the City of Anniston (HCACA) a 3-hospital health system in northeast Alabama (AL), has performed the 2017 Community Health Needs Assessment (CHNA) mandated by the Patient Protection and Affordable Care Act (P.L. 111-148) of 201.50 (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 IRS Form 990 and CHNA for HCACA, are inclusive of the three Calhoun County, AL hospitals governed and operated by HCACA, restructured in 2016 as a health care authority from the Regional Medical Center (RMC) Board, DBA Northeast Alabama Regional Medical Center.

With a total of 323 beds at HCACA's main campus at RMC-Anniston, 104 beds at Jacksonville, and 125 beds at Stringfellow, along with numerous outpatient facilities and services, HCACA (552 total beds) is the provider of choice for over 14,000 inpatients, 100,000 outpatients, nearly 2,000 newborn deliveries, and over 55,000 emergency room visits each year. Quality, compassionate care is provided by more than 1,800 employees, 300 volunteers and over 200 physicians in a full range of specialties.

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

Our CHNA represents a collaborative, community-based approach to identify, assess and prioritize important health issues affecting our northeast AL community, comprised of a 5-county service area, predominantly three counties - Calhoun, Cleburne, and Talladega - along with Clay and Randolph. The CHNA process is the foundation that healthcare providers and the community use to collaboratively plan, develop and foster programs to effectively address health needs in our community.

The CHNA looks at health indicators, health status, barriers to care, and other demographic and social issues affecting all residents and organizations in the community. Health improvement plans that address the needs identified in the CHNA ensure that HCACA remains focused on improving the health of the communities we serve. The CHNA serves as the key tool in delineating the health needs of the community. The quantitative and qualitative data research and analysis, serves as the base for Health Service Priority need areas development.

The qualitative data was obtained through key informant interviews and questionnaires and focus group sessions. The stakeholders involved in providing input, included broad representation from the 3-county service area community served by HCACA: HCACA Management, HCACA Board, Medical Staff/community physicians, school boards, agencies, other providers, and community leaders.

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

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, and income level, as well as access to nutritious food, transportation, and housing affects health status and access to healthcare. The ages of a population impact the prevalence and severity of disease as well as program needs.

The total population in each of HCACA's service area's three counties continues to decline when comparing the prior CHNA (2014 estimate) to the current CHNA (2016 estimate), of which clearly, program and service development may be impacted in the future. The 3-county service area decline in population trend, is indicative of many rural areas throughout the country, not just Alabama.

	Calhoun County	Cleburne County	Talladega County	Alabama State
Population estimates, July 1, 2016	114,611	14,924	80,103	4,863,300
Population, 2014 estimate	115,916	15,080	81,322	4,849,377
Population % change, 2014-2016	-1.01%	-1.01%	-1.02%	1.00%

Like other areas of the U.S., our service area's pediatric population ages 0-19 is projected to decline, along with a corresponding increase in the ages 65+ population. Older people, due to their age and incidence of chronic disease, frequently with co-morbid clinical conditions, are requiring more primary care resources; whereas, 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 along with a higher percentage of the population being elderly.

Although obstetrical services are still important, women of childbearing years ages 15-44 in our service area are expected to decline into future years. This trend as many women move past childbearing age, will create a need for women's health and other healthcare services, i.e. cardiac, orthopedic, rehabilitation and cancer.

The CHNA's key informant survey/questionnaire process offers providers and other organizations to engage and collaborate with HCACA relative to their communities in identifying, addressing, and prioritizing community health needs. The 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 health system. Representative consensus findings from the key informant questionnaire/survey process follow:

- Providers, when asked about the worse health indicators and worse disparities in the community…
  - …responded untreated mental disease, particularly as expressed by substance abuse disorders - this is a current theme expressed elsewhere throughout this interview process.

- Providers, when asked about how HCACA could better meet the needs of the community…
  - …more education, more wellness screenings, create more awareness of services provided, work and coordinate more with agencies/organizations.

- Community members, when asked about if the community has adequate access to healthcare services…
  - …inadequate preventive programs for low-income population, inadequate access to mental health services regardless of income, greater emphasis needed for drug & alcohol education programs – particularly directed at youth, and access to primary care physicians is adequate for insured but not adequate for uninsured.

- Community members, when asked if HCACA adequately addresses community needs and is successful in improving health indicators and reducing health disparities, and adequacy of program services…
  - …HCACA rated high in adequacy of services other than mental health services, and "yes" regarding health indicators/health disparities efforts to improve the community with available resources.

- Board members, when asked what are the strengths of HCACA…
  - …stayed current with the modern procedures and equipment, it has implemented a hospitalist program - its technology is current and in summary the medical center is community oriented, nonprofit – and creating access is the focus.

- Board members, when asked what external factors pose the greatest challenges to the viability of HCACA over the next five years…
  - …cutbacks or reduction of Medicare funding and state support is considered the greatest threat, other threats include demographic changes – aging population, changing needs of the community.

- Executive team members, when asked what are the barriers/risks that threaten the hospital's ability to achieve its mission vision…
    - …responses varied but common theme was lack of adequate reimbursement, other barriers/risks include recruitment and retention of physicians, aging medical staff, higher income community members' perception of better care in Birmingham.

- Executive team members, when asked does HCACA perform an adequate job on improving health indicators and reducing health disparities…
    - …some felt more could be done but all acknowledge major pressure - financial resources negatively impact efforts, prevention & education programs are difficult to sustain in present reimbursement environment, collaborate more with regional FQHC.

Health Service Priority need areas' recommendations derived from the CHNA process are also consistent with the tenets of health reform and ongoing, evolving payment systems since they focus on healthier individuals (through preventive, wellness, and primary medical care services) 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, which included a delineation of objectives and potential activity recommendations for meeting the challenge, recognizing that the Health Service Priorities are linked since they are all highly inter-related.

- Systems to Reduce Socioeconomic Stressors;
- Access to Primary Medical Care and Behavioral Health Care;
- Healthcare Education, Prevention, Wellness, Promotion;
- Healthcare Services for Chronic Conditions; and
- Healthcare Services for the Elderly

In addition to the delineation of Health Service Priority need areas' recommendations, there are three concurrent overarching themes that were apparent from the key informant survey/interview process:

1. To improve access for all community residents to health and social services;
2. To achieve health equity for all community residents; and
3. To enhance the physical and social environment to support health well-being and reduce unhealthy behaviors.

As HCACA continues to position the health system for success in the future relative to health reform and regulatory and reimbursement changes, along with external factors outside its control (i.e. population, socioeconomic and demographic characteristics and determinants), 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.

DETAILED REPORT

INTRODUCTION

Executive Resources, LLC (EXEC) was engaged by The Health Care Authority of the City of Anniston (HCACA) to provide the Authority with a written report relative to documentation of a 2017 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 PPACA and ACA and regulated by the Internal Revenue Service (IRS).

The IRS Form 990 and CHNA for HCACA, is inclusive of the three Calhoun County, AL hospitals governed and operated by HCACA. It is similar to prior years' CHNAs performed for the Regional Medical Center Board, DBA Northeast Alabama Regional Medical Center (RMC), delineated as 501(c)(3) tax-exempt status. RMC was restructured in 2016 from a hospital board to a health care authority to allow the 3-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. On July 25, 2011, the IRS released Notice 2011-52 regarding the CHNA requirements of the PPACA for tax-exempt hospitals. 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 performed by EXEC for RMC, the communities are those, predominantly in three counties: Calhoun, Talladega, and Cleburne. 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.

PROJECT OBJECTIVE

The objective of the engagement was to provide HCACA with 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. In 2012 and 2015, EXEC performed the CHNA for RMC. HCACA has undertaken this CHNA in 2017 as RMC-Jacksonville Hospital was folded under HCACA's governance and operation in 2014. As such, EXEC undertaken this CHNA for the 3-hospital health system 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 since there is a need to review, adapt, cease, and commence healthcare programs and services in a changing marketplace as the population ages and the healthcare environment continues to evolve. The findings and results could serve as the nucleus for healthcare program and service development, for physician growth, and for revenue enhancement to the betterment of health in the northeast Alabama service area communities and their residents as well as for the HCACA health system.

PROJECT SCOPE

EXEC's performance of a CHNA, which must be conducted by the end of the hospital's first fiscal year starting after March 23, 2012, and at least once every three years thereafter (i.e. 2015 – subsequent second three years, 2018) (required for 2017 as RMC-Jacksonville Hospital was folded under HCACA's governance and operation in 2014), will provide the foundation for HCACA's submission of IRS Form 990 Schedule H. It 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 health care needs of the community, including those specific to low-income and minority populations;
- Identification of unmet need areas that can be used as the basis of the Implementation Strategy Report to be developed by HCACA;
- Community involvement through an interview process (including interview development) to take into account input from persons who represent the broad interests of the community served by HCACA: HCACA Management, HCACA Board, HCACA Medical Staff/community

physicians, local Anniston/Calhoun County agencies and providers, and community leaders; and

- Preparation, documentation, and completion of Community Health Needs Assessment (CHNA) report.

APPROACH & METHODOLOGY

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

- To project need to more appropriately target HCACA 3-hospital health system resources regarding current and future healthcare program accessibility; and

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

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

- **Key Informant Interviews:** EXEC conducted interviews with key individuals, as recommended by the HCACA Management Team. The interviews were performed at RMC and in the community, including at governmental entities, private and public organizations, and providers' offices. The purpose of the interview process was to provide indications of healthcare service and program need in the communities, access issues for various population segments, apparent gaps in services, challenges posed by community residents and the healthcare community, and potential strategic areas of opportunity for the hospital. Interviews were conducted primarily as direct face-to-face and to a lesser extent, on the telephone, depending on the preference of the interviewee. A list of persons interviewed is included in Attachment A;

- **Secondary Data Analysis:** EXEC reviewed an extraordinary amount of current existing reports and data available specific to the United States; State of 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 ADPH, 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 RMC, ADPH, HRSA, Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS), Countyhealthrankings.org, KidsCount and other sources;

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

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

PROJECT LIMITATIONS

The project was intended to provide HCACA and community-interested parties with a 2017 CHNA report, which was required for 2017 since in 2014, RMC-Jacksonville Hospital was folded under HCACA's governance and operation. Generally, CHNA's are required every three years (i.e. 2012, 2015, 2018). 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 3-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 Calhoun, Cleburne, and Talladega Counties, which were not viewed as the health system's service area for the CHNA and therefore, not within the scope of the project. Further analyses relative to broadening the scope to include healthcare services in other Alabama counties, cities, and towns, i.e. Randolph County may be warranted for future study to further quantifying healthcare need and gaps.

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

DETAILED FINDINGS

A. Description of Community Served by a Hospital

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

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

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

HCACA's community is the health system's geographic area referred to as the service area in which the majority of its patients reside among factors. HCACA's 3-hospital

health system, through its strategic planning process, reviews its service area periodically as follows:

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

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

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

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

In addition to internal inpatient patient discharge record capturing, patient origin analyses (zip codes of inpatient patient discharge records) are reported relative to the Centers for Medicare & Medicaid Services' (CMS) Medicare hospital cost report, Form 2552-10, subsequently captured by the American Hospital Directory ***(Source: American Hospital Directory/AHD***). CMS Form 2552-10 is a consistent data base reporting mechanism for all hospitals. Subsequently, internal inpatient patient discharge record capturing is validated by a comparison to annual AHD reporting. This comparison is the basis of patient origin analyses that are routinely performed, thereby ensuring that the determined service area is accurate.

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

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

MUAs/MUPs are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty, and/or high elderly population. MUAs may be a whole county or a group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts in which residents have a shortage of personal health services. MUPs may include groups of persons who face economic, cultural, or linguistic barriers to healthcare.

Therefore, HCACA utilizes a combination of different methodologies in determining its service area, including patient origin studies as the base and incorporating MUA/MUP federal designations 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 3-hospital health system (geographic service area) is defined in the Phase II rule as "the area composed of the lowest number of contiguous zip codes from which the hospital (i.e. HCACA's 3-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 12/31/2016, specific for this 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. AHD reporting for calendar year ending, 12/31/2015 and 9/30/2016, and hospital discharge data for calendar year ending 12/31/2016.

For the reference period, the hospital (i.e. HCACA's 3-hospital health system) should next determine its total inpatient population, i.e. discharges and divide that number by 75 percent. Next, the hospital should identify all zip codes in which those inpatients reside as determined from the patient origin study/discharge analysis and array the zip code areas in order of their contribution to the total inpatient population from highest (zip code contributing the most inpatients) to lowest. Using a map ***(Source: HRSA's UDS Mapper***) with a zip code overlay, the hospital can then determine the geographic array of contiguous zip codes that comprises 75 percent or more of the hospital's inpatient population and physically identify it's "geographic service area."

Analyzing AHD reporting for calendar year ending 12/31/2015 and 9/30/2016, based on Medicare inpatient prospective payment system (IPPS) claims data (Anniston, Medicare provider number 010078; Jacksonville 010146; and Stringfellow 010038), and HCACA's three hospitals' discharge data for calendar year ending 12/31/2016, HCACA performed a patient origin study of inpatient patient discharges to ensure that the determined

service area is accurate. HCACA identified all zip codes in which those inpatients reside as determined from the patient origin study/discharge analysis from the three hospitals combined and arrayed the zip code areas in order of their contribution to the total inpatient discharge population from highest (zip code contributing the most inpatients) to the lowest based on the following figure, which has been determined to be the community (primary service area) served by the health system.

Figure 1 - Community Served by the Health System

Zip Code	Place	County	Anniston Discharges	Jacksonville Discharges	Stringfellow Discharges	Combined Discharges	Percent	Cumulative Percent
36201	Anniston	CA	2,360	84	749	3,193	17.8%	17.8%
36203	Oxford	CA,CL,TA	1,569	60	353	1,982	11.0%	28.8%
36207	Anniston	CA	1,530	40	339	1,909	10.6%	39.4%
36265	Jacksonville	CA	1,137	290	179	1,606	8.9%	48.4%
36206	Anniston	CA	882	57	306	1,245	6.9%	55.3%
36264	Heflin	CL	803	9	155	967	5.4%	60.7%
36272	Piedmont	CA	624	196	70	890	5.0%	65.6%
36277	Weaver	CA	392	38	103	533	3.0%	68.6%
36271	Ohatchee	CA	309	20	74	403	2.2%	70.9%
35160	Talladega	TA	367	13	53	433	2.4%	73.3%
36260	Oxford	TA	353	11	68	432	2.4%	75.7%
Subtotal			10,326	818	2,449	13,593	75.7%	
All Others			3,478	262	630	4,370	24.3%	
Total			13,804	1,080	3,079	17,963	100.0%	

Source: HCACA 2016 hospital discharges; Legend: CA-Calhoun, CL-Cleburne, T-Talladega

Further validation of the zip code service area delineated in the preceding figure, was mapped to HCACA's 3-hospital system's emergency room/department (ED) (outpatient) utilization for the same period in time (2016 calendar year) for which, RMC-Anniston alone, reported 36,944 total visits. Of these total ED visits, 18% (6,832) were admitted as inpatients to the hospital and 21% (7,905) were for primary care visits only to the ED (Primary Care Levels 1 and 2). It should be noted that the same zip codes for ED visits (75%) correspond to the above patient origin study/discharge analysis for the three hospitals combined.

The three counties delineated as the Community Served by the Health System in the above figure, of which Calhoun County is the "dominant" county and where the three hospitals are domiciled, are all MUA-designated by HRSA's SDB as demonstrated in Attachment B. Calhoun County's Index of Medical Underservice (IMU) score is 61.90, Cleburne County is 61.10, and Talladega County is 45.20 ***(Source: HRSA Geospatial Website***). 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***). It should be noted that HCACA has a significant ambulatory care presence as well in Randolph County by operating Rural Health Clinics (RHC), including the expansion of services to the Roanoke RHC originally purchased in 2012.

The community (primary service area) served by the health system, 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 Uniform Data System (UDS) Mapper, a detailed map of which, is included in Attachment C along with other maps in Attachment D of this report. The combined eleven-zip code community (service area) constitutes a total population of 152,402 ***(Source: U.S. Census Bureau, 2010 Census)***, including 65,633 (43.1%) low-income individuals, those having income equal to or less than 200 percent of federal poverty level.

Figure 2 - Community Served by the Health System – Population

Zip Code	Place	County	Total Population 2011-2015	Low-Income Population 2011-2015	Low-Income % Total Population 2011-2015
Total Zip Codes			***152,402***	***65,633***	***43.1%***
36201	Anniston	CA	18,544	10,981	59.2%
36203	Oxford	CA, CL, TA	18,138	6,252	34.5%
36207	Anniston	CA	20,679	7,852	38.0%
36265	Jacksonville	CA	20,833	8,581	41.2%
36206	Anniston	CA	12,138	5,575	45.9%
36264	Heflin	CL	8,375	3,850	46.0%
36272	Piedmont	CA	12,229	5,114	41.8%
36277	Weaver	CA	4,846	1,427	29.4%
36271	Ohatchee	CA	5,959	2,158	36.2%
35160	Talladega	TA	26,320	11,773	44.7%
36260	Oxford	TA	4,341	2,070	47.7%

Source: UDS Mapper June 22, 2017, udsmapper.org 2017, U.S. Census/2011-2015 American Community Survey (ACS)

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 608 square miles and based on the July 1, 2016 U.S. Census Bureau population estimates of 114,611, the population density is 188.5 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, HCACA will detail the description of the process used by the health system to take into account input from persons who represent the broad interests of the community served by the 3-hospital health system. HCACA will detail the description of the process and methods used by the health system to conduct the CHNA including sources of information and collaboration with other organizations.

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

- Internal Revenue Service (IRS) Notice 2011-52;
- IRS Instructions for Schedule H (Form 990);
- Federal Register, Vol. 79, No. 250, 12/31/2014;

- HCACA: Anniston, Jacksonville, and Stringfellow internal and external reporting information;
- U.S. Census Bureau, 2010 Census, American FactFinder, April 10, 2010 – July 1, 2016, Population Estimates, U.S. Census QuickFacts;
- American Community Survey (ACS) 2011-2015;
- American Hospital Directory – www.ahd.com;
- National Cancer Institute, SEER Cancer Statistics 2010-2014;
- Health Resources and Services Administration (HRSA) Geospatial Website – www.hrsa.gov;
- HRSA Community Fact Sheets (Calhoun, Cleburne, and Talladega Counties);
- UDS Mapper (2015 reporting) - www.udsmapper.org;
- HRSA/Shortage Designation Branch (SDB);
- Alabama Department of Public Health (ADPH) Selected Health Status Indicators (Calhoun, Cleburne, and Talladega Counties);
- Local Health Departments (Calhoun, Cleburne, and Talladega Counties);
- HRSA Community Health Status Reports;
- Centers for Disease Control and Prevention (CDC) – Behavioral Risk Factor Surveillance System (BRFSS) – www.cdc.gov 1999-2014;
- Kaiser State Health Facts, Kaiser Family Foundation - kff.org
- Alabama Cancer Facts & Figures 2015;
- Alabama Statewide Cancer Registry 2016: Data Years 2004-2103;
- Alabama Center for Health Statistics, 2015 – County Health Statistics, County Health Profiles;
- National Women's Law Center, 2010;
- KidsCount.org, Annie E. Casey Foundation 2015;
- Robert Wood Johnson Foundation (RWJF) County Health Rankings 2012-2014, 2017/other reports; and
- Patient Protection and Affordable Care Act (P.L. 111-148) of 201.50 (PPACA and ACA).

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

The CHNA process utilized national-level data from the above-mentioned sources (U.S. Census Bureau/American Community Survey, HRSA, CDC, SAMSHA, Kaiser), many of which contain valuable county-level data, for example, from HRSA, Community Fact

Sheet and Community Health Status Report. Examining this data helps identify areas where local Calhoun County or State data can fill critical gaps or where national data can be enhanced.

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

Regarding national sources in data gathering and analysis for the CHNA, HRSA and the CDC are important agency sources, especially regarding projects that involve health needs and health disparities. HRSA is an agency within the U.S. Department of Health and Human Services (HHS). As the Nation's "Access Agency," HRSA focuses on uninsured, underserved, and special needs populations. The HRSA Geospatial Data Warehouse provides a single point of access to current HRSA information, health resources, and demographic data for reporting on HRSA activities and Federally-funded community health centers. 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 and more. HRSA's and CDC's resources assist communities plan, implement and evaluate community health interventions and programs to address chronic disease and health disparities issues.

C. Population, Socioeconomic, and Demographic Profile

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

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

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

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

Physicians realize the impact that these unmet social needs for their patients are critical. but don't know how to help address them. Moving from physicians to hospitals, another May 2017 RWJF report mentions hospitals and health systems have a tradition of serving the need of their communities—of not only improving community health by providing healthcare services, but also of bolstering the local economy and quality of life, which supports their charitable purpose and mission of providing community benefit in addressing unmet need in the community. The following sections will take into consideration these characteristics and met/unmet needs for Calhoun, Cleburne, and Talladega Counties.

C.1 Population Age Subgroups and Estimates

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

Figure 3 – Population and Population 2016 Estimates

	Calhoun County	Cleburne County	Talladega County	Alabama State
Population estimates, July 1, 2016	114,611	14,924	80,103	4,863,300
Population, 2010 (April 1) estimates base	118,586	14,972	82,291	4,780,131
Population % change, April 1, 2010 to July 1, 2016	-3.4%	-0.3%	-2.7%	1.7%
Population, 2011-2015 American Community Survey (ACS)	116,648	15,002	81,437	4,830,620
Persons under 5 years, percent, July 1, 2015	5.8%	5.7%	5.4%	6.0%
Persons under 18 years, percent, July 1, 2015	22.1%	23.1%	21.9%	22.7%
Persons 65 years and over, percent, 2015	16.3%	18.8%	16.6%	15.7%
Female persons, percent, 2015	51.8%	50.6%	51.6%	51.6%

Source: U.S. Census Bureau/U.S. Census Quick Facts/American Community Survey (ACS) 2011-2015

It is important to note that the total population in each of the counties in the 3-county service area continues to decline as shown above when comparing 2010 to 2016 and below when comparing the prior CHNA (population 2014 estimate) to the current CHNA (population 2016 estimate), of which, program and service development may be impacted in the future. The 3-county service area decline trend in population, is indicative of many rural areas throughout the country, not just Alabama.

Figure 4 – Population and Population 2014/2016 Estimates Comparison

	Calhoun County	Cleburne County	Talladega County	Alabama State
Population estimates, July 1, 2016	114,611	14,924	80,103	4,863,300
Population, 2014 estimate	115,916	15,080	81,322	4,849,377
Population % change, 2014-2016	-1.01%	-1.01%	-1.02%	1.00%

Source: U.S. Census Bureau/U.S. Census Quick Facts/American Community Survey (ACS) 2011-2015

Regarding the need for children's and adolescent programs, the pediatric population, based on American Community Survey 5-Year Estimates 2011-2015 of Calhoun (25.1%), Cleburne (25.2%), and Talladega Counties (24.6%) - all had a similar, but slightly less percentage of the population that is 0 - 19 years old than the State (25.7%) (Figure 5). Relative to 2014 U.S. Census Population Estimates (Figure 3), Calhoun County's and Alabama's total population are estimated at 114,611 and 4,863,300 respectively, with Calhoun County indicating a 3.4% decrease, whereas the State of Alabama indicates a 1.7% increase from April 1, 2010.

Figure 5 – Pediatric Population

	Calhoun County	Cleburne County	Talladega County	Alabama State
Total population	116,648	15,002	81,437	4,830,620
Under 5 years	6,816	883	4,608	295,054
5 to 9 years	7,538	948	4,567	305,714
10 to 14 years	7,168	1,071	5,794	318,437
15 to 19 years	7,780	876	5,060	324,020
Children 0-19	29,302	3,778	20,029	1,243,225
2011-2015 ACS %	25.12%	25.18%	24.59%	25.74%

Source: U.S. Census Bureau, 2010 Census/American Community Survey (ACS) 2011-2015

The working years' population that is 20 – 64 years old, based on American Community Survey 5-Year Estimates 2011-2015 of Calhoun (59.39%), Cleburne (57.12%), and Talladega Counties (59.8%) – shows that Calhoun and Talladega had a similar percentage of the population that is 20-64 years to the State percentage (59.37%), with Cleburne slightly less than the other two counties.

Figure 6 – Working Years Population

	Calhoun County	Cleburne County	Talladega County	Alabama State
Total population	116,648	15,002	81,437	4,830,620
20 to 24 years	8,646	804	5,294	348,044
25 to 34 years	14,763	1,637	9,792	621,592
35 to 44 years	14,167	1,981	10,744	609,415
45 to 54 years	15,887	2,171	11,599	665,372
55 to 59 years	8,110	1042	6,000	326,349
60 to 64 years	7,706	934	5,268	297,297
Working Years 20-64	69,279	8,569	48,697	2,868,069
2011-2015 ACS	59.39%	57.12%	59.80%	59.37%

Source: U.S. Census Bureau, 2010 Census/American Community Survey (ACS) 2011-2015

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 2011-2015, Calhoun (15.49%) and Talladega (15.58%) Counties had a higher percentage of the population that are 65 years and older than the State (14.89%), with Cleburne (8.87%) dropping significantly than the other counties.

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 2017. The large increase in the average annual growth in the 65+ population between 2000 and 2010, compared to the same between 2010 and 2013 and beyond (2018) clearly demonstrates the aging.

Based on American Community Survey 5-Year Estimates 2011-2015, the State was comparable to the Nation and is projected to have a similar percentage of the population over 65 in 2017, as is the overall United States. As indicated regarding the 2014 U.S. Census Population estimates, Calhoun County's 65 and older population is estimated to increase to 15.49 percent, whereas Alabama's 65 and older population is estimated to increase to 14.89 percent.

Like other parts of the United States, the pediatric population is projected to decline while the 65 and older population is projected to increase. Older people, due to their age and incidence of chronic disease, frequently with co-morbid clinical conditions, are requiring more primary care resources. 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.

Figure 7 – Population 65 and Older

	Calhoun County	Cleburne County	Talladega County	Alabama State
Total population	116,648	15,002	81,437	4,830,620
65 to 74 years	10,400	776	7,637	416,983
75 to 84 years	5,777	304	3,673	220,721
85 years and over	1,890	250	1,381	81,622
Elderly 65+	18,067	1,330	12,691	719,326
2011-2015 ACS %	15.49%	8.87%	15.58%	14.89%

Source: U.S. Census Bureau, 2010 Census/American Community Survey (ACS) 2011-2015

Based on American Community Survey 5-Year Estimates 2011-2015, relative to the need for obstetrical programs (prenatal, postpartum, and delivery), the women of childbearing years' percentage of the Calhoun County population (19.44%) is similar to that of the State, whereas Cleburne (17.03%), and Talladega Counties (18.82%) both had a percentage of the population 15 - 44 years old that is lower than the State (19.59%).

Women of childbearing years are expected to decline into future years for both Calhoun County and for the State of Alabama based on U.S. Census Population estimates. The population of women of childbearing age is declining, which is the nationwide trend as many women move past childbearing age and have a need for women's health and other healthcare services. Rural areas, besides having an increasing percentage of the elderly ages 65 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.

Figure 8 – Women of Childbearing Years

	Calhoun County	Cleburne County	Talladega County	Alabama State
Total Population	114,611	14,924	80,103	4,863,300
15 to 19 years	3,754	442	2,528	158,008
20 to 24 years	3,689	392	2,407	165,297
25 to 29 years	4,217	403	2,729	167,746
30 to 34 years	3,588	453	2,439	155,897
35 to 39 years	3,624	379	2,433	154,460
40 to 44 years	3,407	473	2,538	151,388
Childbearing Years 15-44	22,279	2,542	15,074	952,796
2016 Pop. Estimate %	19.44%	17.03%	18.82%	19.59%

Source: U.S. Census Bureau, 2010 Census/American Fact Finder, April 10, 2010 to July 1, 2016, 2016 Population Estimates

Based on American Community Survey 5-Year Estimates 2011-2015, the median age of Calhoun, Cleburne, and Talladega Counties were all older than the State. Calhoun (39.1) was more comparable to the State (38.4), followed by Talladega County and then Cleburne County with Cleburne's median age of 41.3 years, 3 years greater than the State and Talladega's being 2 years greater than the State. 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.

Figure 9 – Median Age and Male/Female

	Calhoun County	Cleburne County	Talladega County	Alabama State
Total population	116,648	15,002	81,437	4,830,620
Median age (years)	39.1	41.3	40.9	38.4
Male population	56,274	7,334	39,494	2,341,093
2015 Census %	48.24%	48.89%	48.50%	48.46%
Female population	60,374	7,668	41,943	2,489,527
2011-2015 ACS %	51.76%	51.11%	51.50%	51.54%

Source: U.S. Census Bureau, 2010 Census/American Community Survey (ACS) 2011-2015

C.2. Population Race and Hispanic Origin

Relative to racial composition, based on American Community Survey 5-Year Estimates 2011-2015, Calhoun and Talladega Counties are more comparable to the State regarding White and Black/African American percentages. Almost three-quarters of the State (69.5%) is White and more similar to Calhoun (75.6%) and Talladega (64.9%), whereas Cleburne is 94.4% White.

Since 1992, Alabama has experienced a dramatic increase of the Hispanic/Latino population. Alabama's rural population has greater ethnic diversity primarily due to the relatively sudden increase in the Hispanic population. Alabama's Hispanic/Latino population increased by nearly 208% between the 1990 and 2000 Censuses - the seventh greatest increase among all 50 states and this trend has continued into the 2016 census estimates. There is general agreement that estimates of the Hispanic/Latino population are likely to be understated as many are undocumented and as such, do not appear on any official enumerations.

The Hispanic population has risen steadily and now represents 4.2% (2015) of the population vs. 4.1% in 2013 ***(Source: U.S. Census QuickFacts***). This increase in Alabama's Hispanic/Latino population has posed a challenge in counties where this growth has been the greatest. The presence of a language barrier in many instances makes the services of an interpreter necessary. There is also a lack of knowledge about and experience with the cultural differences in providing healthcare to persons of Hispanic/Latino ethnicity. There have also been financial challenges in the service area where Alabama's new Hispanic/Latino population has a low rate of insurance. Alabama's Rural Hospital Flexibility Program subcontract funding has been used to

greatly assist in providing care for Hispanic/Latino Alabamians by securing training in medical Spanish fluency for RMC's emergency department staff.

Figure 10 – Race and Hispanic Origin

	Calhoun County	Cleburne County	Talladega County	Alabama State
White alone, percent, July 1, 2015	75.60%	94.40%	64.90%	69.50%
Black or African American alone, July 1, 2015	21.20%	3.60%	32.60%	26.80%
American Indian and Alaska Native alone, percent, July 1, 2015	0.50%	0.40%	0.40%	0.70%
Asian alone, percent, July 1, 2015	0.90%	0.20%	0.60%	1.40%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2015	0.10%	0.10%	**Z**	0.10%
Two or More Races, percent, July 1, 2015	1.70%	1.20%	1.50%	1.60%
Hispanic or Latino, percent, July 1,2015	3.60%	2.50%	2.30%	4.20%
White alone, not Hispanic or Latino, percent, July 1, 2015	92.20%	72.60%	63.10%	66.00%

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

Source: U.S. Census Bureau, 2010 Census/American Community Survey (ACS) 2011-2015

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

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

The health status in Calhoun, Cleburne, and Talladega Counties can be expected to decline as the population ages, the extent of which will be somewhat related to

preventive seeking and healthy behaviors of the population throughout their life cycle as well as the ability of the healthcare system to respond to the population needs. Just as alarming is the fact that between 2010 and 2014, is the decline in the total population in both Calhoun (-2.3%) and Talladega (-1.2%) 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 figure below from the Kaiser Family Foundation, which also shows that Hispanics and Asian/Pacific Islanders have lower death rates;
- Relative to 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 18% higher respectively and while the overall death rates have declined in the U.S., they have increased in Alabama since the last CHNA performed in 2015; and
- ADPH 2015 reports show an overall improvement in AL Infant Mortality Rate (IMR); however, the IMR gap between Black (15.3) and White (5.2) babies is huge and growing, with the former dying at three times the rate of the latter with the AL state rate (8.3) one of the highest in the U.S.

Figure 11 - 2014 Deaths/100,000

	U.S.	AL
Overall Death Rate	724.6	909.1
White	725.4	897.7
Black	849.3	979.5
Other	421.5	257.3

Source: Kaiser State Health Facts, Kaiser Family Foundation – kff.org

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

Inequalities in income and education underlie many health disparities and generally, population subgroups that suffer the worst health status are also those that have the highest poverty rates and the least education. Poverty is generally more common among racial and ethnic minorities, thereby adversely affecting health status by decreasing healthcare access and contributing to lifestyles and behaviors that place individuals at risk for chronic disease. Chronic disease management has become a more apparent issue as our country ages, affecting both urban and rural areas.

Based on the American Community Survey 5-Year Estimates 2009-2013, 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 median value indicators by approximately one-third. The absolute amounts are not projected to change drastically over time.

Figure 12 - Median Household Income

	Med HHD Income	Med Value Housing Units	Members HHD Size
Calhoun County	$41,703	$105,900	2.52
Cleburne County	38,056	108,000	2.57
Talladega County	35,155	93,400	2.48
Alabama – Statewide	43,623	125,500	2.55

Source: U.S. Census Bureau, 2010 Census/American Community Survey (ACS) 2011-2015/U.S. Census QuickFacts

Other selective socioeconomic indicators from the Health Resources and Services Administration's (HRSA) Community Fact Sheets (Attachment G) show the difficulties that children and families in Calhoun, Cleburne, and Talladega Counties face relative to living in poverty. Specifically, 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.

Figure 13 – Selective Socioeconomic Indicators

Indicator	Calhoun County	Cleburne County	Talladega County
Family Poverty Below Poverty Level 100% 2011-2015	16.49%	10.60%	19.35%
Family Poverty Below Poverty Level 150% 2011-2015	25.49%	18.09%	30.16%
Family Poverty Below Poverty Level 200% 2011-2015	35.98%	33.97%	40.67%
Estimate Living Below USFPL All Ages 2010	18,450	2,217	14,835
Estimate Living Below USFPL Ages 0-18 2005	9,818	1,160	8,376
Uninsured Adults Age <65, 2014	12,729	1,593	8,283

Source: HRSA Community Fact Sheets/RWJF County Health Rankings (Uninsured) 2012-2014

Educational issues further compound the income disparities, particularly among children. In two key indicators below (percent of population ages who have graduated from high school and percent of teen population who are not at school and not working), Calhoun, Cleburne, and Talladega Counties' children are shown to be at a disadvantage compared to the State overall. Further, all three counties have higher percentages of children in poverty compared to the State and both Calhoun (40.0%) and Talladega (45.0%) have higher percentages of children in single-parent families.

Figure 14 - Education Indicators

Indicator	Calhoun County	Cleburne County	Talladega County	Alabama State
High School Graduation	88.0%	96.0%	90.0%	86.0%
Children in Poverty	31.0%	28.0%	31.0%	27.0%
Unemployment	6.8%	5.6%	6.4%	5.9%
Children in Single-Parent Families	40.0%	25.0%	45.0%	38.0%
Percent of population who are school dropouts	0.6%	0.1%	0.4%	0.8%
Percent of teen population ages who are not at school and not working	9.8%	8.5%	15.3%	9.5%

Source: KidsCount.org, Annie E. Casey Foundation 2015/RWJF County Health Rankings 2012-2014

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 figure, 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. The U.S. rate of 25% is high and all three counties and the State of Alabama are even higher, indicating an unhealthy community.

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

Figure 15 - Selected Behavioral Risk Factors

Indicator	Calhoun County	Cleburne County	Talladega County	AL	U.S. Median
Percent of adults who are currently smoking	20%	18%	22%	21%	17%
Obese: BMI greater than 30 (note: all are high)	32%	30%	39%	34%	31%
Quality of life – percent in poor or fair health	22%	17%	24%	21%	16%
Adults 20+ with no leisure time physical activity	31%	30%	34%	28%	26%
Access to exercise opportunities	59%	40%	66%	63%	62%
Adults with binge drinking in last 30 days or daily heavy drinking	15%	15%	13%	13%	17%
Medicare diabetics receiving HbA1c in past year	81%	83%	83%	85%	86%
Medicare enrollees (age 67-69) receiving mammography screening	57%	49%	58%	63%	61%
Food environment index based on factors with ranking 0 to 10	6.1	7.9	6.2	6.5	7.3
Percent of live births with low birth weight (<2500 grams)	9%	9%	12%	10%	8%
Infant Mortality Rate	8	N/A	13	9	5
Teen Birth Rate per 1,000 female ages 15-19	45	54	44	41	38
Sexually Transmitted Infections (STI) – chlamydia new cases per 100,000 persons	723.9	213.4	695.5	600.2	294.8
Air pollution – Average daily density of fine particulate matter/micrograms per cubic meter 2.5	11.6	10.3	11.4	10.1	9.2
Hospitalization rate for ambulatory sensitive conditions per 1,000 Medicare enrollees*	71	72	72	61	56

Sources: RWJF County Health Rankings 2017

Despite these indicators, and the relatively high rates shown below, screening indicators are similar in Alabama and the U.S. Exceptions are the level of diabetes (adults and adult women) and child obesity, giving rise to future, potential chronic disease management problems. County level data is not available for many of the indicators.

Figure 16 - Additional Selected Behavioral Risk Factors

Indicator	Calhoun County	Cleburne County	Talladega County	AL	U.S.
Adults 65+ who had a flu shot in past year	NA	NA	NA	61.6%	60.8%
Children 0-17 who had both a medical and dental preventive care visit in the last 12 months	NA	NA	NA	69.7%	68.1%
Adults told by Dr. they have Diabetes	NA	NA	NA	13.5%	10.4%
Adult women who have been told they have Diabetes	NA	NA	NA	14.0%	10.0%
Adults self-reported current Asthma Prevalence Rate	NA	NA	NA	9.9%	8.8%
Children 0-17 who are overweight or obese	NA	NA	NA	35.0%	31.3%
Adults who visited dentist in past year any reason	NA	NA	NA	60.0%	64.4%

Sources: Kaiser State Health Facts, Kaiser Family Foundation kff.org

Likely, as the result of some of the behaviors identified above, as well as other issues, the population in the three counties has worse access to primary care providers, behavioral health providers, or other providers in the healthcare system, and sees itself as sicker with less social and emotional support than the State and is above the benchmark in almost all areas, as indicated by the 90th percentile in the U.S. The number of poor mental health days per month is a predictor of future health, forecasting office visits, and hospitalizations. Poor mental health can lead to suicide.

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

Indicator	Calhoun County	Cleburne County	Talladega County	AL	U.S. Median
Fair or Poor Health reported in Adults	22%	17%	24%	21%	16%
Physically Unhealthy Days in Adults in Last Month	4.9	4.1	4.7	4.5	3.8
Mentally Unhealthy Days in Adults in Last Month	4.7	4.3	4.7	4.4	3.8
Frequent Mental Distress	14%	13%	15%	14%	9%
Excessive Drinking	15%	15%	13%	13%	12%
Uninsured, Adults under 65 years	14%	14%	13%	14%	14%
Ratio of Population to PCP	1,510:1	3,770:1	3,010:1	1,550:1	2,030:1
# social orgs. 10,000 pop - social/emotional support	14.7	8.6	12.1	12.4	12.6
Food Environment Index – Healthy food 0-10 scoring	6.1	7.9	6.2	6.5	7.3

Sources: Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS) 2010/RWJF County Health Rankings 2017

The 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. In Alabama compared to the Nation, males/females combined (KFF, 2015), Whites, Blacks, and Hispanics are 11% vs. 8%, 14% vs. 12%, and 28% vs 17% respectively. This situation is exacerbated relative to women of color. The National Women's Law Center's 2010 Healthcare Report Card used in the 2012 CHNA showed a dramatic difference in the percentage of uninsured women across racial/ethnic groups. Based on the KFF's findings (2013), this trend continues, indicative of both the country and state. This likely contributes to poorer health among the uninsured groups, particularly if there is not a strong community of caring for them.

Figure 18 - Uninsured Women by Ethnicity

Race/Ethnicity	% Uninsured of Adult Women- U.S.	% Uninsured of Adult Women- AL
White	12%	17%
Black	17%	18%
Hispanic	26%	34%
Other	15%	N/A
Total	15%	18%

Source: U.S. Census Bureau, 2013 Census/National Women's Law Center 2010

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

Children who witness the violence also have neurological, mental and physical health issues. Only a small percentage of primary care physicians indicate that they routinely inquire about IPV; 6% of internists, 10% of family practitioners and 17% of OBGYNs. There is no specific data on IPV in the three counties against adults but the level of abuse against children is higher in the counties compared to the State. This is especially so in Cleburne (17.0) and Talladega (16.2) as indicated in Kidscount.org in 2015. The 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.

Figure 19 - Indicators of Abuse Among County Children

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

Source: KidsCount.org Annie E. Casey Foundation 2015

Healthy behavior generally varies widely across different age groups and also across different races and ethnicities. National trends delineate that adults < age 65, males, racial and ethnic minorities, and adults in poverty are more likely to engage in unhealthy

behaviors as contrasted to older adults, women, whites, and adults with higher incomes. Whatever the population subgroup, healthy behaviors are related to many complex social, biological, and environmental factors and the BRFSS and ADPH information needs to be used to target health education programs to population subgroups.

In addition, any programs that target specific population subgroups need to be tailored to remove financial, cultural, and other barriers to access. This requires an approach that needs to be coordinated with both other provider and non-provider members of the community relative to the 3-county service area.

E. Health Indicators – Incidence and Mortality

The implications of the behaviors and related health status outlined in the prior section can be further supported by Incidence and Mortality data. As shown below, the U.S., AL, and each of the counties have similar leading causes of death, but in slightly different orders. Heart Disease, Cancer and Chronic Lower Respiratory Disease (CLRD) rank #1, #2 and #3 for all three counties, as it does for AL and U.S. respectively. In Calhoun County, Alzheimer's Disease appears in the top five and Accidents does not, unlike the others. For Talladega County, Accidents as a leading cause of death is higher than in the other areas and ranked at #4.

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

Rank	U.S.	AL	Calhoun County	Cleburne County	Talladega County
1	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease
2	Cancer	Cancer	Cancer	Cancer	Cancer
3	Chronic Lower Resp. (CLRD)	CLRD	CLRD	CLRD	CLRD
4	Cerebrovascular Diseases (Stroke)	Stroke	Stroke	Stroke	Accidents
5	Accidents	Accidents	Alzheimer's Disease	Accidents	Stroke

Source: Center for Health Statistics 2015, County Health Statistics

The figure below summarizes the death rate per 100,000 population for the leading causes of death. In almost all areas, Alabama and the three Counties have higher death rates than the U.S., in some cases significantly higher. The only areas where the rates in the three Counties are not higher than the U.S. are Diabetes and HIV; the State rate is higher. In addition, Cleburne has a lower rate for Cerebral Disease/Stroke. The level of preventable teen deaths ages 15-19 is higher when comparing the State of Alabama to the U.S.

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

Indicator	Calhoun County	Cleburne County	Talladega County	AL	U.S.
Heart Disease	391.8	426.2	294.3	266.9	168.5
Cancer	221.4	206.4	230.0	213.0	158.8
Chronic Lower Respiratory Disease	87.4	179.8	89.0	67.4	41.6
Cerebral Disease/Stroke	56.2	73.2	59.4	60.4	37.6
Influenza/Pneumonia	25.1	20.0	30.9	22.6	15.2
Accidents	50.2	73.2	61.8	52.0	43.2
Preventable Teen Deaths (suicide, homicide, accidents) per 100,000 teens ages 15-19				52.0	36.0
Diabetes	21.6	33.3	34.6	25.8	21.3
HIV	1.7	0.0	4.9	2.6	
Alzheimer's Disease	54.5	66.6	24.7	46.9	29.4

Source: Center for Health Statistics 2015, County Health Profiles/KidsCount.org, Annie E. Casey Foundation 2015

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

Calhoun County has an overall higher incidence rate of cancer in the three counties 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. for all three counties and less than the U.S. Cleburne and Talladega Counties have overall lower incidence rates than Calhoun but in Cleburne County, the black population (both males and females) has a higher incidence than the U.S. and the white female population has a lower incidence; this is particularly striking relative to black incidence. In all areas, black males have a higher incidence than white males, and in most areas, black females have a lower incidence than white females, except Cleburne County where black females are significantly higher than white females.

The total population and male and female cancer mortality rates in all three counties and the state are, in the majority, 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.

Figure 22 - Cancer Incidence in Alabama and U.S.

Cancer Incidence: All Cancer	Calhoun County	Cleburne County	Talladega County	AL	U.S.
Total Population	470.2	448.4	467.2	463.6	177.3 to 199.1
Males	598.6	548.3	569.5	561.1	463.8
Females	384.2	377.7	393.9	394.0	408.7
Black Males	630.4	721.8	605.7	609.8	496.4
Black Females	345.9	523.0	353.2	374.9	386.2
White Males	596.8	544.3	554.8	545.6	459.7
White Females	393.0	372.0	409.2	400.2	414.0

Source: Centers for Disease Control and Prevention (CDC) 1999-2014/Alabama Statewide Cancer Registry 2016, Data Years: 2004-2013/Alabama Cancer Facts & Figures 2015

Figure 23 - Cancer Mortality in Alabama and U.S.

Cancer Mortality: All Cancers	Calhoun County	Cleburne County	Talladega County	AL	U.S.
Total Population	221.4	206.4	230.0	213.0	158.8
Males	272.6	282.9	263.0	250.7	193.6
Females	173.7	131.7	199.0	153.9	137.9
Males Black* & Other	182.6	0	185.8	191.4	234.1*
Females Black* & other	125.8	231.5	147.4	143.1	157.0*
White Male	300.4	299.2	303.4	265.4	193.6
White Females	189.9	125.7	227.9	203.0	138.6

*Source: Center for Health Statistics 2015, County Health Profiles/Center for Disease Control and Prevention (CDC)1999-2014 *U.S. ethnic rate is just for Blacks/Alabama Center for Health Statistics 2015*

The Cancers where the incidence is relatively higher in all the Counties and State include Lung/Bronchus and Colorectal for males. Overall, mortality for Colorectal Cancer is similar to the State and U.S. other than in Cleburne. For Breast Cancer and Prostate Cancer, all areas, except in the State relative to Prostate Cancer, as summarized below, the incidence is similar to, or lower than the U.S. incidence, but the mortality is higher. Non-Hodgkin Lymphoma mortality is elevated in Cleburne County and is 20% higher than both State and U.S. rates. Also relative to Cleburne County, Pancreatic mortality is twice both State and U.S. rates.

Figure 24 - Selected Cancer Incidence and Mortality per 100,000 Population (Age Adjusted to the U.S. 2000) 2004-2013

Indicator	Calhoun County	Cleburne County	Talladega County	AL	U.S. (SEER)
Breast Cancer Incidence Female	102.5	92.4	113.2	118.5	123.9
Breast Cancer Mortality	15.6	0.0	17.3	15.1	21.1
Lung and Bronchus Incidence	87.9	73.1	80.8	73.8	58.5
Lung Cancer Mortality	61.4	59.9	66.8	61.4	44.7
Colorectal Incidence Male/Female	67.2/40.2	73.7/35.9	60.9/40.4	56.5/39.8	38.4
Colorectal Mortality	21.6	33.3	22.3	19.8	14.8
Prostate Incidence Male	138.8	111.0	145.7	148.7	95.5
Prostate Mortality	11.2	0.0	9.9	10.2	20.1
Pancreas Mortality	16.4	26.6	11.1	14.1	10.9
Non-Hodgkin Lymphoma Mortality	1.7	6.7	2.5	5.7	5.9

Sources: Alabama Center for Health Statistics 2015, County Health Profiles/ Alabama Cancer Facts & Figures 2015/ Centers for Disease Prevention and Control (CDC) 1999-2014/National Cancer Institute, SEER Cancer Statistics Review 2010-2014

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

Figure 25 - Colorectal Cancer Screening, Adults 50+

Screening	AL	U.S.
Sigmoidoscopy/Colonoscopy	67.8%	67.3%
Fecal Occult Blood Test in Past 2 Years	16.7%	14.2%

Source: Alabama Cancer Facts & Figures 2015, Alabama Statewide Cancer Registry 2016 Data Years 2004-2013

Derived from the Health Status and Health Indicators sections, the following, while not necessarily all-inclusive, demonstrates potential, ***selective*** goal areas to be considered in a healthcare plan specific to HCACA's service area constituting Calhoun, Cleburne, and Talladega Counties with specific relevance to chronic diseases:

- **HEART DISEASE - Problem/Need**: The age-adjusted death rate from heart disease is higher in Calhoun, Cleburne, and Talladega Counties relative to the State and the U.S. rates. The State rate is higher than the U.S. rate. The Counties' and State rates are higher than the Healthy People 2010 target rate of 166.0/100.000 population. The Counties' White rates are higher than Black rates. Hypertension, smoking, high blood cholesterol levels and obesity are all risk factors in chronic heart

disease. Based on the United Health Foundation, America's Health Rankings 2014 report, Alabama ranked 43 of all states relative to obesity, 410,000 more than 10 years ago, plus the state ranked 46 and 47 as to heart disease and heart attacks. Most of the behaviors of the area population show elevated levels for all risk factors, including limited physical activity. Diet and lifestyle interventions should be the treatment focus. ***Healthy People 2020 overall coronary health disease target death rate objective is 103.4 deaths per 100,000 population.***

- **CANCER - Problem/Need**: The age-adjusted death 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. Calhoun and Talladega Counties' White rates are higher than Black rates and the reverse situation exists in Cleburne County. In addition to community education services regarding lifestyle changes that impact on chronic and preventable diseases, programs must be developed that bring patients in to get screened and educated on health awareness so that they don't die at a relatively higher rate from these diseases. ***Healthy People 2020 overall cancer target death rate objective is 161.4 deaths per 100,000 population.***

- **DIABETES - Problem/Need:** The-age adjusted death rate from diabetes is less in Calhoun and Cleburne Counties and Talladega is higher relative to the State rate. Based on the United Health Foundation, America's Health Rankings 2014 report, Alabama ranked 50 of all states relative to Diabetes and the prevalence has doubled in the last 10 years with 481,000 affected with seniors especially affected as to receiving normal HbA1c values. The White and Black rates are comparable in Calhoun and Talladega, with White slightly higher. There is no detailed reporting for Cleburne. However, even though the diabetes incidence, as measured by diagnosed diabetics, was less in the three Counties to the State and U.S., the situation still may exist that people don't not get appropriate treatment and education in a timely manner. It continues to be indicated during the key informant surveys that diabetic treatment is adequate. ***Healthy People 2020 overall diabetes target death rate objective is 66.6 deaths per 100,000 population.***

- **CEREBROVASCULAR DISEASE - Problem/Need:** The age-adjusted death rate from cerebrovascular disease is higher in Calhoun and Talladega Counties and Cleburne is less relative to the State and the U.S. rates. The State rate is higher than the U.S. rate. The White and Black stroke rates are comparable in Calhoun and Talladega, with White higher in Talladega and Black slightly higher in Calhoun. There is no detailed reporting for Cleburne. Lifecycle changes such as improving blood cholesterol levels, eating a heart-healthy diet, etc. through community education services will have a profound impact on chronic and preventable diseases such as cerebrovascular disease. ***Healthy People 2020 overall stroke target death rate objective is 34.8 deaths per 100,000 population.***

- **CHRONIC LOWER RESPIRATORY DISEASE - Problem/Need:** The age-adjusted death rate from chronic lower respiratory disease is higher in Calhoun, Cleburne,

and Talladega Counties relative to the State rate. The State rate is higher than the U.S. rate. The White rates are significant higher than Black rates when comparing Calhoun to Talladega. Relative to Chronic Obstructive Pulmonary Disease (COPD), smoking cessation remains the most effective, and cost-effective way to reduce the risk of COPD and to stop its progression. Pulmonary rehabilitation can reduce symptoms, improve quality of life, and increase physical and emotional participation in everyday activities. ***Healthy People 2020 overall COPD target death rate objective is 102.6 deaths per 100,000 population.***

- **CHANGES IN NEGATIVE LIFESTYLE BEHAVIORS: SMOKING CESSATION AND OBESITY - Problem/Need**: Tobacco is the major contributing factor to premature deaths from heart disease, stroke, cancer, and chronic obstructive pulmonary disease (COPD). Smoking, as well as other risky behaviors is higher among Alabama's population compared to other states and the U.S. relative to percentage of adults who are current smokers, thereby delineating AL at 21% compared to the U.S. at 17% based on RWJF's state and county rankings 2017 reporting. Another sample determinant and ranking is adult obesity with AL at 34% versus 31% for the U.S. relative to the percentage of adults reporting BMI $\geq$ 30. This indicates a negative lifestyle that needs to be worked on with the whole community, which contributes to short and long-term health problems. ***Healthy People 2020 overall objectives to reduce cigarette smoking by adults (ages 18+) is 12.0% and by adolescents (past month, grades 9-12) is 16.0%.***

- **TEEN PREGNANCY PREVENTION, ADOLESCENT RISK REDUCTION - Problem/Need**: The teen birth rate (ages 10-19) is significantly higher for all three service area counties (Calhoun, Cleburne, and Talladega), than the State (Alabama is ranked 42 in 2014 reporting) and the U.S. According to Healthy People 2010, approximately 77% of births to adolescents, ages 15-19 years are unintended. The Healthy People 2020's Objective is to increase the proportion of pregnant women who receive prenatal care beginning in the first trimester to 77.9% of all females. Adolescents are more likely to engage in risky behaviors, such as smoking, substance use and abuse, unprotected sex/high chlamydia rate, and driving recklessly. ***Healthy People 2020 overall infant mortality rate objective (one year) is 6.0 infant deaths per 1,000 live births and for pregnant women ages 15-44, the objective to increase abstinence from alcohol among pregnant women is 98.3 percent.***

- **BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE ABUSE): NATIONWIDE AND STATEWIDE OPIOID EPIDEMIC - Problem/Need**: With 4.9 million+ residents, Alabama struggles with its fair share of mental health and substance abuse issues. Depression and other mental health diagnoses are as common as alcoholism, heroin addiction, and prescription painkillers i.e. opioids. AL prescribes the most opioids in the nation with 5,840,754 pain pills prescribed in the State in 2015, which averages to 1.2 prescriptions per person, as reported by The AP and the Center for Public Integrity. The number of overdose deaths from prescription painkillers has claimed the lives of 165,000 people in the U.S. since

2000. In 2014, there were 723 deaths due to drug overdose in AL versus the prior year's 598 deaths. A main reason for failure to address need has been separation between care for the substance abuse diagnosis and the rest of the healthcare system. Despite the stigma surrounding substance abuse, the opioid crisis touches a wide-range of the population, including people with stable lives, jobs and families, and workplaces too. The need to start/expand mental health and substance abuse services and to integrate with primary care services is critical with a specific focus on treatment, prevention, and awareness of opioid abuse. ***Relative to opioid abuse, specifically, the objective is to "reduce the past-year nonmedical use of prescription drugs," however, currently there is no Healthy People 2020 objective.***

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. Part of the impetus has been coming from payor pressures and from states as well (regardless or not if they chose health reform) to simultaneously reduce cost, improve quality, and implement value-based payment programs which will, in turn, require organizations to examine how to best manage the health of their patient populations. Many of the strategies will be through increasing care coordination and preventive services.

The national Affordable Care Act ("ACA") expands coverage for a wide range of prevention and wellness services, by increasing incentives for employers that establish wellness programs and eliminating copayments for immunizations, screenings, and other clinical preventive services. Health reform is forcing provider systems to be accountable for the full breadth of care, beyond the hospital and physician office. Programs such as the elimination of payment for unnecessary hospital readmissions, the development of delivery payment pilots for bundled services, medical home demonstrations, coordination grants, and increased financial support for health centers (FQHCs) encourage partnerships between hospitals and other community organizations. ACA creates a fund to provide sustained national investment in preventive and public health programs, including those offered by hospitals to increase access to clinical preventive services and create healthier communities.

A central goal of the ACA is to significantly reduce the number of uninsured by providing a continuum of affordable coverage options through Medicaid and the Health Insurance Marketplaces, hence the national investment in preventive and public health programs. But AL hasn't expanded Medicaid under the ACA, so the poorest residents in the state have not benefited from the ACA.

Alabama uses the federally-facilitated marketplace; AL residents enroll in exchange plans through Healthcare.gov. The federal government operates the health insurance marketplace in AL, based on Gov. Robert Bentley's November 2012 decision against a state-run marketplace. Humana and Blue Cross and Blue Shield of Alabama, which dominate the health insurance market in the state, sold individual health insurance

through the federal marketplace in AL for 2014. UnitedHealthcare joined the exchange for 2015, and its plans are now available through the marketplace in all 67 Alabama counties. However, only Blue Cross and Blue Shield of Alabama remains for 2017.

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

Blue Cross Blue Shield of Alabama is the only health insurance carrier offering plans in the AL exchange in 2017. The Blues already insured the majority of the state's exchange enrollees prior to 2017, when there were multiple insurers offering coverage. In June 2017, they confirmed that they would continue to offer coverage in all counties in AL in 2018. For 2018, Bright Health is joining the AL exchange, but only in the Birmingham metropolitan area (excludes the HCACA 3-county service area). According to a U.S. Department of Health and Human Services (HHS) report released in December 2016, the number of people in Alabama with health insurance increased by 215,000 from 2010 to 2015 as a result of the ACA. This includes young adults who have been able to remain on a parent's plan and people who enrolled through the exchange, as well as people who have gained coverage through other avenues.

As indicated above, AL hasn't expanded Medicaid under the ACA, so the poorest residents in the state have not benefited from the ACA. Although expansion has been considered by lawmakers and by former Governor Bentley, they never moved forward with it. Expanding Medicaid helps to stabilize the risk pools in the individual market by taking those with the lowest incomes out of the private market. In states like AL, where Medicaid has not been expanded, premium subsidies are available in the exchange to people with income at or above the poverty level.

But 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.

Since Medicaid has not been expanded, low-income AL residents would not see as much of a change if the ACA were to be repealed as their counterparts in states that have expanded Medicaid. In 2016, five health insurance carriers offered individual market coverage in Alabama, including UnitedHealthcare and UnitedHealthcare Life, but only three — Humana, Blue Cross Blue Shield of Alabama, and UnitedHealthcare, offered plans in the exchange. Also, Blue Cross Blue Shield of Alabama covered the majority of the state's exchange enrollees. But United and Humana both left the Alabama exchange at the end of 2016, leaving just the Blues.

The Alabama Department of Insurance confirmed that both carriers' exits applied to the entire individual market in the state, so individual market United and Humana plans have not available on or off-exchange in Alabama in 2017. 171,641 Alabamians signed up for qualified health plans (QHPs) through HealthCare.gov during 2015 open enrollment, according to the HHS. That amount was a significant increase over the 97,870 residents who enrolled during the 2014 open enrollment period.

F. Description of Existing Healthcare Facilities within the Community

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

F.1. Federal Designations and Physician Shortage

Federal criteria relative to healthcare provider need in an area (county or county subset) continues to be predicated on two federal designations: 1) Health Professional Shortage Area (HPSA) and Medically Underserved Area/Population (MUA/P). For purposes of this Community Health Needs Assessment (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 only HPSA – Primary Medical Care designation in Calhoun County is the minor civil division of Piedmont as of the 5/30/2012 last update. The "whole county" of Calhoun has no designation (Geographic Area or Population Group). Cleburne County is wholly designated HPSA (Geographic Area) as of the 3/19/2014 last update and Talladega County is wholly designated HPSA (Population Group – Low Income) as of the 6/22/2011 last update. All three counties ("single county") are HPSA Dental Health-designated. All three counties are HPSA Mental Health-designated ("single county").

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

Figure 26 – Primary Care Indicators

Primary Care Indicator	Calhoun County	Cleburne County	Talladega County
Total Population	115,620	15,018	80,862
Primary Care Physicians Per Population*	76.6	4.0	26.9
Dentists Per Population*	63.9	2.0	21.0
Mental Health Providers Per Population*	103.2	6.0	6.0
Health Professional Shortage Area (HPSA) – Primary Medical Care	In Part	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: HRSA Community Fact Sheets/HRSA Shortage Designation Branch 2015/RWJF County Health Rankings 2017

It should be noted that the above figure 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. RWJF's county rankings shows 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 76.6, 26.9 and 4.0 respectively.

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

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

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

- Expanded medical coverage achieved under ACA once fully implemented, will likely increase demand by about 16,000 to 17,000 physicians over the increased demand resulting from changing demographics.

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

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

Reports from most specialty associations or workgroups project shortages and generally support the AAMC report, including the following:

- Primary Care: Expected 20 to 27% shortfall by 2025 due to aging of population and chronic diseases since those over 65 seek care from PCPs at twice the rate of those under 65. The number of primary care residency graduates has declined each year since 1998. The practice of primary care needs to be made more lucrative and require less administrative work to attract new physicians. Larger group practices and employment options help to alleviate these concerns somewhat. Further, Alabama, has not chosen to expand Medicaid, which could further impact a shortage

of physicians in rural areas in the future, thereby disproportionately affecting already overburdened healthcare resources;

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

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

- Critical Care: Demand will exceed supply through 2020;

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

- Emergency Medicine: Demand increased 32% and supply dropped 7%; crowding due to aging of population relative to co-morbidity arising from chronic disease management, lack of on-call specialists and greater use of ED for non-emergency issues. This is critical as KFF 2015 reporting shows AL the 2nd highest state in the U.S. regarding hospital ED visits per 1,000 population – 262 versus 63 for the U.S. More FQHC collaboration and/or site/service development (i.e. free clinic on West Side) could stem the tide in a more appropriate and less costly setting than hospital EDs;

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

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

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

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

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

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 the Affordable Care Act 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 is especially apparent for the low-income population (income equal to or less than 200% of federal poverty level) of the Calhoun, Cleburne, and Talladega Counties combined service area. Even with the presence of now 4 satellite Federally Qualified Health Center (FQHC) site in the three-county service area by Quality of Life Health Services, Inc. (Calhoun/Anniston-2, Cleburne/Heflin-1, Talladega/Talladega-1), there remains a significant void in primary medical care capacity in the three counties combined and it should be noted that that this Gadsden-based FQHC network organization has received additional section 330 dollars for New Access Point (NAP) satellite site expansion during ACA health reform.

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 eleven-zip code community (service area) constitutes 152,402 total, general civilian population ***(Source: U.S. Census Bureau)***, which includes 65,633 (43.1%) low-income individuals, those having income equal to or less than 200 percent of federal poverty level. The low-income percentage is comparable to prior CHNAs, but clearly, almost one-half of the total population is low-income.

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

Zip Code	Place	County	Total Population 2011-2015	Low-Income Population 2011-2015	Low-Income % Total Population 2011-2015
Total Zip Codes			***152,402***	***65,633***	***43.1%***
36201	Anniston	CA	18,544	10,981	59.2%
36203	Oxford	CA, CL, TA	18,138	6,252	34.5%
36207	Anniston	CA	20,679	7,852	38.0%
36265	Jacksonville	CA	20,833	8,581	41.2%
36206	Anniston	CA	12,138	5,575	45.9%
36264	Heflin	CL	8,375	3,850	46.0%
36272	Piedmont	CA	12,229	5,114	41.8%
36277	Weaver	CA	4,846	1,427	29.4%
36271	Ohatchee	CA	5,959	2,158	36.2%
35160	Talladega	TA	26,320	11,773	44.7%
36260	Oxford	TA	4,341	2,070	47.7%

Source: UDS Mapper June 22, 2017/ U.S. Census/American Community Survey (ACS) 2011-2015

Based on HRSA's Uniform Data System (UDS) Mapper 2015 reporting required of all FQHCs, less than twenty percent (13,066 – 19.9%) of the total zip codes' low-income population (65,643) is being served by all FQHC organizations of which, the predominant FQHC is Quality of Life Health Services, Inc. The remainder, which totals 52,567 low-income individuals (with income less than or equal to 200% of federal poverty level), is not currently served by any FQHC organization and consequently, there remains 80.1 percent primary medical care capacity or "unmet need" for the low-income population relative to the combined eleven-zip code service area. This is even greater when consideration is given to total three-county service area of Calhoun, Cleburne, and Talladega Counties (all zip codes). The unmet need percentage basically has remained the same, even with $11 Billion of Affordable Care Act operational and capital grant funding provided to FQHCs throughout the nation over a five-year period.

Quality of Life Health Services, Inc. has been the recipient of such funding, but no Federal U.S. Public Health Service Section 330/HRSA grant funding has been reported directly to Calhoun County. Quality of Life Health Services, Inc. has increased comprehensive preventive and primary medical care access for the predominantly low-income population in the three-county service area, as well as in Randolph County. With assistance in part from New Access Point (NAP) Section 330/HRSA funding provided by ACA health reform, QLHS service delivery sites are as follows: 1) 1316 Noble Street, Anniston (Calhoun); 2) 601 Leighton Avenue, Anniston (Calhoun); 3) 64 Giles Street, Heflin (Cleburne – 14 miles from Anniston); and 4) 110 Spring Street N., Talladega (Talladega – 22 miles from Anniston). Quality of Life Health Services, Inc. is based

corporately in Gadsden in contiguous Etowah County to the northwest of Calhoun County.

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

Zip Code	Place	County	Low-Income Population 2011-2015	Low-Income Served by Existing FQHCs	Low-Income % Served by Existing FQHCs	Low-Income Unserved by Existing FQHCs	Low-Income % Unserved by Existing FQHCs
Total Zip Codes			***65633***	***13066***	***19.9%***	***52567***	***80.1%***
36201	Anniston	CA	10981	3614	32.9%	7367	67.1%
36203	Oxford	CA, CL,TA	6252	1287	20.6%	4965	79.4%
36207	Anniston	CA	7852	1326	16.9%	6526	83.1%
36265	Jacksonville	CA	8581	833	9.7%	7748	90.3%
36206	Anniston	CA	5575	892	16.0%	4683	84.0%
36264	Heflin	CL	3850	1735	45.1%	2115	54.9%
36272	Piedmont	CA	5114	816	16.0%	4298	84.0%
36277	Weaver	CA	1427	251	17.6%	1176	82.4%
36271	Ohatchee	CA	2158	356	16.5%	1802	83.5%
35160	Talladega	TA	11773	1661	14.1%	10112	85.9%
36260	Oxford	TA	2070	295	14.3%	1775	85.7%

Source: UDS Mapper June 22, 2017/U.S. Census/American Community Survey (ACS) 2011-2015

F.2. Existing Healthcare Facilities

The CHNA offers providers such as HCACA the ability to engage their communities in their service area in identifying, addressing, and prioritizing community health needs. The description by facility type, number, and licensed capacity of existing healthcare facilities within the Calhoun, Cleburne, and Talladega service area community available to meet the community health needs identified in this CHNA are presented in the following figure (based on ADPH reporting, authorized bed capacity and validated by HCACA hospitals reporting).

Figure 29 – Existing Healthcare Facilities

Facility Type - Description	Calhoun County	Cleburne County	Talladega County
Ambulatory Surgical Centers	1	0	0
Assisted Living Facilities	6 (205 beds)	0	3 (68 beds)
Assisted Living Facilities (Specialty Care)	4 (140 beds)	0	1 (16 beds)
Community Mental Health Centers	0	0	0
End Stage Renal Treatment Centers	7 (89 stations)	0	4 (73 stations)
Federally Qualified Health Centers (Core/Satellite)	1	0	0
Home Health Agencies	2	0	4
Hospices	4	0	56
Hospitals – General Acute	3 (552 beds)	0	2 (285 beds)
Hospitals – Specialized	1 (38 beds)	0	0
Independent Clinical Laboratories	14	1	11
Independent Physiological Laboratories	1	0	1
Nursing Homes	5 (667 beds)	1 (82 beds)	5 (468 beds)
Rehabilitation Centers	1	0	0
Rural Health Clinics	0	0	8

Source: Alabama Department of Public Health (ADPH) August 28, 2017

The Calhoun, Cleburne, and Talladega service area hospitals still constitute four 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
323 bed General Hospital
Authorized bed capacity: 323

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

HCACA - RMC Jacksonville
Jacksonville, AL 36265
104 bed General Hospital
Authorized bed capacity: 104

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

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

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

G. Input from the Community

Based on IRS Notice 2011-52, "Treasury and the IRS intend to provide that a 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, including those with special knowledge of or expertise in public health. To accomplish this task, EXEC developed survey instruments (example and summary in Attachment H), which were used in a personal interview survey process. A particular survey instrument was used with community physicians in an effort to ascertain additional insight with regard to perception of HCACA meeting community needs by the physician community practicing in the primary service area of HCACA.

In order to be compliant with IRS Notice 2011-52, the process that EXEC utilized, encompassed conducting interviews with key individuals, as recommended by the HCACA Management Team, which were performed at the hospital; at governmental; private, and public organizations; physician offices, school boards, and elsewhere in the community during November of 2017. 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 qualitative 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.

Interviews were conducted by EXEC's Executive Vice President and by a Board-Certified Health Care Executive (Fellow American College of Healthcare Executives-FACHE), of which both healthcare professionals have considerable knowledge of the health indicators of the HCACA primary service area, and they both possess backgrounds in healthcare delivery with specific knowledge of hospital/medical center delivery systems, and experience in conducting personal interviews. The following sections provide the detailed findings of the survey process.

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

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

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

1. Physician Group I (Primary Care) Interview Results

A private practice pediatrician with over fifteen years of practice experience in this community was interviewed. Although HCACA employs a hospitalist group for inpatient coverage for adult services, the medical staff pediatricians admit and follow pediatric patients. This physician shares hospital call coverage with 7 other pediatricians on the hospital staff and therefore, is capable of providing valuable insight. Furthermore, this physician's spouse is leader of the hospitalist group serving HCACA. This physician and associates view the service area of their practices to be the same as that of HCACA.

- The interviewee reported that the "hospital" could do a better job in supporting the private pediatric practice. It was stated that pediatrics is losing market share to the Birmingham-based services.

- When asked about the practice relationship with the hospital…
  - the interviewee reported a good relationship however did state that the "hospital" provides no compensation for private practice physicians "taking call" for the hospital.

- The practice has a low percent of uninsured patients, with about 45% of the patients having Medicaid coverage and 45% commercial insurance.

- Wait times for new patient appointments was reported to be less than one week and same day appointments available for current patients. Most new patients occur as a result of other patient referral or "word of mouth"…
  - the physician stated that HCACA could do more "advertising" and organizing of community events for pediatric services.

- The practice uses an electronic medical record, e-prescribes for pharmacy services and the EMR is linked to LabCorp for laboratory services. The practice meets meaningful use criteria (level II) and also meets or exceeds BC/BS of Alabama quality standards; however, the practice is not recognized by the National Committee for Quality Assurance (NCQA) as a patient-centered medical home (PCMH).

- The practice was queried relative to waiting times for new patient appointments, of which the practice reports wait times of about 2 weeks. The practice accepts Medicare, Commercial and Private Pay Patients. It does accept Medicaid but only as a secondary payer…
    - the physician interviewed representing the practice, reported that the practice has a very low percent (single digits) of uninsured patients.

- When asked about the adequacy of the number of primary care or specialty physicians in the community…
    - it was stated that there is adequate number of pediatricians but could benefit from more family practice or internal medicine physicians in the community. This physician also reported a lack of mental health service providers in the community.

The interviewee stated that HCACA pediatric physicians perceive competition from a pediatric advanced practice registered nurse, nurse practitioner, business development effort in the community that is aligned with a Birmingham hospital. There is concern by the HCACA affiliated pediatricians that this will result in eroding market share and shift of business to Birmingham acute care providers. It was stated that HCACA could and should take action to assist in advertising and program development for pediatric practices of the medical staff.

When inquired about perhaps further aligning with the “hospital”, to the extent to even consider employment with the hospital she stated that she and other pediatricians preferred private practice and were not interested in becoming “hospital employees”.

2. Physician Group II (Subspecialty Care) Interview Results

A physician with the subspecialty of Psychiatry was interviewed. The interviewee was recruited to service HCACA’s hospitals’ in-patient program and has been employed by the system for nearly a year. This physician serves as medical director for program and is a full-time employee and consequently routinely interacts with other members of the hospital medical staff, the executive staff, other employees and is regularly exposed to community attitudes and perceptions regarding the adequacy of health care services.

- The service area of this practitioner was the same five-county area as the HCACA system.

- When asked about the worse health indicators and worse disparities in the community…
    - this practitioner responded untreated mental disease, particularly as expressed by substance abuse disorders. This is a current theme expressed elsewhere throughout this interview process.

- When asked about quality measures used in the practice/service…
    - this practitioner reported used a numeric scale that monitors progress numerically.

- Replying to questions about wait times for new patients…
    - the practice responded that wait times are 4 to 6 weeks for new patient appointments in the outpatient setting. The practice accepts all payors and makes arrangements for those unable to pay for services.

- The practice receives referrals from community PCPs, community service agencies, the ER, and "word of mouth".

- The practitioner stated that she communicates primarily via phone with the referring physicians.

- The practice does not use an EMR.

- With respect to opportunities for growth of this service…
    - the practitioner stated the need for more mental health service providers in the service area and stated there is a tremendous unmet need for behavioral/mental health services in the HCACA primary service area. The practitioner stated the need for partial hospital program and intensive outpatient program services in the HCACA primary service area.

- When asked about the need for more primary care physicians in the community…
    - this practitioner identified as having not enough knowledge to adequately respond. With respect to specialty physicians it was stated that there was a need particularly for endocrinologists and rheumatologists.

- When asked about the role of HCACA in practice expansion and the issue of practice/hospital competitors…
    - this practitioner reported that psychiatrists don't view other physician providers as competitors' due to the saturation of

behavioral/mental health needs and the lack of new providers in the service area.

- This practitioner stated that HCACA initiatives around mental health services included such things as providing community education and awareness about mental health and substance abuse – it should be noted that other community members interviewed did not express knowledge about these efforts.

Other queries and results from the physician interview included the following:

- Because this is a subspecialty practice there was little knowledge or interest in patient centered medical home (PCMH) initiatives.

- This practice has no formal process to measure patient satisfaction and reports no negative patient satisfaction

- The practice reported HCACA as user friendly and welcoming MD friendly.

- HCACA could better meet the needs of the community with; more education, more wellness screenings, create more awareness of psychiatric services provided, work and coordinate with NAMI and other MH agencies /organizations.

I. Community Member (Non-Provider) Interview Questions and Results Summary

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

- The Calhoun County Health Department,
- East Alabama Planning Commission,
- Agency on Aging and Disability,
- Interfaith Ministries of Calhoun County,
- Health Services Center, Inc.
- Anniston City School System,
- Talladega County NAACP, and
- St. Michael's and All Angels Church and Free Health Clinic.

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 (patients) of their respective organizations/agencies.

The participants to the survey logged over one thousand hours per month of community service and collectively represented hundreds of years of community activity/services. It is the opinion of Executive Resources, LLC that these interviews provide a "broad and deep" community perspective and thus very adequately meet the requirement of community participation in the CHNA survey process.

The Community Members interview started with a question asking…"How many years have you lived in the Calhoun County area?"

Obviously, the purpose of this question was to determine the thoroughness of the interviewee's perspective as it might be influenced by the duration one resides in the primary service area of HCACA. In total, the interviewees had hundreds of years' residence in the area- the minimum being 5 years; most over 20 years –some stating "most of my life." The Community Members-from the characteristics of residing in the community –more than adequately represent the community itself.

Community Members were asked… "About how many hours do you spend per month working with or in support of community, civic, religious, or political activities?"

The responses varied, from a minimum of about 20 hours per month to over 200 hours per month. In total, the Community Members reported over one thousand hours of community activity per month; these interviewees should more than adequately – from this particular characteristic - represent the community perspective.

Community Members were asked…"In what role do you experience most of your contact with the community?"

Responses were varied and included the perspective of "employment" or job-related exposure, and religious or social organizations' prospective. The "job or employment related" perspectives and social services organizations/agencies were in the majority as well as planning and philanthropic funding agencies perspectives.

When Community Members were asked…"Indicate what you think the level at which most members of the community attend to their heath needs?"

The responses varied but did concentrate between moderately attentive to moderately inattentive. It did appear that interviewees with the longest duration of "service" and larger service organizations/agencies classified community members as "moderately inattentive". The survey instrument next choice would classify community members as "emergency situation only" – thus a moderately inattentive community member would generally not participate in much, if any, preventative health care activity –and would not regularly participate in primary care.

An individual exhibiting these characteristics would benefit from assignment to an active "patient centered medical home" with outreach and pro-active preventative care components. Often adult and senior citizens characterized as "inattentive," experience

multiple chronic disease conditions that are either marginally or not managed and consequently over utilize the emergency room and acute care services compared to individuals that are "moderately" or very attentive" to their health needs. This therefore may represent a significant opportunity for HCACA to further engage with organizations/agencies whose goals and objectives emphasize "engagement" and "education" regarding the importance of the individual(s) attitude regarding "their health needs."

Community Member interviewees were asked…"Which of the following health related issues have you observed or encountered within the community?"

They were then provided a comprehensive list of conditions from which to choose. Most respondents expressed observing or encountering almost every condition. Thus, the full range of health "conditions" or "issues" the community residents experience was considered in this survey process.

Community Member interviewees were asked…Do you believe that the community has adequate access to the following healthcare services?

a) **Preventative Programs (screenings, education**) - Interviewees more directly servicing low-income/uninsured segment of the community responded "no."

b) **Women's Health Services** – Almost all responded "yes" regarding access to this service. Women's Health Services, often understood to include OB/GYN, Family Planning, and Cervical & Breast Center are services provided to low-income women thru federally-mandated state Medicaid programs – thus are generally perceived by many community members to have "adequate access." However, it is again important to emphasize that ***community members not adequately engaged and responsible for their "health" often access these programs "late***" and consequently result in higher cost for the services to the respective agencies, i.e. late entry into prenatal care.

c) **Surgical Services –** With respect to adequacy of access to these services often the response was **Yes** or **Not-Sure**, it was noted that in emergent situations, access to surgical services was deemed adequate by all respondents. This may be interpreted to mean that financial hurdles to access this service are less when the access to surgical services is via the "hospital emergency room."

d) **Mental Health Services** – Almost all respondents answered "**No**" regarding adequate access to mental health services. Regardless of income level and insurance status, if rated at all, access to mental health services is considered

Not Adequate. Recent increase in public exposure to the opioid addiction crisis in this country has resulted in increased public awareness of substance abuse and mental disease but due to many factors including lack of funding for services, lack of treatment programs, and insufficient number of mental health providers results in making access to service more than problematic. Currently HCACA emergency departments are routinely impacted with patients experiencing psychiatric/mental health crisis meeting these patients care needs is difficult and lack of adequate referral opportunities for these patients contributes to inefficiency in emergency service delivery.

e) **Drug & Alcohol Treatment** – Highly associated with and often underlying chronic mental health disease are the lack of adequate drug and alcohol treatment programs. Respondents that had regular interaction with mostly low-income/poor understood that poverty and drug/alcohol use (dependence) are highly correlated. Drug and alcohol treatment programs in the service area for the low income/poor population are essentially not available. All respondents reported that ***greater emphasis of drug & alcohol education programs – particularly directed at youth*** as a "strategy" that should be of paramount focus.

f) **Dental** – Access to dental care was directly correlated with income from respondents' perspective. Some respondents also reported awareness of the significance of oral (dental) care on overall health status. Poor oral health exacerbates almost all chronic disease conditions thus negatively impacting health and increasing overall health care treatment cost.

g) **Cancer -see below statement**

h) **Cardiac** -
Access for treatment for both these conditions were ***income and insurance status-dependent.*** Access to cancer and cardiac treatment services via hospital emergency room were characterized as accessible, however low-income uninsured were felt to lack access to "routine outpatient" care for these conditions.

i) **Diabetes** – In as much as this condition is more and more prevalent it did generate considerable discussion. The low-income and uninsured community members' access to care for this condition, as reported by respondents, was not adequate. Community members with acute need for this condition access care via the hospital emergency room. Even when this disease is managed

during the acute episode it was reported that ***lack of access to pharmaceuticals and on-going primary care treatment was the problem. It is generally acknowledged that the "low hanging fruit" for achieving health care cost reduction is – smoking cessation and weight management.*** Weight management improvement is exceedingly complicated from a program outcome perspective but minimal improvement in community nutrition education can result in significant dividend regarding diabetes management and the associated cost of treatment. Pharmaceutical access programs that make drugs available to the low income, uninsured – with proper emphasis on the educational aspect have the multiple payback of reduced emergency and acute care cost.

j) **Primary Care Physicians and**

k) **Geriatric Services** – Most respondents reported ***access to primary care physicians as adequate for insured but not adequate for uninsured.*** Geriatric services access was considered adequate. Many if not most elderly community members are covered by Medicare and therefore although often inconvenient or difficult from a transportation aspect, "access" was considered adequate. Stated simply – most physicians and health care providers accept Medicare insurance and therefore an individual with Medicare that can "get to" the provider will have "access" to care. Most respondents reported a geographic mal-distribution of both primary care and geriatric services – ***the more rural the area the less access to care due to lack of transportation.*** Note; it was not within the scope of this survey to further "pursue" the transportation "needs" as it impacts access to care as reported by survey respondents.

l) **Physical Rehabilitation Services** – Most respondents characterized access to this service as adequate.

m) **Referrals to Specialty Care Physicians** - Respondents characterized this as income/insurance status dependent- access to specialty care physicians by low-income uninsured as being available primarily via emergency department. Some respondents expressed access as available in Birmingham at the University Hospital; however, long wait time and transportation limitations generally resulted in access to specialty care being available only when the underlying condition causing the "need" becoming so significant that it had affected almost all "quality of life" issues.

In response to survey question #7 wherein Community Member respondents were asked to consider which two of the following three objectives should HCACA pursue:

- Highest quality
- Widest access
- Lowest cost

Most responded "widest access-lowest cost"

Interestingly, most major acute/tertiary care organizations engage in community awareness programs/campaigns that accentuate "highest quality." If results of this survey are truly representative of the community members opinions, then educational strategies and programs that explain and emphasize "widest access – lowest cost" may resonate better with community members than education objectives that "focus on" highest quality.

When asked "how familiar are you with the following characteristics of HCACA, respondents answered:

- Location and facilities - considered very familiar
- Leadership – very to somewhat familiar
- Mission – very to somewhat familiar
- Programs and services – somewhat
- Community involvement – somewhat

A follow-up question inquired "we would like to know and understand your perception of HCACA;" on a scale of 1 to 5 with 1 representing "inadequate" programs and services, 3 representing "incomplete program and services" and 5 meeting the "total means of the community."

Representatives were asked to consider:

- Women's health services
- Mental health services
- Emergency services
- Surgical services
- Clinic and outreach programs
- Radiology services
- Cardiac programs and services
- Cancer programs and services
- Diabetes program and services
- Children's services

- Geriatric services
- Services to all individuals

The interviewees rated HCACA either 4 or 5 in almost every category; the major exception being (b) mental health services. There were some "can't rate" responses that were a result of lack of knowledge about HCACA programs in the specific area. It could therefore be concluded that notwithstanding, lack of access consequent to insurance status HCACA is perceived by the community to be nearly meeting the "total needs (5)" of the community.

The questions (#10, 11, 12) were designed to elicit from the interviewee an impression as to if HCACA "is vital to the health and welfare of the community."

All interviewees responded yes.

"If HCACA did not exist, do you believe the community's health care needs would be met"?

All interviewees responded **No**.

"Do you think that HCACA adequately addresses the needs of the community and is successful in improving health indicators and reducing health disparities?"

All interviewees responded **Yes**, more than one respondent qualified this response "with resources available."

One may conclude from this section that HCACA is considered as much more than just a community hospital; but more so as a vital link to health and welfare in the community without which the community needs would not be met. The last part of this section further implies that there is confidence in HCACA's efforts to improve the community with the resources it has available – the corollary that perhaps even more could be done if more resources were available -that would indicate community confidence in HCACA as a responsible steward of its resources and perhaps the community would support greater resource allocation to HCACA.

Question 13 of the survey inquired about the "need for more primary care physicians…specialty care physicians, in the community."

This inquiry is designed to further expose the access to care concept. Generally, respondents felt that the number of physicians either primary care or specialty was not particularly problematic; except mental health providers, but access to the physicians due to insurance status or location (more rural less access) was the underlying issue. Stated another way, respondents concluded the number of physicians was probably satisfactory, but lack of insurance made access by part of the population a problem; and

the further from HCACA a person lived, the more transportation became a problem regarding accessing care.

This survey did not attempt to educate respondents on the adequacy/inadequacy of existing transportation for medical services – excluding emergency ambulance service (that was considered adequate) respondents' experience residing in the community (hundreds of years in total) and activity level (nearly 15,000 services hours per year) should result in awareness of local transportation resources.

The concluding question was "How can HCACA better meet the needs of the community?

The question drew the following responses,

- More prevention and education programs for the diabetic population
- Expand mental health/substance(drug)abuse education and treatment
- Recruit more mental health service providers to the community
- Preventative care
- More screening and health fairs
- Continuously survey community members
- Coordinate more with "free clinics" or clinics providing care to low-income uninsured

J. Board of Directors Interview Questions and Results Summary

The Board of Directors participated in the interview process. When asked "is the hospital achieving its mission and vision?"

- The response was yes. Board members emphasized that "integrity – doing the right thing when no one is watching" was an underlying value of the system. The system board and management approach their responsibilities with a "servant leadership" perspective. And that they have "miles to go before they sleep", indicating that there the Board realizes there is much more work to do to meet the community health care needs.

When asked "does the mission need to be revised, expanded, changed?"

- The response was that the mission statement was recently revised and therefore is current.

The query posed was "What are the barriers that threaten the hospital's ability to achieve its mission, vision?

- It was stated that the number one issue or barrier is payment for services rendered. MC/MA/BC rates are poor, the board and senior management have embarked on a reclassification strategy that should improve reimbursement but compared to hospital systems in Birmingham, HCACA is underpaid for services.

Question 6 of the survey asked, "How do you envision the impact of health reform will affect HCACA's ability to meet its mission?"

- It is the Board's opinion that most of the proposed legislation will have a negative impact on HCACA; Alabama does not adequately fund Medicaid, it is one of the most restricted Medicaid programs in the country.

Question 7 asked "if a healthcare organization could only achieve two of the three major objectives: 1) highest quality, 2) widest access, or 3) lowest costs which two would be select?"

- The Board indicated highest quality and widest access as the two major objectives that should be pursued. Note: this differs from community members wherein they stated widest access and lowest cost.

Question 8 inquired "What are the strengths of HCACA – have they changed in the last five years – describe changes if any."

- The Board responded a major strength of the medical center is that it has stayed current with the modern procedures and equipment; it has implemented a hospitalist program - its technology is current and in summary the medical center is community oriented, nonprofit – and creating access is the focus. It further stated that "affiliation" with other major health care systems on service lines, i.e. cancer treatment, will be an area of focus in the next 3 to 5 years.

Question 9 asked the Board to consider "external factor or factors (rank them) that pose the greatest challenges to the viability of HCACA over the next five years."

- Competition from other hospital or health care providers – including doctor ASC's, urgent care centers etc. was viewed to be very low threat;
- Cutbacks or reduction of Medicare funding and state support is considered the greatest threat;

- Federal and State regulatory changes is also viewed as a substantial threat;
- Recruiting physician, nurses, and other skilled staff although not a current issue is considered a material long term threat; and
- Demographic changes – aging of the population, changing needs of the community are material challenges to the viability of the medical center from the board perspective.

Question 11 of the survey asked the Board to "consider the top three strategic priorities of HCACA."

- Improving quality of clinical services and patient satisfaction was rated number one.
- Facility improvement and expansion was rated second.
- Physician recruitment was rated third.
- Other priorities that were considered but not rated in the top three were:

    - Program expansion –inpatient and/or outpatient
    - Improving current medical technology
    - Strengthening the hospital's current financial position
    - Service area expansion for inpatient and outpatient services
    - Increasing current market share
    - Cost reduction

Question 12 asked the Board member, "Based on your perception of the healthcare industry, do you expect HCACA to experience increased pressure or decreased pressure from the following issues over the next year?"

The Board considered "increased pressure" would result from the following:

- Inadequate Medicare/Medicaid reimbursement
- HMO payment rates/payment denials
- Health Reform - increased number of uninsured patients in the market place
- Inpatient service volume decline
- Government regulation (federal and state)

HCACA would experience decreased pressure from the following:

- Less Competition (local market due to merger/acquisition)
- Physician practice acquisitions/consolidations needs
- For-profit health care

Question 13, the final question asked, "Do you think HCACA should get more involved in addressing the following - and if so how?"

- Public health issues: – More could be done.
- Health indicators: – More awareness at the community level.
- Health disparities: – More education and access to preventive and primary care
- Chronic disease: – Better education on chronic disease management and avoidance, particularly with the youth population

K. Senior Management Interview Questions and Results Summary

Seven members of "senior management" – were participants in the CHNA survey process at three separate times – CFO and AVP/Compliance Officer initially, then the Chaplain, then the remainder the third time); the following summarizes the responses of these interviewees.

Question 1 asked "Describe the mission and vision of HCACA. Is HCACA currently achieving its mission?"

- Interviewees stated HCACA mission - all were very familiar with the mission statement and emphasized that it had recently changed. All interviewees reported that RMC-A was achieving its mission.

When asked in Question 2 "Do you think that mission needs to be revised, expanded, changed and why?"

- No responder indicated a need to change the mission and most stated that it was recently modified/changed and was currently more than adequate.

Question 3 asked "What are the barriers/risks that threaten the hospital's ability to achieve its mission/vision?"

- The responses varied but the common theme was lack of adequate reimbursement. Also, coincident to low reimbursement the replacement of high cost assets is more and more challenging. The recruiting and retention of physicians particularly with an aging medical staff is and will continue to be a major challenge. And a perception by some, typically the commercially insured and higher income members of the community, that "better care" is available in Birmingham.

Question 4 asked "How do you envision the impact of health reform will affect HCACA's ability to meet the mission? What steps has management taken to address these issues?"

- The responses were that increased financial pressure was felt to be a major impact of health reform; increasing financial pressure negatively impacts quality – HCACA will be required to provide more free care, diminished funding means diminished facilities, and reduced ability to deliver high quality healthcare. Senior management steps include current efforts to become more competent in third party payer shared saving arrangements, however it was emphasized that because of the BC/BS market share in Alabama negotiations for improved reimbursement have not been considered successful.

Question 5 "What do you think is HCACA's service area of inpatient and outpatient programs and services?

- The responses were consistently answered by senior management as a five-county area.

Question 6 asked "Do you think HCACA does a good job at providing inpatient and outpatient programs and services to its service area and meeting the needs of the community?

- Responses by senior management were affirmative and all stated HCACA is doing "very well."

Question 7 asked "Do you think HCACA's service area for inpatient and outpatient programs and services should be expanded and if so how do you think it should be expanded?"

- Responses by senior management stated HCACA had a 60-65% market share in the five-county area and that HCACA's geographic service area is near the limit; the "geographic footprint is adequate and doesn't need to add." There was acknowledgement that consideration of an association of some type or another with large health care system may be key to longer term sustainability but in and of itself HCACA has no major service area expansion plans.

Question 8 asked "How does HCACA differentiate itself in the service area?"

- Service, Quality, & Patient Satisfaction. Previously "Technology" was included as a characteristic of the differentiation however due to inadequate reimbursement from Medicare, Medicaid and Commercial payers continued emphasis on high cost "Technology" as a differentiation strategy requires reconsideration.

Question 9 asked "Does HCACA do an adequate job on improving health indicators and reducing health disparities?"

- Senior management mentioned the many efforts undertaken by HCACA; some felt more could be done but all acknowledge the major pressure - financial resources negatively impact such efforts. It was stated that prevention/education programs are difficult to sustain in the present reimbursement environment. Senior management referenced recent effort to better collaborate with the regional FQHC network (Quality of Life) had included a FQHC satellite site near the HCACA medical center emergency department but the FQHC was unable to operate the site due to financial constraints (Note: Quality of Life has satellite FQHC sites in Calhoun, Cleburne, and Talladega Counties).

Question 10 "What best describes the organizational culture of HCACA?"

- The term "compassionate and caring" resonated as a response to this inquiry.

Question 11 "What external threats post greatest challenges to HCACA's future?"

- The responses relative to threats were listed and ranked by senior management as follows:

    - Decreased reimbursement from government programs were rated "greatest challenges"
    - Increased regulation
    - Changing needs of the community, i.e. chronic disease
    - Ability to recruit physicians
    - Market consolidation
    - Demographic, population changes

Question 12 "What internal factors pose the greatest challenges to HCACA's future?"

- Physician recruitment – primary care, subspecialty care and surgical was rated the greatest internal challenge. Immediately followed by maintaining adequate staffing levels and employee retention. Senior management has labored so long with budget constraints that it has developed great expertise in the ability to manage cost but this obviously still presents challenges.

Question 13 "What do you consider the top Three Strategic Priorities for HCACA?"

- Responses varied and not all interviewees ranked these in the same sequence but for the most part strategic priority responses were ranked as follows:

    - " Strengthen the hospital" financial position"

- Physician recruitment and retention
- Improve available medical technology
- Merger, affiliation at the system level for cancer, cardiac, surgery treatment

Question 14 requested senior management respond, "Do you expect HCACA to experience increased pressure or decreased pressure for the following issues over the next five years" the following are expected to have increased pressure.

- Medicare/Medicaid reimbursement
- Health reform and conversion of uninsured
- HMO payment rates/payment denials
- Inpatient service volume
- Government regulations (federal and state)
- Mergers/Affiliations (regional)
- Physician practice acquisitions/consolidations

Senior management responded that it expects considerable increased pressure from almost all of the major healthcare service delivery issues.

Question 15 inquired of senior management "Do you think HCACA should get more involved in addressing the following – and if so how?"

- Public health issues
- Health indicators
- Health outcomes
- Health disparities
- Social population group health issues
- Chronic disease

Senior management responded that HCACA could do more in all categories and that all categories warranted more involvement by HCACA. It was stated and well understood by senior management that the improved outcomes of the system's patients through improvements in chronic disease management will pay great dividends by reducing unnecessary cost thus making the challenge of sustainability more achievable.

PRIORITIZATION OF COMMUNITY HEALTHCARE NEEDS

A. Overview

HCACA's 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 biggest factors driving today's healthcare strategy for all providers, and HCACA is no exception, are the aging population, rising chronic disease rates (co-morbid conditions), gaps in supply and demand of physicians (especially in rural areas), the delivery options that technological advances enable, more information on evidence-based care and the change in the payment system relative to ACA which is requiring collaboration along the care continuum and continuing to reduce payment for unnecessary admissions (readmissions to hospitals such as HCACA's hospitals) or other services. These factors are expanding the definition of the provider and requiring all providers (i.e. primary, 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 community is the health system's geographic area referred to as the service area in which the majority of its patients reside. HCACA's 3-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. Hospital readmissions is the driving force, as in today's world, hospitals in themselves, and HCACA is no exception, have a limited ability to impact this outcome and must coordinate the continuum of care with other providers in healthcare service delivery. Providers include primary care and subspecialty care physicians, other clinicians, post-acute care providers such as home health agencies, social and community service workers and health coaches, and public health workers, along with the acute care hospital – HCACA's 3-hospital health system.

B. Identification and Prioritization of Community Healthcare Needs

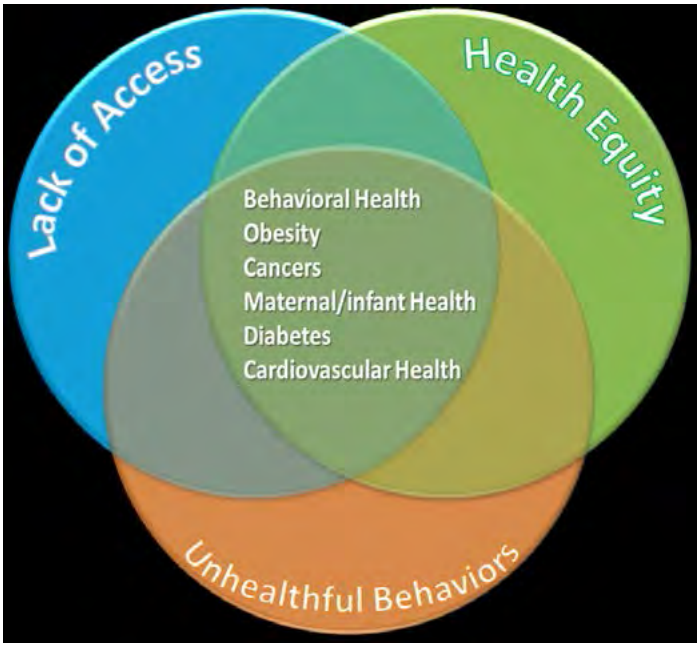
Within this context, the priority needs for HCACA's three-county primary service area (Calhoun, Cleburne, and Talladega Counties) were developed from the Health Status and Health Indicators sections of this CHNA and based on the health issues at hand that present a threat to the health of the community 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 revised mission, vision, and strategic plan;
2) Quality considerations;
3) Governance and organizational structure issues;
4) Financial and operations impacts; and
5) Risk.

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

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

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



The recommendations in this section are also consistent with the tenets of health reform and ongoing, evolving payment systems since they focus on healthier individuals (thru preventive, wellness, and primary medical care) and communities, integration among a full range of providers and managing awareness and prevention to reduce longer-term costs. 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 Systems to Reduce Socioeconomic Stressors
B.2 Access to Primary Medical Care and Behavioral Health Care
B.3 Healthcare Education, Prevention, Wellness, Promotion;
B.4 Healthcare Services for Chronic Conditions; and
B.5 Healthcare Services for the Elderly

B.1. Systems to Reduce Socioeconomic Stressors

As noted in other sections of this CHNA, “The health of a community is largely related to the characteristics of its residents; it has been well-documented that an individual’s age, sex, race, ethnicity, education, income level, as well as access to nutritious food, transportation and housing affects health status and access to healthcare.” Clearly, socioeconomic stressors on the individuals, families and children in the HCACA service

area are significant in their homes, their neighborhoods and their schools (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.1.a. Objectives:

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

- To 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.1.b. Potential Activity Recommendations:

- HCACA to assume an innovative and leadership role in addressing the social determinants of health by way of cultivating health equity through collaboration, policy development, advocacy and education;

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

- Based on the key informant interview process, review/rethink outreach activities to enable more of the service area population (especially Cleburne County) to be reached, along with Randolph County. Appoint a champion to lead this effort. They should assemble a task force with key individuals throughout the community to develop an Action Plan. Collaborate more with public school systems and the local FQHC network (Quality of Life Health Services-QLHS) as outreach is an FQHC required service.

- As part of the Action Plan, specific financial analyses can be completed to evaluate the relative cost and benefit of a range of proposals – QLHS has a site in all three counties and Randolph as well, and also collaborates with many of those interviewed during the key informant survey/interview process;

- The task force should include members of the payor community i.e. Blue Cross Blue Shield of Alabama since it is important to include them in the dialogue of resolving these stressors;

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

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

- Create an understanding within the HCACA service area provider community about the multi-faceted nature of health and its relationship with socioeconomic determinants of health. Provide cultural competency training for PCPs, HCACA health system employees and other collaborative providers and agencies that addresses the pervasive barriers to a consistently healthy lifestyle;

- As the payors become more involved in new payment systems, i.e. bundled payments, risk-sharing, value-based contracting, HCACA should consider and evaluate each of these alternatives, which has at its core, improving health outcomes;

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

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

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

Access to comprehensive preventive and primary medical care, along with access to behavioral health care (mental health and substance abuse) is a critical issue throughout the three-county service area, especially for the low-income population and where financial and non-financial barriers prevent patients from receiving timely and appropriate diagnosis, assessment, and treatment of their condition. The key informant interview/survey process delineated the increasing and resounding need and lack of access to behavioral health care services and the increasing opioid epidemic throughout the service area.

In 2015, the presence of OB service delivery continues to remain a luxury in many of Alabama's counties. Only 24 of the 55 rural counties have hospitals that deliver babies today. Calhoun County and the contiguous service area is fortunate in having HCACA's RMC's Women's and Children's Center, Baby Friendly Hospital, Alabama's First and Only 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, HCACA's RMC became the first hospital in Alabama to receive the Blue Distinction® Center for Maternity Care designation by Blue Cross and Blue Shield of Alabama. This new 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 of 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;

- High primary care utilization in HCACA's hospitals' emergency rooms, specifically RMC with the most paramount utilization (EXEC's analysis performed for 2016), particularly among low-income groups and the potential need for HCACA to establish, develop, and implement a "free clinic" on Anniston's "west" side;

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

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

- 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.2.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 development of a "free clinic" on Anniston's "west" side 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 RMC's emergency room, 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 low-income unmet need in the 3-county service area;

- To collaborate on expansion of primary medical care and urgent care services to be more conducive based on community needs (need to schedule based on community need – hours and days of week) along with integration of primary medical care with behavioral health care, and further development of referral mechanisms for the HIV/AIDS population with the Health Services Center, which could potentially develop as an FQHC "Look-Alike" provider and take more advantage of benefits accorded to an FQHC provider, 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 mortality rates continue in the CHNA in 2017 and from the CHNAs performed in 2012 and 2015.

B.2.b. Potential Activity Recommendations:

- Create a medical staff development plan that summarizes primary care and specialty care physician need in the service area, along with other key criteria, i.e. age, medical staff status, admissions, loyalty factors; and identifies options and opportunities for filling those needs. As part of this plan, develop innovative recruitment and retention strategies, while concurrently, remaining competitive in order to attract physician candidates;

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

- Work with aging and/or retiring physicians (solo and group practice) to transition their practices in the most seamless manner;

- Develop a structure to enable the use midlevel providers (NP, PA, CNMW) in a wider capacity in the community – consideration for "free clinic" on Anniston's "west" side development;

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

- Explore expanding Quality of Life Health Services, Inc.'s sites relative to additional FQHC-related services in Talladega and Cleburne Counties

(since first CHNA performed in 2012 – new sites) - structure the hours of operation at each site to meet the needs of the community and patient population; this will likely include evening hours and possibly weekend hours to provide more sorely needed access;

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

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

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

- Further development of HCACA's RMC's Women's and Children's Services for issues for all women relative to maternity and gynecological issues, including, but not limited to breast health, menopause, Urogynecology, GynOncology, bone, joint, osteoporosis, and da Vinci Hysterectomy using the da Vinci™Surgical System. Women's health services can be developed in such a way that it is attractive to the various components of the service area population and the promotion/marketing effort to attract these services could be used for primary medical care, education, and prevention for these women as well. The Women's health services center should attract women from all income categories to provide much-needed access across all ages and incomes; and

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

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

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 number of overweight and obese individuals in the service area (major problem, not only in the service area and in Alabama but throughout the country – the future of our country is in our children and child obesity is a rampant issue that needs to be dealt with at the current time);

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

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

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

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

B.3.b. Potential Activity Recommendations:

- Develop a plan with community providers and leaders, including religious organizations, i.e. St. Michael's and All Angel's Church, Interfaith Ministries for the younger population and who may or may not have had any healthcare episode as the result of their risky behaviors; they need to be contacted where they live, work or otherwise congregate. The plan needs to be more grassroots oriented to reach this population;

- Consider block-by-block programs for door-to-door screenings and education in the three-county service area and in Anniston's "east" and "west" sides, as well as chronic disease management;

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

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

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

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

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

- Set up formal meetings with leadership within the Anniston City School System and other local school systems to identify ways to improve health education, awareness and screening in the schools – consider individual school linkage with QLHS, the local FQHC regarding school-based health center (SBHC) development. Use students to also identify opportunities to reach their parents; and

- Partner with service area grocery stores to provide recipes for healthy eating in a way that makes it easy and affordable for the population to provide healthier choices for their families – especially for lower income levels, which generally equates to poorer food quality and less consumption of healthy foods like fruits and vegetables.

B.4. Health Services for Chronic Disease Conditions

The high level of mortality from chronic disease (i.e. heart disease, cancer) in Calhoun, Cleburne, and Talladega Counties makes it imperative to improve management of these chronic disease conditions. As the population ages, which is the case in all three of the counties, the prevalence of these chronic disease conditions and co-morbidity will increase, particularly if the underlying risk factors are not addressed.

Chronic medical conditions such as diabetes, high blood pressure, high cholesterol, COPD, asthma, and behavioral health conditions (both mental health, i.e. depression and substance abuse i.e. alcohol, painkillers) along with co-morbidity in combinations thereof, respond well to careful chronic disease management. Barriers to the appropriate management of chronic care include the lack of reimbursement to providers for secondary prevention services, patient self-management education, patient support services such as health coaches, transportation, and proven complementary alternative medicine services, follow-up care and communication among providers and between providers and patients. 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. Potential Activity Recommendations:

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

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

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

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

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

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

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

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

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

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

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

B.5. Healthcare Services for the Elderly

The fact remains that HCA's 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, have realized a growing percentage of the population to be over 65 years of age, and more 75 years and older ("old old"). Based on the declining population overall as indicated in this CHNA, and "working age" groups comprising younger age groups, departing to other areas, it is cause for alarm from a healthcare service delivery provision with the elderly as the base. 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 i.e. mental health – depression, substance abuse – pain killers; 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 HCACA's immediate three-county service area by exploring and developing a virtual, integrated healthcare delivery system aimed at reducing fragmentation and duplication.

B.5.b. Potential Activity Recommendations:

- Expand geriatric services in the community, where the older patients reside at their home, through physician and nurse practitioner availability

and through strategic partnerships with home health agencies in the service area;

- Improve the efficiency of caring for age 65 and older, and age 75 and older "old old" medical and surgical patients in HCA's 3-hospital health system based on their healthcare diagnoses;

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

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

- Integrate mental health services with medical services in order to treat the whole individual, inclusive of capitalizing on for behavioral health, Genesis Senior Emotional Care 25-bed program located at HCACA's Jacksonville campus that specializes in treating older individuals that experience serious behavioral or emotional problems.

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

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

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

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

C. HCACA as Leader in Transforming Community Health

As HCACA continues to position the health system for success in the future relative to health reform and regulatory and reimbursement changes, along with external factors outside its control (i.e. population, socioeconomic and demographic characteristics and determinants), 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:

- UAB Cancer Center 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

- Certificate of Need (CON) approval for more inpatient psychiatric beds at HCACA's RMC campus and commitment to behavioral health (mental health and substance abuse) problems inherent in the three-county primary service area.

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 3-hospital health system, which is based on improving health outcomes throughout the health system's service area. Because of the relatively large population and age distribution in its service area (even though the population growth is static at best and is actually declining by approximately 1% for each of the three primary service area counties based on 2016 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 figure. In many cases, the older half of the 18-44 and the 45-64 ages groups, continue to represent working, well-insured individuals who will often be the most aggressive in seeking quality care and the most informed in their decision process. It is also a potential reason for outmigration of hospital-related services by these individuals to hospitals/health systems in Birmingham and Atlanta as indicated during the key informant questionnaire/survey process.

Figure 31 - Examples of Service Distribution Across the Age Segments

<table>
<tr><td>0-17</td><td>Pediatric Subspecialties</td><td rowspan="2">Maternity Care</td><td rowspan="4">Behavioral Health</td><td rowspan="4">Comprehensive Cancer</td><td></td></tr>
<tr><td>18-44</td><td rowspan="3"></td><td rowspan="3">Cardiology</td></tr>
<tr><td>45-64</td><td rowspan="2">Women's

Center Beyond Maternity</td></tr>
<tr><td>65+</td><td>Palliative Care</td></tr>
</table>

The goal of this Community Health Needs Assessment (CHNA) in 2017, similar to the CHNA performed in 2015, continues to position HCACA, now as a 3-hospital health system, as the premier medical center and health system in the Calhoun, Cleburne, and Talladega primary service area with critical linkages throughout the community to address community needs as well as to build programs and services within the health system in response to those community needs and in an integrated way. If the health system can link more closely with the community and other providers and agencies (ambulatory/FQHC - vertical, and horizontal) to even better position the organization as the provider of choice for certain key services in serving the community, HCACA should be able to improve its reputation for quality that will allow HCACA's hospitals to continue to attract patients to its Centers of Excellence such as 1) UAB Cancer Center affiliation in the UAB Cancer Care Network programs, 2) Center for Balance Disorders relative to problems associated with dizziness or imbalances especially for those age 55+, and 3) 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.

ATTACHMENTS

ATTACHMENT A

KEY INFORMANT INTERVIEW LIST

Community Health Needs Assessment (CHNA) Interviews

RMC Regional Medical Center Anniston

Monday, November 13, 2017	Organization	Contact	Location
8:30 AM	Regional Medical Center	Mark North, CFO 256-741-6370	Administrative Offices 400 East 10th Street
	Regional Medical Center	Andy Pody, AVP/Compliance Officer 256-235-5041	Administrative Offices 400 East 10th Street
10:00 AM	Calhoun County Health Depart	Mary Gomillion 256-569-8117	Health Department 3400 McClellan Blvd Anniston
11:15 AM	East AL Planning Commission	Albertha Grant Executive Director Lori Corley, Director Agency on Aging and Disability 256-237-6741	Quintard Towers Buiding 1130 Quintard Avenue Anniston
1:30 PM	Interfaith Ministries of Calhoun County	April Lafollette Executive Director 256-237-1472 o 205-913-1294 c	1431 Gurnee Avenue Anniston (The Bridge at the First United Methodist Church of Anniston Noble St.)
2:45 PM	Health Services Center, Inc (14 County Area)	Denise Meadows Chief Executive Officer 256-832-0100 o 256-454-5635 c	608 Martin Luther King Dr. Anniston (Building #2)
4:00 PM	Model City Pediatrics	Tatiana Bidikov, M.D. 256-237-0023 o	1300 Leighton Avenue Anniston

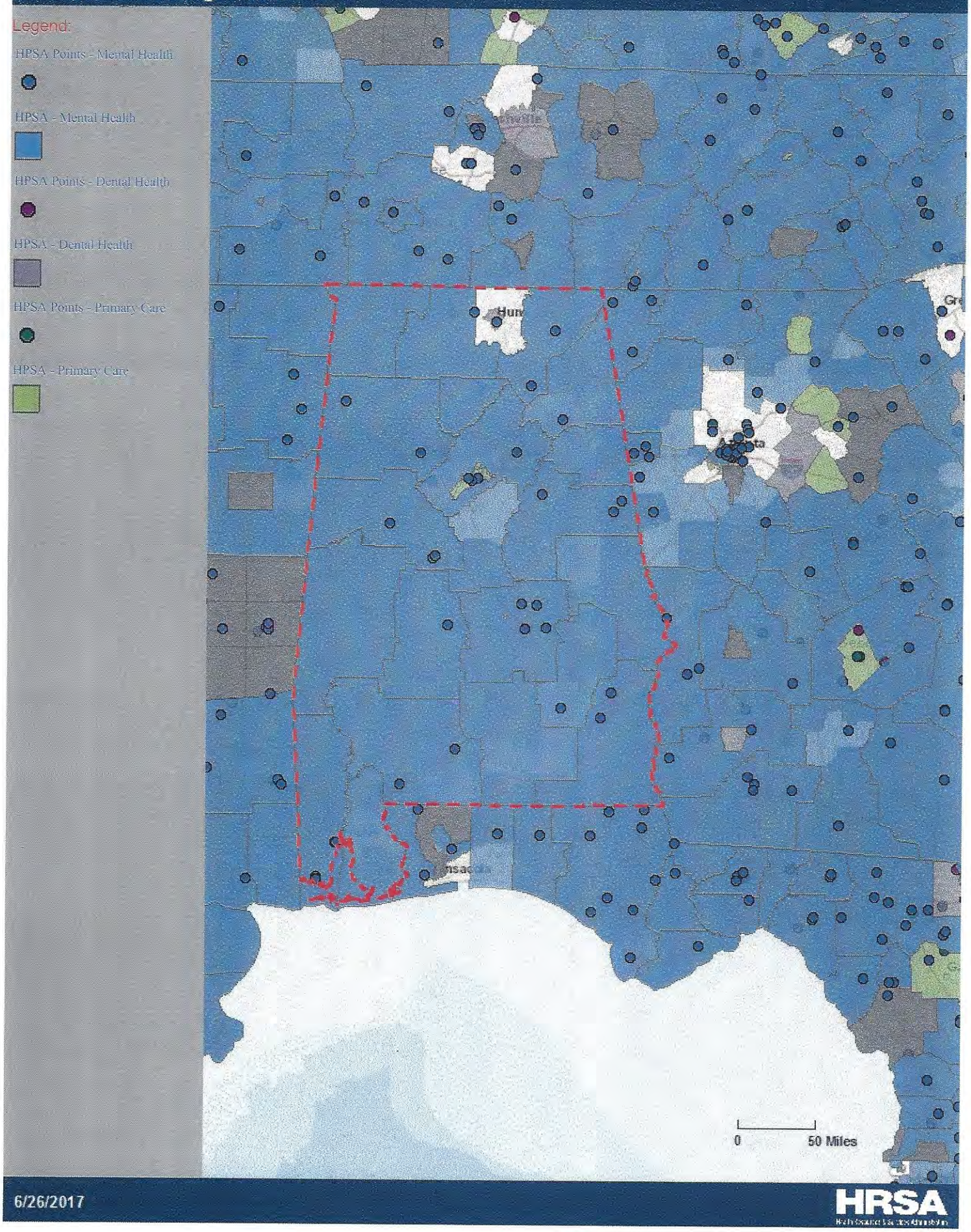
		256-225-7302 c	
Tuesday, November 14, 2017			
8:30 AM	Anniston City Schools System	Darren Douthitt, Superintendent 256-235-5000	Anniston Middle School Campus 4500 McClellan Blvd Anniston
10:00 AM	St. Michaels and All Angles Church and Free Health Clinic	Father Chris Hartley Nannette Mudiam, RN, Practitioner, Clinic Director 256-236-6060 clinic 256-237-4011 o 205-516-6244 c	1005 West 18th Street Anniston
11:30 AM	Grayson and Associates (Psychiatrist)	Andrea Thomas, M.D. athomasle@gmail.com 205-470-3845	BB&V Bank Building 801 Noble Street Anniston
2:00 PM – 4:00 PM	RMC 3-Hospital Executive Team and Board of Directors (BOD): -James Roberts, BOD Vice Chair -Louis Bass, RMC President/CEO -Joe Weaver, Stringfellow Hosp. CEO -Elaine Davis, RMC CNO -David Zinn, MD, CMO	Members invited and Attendees as follows:	RMC Admin Conference Room (Main hospital, 3rd floor, admin suite)
4:00 PM	RMC Chaplain / Parish Nurses Program (presently on hold)	Jim Wilson, Chaplain 256-235-5146 256-225-0146	RMC Admin Conference Room

Not scheduled (Scheduling attempted during the course of the interview and survey process)	Quality of Life Gadsden	Amelia Wofford 256-439-6309	Phone Interviews If needed
Telephone Interview/Survey Process Performed 11/15/2017	Talladega County NAACP President	Reverend Hugh Morris 256-493-0525	
	Randolph Rural Health and Urgent Care Center	J. Melburn Holmes, M.D. Michael Robinson, D.O. 334-863-2311	

ATTACHMENT B

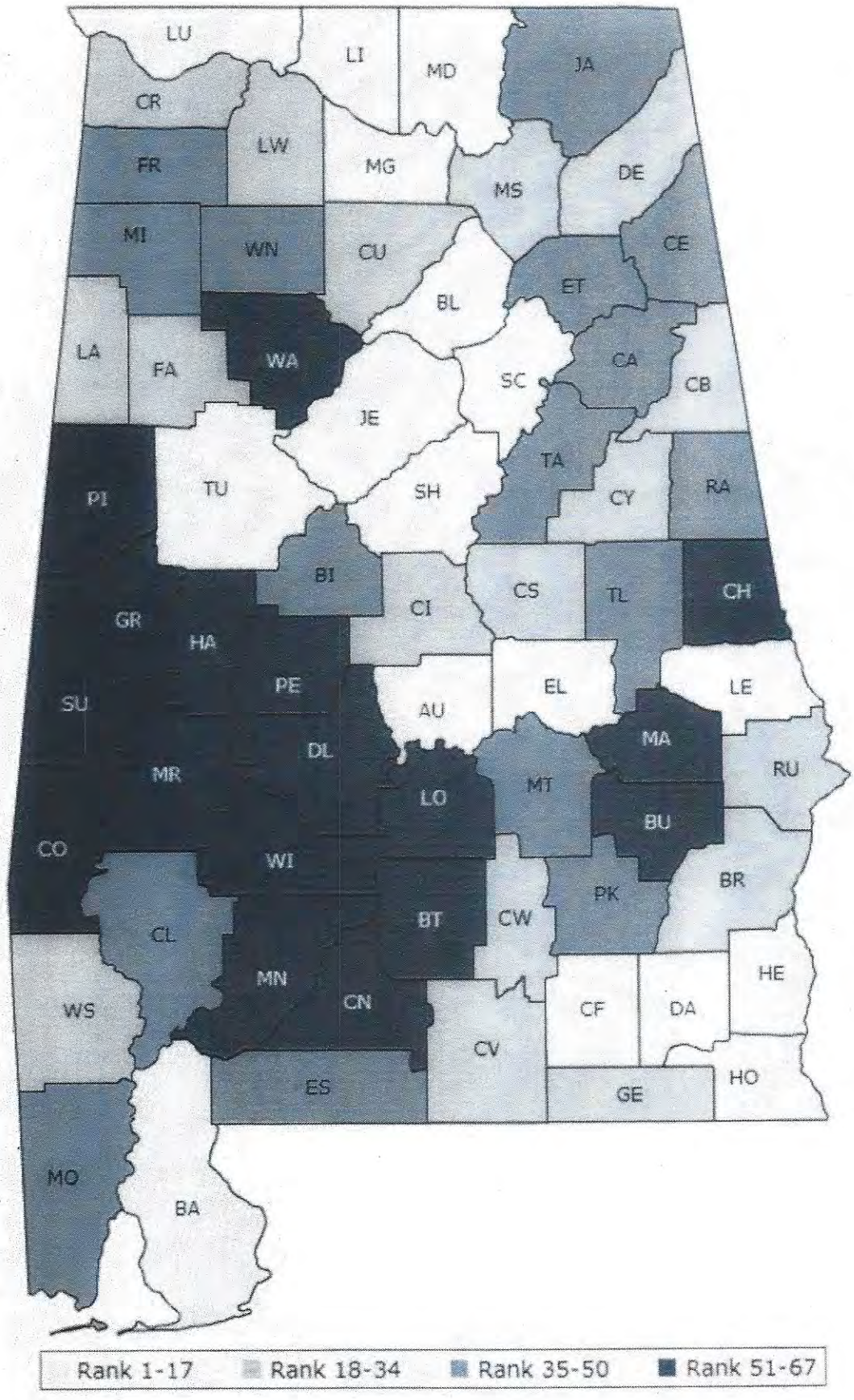
MEDICALLY UNDERSERVED AREA/ POPULATION (MUA/P) DESIGNATION

HPSA Shortage Areas



6/26/2017

HRSA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WS
CN
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Rank 18-34
Rank 35-50
Rank 51-67

HPSA Find Results

Search Criteria

Click on a column heading to sort the results in ascending or descending order.

Start Over | Modify Search Criteria | Map View

Data as of 8/25/2017

State: Alabama
County: Calhoun County
Discipline: Primary Care
Metro: All
Status: D,P
Type: All
Date of Last Update: All Dates
HPSA Score: From 0 To 26

Collapse All

1 Page Size: 20

01 items in 01 pages

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	Population Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Calhoun County	015	101999019C	Cherokee/North Calhoun	Primary Care	HPSA Geographic	Geographic Population	4	13	Designated	05/30/2012

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Updated Date
Calhoun County	015		Piedmont	Primary Care	Minor Civil Division			Designated	05/30/2012

1 Page Size: 20

01 items in 01 pages

Note: Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee – they are not listed separately.

HPSA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 8/25/2017

State: Alabama
County: Calhoun County
Discipline: Dental Health
Metro: All
Status: D,P
Type: All
Date of Last Update: All Dates
HPSA Score: From 0 To 26

Collapse All

1 Page Size: 20

01 items in 01 pages

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	Population Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Calhoun County	015	6019990184	Low Income - Calhoun/Cleburne Counties	Dental Health	HPSA Population	Low Income Population on HPSA	5	17	Designated	11/06/2013

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Updated Date
Calhoun County	015		Calhoun	Dental Health	Single County			Designated	11/06/2013

1 Page Size: 20

01 items in 01 pages

Note: Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee – they are not listed separately.

HPSA Find Results

Search Criteria

Click on a column heading to sort the results in ascending or descending order.

Start Over | Modify Search Criteria | Map View

Data as of 8/25/2017

State: Alabama
County: Calhoun County
Discipline: Mental Health
Metro: All
Status: D,P
Type: All
Date of Last Update: All Dates
HPSA Score: From 0 To 26

Collapse All

1 Page Size: 20

01 items in 01 pages

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	Population Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Calhoun County	015	7019990105	Calhoun/ Cleburne - Mental Health C atchment Area 7	Mental Health	HPSA Geog raphic	Geographi c Populatio n	4	15	Designated	04/19/2012

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Updated Date
Calhoun County	015		Calhoun	Mental Health	Single County			Designat ed	04/19/2012

1 Page Size: 20

01 items in 01 pages

Note: Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee – they are not listed separately.

Data Portal Results

Related data may be displayed under an individual record and can be expanded to view. Results can be sorted, filtered, exported, or viewed on a map using the HRSA Data Warehouse Map Tool.

New Feature – Secondary Dataset Export (Excel and CSV) : Users can now export primary and secondary datasets for offline use in Excel and CSV format. One column of the export file will contain a "key" to allow users to associate the datasets.

Map View | Edit Indicators | Start Over | Help

Datasets Export:

You are leaving Data Portal

Click on a column heading to sort the results in ascending or descending order. View in Map Tool

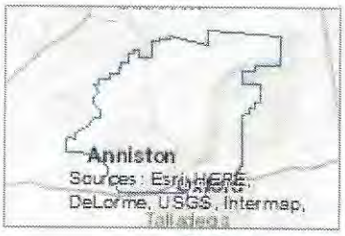
Primary Dataset: Health Center Service Delivery and Look-Alike Sites - Health Center Service Delivery Sites

Site Name	Services Delivered at Site	Health Center Type	Health Center Location Type	Health Center Location Setting	County Name	Site State Abbreviation
ANNISTON QUALITY HEALTH CARE	Yes	Service Delivery Site	Permanent	All Other Clinic Types	Calhoun County	AL
Calhoun Quality Health Care	Yes	Service Delivery Site	Permanent	All Other Clinic Types	Calhoun County	AL

Visit the Data Sources and Refresh Dates page for more information about the refresh cycle for data within the Data Warehouse.

Note: An active grant is defined by HRSA as a grant whose project period end date is beyond the current date. Grants can be active whether or not they have received an award funding in the current fiscal year.

Data by Geography - Calhoun County, AL



Enlarge Map

HRSA's programs improve access to health care by strengthening the health care workforce, building healthy communities, and achieving health equity. These programs provide health care to people who are geographically isolated, economically or medically vulnerable.

Click the icons next to each data indicator to display the data detail in the Data Portal or Map Tool.

Data as of 08/24/2017

HRSA Grants

HRSA has thousands of active grants worth billions of dollars to improve and expand health care services for underserved people.

HRSA Grants		
Active Grants*: $2,985,271 through 3 grants to 1 grantee	▦	📍
FY 2017** Awarded Grants: $1,277,763 through 2 grants to 1 grantee	▦	📍
FY 2016 Awarded Grants: $1,377,899 through 3 grants to 1 grantee	▦	📍
FY 2015 Awarded Grants: $1,277,899 through 2 grants to 1 grantee	▦	📍
FY 2014 Awarded Grants: $1,433,062 through 3 grants to 1 grantee	▦	📍
FY 2013 Awarded Grants: $1,677,899 through 3 grants to 1 grantee	▦	📍
FY 2012 Awarded Grants: $1,772,416 through 4 grants to 1 grantee	▦	📍
FY 2011 Awarded Grants: $1,629,709 through 5 grants to 2 grantees	▦	📍
FY 2010 Awarded Grants: $1,532,319 through 4 grants to 2 grantees	▦	📍

Health Care and Other Services

HRSA programs provide vital health services for medically vulnerable populations.

Health Care and Other Services		
Health Center Service Delivery and Look-Alike Sites: 2	▦	📍
Total Number of Reporting Program Grantees[1]: 0		
Ryan White HIV/AIDS Providers: 1	▦	
Organ Transplant Programs[2]: 0		
National Health Service Corps (NHSC) Approved Sites: 0		
National Health Service Corps (NHSC) Full Time Equivalents: 0.00		
National Health Service Corps (NHSC) Job Vacancies: 0		

Shortage Areas

HRSA identifies geographic areas, population groups, and facilities with too few primary care, dental, and mental health providers.

Shortage Areas[3]

Health Professional Shortage Areas (HPSA): 3

Description	Count
Total Dental Health HPSAs all or partially in the area	1
Total Mental Health HPSAs all or partially in the area	1
Total Primary Care HPSAs all or partially in the area	1

Medically Underserved Areas/Populations (MUA/P): 1

Description	Count
Total Governor all or partially in the area	0
Total MUA all or partially in the area	1
Total MUP all or partially in the area	0

*An active grant is defined by HRSA as a grant whose project period end date is beyond the current date. Grants can be active whether or not they have received an award funding in the current fiscal year.

**Fiscal year-to-date funding. This data represents real time awards to date and may not include funds that have been committed but not yet awarded.

[1] Health Center Service Delivery Site Grantee data as reported in the Uniform Data System calendar year reporting cycle. Data is reported at the health center organizational level and not the individual site level. To learn more about the Uniform Data System and view more detailed information, please visit the HRSA Health Center Program Grantee Data site.

[2] Organ Transplant Programs are listed at the state level.

[3] Shortage area boundaries can cross state, county, congressional district, and ZIP Code boundaries. Counts include any area all or partially within the selected geographic area.

Visit the Data Sources and Refresh Dates page for more information about the refresh cycle for data within the Data Warehouse.

HPSA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 8/25/2017

State: Alabama
County: Cleburne County
Discipline: Primary Care
Metro: All
Status: D,P
Type: All
Date of Last Update: All Dates
HPSA Score: From 0 To 26

Collapse All

1 Page Size: 20

01 items in 01 pages

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	Population Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Cleburne County	029	101029	Cleburne County	Primary Care	HPSA Geographic	Geographic Population	2	11	Designated	03/19/2014

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Updated Date
Cleburne County	029		Cleburne	Primary Care	Single County			Designated	03/19/2014

1 Page Size: 20

01 items in 01 pages

Note: Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee – they are not listed separately.

HPSA Find Results

Search Criteria

Click on a column heading to sort the results in ascending or descending order.

Start Over | Modify Search Criteria | Map View

Data as of 8/25/2017

State: Alabama
County: Cleburne County
Discipline: Dental Health
Metro: All
Status: D,P
Type: All
Date of Last Update: All Dates
HPSA Score: From 0 To 26

Collapse All

1 Page Size: 20

01 items in 01 pages

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	Population Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Cleburne County	029	6019990184	Low Income - Calhoun/Cleburne Counties	Dental Health	HPSA Population	Low Income Population on HPSA	5	17	Designated	11/06/2013

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Updated Date
Cleburne County	029		Cleburne	Dental Health	Single County			Designated	11/06/2013

1 Page Size: 20

01 items in 01 pages

Note: Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee – they are not listed separately.

HPSA Find Results

Search Criteria

Click on a column heading to sort the results in ascending or descending order.

Start Over | Modify Search Criteria | Map View

Data as of 8/25/2017

State: Alabama
County: Cleburne County
Discipline: Mental Health
Metro: All
Status: D,P
Type: All
Date of Last Update: All Dates
HPSA Score: From 0 To 26

Collapse All

1 Page Size: 20

01 items in 01 pages

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	Population Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Cleburne County	029	7019990105	Calhoun/ Cleburne - Mental Health C atchment Area 7	Mental Health	HPSA Geog raphic	Geographi c Populatio n	4	15	Designated	04/19/2012

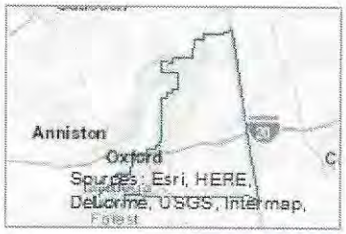
County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Updated Date
Cleburne County	029		Cleburne	Mental Health	Single County			Designat ed	04/19/2012

1 Page Size: 20

01 items in 01 pages

Note: Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee -- they are not listed separately.

Data by Geography - Cleburne County, AL



Enlarge Map

HRSA's programs improve access to health care by strengthening the health care workforce, building healthy communities, and achieving health equity. These programs provide health care to people who are geographically isolated, economically or medically vulnerable.

Click the icons next to each data indicator to display the data detail in the Data Portal or Map Tool.

Data as of 08/24/2017

HRSA Grants

HRSA has thousands of active grants worth billions of dollars to improve and expand health care services for underserved people.

HRSA Grants

Active Grants*: $0 through 0 grants to 0 grantees

Description	Amount	Distinct Grant Count	Distinct Grantee Count
Health Workforce Active Grants	$0	0	0
Healthcare Systems Active Grants	$0	0	0
HIV/AIDS Active Grants	$0	0	0
Maternal and Child Health Active Grants	$0	0	0
Office of the Administrator Active Grants	$0	0	0
Primary Health Care Active Grants	$0	0	0
Rural Health Active Grants	$0	0	0

FY 2017** Awarded Grants: $0 through 0 grants to 0 grantees

FY 2016 Awarded Grants: $0 through 0 grants to 0 grantees

FY 2015 Awarded Grants: $0 through 0 grants to 0 grantees

FY 2014 Awarded Grants: $0 through 0 grants to 0 grantees

FY 2013 Awarded Grants: $0 through 0 grants to 0 grantees

FY 2012 Awarded Grants: $0 through 0 grants to 0 grantees

FY 2011 Awarded Grants: $0 through 0 grants to 0 grantees

FY 2010 Awarded Grants: $0 through 0 grants to 0 grantees

Health Care and Other Services

HRSA programs provide vital health services for medically vulnerable populations.

Health Care and Other Services

Health Care and Other Services

Health Center Service Delivery and Look-Alike Sites: 1

Description	Count
Total Health Center Administrative Sites	0
Total Health Center Service Delivery Sites	1
Total Health Center Look-Alike Administrative Sites	0
Total Health Center Look-Alike Service Delivery Sites	0

Total Number of Reporting Program Grantees[1]: 0

Ryan White HIV/AIDS Providers: 0

Organ Transplant Programs[2]: 0

National Health Service Corps (NHSC) Approved Sites: 0

National Health Service Corps (NHSC) Full Time Equivalents: 0.00

National Health Service Corps (NHSC) Job Vacancies: 1

Shortage Areas

HRSA identifies geographic areas, population groups, and facilities with too few primary care, dental, and mental health providers.

Shortage Areas[3]

Health Professional Shortage Areas (HPSA): 3

Description	Count
Total Dental Health HPSAs all or partially in the area	1
Total Mental Health HPSAs all or partially in the area	1
Total Primary Care HPSAs all or partially in the area	1

Medically Underserved Areas/Populations (MUA/P): 1

Description	Count
Total Governor all or partially in the area	0
Total MUA all or partially in the area	1
Total MUP all or partially in the area	0

*An active grant is defined by HRSA as a grant whose project period end date is beyond the current date. Grants can be active whether or not they have received an award funding in the current fiscal year.

**Fiscal year-to-date funding. This data represents real time awards to date and may not include funds that have been committed but not yet awarded.

[1] Health Center Service Delivery Site Grantee data as reported in the Uniform Data System calendar year reporting cycle. Data is reported at the health center organizational level and not the individual site level. To learn more about the Uniform Data System and view more detailed information, please visit the HRSA Health Center Program Grantee Data site.

[2] Organ Transplant Programs are listed at the state level.

[3] Shortage area boundaries can cross state, county, congressional district, and ZIP Code boundaries. Counts include any area all or partially within the selected geographic area.

Visit the Data Sources and Refresh Dates page for more information about the refresh cycle for data within the Data Warehouse.

HPSA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 8/25/2017

State: Alabama
County: Talladega County
Discipline: Primary Care
Metro: All
Status: D,P
Type: All
Date of Last Update: All Dates
HPSA Score: From 0 To 26

Collapse All

1 Page Size: 20

02 items in 01 pages

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	Population Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Talladega County	121	1019990185	Low Income - Talladega County	Primary Care	HPSA Population	Low Income Population HPSA	7	13	Designated	06/22/2011

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Updated Date
Talladega County	121		Talladega	Primary Care	Single County			Designated	06/22/2011

Talladega County	121	1019990164	Federal Correctional Institution - Talladega	Primary Care	Correctional Facility	0	12	Designated	12/30/2013

1 Page Size: 20

02 items in 01 pages

Note: Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee – they are not listed separately.

HPSA Find Results

Search Criteria

Click on a column heading to sort the results in ascending or descending order.

Start Over | Modify Search Criteria | Map View

Data as of 8/25/2017

State: Alabama
County: Talladega County
Discipline: Dental Health
Metro: All
Status: D,P
Type: All
Date of Last Update: All Dates
HPSA Score: From 0 To 26

Collapse All

1 Page Size: 20

02 items in 01 pages

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	Population Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Talladega County	121	6019990110	Federal Correctional Institution - Talladega	Dental Health	Correctional Facility		0	12	Designated	12/30/2013
Talladega County	121	6019990139	Low Income - Talladega County	Dental Health	HPSA Population	Low Income Population HPSA	2	17	Designated	11/06/2013

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Updated Date
Talladega County	121		Talladega	Dental Health	Single County			Designated	11/06/2013

1 Page Size: 20

02 items in 01 pages

Note: Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee – they are not listed separately.

HPSA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 8/25/2017

State: Alabama
County: Talladega County
Discipline: Mental Health
Metro: All
Status: D,P
Type: All
Date of Last Update: All Dates
HPSA Score: From 0 To 26

Collapse All

1 Page Size: 20

02 items in 01 pages

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	Population Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Talladega County	121	7019990107	Clay/Coosa/Randolph/Talladega Mental Health Catchment Area 9	Mental Health	HPSA Geographic High Needs	Geographic Population	0	17	Designated	04/24/2012

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Updated Date
Talladega County	121		Talladega	Mental Health	Single County			Designated	04/24/2012

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Updated Date
Talladega County	121	7019990164	Federal Correctional Institution - Talladega	Mental Health	Correctional Facility	0	21	Designated	05/03/2013

1 Page Size: 20

02 items in 01 pages

Note: Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee – they are not listed separately.

Data by Geography - Talladega County, AL

Enlarge Map

HRSA's programs improve access to health care by strengthening the health care workforce, building healthy communities, and achieving health equity. These programs provide health care to people who are geographically isolated, economically or medically vulnerable.

Click the icons next to each data indicator to display the data detail in the Data Portal or Map Tool.

Data as of 08/24/2017

HRSA Grants

HRSA has thousands of active grants worth billions of dollars to improve and expand health care services for underserved people.

HRSA Grants

Active Grants*: $1,798,031 through 2 grants to 2 grantees

Description	Amount	Distinct Grant Count	Distinct Grantee Count
Health Workforce Active Grants	$0	0	0
Healthcare Systems Active Grants	$0	0	0
HIV/AIDS Active Grants	$0	0	0
Maternal and Child Health Active Grants	$0	0	0
Office of the Administrator Active Grants	$0	0	0
Primary Health Care Active Grants	$0	0	0
Rural Health Active Grants	$1,798,031	2	2

FY 2017** Awarded Grants: $0 through 0 grants to 0 grantees

FY 2016 Awarded Grants: $300,000 through 1 grant to 1 grantee

FY 2015 Awarded Grants: $599,267 through 2 grants to 2 grantees

FY 2014 Awarded Grants: $599,653 through 2 grants to 2 grantees

FY 2013 Awarded Grants: $299,111 through 1 grant to 1 grantee

FY 2012 Awarded Grants: $0 through 0 grants to 0 grantees

FY 2011 Awarded Grants: $100,000 through 1 grant to 1 grantee

FY 2010 Awarded Grants: $597,820 through 4 grants to 2 grantees

Health Care and Other Services

HRSA programs provide vital health services for medically vulnerable populations.

Health Care and Other Services

Health Care and Other Services

Health Center Service Delivery and Look-Alike Sites: 1

Description	Count
Total Health Center Administrative Sites	0
Total Health Center Service Delivery Sites	1
Total Health Center Look-Alike Administrative Sites	0
Total Health Center Look-Alike Service Delivery Sites	0

Total Number of Reporting Program Grantees[1]: 0

Ryan White HIV/AIDS Providers: 0

Organ Transplant Programs[2]: 0

National Health Service Corps (NHSC) Approved Sites: 0

National Health Service Corps (NHSC) Full Time Equivalents: 2.00

National Health Service Corps (NHSC) Job Vacancies: 0

Shortage Areas

HRSA identifies geographic areas, population groups, and facilities with too few primary care, dental, and mental health providers.

Shortage Areas[3]

Health Professional Shortage Areas (HPSA): 6

Description	Count
Total Dental Health HPSAs all or partially in the area	2
Total Mental Health HPSAs all or partially in the area	2
Total Primary Care HPSAs all or partially in the area	2

Medically Underserved Areas/Populations (MUA/P): 1

Description	Count
Total Governor all or partially in the area	0
Total MUA all or partially in the area	1
Total MUP all or partially in the area	0

*An active grant is defined by HRSA as a grant whose project period end date is beyond the current date. Grants can be active whether or not they have received an award funding in the current fiscal year.

**Fiscal year-to-date funding. This data represents real time awards to date and may not include funds that have been committed but not yet awarded.

[1] Health Center Service Delivery Site Grantee data as reported in the Uniform Data System calendar year reporting cycle. Data is reported at the health center organizational level and not the individual site level. To learn more about the Uniform Data System and view more detailed information, please visit the HRSA Health Center Program Grantee Data site.

[2] Organ Transplant Programs are listed at the state level.

[3] Shortage area boundaries can cross state, county, congressional district, and ZIP Code boundaries. Counts include any area all or partially within the selected geographic area.

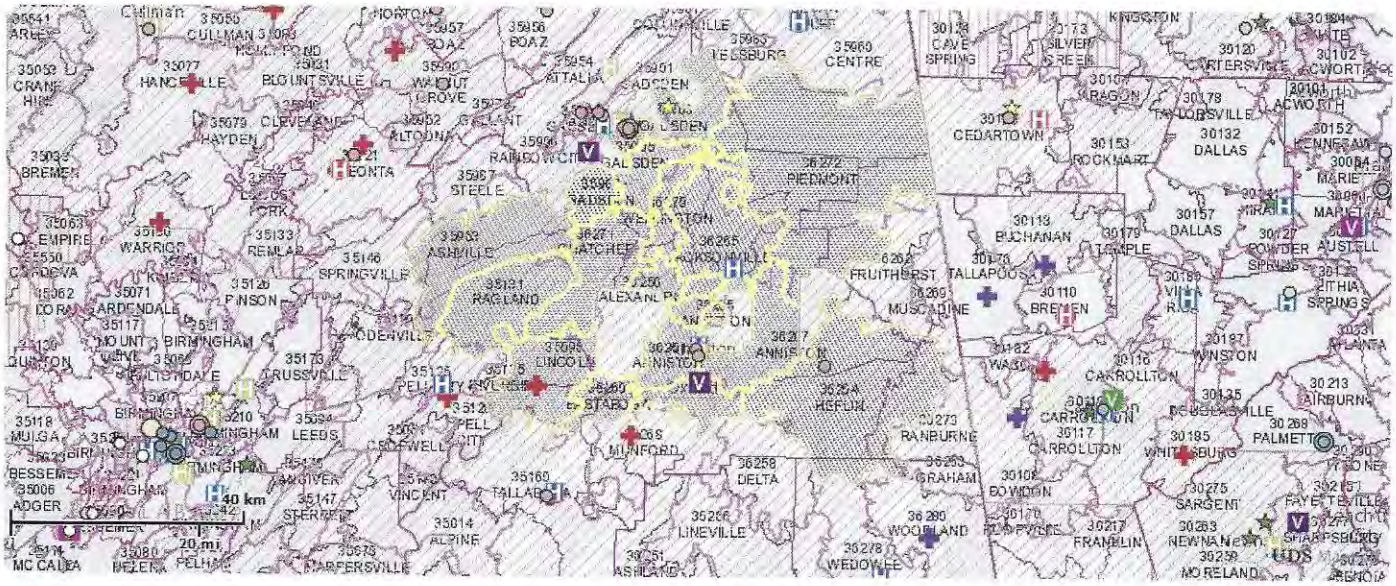
Visit the Data Sources and Refresh Dates page for more information about the refresh cycle for data within the Data Warehouse.

ATTACHMENT C

UDS MAPPER REPORT

RMC CALHOUN COUNTY 2016 DATA

UDS Mapper



States

Counties

ZCTAs

ZIP Codes

Medically Underserved Areas/Populations

Medically Underserved Area

Medically Underserved Population

Governor Designated

PCSAs

Selected ZCTAs

HCP Grantee Administrative Locations

HCP Look-Alike Administrative Locations

HCP Grantee Service Access Points

HCP Look-Alike Service Access Points

NHSC Sites

★ Less than 1 PC FTE

☆ 1-5 PC FTEs

★ 5+ PC FTEs

★ All Other Providers

Rural Health Clinics

Facility and Point HPSAs

- HCP Look-Alike
- Rural Health Clinic
- Indian Health Service Facility
- Alaskan Native Tribal Population
- Native American Tribal Population
- HCP Grantee

Hospitals

- Short Term Hospitals
- Critical Access Hospitals
- Other Hospitals
- **VHA Facilities**

ZCTA	Post Office Name	State	Health Center Count, 2016	Dominant Health Center, 2016	Total Population, 2011-2015	Low-Income Pop, 2011-2015	Total # Health Center Patients, 2016	Penetration of Low-Income	Penetration of Total Pop	Penetration of Uninsured Population
Summary:					185,779	76,297	18,364	24.06 %	9.88 %	73.13 %
35903	Gadsden	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	17,709	9,056	4,207	46.45 %	23.75 %	135.89 %
35905	Gadsden	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	6,663	1,873	567	30.27 %	8.50 %	62.87 %
35907	Gadsden	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	8,391	1,419	347	24.45 %	4.13 %	45.75 %
35953	Ashville	AL	2	QUALITY OF LIFE HEALTH SERVICES, INC.	7,066	3,194	399	12.49 %	5.64 %	39.82 %
35096	Lincoln	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	7,786	2,501	311	12.43 %	3.99 %	30.62 %
36207	Anniston	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	20,679	7,852	1,325	16.87 %	6.40 %	54.25 %
36250	Alexandria	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	4,770	1,206	149	12.35 %	3.12 %	30.08 %
36260	Eastaboga	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	4,341	2,070	317	15.31 %	7.30 %	57.93 %
36264	Heflin	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	8,375	3,850	1,848	48.00 %	22.06 %	156.47 %
36265	Jacksonville	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	20,833	8,581	925	10.77 %	4.44 %	35.85 %
36201	Anniston	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	18,544	10,981	3,842	34.98 %	20.71 %	135.82 %
36203	Oxford	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	18,138	6,252	1,369	21.89 %	7.54 %	69.05 %
36205	Anniston	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	461	91	44	48.35 %	9.54 %	43.28 %
36206	Anniston	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	12,138	5,575	924	16.57 %	7.61 %	60.17 %
36271	Ohatchee	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	5,959	2,158	367	17.00 %	6.15 %	53.83 %
36272	Piedmont	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	12,229	5,114	833	16.28 %	6.81 %	55.00 %
35131	Ragland	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	4,189	2,112	151	7.14 %	3.60 %	33.17 %
36277	Weaver	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	4,846	1,427	262	18.36 %	5.40 %	43.73 %

ZCTA	Post Office Name	State	Health Center Count, 2016	Dominant Health Center, 2016	Total Population, 2011-2015	Low-Income Pop, 2011-2015	Total # Health Center Patients, 2016	Penetration of Low-Income	Penetration of Total Pop	Penetration of Uninsured Population
36279	Wellington	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	2,662	985	177	17.96 %	6.64 %	58.71 %

ZCTA	Post Office Name	Penetration of Population with Medicaid and Other Pub Ins	Penetration of Population with Medicare or Priv Ins	15-16 (1-year) Patient % Change	14-16 (2-year) Patient % Change	14-16 (2-year) Patient Change (#)	15-16 (1-year) Uninsured Patient % Change	14-16 (2-year) Uninsured Patient % Change	15-16 (1-year) Medicaid and Other Pub Ins Patient % Change	14-16 (2-year) Medicaid and Other Pub Ins Patient % Change
Summary:		9.78 %	1.95 %	6.13 %	8.82 %	1489	9.35 %	11.66 %	17.63 %	21.34 %
35903	Gadsden	34.87 %	3.57 %	8.34 %	8.73 %	338	14.33 %	12.51 %	9.40 %	12.55 %
35905	Gadsden	15.63 %	1.30 %	6.17 %	8.00 %	42	8.13 %	9.11 %	3.73 %	6.92 %
35907	Gadsden	5.58 %	0.66 %	3.89 %	5.47 %	18	8.77 %	9.73 %	-8.92 %	-7.27 %
35953	Ashville	4.50 %	0.49 %	7.25 %	11.14 %	40	5.94 %	9.18 %	10.63 %	15.55 %
35096	Lincoln	5.08 %	0.47 %	8.74 %	10.67 %	30	9.32 %	10.47 %	17.74 %	19.67 %
36207	Anniston	3.92 %	1.46 %	-0.07 %	4.41 %	56	2.64 %	7.50 %	21.87 %	27.86 %
36250	Alexandria	0.98 %	0.78 %	4.19 %	5.67 %	8	3.73 %	5.71 %	-11.11 %	-11.11 %
36260	Eastaboga	4.67 %	1.97 %	7.45 %	18.72 %	50	9.50 %	19.02 %	27.27 %	35.48 %
36264	Heflin	18.48 %	7.07 %	6.51 %	9.67 %	163	11.15 %	14.51 %	14.49 %	18.00 %
36265	Jacksonville	2.29 %	0.92 %	11.04 %	14.19 %	115	13.79 %	17.25 %	16.66 %	20.98 %
36201	Anniston	15.63 %	5.87 %	6.30 %	9.67 %	339	11.11 %	14.42 %	50.19 %	54.72 %
36203	Oxford	5.36 %	0.98 %	6.37 %	9.34 %	117	7.81 %	11.00 %	20.94 %	24.30 %
36205	Anniston	1.23 %	2.99 %	7.31 %	12.82 %	5	7.40 %	11.53 %	0.00 %	0.00 %
36206	Anniston	5.66 %	1.75 %	3.58 %	6.69 %	58	4.11 %	7.28 %	15.38 %	18.42 %
36271	Ohatchee	3.95 %	1.18 %	3.08 %	5.76 %	20	4.29 %	6.37 %	-2.32 %	2.43 %
36272	Piedmont	5.27 %	1.07 %	2.08 %	5.04 %	40	2.04 %	5.08 %	4.54 %	6.97 %
35131	Ragland	1.20 %	0.23 %	11.02 %	13.53 %	18	11.29 %	14.04 %	20.00 %	0.00 %
36277	Weaver	2.50 %	1.27 %	4.38 %	7.37 %	18	5.11 %	8.18 %	8.00 %	17.39 %
36279	Wellington	6.28 %	1.15 %	4.73 %	8.58 %	14	8.47 %	10.34 %	4.00 %	23.80 %

ZCTA	Post Office Name	15-16 (1-year) Medicare or Priv Ins Patient % Change	14-16 (2-year) Medicare or Priv Ins Patient % Change	Low-Income Not Served by Health Centers	Uninsured Not Served by Health Centers	Medicaid and Other Pub Ins Not Served by Health Centers	Medicare or Priv Ins Not Served by Health Centers	Total Population Not Served by Health Centers	% Patients Uninsured, 2016	# Patients Uninsured, 2016
Summary:		-15.99 %	-13.09 %	57,933	4,462	32,639	133,783	167,415	66.15 %	12,148
35903	Gadsden	-17.92 %	-15.42 %	4,849	-653	2,411	11,969	13,502	58.75 %	2,472
35905	Gadsden	1.47 %	4.54 %	1,306	212	750	5,207	6,096	63.31 %	359
35907	Gadsden	-4.00 %	0.00 %	1,072	294	862	7,198	8,044	71.46 %	248
35953	Ashville	18.18 %	30.00 %	2,795	485	1,103	5,175	6,667	80.45 %	321
35096	Lincoln	-12.90 %	-6.89 %	2,190	478	1,363	5,628	7,475	67.84 %	211
36207	Anniston	-18.21 %	-15.30 %	6,527	785	3,814	15,954	19,354	70.26 %	931
36250	Alexandria	11.11 %	11.11 %	1,057	258	801	3,772	4,621	74.49 %	111
36260	Eastaboga	-9.67 %	7.69 %	1,753	159	856	2,779	4,024	69.08 %	219
36264	Heflin	-9.00 %	-6.48 %	2,002	-410	1,358	5,310	6,527	61.47 %	1,136
36265	Jacksonville	-4.28 %	-2.89 %	7,656	1,240	4,175	14,387	19,908	74.91 %	693
36201	Anniston	-29.29 %	-26.68 %	7,139	-638	4,149	10,479	14,702	62.96 %	2,419
36203	Oxford	-15.06 %	-13.49 %	4,883	470	3,155	14,215	16,769	76.62 %	1,049
36205	Anniston	8.33 %	18.18 %	47	38	160	421	417	65.90 %	29
36206	Anniston	-6.58 %	-3.70 %	4,651	419	2,250	8,753	11,214	68.50 %	633
36271	Ohatchee	1.75 %	5.45 %	1,791	229	1,021	4,851	5,592	72.75 %	267
36272	Piedmont	-1.03 %	2.12 %	4,281	490	2,480	8,828	11,396	71.90 %	599
35131	Ragland	0.00 %	16.66 %	1,961	278	493	2,999	4,038	91.39 %	138
36277	Weaver	0.00 %	0.00 %	1,165	238	1,050	3,886	4,584	70.61 %	185
36279	Wellington	-11.53 %	-11.53 %	808	90	388	1,972	2,485	72.31 %	128

ZCTA	Post Office Name	% Patients with Medicaid and Other Pub Ins, 2016	# Patients with Medicaid and Other Pub Ins, 2016	% Patients with Medicare or Priv Ins, 2016	# Patients Medicare or Priv Ins, 2016	% Pop in Poverty, 11-15	% Low-Income Pop, 11-15	% Non-White, 11-15	% Hispanic, 11-15	% Black, 11-15
Summary:		19.28 %	3,542	14.56 %	2,674	19.20 %	41.93 %	24.30 %	3.12 %	18.34 %
35903	Gadsden	30.68 %	1,291	10.55 %	444	23.61 %	51.67 %	39.44 %	5.15 %	32.27 %
35905	Gadsden	24.51 %	139	12.16 %	69	11.79 %	28.36 %	7.84 %	1.21 %	4.33 %
35907	Gadsden	14.69 %	51	13.83 %	48	4.42 %	16.95 %	4.67 %	1.76 %	1.19 %
35953	Ashville	13.03 %	52	6.51 %	26	27.20 %	46.49 %	16.75 %	3.11 %	10.96 %
35096	Lincoln	23.47 %	73	8.68 %	27	15.21 %	32.24 %	24.04 %	0.34 %	20.34 %
36207	Anniston	11.77 %	156	17.96 %	238	19.23 %	38.58 %	32.57 %	3.65 %	25.89 %
36250	Alexandria	5.36 %	8	20.13 %	30	11.30 %	25.76 %	6.58 %	1.36 %	5.22 %
36260	Eastaboga	13.24 %	42	17.66 %	56	17.36 %	47.68 %	21.26 %	8.15 %	9.99 %
36264	Heflin	16.66 %	308	21.86 %	404	19.86 %	47.06 %	11.91 %	2.75 %	6.18 %
36265	Jacksonville	10.59 %	98	14.48 %	134	22.33 %	44.52 %	19.38 %	2.42 %	14.46 %
36201	Anniston	20.01 %	769	17.02 %	654	34.44 %	60.60 %	48.81 %	1.81 %	46.00 %
36203	Oxford	13.07 %	179	10.29 %	141	10.64 %	35.33 %	24.09 %	6.36 %	13.86 %
36205	Anniston	4.54 %	2	29.54 %	13	12.14 %	19.73 %	13.66 %	0.00 %	10.62 %
36206	Anniston	14.61 %	135	16.88 %	156	20.67 %	46.48 %	39.66 %	5.85 %	26.35 %
36271	Ohatchee	11.44 %	42	15.80 %	58	14.65 %	36.21 %	3.70 %	0.43 %	3.10 %
36272	Piedmont	16.56 %	138	11.52 %	96	20.68 %	42.10 %	9.00 %	1.23 %	5.10 %
35131	Ragland	3.97 %	6	4.63 %	7	22.52 %	50.92 %	11.10 %	0.35 %	9.97 %
36277	Weaver	10.30 %	27	19.08 %	50	5.96 %	29.53 %	20.53 %	2.20 %	11.12 %
36279	Wellington	14.68 %	26	12.99 %	23	7.91 %	37.11 %	3.79 %	0.00 %	0.00 %

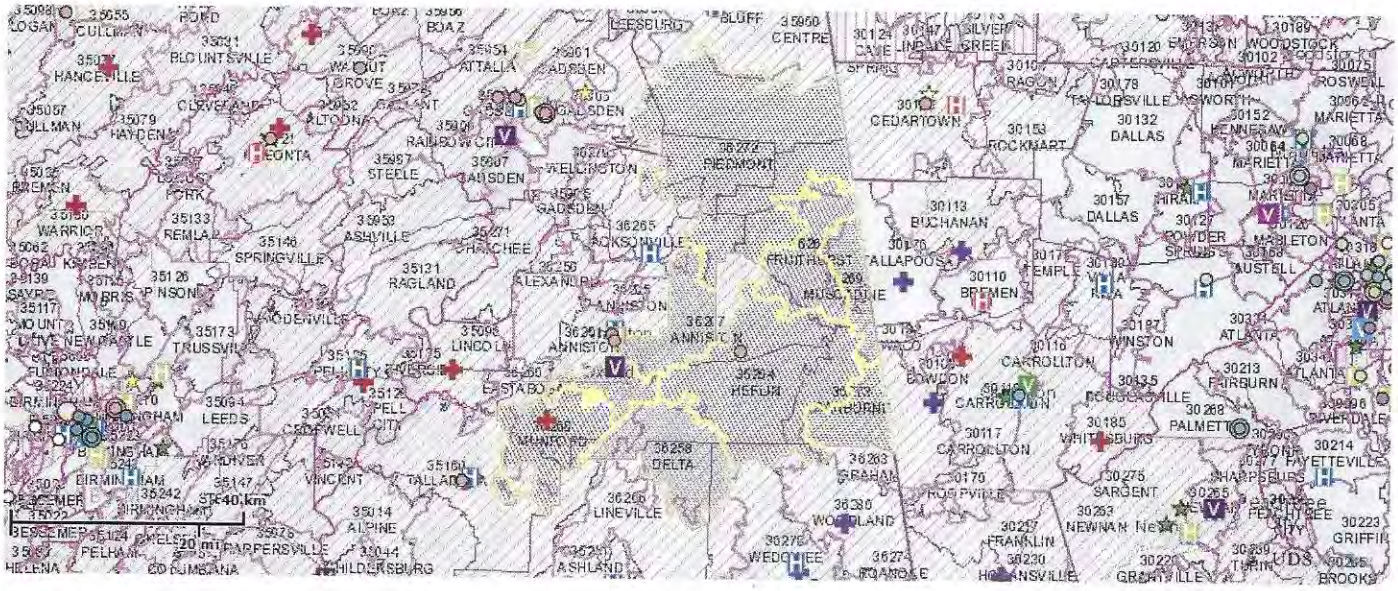
ZCTA	Post Office Name	% Asian, 11-15	% American Indian/Alaska Native, 11-15	% Population Uninsured, est. 2015 (Main Map)	Population Uninsured, est. 2015	13-15 (2-year) Population Uninsured % Change	14-15 (1-year) Population Uninsured % Change	% Population with Medicaid and Other Pub Ins, est. 2015 (Main Map)	Population with Medicaid and Other Pub Ins, est. 2015	13-15 (2-year) Change % Pop with Medicaid and Other Pub Ins
Summary:		0.69 %	0.30 %	8.77 %	16,610	-35.28 %	-16.36 %	19.11 %	36,181	10.81 %
35903	Gadsden	0.13 %	0.05 %	10.14 %	1,819	-30.33 %	-16.52 %	20.64 %	3,702	18.31 %
35905	Gadsden	0.16 %	0.79 %	8.47 %	571	-26.98 %	-26.51 %	13.19 %	889	10.84 %
35907	Gadsden	1.44 %	0.27 %	6.22 %	542	-22.79 %	-18.12 %	10.49 %	913	6.65 %
35953	Ashville	0.53 %	0.83 %	11.25 %	806	2.28 %	-13.70 %	16.12 %	1,155	-17.55 %
35096	Lincoln	0.77 %	0.66 %	8.85 %	689	-40.50 %	-20.34 %	18.45 %	1,436	14.87 %
36207	Anniston	0.81 %	0.13 %	7.84 %	1,716	-32.91 %	-11.72 %	18.14 %	3,970	23.59 %
36250	Alexandria	0.00 %	0.00 %	7.40 %	369	-39.00 %	-13.38 %	16.24 %	809	19.85 %
36260	Eastaboga	0.00 %	0.00 %	9.19 %	378	-30.89 %	-15.62 %	21.84 %	898	11.55 %
36264	Heflin	0.13 %	0.39 %	8.95 %	726	-39.95 %	-15.97 %	20.55 %	1,666	5.77 %
36265	Jacksonville	0.88 %	0.14 %	9.32 %	1,933	-41.95 %	-19.25 %	20.61 %	4,273	17.16 %
36201	Anniston	0.09 %	0.08 %	9.98 %	1,781	-45.86 %	-17.92 %	27.57 %	4,918	6.54 %
36203	Oxford	1.69 %	0.23 %	7.90 %	1,519	-29.96 %	-11.89 %	17.35 %	3,334	19.07 %
36205	Anniston	0.00 %	0.00 %	10.10 %	67	-53.79 %	-32.32 %	24.43 %	162	-10.49 %
36206	Anniston	1.89 %	0.70 %	8.52 %	1,052	-36.08 %	-9.46 %	19.31 %	2,385	11.76 %
36271	Ohatchee	0.00 %	0.08 %	7.66 %	496	-37.13 %	-11.74 %	16.43 %	1,063	10.04 %
36272	Piedmont	0.25 %	0.72 %	8.62 %	1,089	-38.68 %	-20.51 %	20.72 %	2,618	7.69 %
35131	Ragland	0.04 %	0.09 %	10.60 %	416	-7.96 %	-14.92 %	12.72 %	499	-35.52 %
36277	Weaver	1.91 %	0.37 %	7.78 %	423	-43.37 %	-20.78 %	19.81 %	1,077	12.53 %
36279	Wellington	0.00 %	0.52 %	8.29 %	218	-39.61 %	-14.84 %	15.75 %	414	-5.47 %

ZCTA	Post Office Name	14-15 (1-year) Change % Pop with Medicaid and Other Pub Ins	% Population with Medicare or Priv Ins, est. 2015 (Main Map)	Population with Medicare or Priv Ins, est. 2015	13-15 (2-year) Change % Pop with Medicare or Priv Ins	14-15 (1-year) Change % Pop with Medicare or Priv Ins	% Under 18, 11-15	% 18 to 64, 11-15	% 65 and Older, 11-15	% Pop Not Employed, 11-15 (Main Map)
Summary:		10.49 %	72.10 %	136,457	9.48 %	5.78 %	22.16 %	62.08 %	15.74 %	48.60 %
35903	Gadsden	1.78 %	69.21 %	12,413	0.67 %	5.41 %	20.11 %	62.37 %	17.51 %	50.01 %
35905	Gadsden	-2.41 %	78.32 %	5,276	15.02 %	12.04 %	18.47 %	63.58 %	17.93 %	50.94 %
35907	Gadsden	-0.54 %	83.27 %	7,246	8.99 %	10.00 %	22.25 %	64.25 %	13.49 %	37.19 %
35953	Ashville	-7.74 %	72.61 %	5,201	-0.81 %	-3.14 %	25.95 %	55.91 %	18.12 %	53.61 %
35096	Lincoln	9.20 %	72.68 %	5,655	0.53 %	1.34 %	20.25 %	65.88 %	13.85 %	45.21 %
36207	Anniston	22.26 %	74.01 %	16,192	19.41 %	8.97 %	21.48 %	59.32 %	19.19 %	47.87 %
36250	Alexandria	15.24 %	76.34 %	3,802	23.36 %	0.42 %	24.71 %	62.53 %	12.74 %	42.76 %
36260	Eastaboga	14.54 %	68.96 %	2,835	2.30 %	-0.35 %	26.23 %	61.11 %	12.64 %	49.33 %
36264	Heflin	0.72 %	70.49 %	5,714	-1.02 %	-3.00 %	23.94 %	56.77 %	19.28 %	52.13 %
36265	Jacksonville	21.98 %	70.05 %	14,521	17.18 %	7.98 %	20.06 %	66.96 %	12.96 %	46.40 %
36201	Anniston	18.50 %	62.43 %	11,133	0.45 %	3.37 %	23.68 %	60.99 %	15.32 %	60.15 %
36203	Oxford	9.52 %	74.73 %	14,356	16.90 %	12.21 %	22.56 %	62.77 %	14.65 %	42.52 %
36205	Anniston	-11.47 %	65.46 %	434	-7.26 %	-1.13 %	15.18 %	56.39 %	28.41 %	59.07 %
36206	Anniston	8.60 %	72.16 %	8,909	14.32 %	12.27 %	25.73 %	60.99 %	13.27 %	46.17 %
36271	Ohatchee	9.81 %	75.89 %	4,909	18.06 %	5.34 %	22.31 %	63.98 %	13.69 %	46.71 %
36272	Piedmont	8.40 %	70.65 %	8,924	1.93 %	0.28 %	22.87 %	60.98 %	16.14 %	50.01 %
35131	Ragland	-9.60 %	76.66 %	3,006	2.41 %	-1.11 %	21.67 %	61.06 %	17.25 %	55.29 %
36277	Weaver	20.87 %	72.40 %	3,936	21.70 %	7.54 %	20.53 %	60.42 %	19.04 %	50.03 %
36279	Wellington	-1.66 %	75.94 %	1,995	4.06 %	2.46 %	17.16 %	70.09 %	12.73 %	41.74 %

ZCTA	Post Office Name	% Households with Limited English Proficiency, 11-15 (Main Map)	% Pop with Less Than High School Education, 11-15 (Main Map)	13-15 (2-year) Change % Total Population	14-15 (1-year) Change % Total Population	Low Birth Weight Rate, est. 12-14	Age-Adjusted Mortality Rate (per 100,000), est. 2012-2014	% Adults Ever Told They Have Diabetes, est. 09-12	% Adults Ever Told They Have High Blood Pressure, est. 07-12	% Adults Who Are Obese, est. 09-12
Summary:		0.83 %	18.58 %	-0.83 %	-0.22 %	8.39	1,007	12.52 %	38.40 %	30.41 %
35903	Gadsden	1.21 %	17.70 %	-2.63 %	2.26 %	8.77	1,054	13.20 %	42.74 %	32.21 %
35905	Gadsden	0.95 %	14.98 %	6.08 %	-0.99 %	7.61	1,051	12.78 %	39.84 %	28.71 %
35907	Gadsden	0.77 %	9.07 %	0.62 %	0.03 %	7.58	1,005	12.26 %	38.97 %	28.19 %
35953	Ashville	0.31 %	23.20 %	7.91 %	0.31 %	8.16	935	16.20 %	38.43 %	29.15 %
35096	Lincoln	0.00 %	15.41 %	-5.44 %	0.38 %	10.80	1,014	12.13 %	40.45 %	34.51 %
36207	Anniston	1.75 %	15.79 %	2.28 %	-0.22 %	8.36	1,008	12.60 %	38.06 %	31.18 %
36250	Alexandria	0.00 %	12.10 %	-3.20 %	-3.98 %	7.55	1,031	12.32 %	37.49 %	29.66 %
36260	Eastaboga	0.70 %	26.55 %	10.73 %	4.45 %	8.28	978	11.01 %	37.87 %	29.77 %
36264	Heflin	0.55 %	25.57 %	-4.14 %	-2.40 %	8.21	935	8.83 %	28.97 %	22.39 %
36265	Jacksonville	0.30 %	15.05 %	-1.48 %	0.11 %	7.87	1,013	12.26 %	37.74 %	30.16 %
36201	Anniston	0.32 %	29.84 %	-4.90 %	1.47 %	9.59	1,027	13.41 %	38.36 %	33.24 %
36203	Oxford	2.89 %	15.86 %	-4.29 %	-2.63 %	8.72	988	11.82 %	38.27 %	31.06 %
36205	Anniston	0.00 %	8.26 %	-1.07 %	15.82 %	8.69	998	12.28 %	36.96 %	30.82 %
36206	Anniston	0.28 %	17.11 %	5.53 %	1.37 %	8.25	982	11.95 %	37.89 %	30.72 %
36271	Ohatchee	0.00 %	21.94 %	0.86 %	-2.69 %	7.48	1,034	12.04 %	37.08 %	28.92 %
36272	Piedmont	0.00 %	21.57 %	-3.87 %	-5.69 %	7.72	1,014	13.07 %	40.85 %	29.96 %
35131	Ragland	0.79 %	23.81 %	-0.16 %	9.60 %	7.85	975	15.99 %	38.80 %	29.62 %
36277	Weaver	0.25 %	14.10 %	0.39 %	1.72 %	7.63	996	11.37 %	36.01 %	28.31 %
36279	Wellington	0.00 %	15.34 %	-2.66 %	-3.86 %	7.14	1,000	11.70 %	36.33 %	28.20 %

ZCTA	Post Office Name	% Adults with No Dental Visit in Past Year, est. 07-12	% Adults Who Have Delayed or Not Sought Care Due to High Cost, est. 09-12	% Adults with No Usual Source of Care, est. 09-12	% Uninsured Population Below 138% FPL, 11-15	% Uninsured Population Below 200% FPL, 11-15	% Uninsured Population at 138%-400% FPL, 11-15
Summary:		40.65 %	19.75 %	21.01 %	6.24 %	8.27 %	4.49 %
35903	Gadsden	35.87 %	19.97 %	16.96 %	59.79 %	77.76 %	37.23 %
35905	Gadsden	37.93 %	14.86 %	18.28 %	39.18 %	60.42 %	43.27 %
35907	Gadsden	35.38 %	13.91 %	20.16 %	40.36 %	55.40 %	31.92 %
35953	Ashville	37.58 %	17.79 %	9.36 %	69.02 %	72.44 %	25.06 %
35096	Lincoln	44.34 %	21.41 %	19.68 %	72.29 %	76.54 %	27.70 %
36207	Anniston	42.21 %	20.32 %	23.38 %	59.99 %	67.81 %	30.15 %
36250	Alexandria	42.36 %	18.42 %	22.72 %	33.73 %	42.34 %	19.13 %
36260	Eastaboga	42.24 %	20.48 %	21.32 %	46.93 %	67.34 %	48.52 %
36264	Heflin	43.65 %	24.80 %	22.95 %	27.63 %	67.45 %	59.67 %
36265	Jacksonville	42.03 %	19.37 %	22.63 %	58.77 %	69.85 %	30.97 %
36201	Anniston	42.41 %	22.14 %	25.11 %	54.00 %	69.24 %	41.60 %
36203	Oxford	42.66 %	21.09 %	21.96 %	34.30 %	66.41 %	50.54 %
36205	Anniston	40.45 %	20.80 %	22.73 %	100.00 %	100.00 %	0.00 %
36206	Anniston	41.30 %	20.41 %	22.41 %	68.32 %	82.71 %	29.58 %
36271	Ohatchee	41.89 %	17.83 %	22.15 %	46.17 %	55.98 %	33.38 %
36272	Piedmont	38.07 %	18.43 %	21.42 %	52.98 %	64.11 %	38.29 %
35131	Ragland	37.98 %	18.57 %	9.95 %	71.55 %	82.29 %	16.03 %
36277	Weaver	39.87 %	18.27 %	20.97 %	25.28 %	73.31 %	68.53 %
36279	Wellington	41.03 %	17.42 %	21.49 %	34.46 %	53.98 %	43.63 %

RMC CLEBURNE COUNTY 2016 UDS Mapper



States

Counties

ZCTAs

ZIP Codes

Medically Underserved Areas/Populations

Medically Underserved Area

Governor Designated

Medically Underserved Population

PCSAs

Selected ZCTAs

HCP Grantee Administrative Locations

HCP Look-Alike Administrative Locations

HCP Grantee Service Access Points

HCP Look-Alike Service Access Points

NHSC Sites

- Less than 1 PC FTE
- 1-5 PC FTEs
- 5+ PC FTEs
- All Other Providers
- **Rural Health Clinics**

Facility and Point HPSAs

- HCP Look-Alike
- Rural Health Clinic
- Indian Health Service Facility
- Alaskan Native Tribal Population
- Native American Tribal Population
- HCP Grantee

Hospitals

- Short Term Hospitals
- Critical Access Hospitals
- Other Hospitals
- **VHA Facilities**

ZCTA	Post Office Name	State	Health Center Count, 2016	Dominant Health Center, 2016	Total Population, 2011-2015	Low-Income Pop, 2011-2015	Total # Health Center Patients, 2016	Penetration of Low-Income	Penetration of Total Pop	Penetration of Uninsured Population
Summary:					72,946	28,395	6,768	23.83 %	9.27 %	75.88 %
36207	Anniston	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	20,679	7,852	1,325	16.87 %	6.40 %	54.25 %
36258	Delta	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	1,378	516	221	42.82 %	16.03 %	124.63 %
36262	Fruithurst	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	1,387	668	327	48.95 %	23.57 %	152.10 %
36264	Heflin	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	8,375	3,850	1,848	48.00 %	22.06 %	156.47 %
36268	Munford	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	5,977	2,741	309	11.27 %	5.16 %	51.22 %
36269	Muscadine	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	1,163	338	237	70.11 %	20.37 %	133.33 %
36203	Oxford	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	18,138	6,252	1,369	21.89 %	7.54 %	69.05 %
36272	Piedmont	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	12,229	5,114	833	16.28 %	6.81 %	55.00 %
36273	Ranburne	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	3,620	1,064	299	28.10 %	8.25 %	82.12 %

ZCTA	Post Office Name	Penetration of Population with Medicaid and Other Pub Ins	Penetration of Population with Medicare or Priv Ins	15-16 (1-year) Patient % Change	14-16 (2-year) Patient % Change	14-16 (2-year) Patient Change (#)	15-16 (1-year) Uninsured Patient % Change	14-16 (2-year) Uninsured Patient % Change	15-16 (1-year) Medicaid and Other Pub Ins Patient % Change	14-16 (2-year) Medicaid and Other Pub Ins Patient % Change
Summary:		7.14 %	2.04 %	5.32 %	8.91 %	554	7.81 %	11.63 %	14.59 %	18.40 %
36207	Anniston	3.92 %	1.46 %	-0.07 %	4.41 %	56	2.64 %	7.50 %	21.87 %	27.86 %
36258	Delta	5.92 %	2.80 %	12.18 %	15.10 %	29	13.90 %	17.00 %	-5.26 %	0.00 %
36262	Fruithurst	24.35 %	8.02 %	14.33 %	22.01 %	59	24.82 %	30.21 %	24.52 %	34.69 %
36264	Heflin	18.48 %	7.07 %	6.51 %	9.67 %	163	11.15 %	14.51 %	14.49 %	18.00 %
36268	Munford	1.65 %	1.16 %	9.57 %	14.86 %	40	10.57 %	14.09 %	30.76 %	41.66 %
36269	Muscadine	18.50 %	3.71 %	11.26 %	13.39 %	28	16.03 %	17.82 %	9.30 %	11.90 %
36203	Oxford	5.36 %	0.98 %	6.37 %	9.34 %	117	7.81 %	11.00 %	20.94 %	24.30 %
36272	Piedmont	5.27 %	1.07 %	2.08 %	5.04 %	40	2.04 %	5.08 %	4.54 %	6.97 %
36273	Ranburne	13.43 %	1.62 %	5.28 %	7.94 %	22	5.46 %	13.52 %	4.61 %	4.61 %

ZCTA	Post Office Name	15-16 (1-year) Medicare or Priv Ins Patient % Change	14-16 (2-year) Medicare or Priv Ins Patient % Change	Low-Income Not Served by Health Centers	Uninsured Not Served by Health Centers	Medicaid and Other Pub Ins Not Served by Health Centers	Medicare or Priv Ins Not Served by Health Centers	Total Population Not Served by Health Centers	% Patients Uninsured, 2016	# Patients Uninsured, 2016
Summary:		-10.00 %	-7.28 %	21,627	1,482	12,954	53,075	66,178	68.91 %	4,664
36207	Anniston	-18.21 %	-15.30 %	6,527	785	3,814	15,954	19,354	70.26 %	931
36258	Delta	14.81 %	14.81 %	295	-34	286	1,074	1,157	77.82 %	172
36262	Fruithurst	-9.09 %	0.00 %	341	-62	205	917	1,060	55.35 %	181
36264	Heflin	-9.00 %	-6.48 %	2,002	-410	1,358	5,310	6,527	61.47 %	1,136
36268	Munford	-2.38 %	10.81 %	2,432	239	1,011	3,484	5,668	81.22 %	251
36269	Muscadine	-2.56 %	0.00 %	101	-38	207	986	926	64.13 %	152
36203	Oxford	-15.06 %	-13.49 %	4,883	470	3,155	14,215	16,769	76.62 %	1,049
36272	Piedmont	-1.03 %	2.12 %	4,281	490	2,480	8,828	11,396	71.90 %	599
36273	Ranburne	5.55 %	-9.52 %	765	42	438	2,307	3,321	64.54 %	193

ZCTA	Post Office Name	% Patients with Medicaid and Other Pub Ins, 2016	# Patients with Medicaid and Other Pub Ins, 2016	% Patients with Medicare or Priv Ins, 2016	# Patients Medicare or Priv Ins, 2016	% Pop in Poverty, 11-15	% Low-Income Pop, 11-15	% Non-White, 11-15	% Hispanic, 11-15	% Black, 11-15
Summary:		14.73 %	997	16.35 %	1,107	17.09 %	39.54 %	20.37 %	3.43 %	14.11 %
36207	Anniston	11.77 %	156	17.96 %	238	19.23 %	38.58 %	32.57 %	3.65 %	25.89 %
36258	Delta	8.14 %	18	14.02 %	31	21.78 %	38.10 %	5.51 %	4.06 %	0.94 %
36262	Fruithurst	20.18 %	66	24.46 %	80	24.36 %	48.16 %	2.73 %	1.94 %	0.43 %
36264	Heflin	16.66 %	308	21.86 %	404	19.86 %	47.06 %	11.91 %	2.75 %	6.18 %
36268	Munford	5.50 %	17	13.26 %	41	21.57 %	46.30 %	23.32 %	1.68 %	20.67 %
36269	Muscadine	19.83 %	47	16.03 %	38	9.11 %	29.06 %	0.94 %	0.00 %	0.00 %
36203	Oxford	13.07 %	179	10.29 %	141	10.64 %	35.33 %	24.09 %	6.36 %	13.86 %
36272	Piedmont	16.56 %	138	11.52 %	96	20.68 %	42.10 %	9.00 %	1.23 %	5.10 %
36273	Ranburne	22.74 %	68	12.70 %	38	9.10 %	29.44 %	3.78 %	0.85 %	0.91 %

ZCTA	Post Office Name	% Asian, 11-15	% American Indian/Alaska Native, 11-15	% Population Uninsured, est. 2015 (Main Map)	Population Uninsured, est. 2015	13-15 (2-year) Population Uninsured % Change	14-15 (1-year) Population Uninsured % Change	% Population with Medicaid and Other Pub Ins, est. 2015 (Main Map)	Population with Medicaid and Other Pub Ins, est. 2015	13-15 (2-year) Change % Pop with Medicaid and Other Pub Ins
Summary:		0.78 %	0.26 %	8.27 %	6,146	-35.33 %	-15.87 %	18.78 %	13,951	13.77 %
36207	Anniston	0.81 %	0.13 %	7.84 %	1,716	-32.91 %	-11.72 %	18.14 %	3,970	23.59 %
36258	Delta	0.00 %	0.00 %	8.92 %	138	-44.12 %	-17.36 %	19.65 %	304	8.57 %
36262	Fruithurst	0.21 %	0.00 %	8.57 %	119	-32.00 %	-13.76 %	19.53 %	271	39.69 %
36264	Heflin	0.13 %	0.39 %	8.95 %	726	-39.95 %	-15.97 %	20.55 %	1,666	5.77 %
36268	Munford	0.26 %	0.00 %	9.71 %	490	-38.20 %	-24.61 %	20.38 %	1,028	13.09 %
36269	Muscadine	0.00 %	0.00 %	8.18 %	114	-35.22 %	-17.98 %	18.24 %	254	14.41 %
36203	Oxford	1.69 %	0.23 %	7.90 %	1,519	-29.96 %	-11.89 %	17.35 %	3,334	19.07 %
36272	Piedmont	0.25 %	0.72 %	8.62 %	1,089	-38.68 %	-20.51 %	20.72 %	2,618	7.69 %
36273	Ranburne	1.07 %	0.00 %	7.61 %	235	-41.39 %	-24.19 %	16.39 %	506	-20.81 %

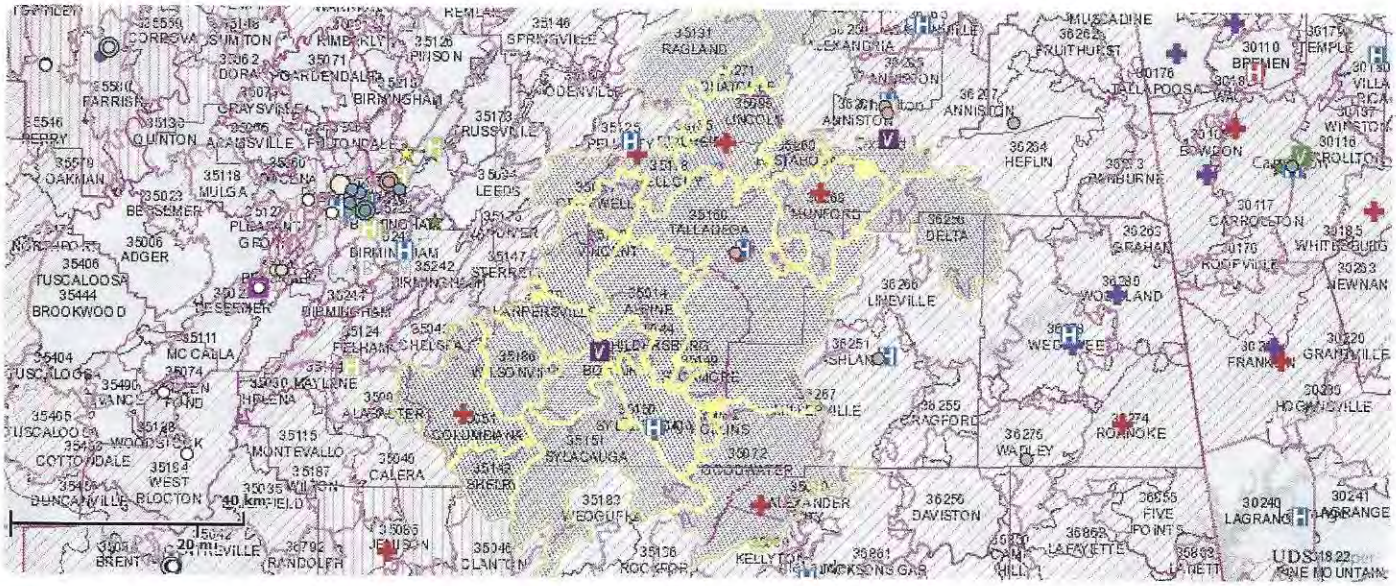
ZCTA	Post Office Name	14-15 (1-year) Change % Pop with Medicaid and Other Pub Ins	% Population with Medicare or Priv Ins, est. 2015 (Main Map)	Population with Medicare or Priv Ins, est. 2015	13-15 (2-year) Change % Pop with Medicare or Priv Ins	14-15 (1-year) Change % Pop with Medicare or Priv Ins	% Under 18, 11-15	% 18 to 64, 11-15	% 65 and Older, 11-15	% Pop Not Employed, 11-15 (Main Map)
Summary:		10.98 %	72.94 %	54,182	10.70 %	5.02 %	22.34 %	60.62 %	17.02 %	47.22 %
36207	Anniston	22.26 %	74.01 %	16,192	19.41 %	8.97 %	21.48 %	59.32 %	19.19 %	47.87 %
36258	Delta	1.67 %	71.42 %	1,105	-3.91 %	-4.24 %	16.25 %	63.57 %	20.17 %	52.97 %
36262	Fruithurst	38.97 %	71.88 %	997	28.14 %	12.91 %	25.81 %	55.58 %	18.60 %	45.24 %
36264	Heflin	0.72 %	70.49 %	5,714	-1.02 %	-3.00 %	23.94 %	56.77 %	19.28 %	52.13 %
36268	Munford	7.19 %	69.89 %	3,525	2.53 %	-1.03 %	22.36 %	62.12 %	15.50 %	48.44 %
36269	Muscadine	22.70 %	73.56 %	1,024	17.97 %	4.59 %	15.21 %	68.18 %	16.59 %	48.50 %
36203	Oxford	9.52 %	74.73 %	14,356	16.90 %	12.21 %	22.56 %	62.77 %	14.65 %	42.52 %
36272	Piedmont	8.40 %	70.65 %	8,924	1.93 %	0.28 %	22.87 %	60.98 %	16.14 %	50.01 %
36273	Ranburne	-8.00 %	75.98 %	2,345	0.21 %	-8.79 %	24.03 %	60.91 %	15.05 %	42.52 %

ZCTA	Post Office Name	% Households with Limited English Proficiency, 11-15 (Main Map)	% Pop with Less Than High School Education, 11-15 (Main Map)	13-15 (2-year) Change % Total Population	14-15 (1-year) Change % Total Population	Low Birth Weight Rate, est. 12-14	Age-Adjusted Mortality Rate (per 100,000), est. 2012-2014	% Adults Ever Told They Have Diabetes, est. 09-12	% Adults Ever Told They Have High Blood Pressure, est. 07-12	% Adults Who Are Obese, est. 09-12
Summary:		1.28 %	19.23 %	-0.13 %	-0.80 %	8.55	991	11.72 %	36.97 %	29.46 %
36207	Anniston	1.75 %	15.79 %	2.28 %	-0.22 %	8.36	1,008	12.60 %	38.06 %	31.18 %
36258	Delta	0.00 %	26.71 %	7.48 %	11.48 %	8.23	895	12.19 %	28.85 %	26.86 %
36262	Fruithurst	1.12 %	21.98 %	6.52 %	-2.59 %	8.86	979	9.36 %	31.82 %	24.24 %
36264	Heflin	0.55 %	25.57 %	-4.14 %	-2.40 %	8.21	935	8.83 %	28.97 %	22.39 %
36268	Munford	0.00 %	21.78 %	17.93 %	11.86 %	11.02	1,010	11.64 %	38.86 %	33.39 %
36269	Muscadine	0.00 %	35.96 %	0.34 %	20.89 %	8.93	976	9.52 %	32.36 %	24.65 %
36203	Oxford	2.89 %	15.86 %	-4.29 %	-2.63 %	8.72	988	11.82 %	38.27 %	31.06 %
36272	Piedmont	0.00 %	21.57 %	-3.87 %	-5.69 %	7.72	1,014	13.07 %	40.85 %	29.96 %
36273	Ranburne	0.00 %	19.33 %	0.33 %	-1.44 %	8.90	983	9.57 %	32.52 %	24.77 %

ZCTA	Post Office Name	% Adults with No Dental Visit in Past Year, est. 07-12	% Adults Who Have Delayed or Not Sought Care Due to High Cost, est. 09-12	% Adults with No Usual Source of Care, est. 09-12	% Uninsured Population Below 138% FPL, 11-15	% Uninsured Population Below 200% FPL, 11-15	% Uninsured Population at 138%-400% FPL, 11-15
Summary:		42.48 %	21.62 %	22.63 %	5.64 %	8.54 %	5.91 %
36207	Anniston	42.21 %	20.32 %	23.38 %	59.99 %	67.81 %	30.15 %
36258	Delta	41.94 %	21.09 %	19.76 %	89.22 %	89.22 %	10.77 %
36262	Fruithurst	47.59 %	27.65 %	25.61 %	57.07 %	69.40 %	39.26 %
36264	Heflin	43.65 %	24.80 %	22.95 %	27.63 %	67.45 %	59.67 %
36268	Munford	45.77 %	24.27 %	21.95 %	40.00 %	67.92 %	53.25 %
36269	Muscadine	48.40 %	28.12 %	26.05 %	34.09 %	70.45 %	65.90 %
36203	Oxford	42.66 %	21.09 %	21.96 %	34.30 %	66.41 %	50.54 %
36272	Piedmont	38.07 %	18.43 %	21.42 %	52.98 %	64.11 %	38.29 %
36273	Ranburne	48.65 %	28.27 %	26.18 %	21.23 %	54.51 %	76.75 %

RMC TALLADEGA COUNTY 2016

UDS Mapper



- States
- Counties
- ZCTAs
- ZIP Codes

Medically Underserved Areas/Populations

- Medically Underserved Area
- Medically Underserved Population
- Governor Designated

- PCSAs

- Selected ZCTAs
- HCP Grantee Administrative Locations
- HCP Look-Alike Administrative Locations
- HCP Grantee Service Access Points
- HCP Look-Alike Service Access Points

NHSC Sites

- ★ Less than 1 PC FTE
- ☆ 1-5 PC FTEs
- ★ 5+ PC FTEs
- ★ All Other Providers
- **Rural Health Clinics**

Facility and Point HPSAs

- HCP Look-Alike
- Rural Health Clinic
- Indian Health Service Facility
- Alaskan Native Tribal Population
- Native American Tribal Population
- HCP Grantee

Hospitals

- Short Term Hospitals
- Critical Access Hospitals
- Other Hospitals

VHA Facilities

ZCTA	Post Office Name	State	Health Center Count, 2016	Dominant Health Center, 2016	Total Population, 2011-2015	Low-Income Pop, 2011-2015	Total # Health Center Patients, 2016	Penetration of Low-Income	Penetration of Total Pop	Penetration of Uninsured Population
Summary:					156,447	64,716	6,489	10.02 %	4.14 %	34.50 %
35014	Alpine	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	4,035	1,353	166	12.26 %	4.11 %	35.69 %
35150	Sylacauga	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	18,260	9,114	597	6.55 %	3.26 %	24.49 %
35151	Sylacauga	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	7,346	3,327	154	4.62 %	2.09 %	17.89 %
35160	Talladega	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	26,320	11,773	1,859	15.79 %	7.06 %	58.25 %
35178	Vincent	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	4,199	1,283	42	3.27 %	1.00 %	11.83 %
35186	Wilsonville	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	4,955	1,361	11	0.80 %	0.22 %	2.79 %
35032	Bon Air	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	61	58	16	27.58 %	26.22 %	228.57 %
35044	Childersburg	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	7,816	4,630	239	5.16 %	3.05 %	25.86 %
35051	Columbiana	AL	1	CHRIST HEALTH CENTER, INC.	8,868	3,049	11	0.36 %	0.12 %	1.11 %
35054	Cropwell	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	3,774	1,230	63	5.12 %	1.66 %	17.98 %
35072	Goodwater	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	5,036	2,596	112	4.31 %	2.22 %	7.85 %
35078	Harpersville	AL	0		2,106	660	0			
35082	Hollins	AL	0		0	0	0			
35096	Lincoln	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	7,786	2,501	311	12.43 %	3.99 %	30.62 %
36258	Delta	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	1,378	516	221	42.82 %	16.03 %	124.63 %
36260	Eastaboga	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	4,341	2,070	317	15.31 %	7.30 %	57.93 %
36268	Munford	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	5,977	2,741	309	11.27 %	5.16 %	51.22 %
36203	Oxford	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	18,138	6,252	1,369	21.89 %	7.54 %	69.05 %
36271	Ohatchee	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	5,959	2,158	367	17.00 %	6.15 %	53.83 %

ZCTA	Post Office Name	State	Health Center Count, 2016	Dominant Health Center, 2016	Total Population, 2011-2015	Low-Income Pop, 2011-2015	Total # Health Center Patients, 2016	Penetration of Low-Income	Penetration of Total Pop	Penetration of Uninsured Population
35128	Pell City	AL	2	QUALITY OF LIFE HEALTH SERVICES, INC.	10,336	3,823	109	2.85 %	1.05 %	9.45 %
35131	Ragland	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	4,189	2,112	151	7.14 %	3.60 %	33.17 %
35135	Riverside	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	1,856	620	27	4.35 %	1.45 %	12.56 %
35143	Shelby	AL	1	HEALTH SERVICES, INC.	3,239	1,158	16	1.38 %	0.49 %	2.23 %
35149	Sycamore	AL	1	QUALITY OF LIFE HEALTH SERVICES, INC.	472	331	22	6.64 %	4.66 %	25.39 %

ZCTA	Post Office Name	Penetration of Population with Medicaid and Other Pub Ins	Penetration of Population with Medicare or Priv Ins	15-16 (1-year) Patient % Change	14-16 (2-year) Patient % Change	14-16 (2-year) Patient Change (#)	15-16 (1-year) Uninsured Patient % Change	14-16 (2-year) Uninsured Patient % Change	15-16 (1-year) Medicaid and Other Pub Ins Patient % Change	14-16 (2-year) Medicaid and Other Pub Ins Patient % Change
Summary:		3.22 %	0.46 %	8.78 %	13.32 %	763	10.88 %	14.26 %	13.11 %	19.25 %
35014	Alpine	1.76 %	0.56 %	8.49 %	12.16 %	18	9.67 %	12.39 %	-6.25 %	0.00 %
35150	Sylacauga	2.88 %	0.15 %	1.35 %	9.54 %	52	4.87 %	9.44 %	3.25 %	8.54 %
35151	Sylacauga	1.80 %	0.09 %	11.59 %	12.40 %	17	14.81 %	15.88 %	-3.84 %	-7.40 %
35160	Talladega	5.01 %	0.41 %	11.92 %	17.06 %	271	14.78 %	18.11 %	19.58 %	36.66 %
35178	Vincent	0.81 %	0.03 %	2.43 %	7.69 %	3	5.55 %	8.57 %	0.00 %	50.00 %
35186	Wilsonville	0.00 %	0.00 %	Newly Served	-21.42 %	-3	Newly Served	22.22 %		-100.00 %
35032	Bon Air	0.00 %	0.00 %	Newly Served	Newly Served	16	Newly Served	Newly Served		
35044	Childersburg	0.92 %	0.25 %	15.45 %	17.15 %	35	14.20 %	15.46 %	11.76 %	5.55 %
35051	Columbiana	0.00 %	0.02 %	Newly Served	-42.10 %	-8	Newly Served	-30.76 %		-100.00 %
35054	Cropwell	0.39 %	0.05 %	23.52 %	31.25 %	15	25.53 %	31.11 %	0.00 %	0.00 %
35072	Goodwater	4.41 %	0.43 %	3.70 %	7.69 %	8	4.08 %	13.33 %	2.17 %	-4.08 %
35078	Harpersville			-100.00 %		0	-100.00 %		-100.00 %	
35082	Hollins					0				
35096	Lincoln	5.08 %	0.47 %	8.74 %	10.67 %	30	9.32 %	10.47 %	17.74 %	19.67 %
36258	Delta	5.92 %	2.80 %	12.18 %	15.10 %	29	13.90 %	17.00 %	-5.26 %	0.00 %
36260	Eastaboga	4.67 %	1.97 %	7.45 %	18.72 %	50	9.50 %	19.02 %	27.27 %	35.48 %
36268	Munford	1.65 %	1.16 %	9.57 %	14.86 %	40	10.57 %	14.09 %	30.76 %	41.66 %
36203	Oxford	5.36 %	0.98 %	6.37 %	9.34 %	117	7.81 %	11.00 %	20.94 %	24.30 %
36271	Ohatchee	3.95 %	1.18 %	3.08 %	5.76 %	20	4.29 %	6.37 %	-2.32 %	2.43 %
35128	Pell City	0.50 %	0.05 %	2.83 %	23.86 %	21	0.00 %	15.29 %	40.00 %	133.33 %
35131	Ragland	1.20 %	0.23 %	11.02 %	13.53 %	18	11.29 %	14.04 %	20.00 %	0.00 %
35135	Riverside	1.41 %	0.07 %	0.00 %	-6.89 %	-2	-4.16 %	-8.00 %	0.00 %	0.00 %
35143	Shelby	2.01 %	0.12 %	23.07 %	Newly Served	16	50.00 %	Newly Served	16.66 %	Newly Served
35149	Sycamore	2.51 %	0.45 %	4.76 %	0.00 %	0	6.66 %	0.00 %	0.00 %	-20.00 %

ZCTA	Post Office Name	15-16 (1-year) Medicare or Priv Ins Patient % Change	14-16 (2-year) Medicare or Priv Ins Patient % Change	Low-Income Not Served by Health Centers	Uninsured Not Served by Health Centers	Medicaid and Other Pub Ins Not Served by Health Centers	Medicare or Priv Ins Not Served by Health Centers	Total Population Not Served by Health Centers	% Patients Uninsured, 2016	# Patients Uninsured, 2016
Summary:		-13.67 %	-3.44 %	58,227	9,606	27,711	108,322	149,958	77.99 %	5,061
35014	Alpine	15.38 %	25.00 %	1,187	245	836	2,657	3,869	81.92 %	136
35150	Sylacauga	-48.57 %	20.00 %	8,517	1,393	4,270	11,477	17,663	75.71 %	452
35151	Sylacauga	25.00 %	66.66 %	3,173	569	1,363	5,266	7,192	80.51 %	124
35160	Talladega	-39.44 %	-35.92 %	9,914	1,079	5,440	15,842	24,461	81.01 %	1,506
35178	Vincent	-50.00 %	-50.00 %	1,241	283	366	2,699	4,157	90.47 %	38
35186	Wilsonville		-100.00 %	1,350	382	514	3,952	4,944	100.00 %	11
35032	Bon Air			42	-9	19	35	45	100.00 %	16
35044	Childersburg	57.14 %	120.00 %	4,391	599	2,042	4,353	7,577	87.44 %	209
35051	Columbiana	Newly Served	Newly Served	3,038	796	868	6,745	8,857	81.81 %	9
35054	Cropwell	0.00 %	100.00 %	1,167	269	499	3,444	3,711	93.65 %	59
35072	Goodwater	7.69 %	40.00 %	2,484	598	1,018	3,171	4,924	45.53 %	51
35078	Harpersville			660	173	209	1,695	2,106		0
35082	Hollins			0	1	2	4	0		0
35096	Lincoln	-12.90 %	-6.89 %	2,190	478	1,363	5,628	7,475	67.84 %	211
36258	Delta	14.81 %	14.81 %	295	-34	286	1,074	1,157	77.82 %	172
36260	Eastaboga	-9.67 %	7.69 %	1,753	159	856	2,779	4,024	69.08 %	219
36268	Munford	-2.38 %	10.81 %	2,432	239	1,011	3,484	5,668	81.22 %	251
36203	Oxford	-15.06 %	-13.49 %	4,883	470	3,155	14,215	16,769	76.62 %	1,049
36271	Ohatchee	1.75 %	5.45 %	1,791	229	1,021	4,851	5,592	72.75 %	267
35128	Pell City	33.33 %	Newly Served	3,714	939	1,375	7,810	10,227	89.90 %	98
35131	Ragland	0.00 %	16.66 %	1,961	278	493	2,999	4,038	91.39 %	138
35135	Riverside	Newly Served	0.00 %	593	160	209	1,280	1,829	85.18 %	23
35143	Shelby	0.00 %	Newly Served	1,142	263	341	2,423	3,223	37.50 %	6
35149	Sycamore	0.00 %	100.00 %	309	47	155	439	450	72.72 %	16

ZCTA	Post Office Name	% Patients with Medicaid and Other Pub Ins, 2016	# Patients with Medicaid and Other Pub Ins, 2016	% Patients with Medicare or Priv Ins, 2016	# Patients Medicare or Priv Ins, 2016	% Pop in Poverty, 11-15	% Low-Income Pop, 11-15	% Non-White, 11-15	% Hispanic, 11-15	% Black, 11-15
Summary:		14.22 %	923	7.78 %	505	19.58 %	42.78 %	27.44 %	2.47 %	22.79 %
35014	Alpine	9.03 %	15	9.03 %	15	13.82 %	37.70 %	46.41 %	0.32 %	45.32 %
35150	Sylacauga	21.27 %	127	3.01 %	18	29.59 %	50.69 %	36.75 %	3.70 %	31.42 %
35151	Sylacauga	16.23 %	25	3.24 %	5	14.33 %	45.28 %	13.92 %	0.05 %	11.74 %
35160	Talladega	15.43 %	287	3.55 %	66	24.92 %	49.65 %	45.35 %	3.18 %	40.20 %
35178	Vincent	7.14 %	3	2.38 %	1	12.76 %	30.55 %	22.07 %	0.00 %	20.21 %
35186	Wilsonville	0.00 %	0	0.00 %	0	13.23 %	27.92 %	8.75 %	0.96 %	6.23 %
35032	Bon Air	0.00 %	0	0.00 %	0	36.06 %	95.08 %	0.00 %	0.00 %	0.00 %
35044	Childersburg	7.94 %	19	4.60 %	11	32.89 %	59.42 %	45.99 %	0.23 %	43.29 %
35051	Columbiana	0.00 %	0	18.18 %	2	17.13 %	38.78 %	18.16 %	2.95 %	13.85 %
35054	Cropwell	3.17 %	2	3.17 %	2	10.28 %	32.59 %	9.64 %	2.80 %	5.27 %
35072	Goodwater	41.96 %	47	12.50 %	14	19.41 %	52.05 %	39.47 %	0.00 %	39.47 %
35078	Harpersville		0		0	18.19 %	31.51 %	33.76 %	0.23 %	23.07 %
35082	Hollins		0		0					
35096	Lincoln	23.47 %	73	8.68 %	27	15.21 %	32.24 %	24.04 %	0.34 %	20.34 %
36258	Delta	8.14 %	18	14.02 %	31	21.78 %	38.10 %	5.51 %	4.06 %	0.94 %
36260	Eastaboga	13.24 %	42	17.66 %	56	17.36 %	47.68 %	21.26 %	8.15 %	9.99 %
36268	Munford	5.50 %	17	13.26 %	41	21.57 %	46.30 %	23.32 %	1.68 %	20.67 %
36203	Oxford	13.07 %	179	10.29 %	141	10.64 %	35.33 %	24.09 %	6.36 %	13.86 %
36271	Ohatchee	11.44 %	42	15.80 %	58	14.65 %	36.21 %	3.70 %	0.43 %	3.10 %
35128	Pell City	6.42 %	7	3.66 %	4	16.60 %	37.21 %	16.78 %	0.25 %	13.01 %
35131	Ragland	3.97 %	6	4.63 %	7	22.52 %	50.92 %	11.10 %	0.35 %	9.97 %
35135	Riverside	11.11 %	3	3.70 %	1	5.94 %	33.49 %	12.17 %	5.01 %	1.45 %
35143	Shelby	43.75 %	7	18.75 %	3	21.91 %	35.85 %	10.25 %	1.51 %	9.20 %
35149	Sycamore	18.18 %	4	9.09 %	2	59.95 %	70.12 %	31.56 %	0.00 %	31.56 %

ZCTA	Post Office Name	% Asian, 11-15	% American Indian/Alaska Native, 11-15	% Population Uninsured, est. 2015 (Main Map)	Population Uninsured, est. 2015	13-15 (2-year) Population Uninsured % Change	14-15 (1-year) Population Uninsured % Change	% Population with Medicaid and Other Pub Ins, est. 2015 (Main Map)	Population with Medicaid and Other Pub Ins, est. 2015	13-15 (2-year) Change % Pop with Medicaid and Other Pub Ins
Summary:		0.74 %	0.35 %	9.64 %	14,667	-29.21 %	-20.24 %	18.82 %	28,634	11.53 %
35014	Alpine	0.14 %	0.24 %	9.75 %	381	-32.44 %	-23.03 %	21.79 %	851	40.42 %
35150	Sylacauga	0.00 %	0.37 %	10.40 %	1,845	-31.94 %	-18.43 %	24.78 %	4,397	24.03 %
35151	Sylacauga	0.00 %	0.09 %	9.42 %	693	-33.17 %	-14.23 %	18.87 %	1,388	9.03 %
35160	Talladega	0.81 %	0.30 %	10.67 %	2,585	-27.81 %	-19.21 %	23.64 %	5,727	19.36 %
35178	Vincent	0.42 %	1.11 %	9.46 %	321	-30.06 %	-30.81 %	10.88 %	369	1.09 %
35186	Wilsonville	0.36 %	0.34 %	8.08 %	393	-33.61 %	-39.81 %	10.57 %	514	33.16 %
35032	Bon Air	0.00 %	0.00 %	11.47 %	7	-30.00 %	-12.50 %	31.14 %	19	35.71 %
35044	Childersburg	0.53 %	0.44 %	11.17 %	808	-29.43 %	-8.59 %	28.49 %	2,061	28.25 %
35051	Columbiana	0.05 %	0.37 %	9.56 %	805	-36.00 %	-39.65 %	10.30 %	868	2.84 %
35054	Cropwell	0.68 %	0.00 %	7.67 %	328	-8.12 %	-24.07 %	11.71 %	501	-27.91 %
35072	Goodwater	0.00 %	0.00 %	13.24 %	649	-25.14 %	-6.61 %	21.73 %	1,065	-4.99 %
35078	Harpersville	0.00 %	7.31 %	8.32 %	173	-29.38 %	-29.38 %	10.06 %	209	27.43 %
35082	Hollins		0.00 %	14.28 %	1	0.00 %	0.00 %	28.57 %	2	100.00 %
35096	Lincoln	0.77 %	0.66 %	8.85 %	689	-40.50 %	-20.34 %	18.45 %	1,436	14.87 %
36258	Delta	0.00 %	0.00 %	8.92 %	138	-44.12 %	-17.36 %	19.65 %	304	8.57 %
36260	Eastaboga	0.00 %	0.00 %	9.19 %	378	-30.89 %	-15.62 %	21.84 %	898	11.55 %
36268	Munford	0.26 %	0.00 %	9.71 %	490	-38.20 %	-24.61 %	20.38 %	1,028	13.09 %
36203	Oxford	1.69 %	0.23 %	7.90 %	1,519	-29.96 %	-11.89 %	17.35 %	3,334	19.07 %
36271	Ohatchee	0.00 %	0.08 %	7.66 %	496	-37.13 %	-11.74 %	16.43 %	1,063	10.04 %
35128	Pell City	2.70 %	0.00 %	10.13 %	1,037	-0.86 %	-18.08 %	13.50 %	1,382	-25.01 %
35131	Ragland	0.04 %	0.09 %	10.60 %	416	-7.96 %	-14.92 %	12.72 %	499	-35.52 %
35135	Riverside	8.67 %	0.00 %	10.91 %	183	3.38 %	-17.93 %	12.64 %	212	-29.56 %
35143	Shelby	0.55 %	0.00 %	8.83 %	269	-35.02 %	-37.44 %	11.43 %	348	63.38 %
35149	Sycamore	0.00 %	0.00 %	9.50 %	63	-37.62 %	-25.88 %	23.98 %	159	41.96 %

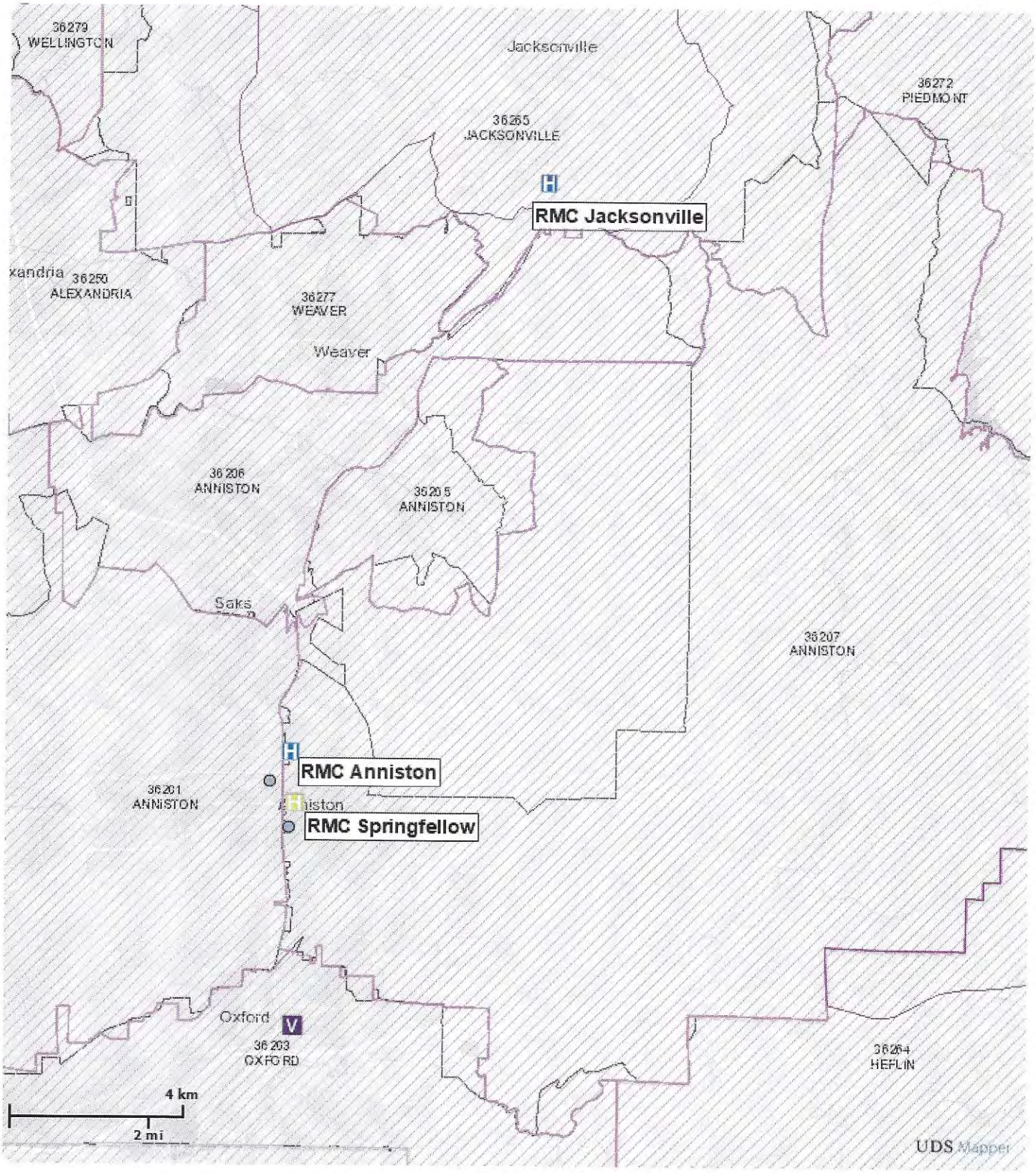
ZCTA	Post Office Name	14-15 (1-year) Change % Pop with Medicaid and Other Pub Ins	% Population with Medicare or Priv Ins, est. 2015 (Main Map)	Population with Medicare or Priv Ins, est. 2015	13-15 (2-year) Change % Pop with Medicare or Priv Ins	14-15 (1-year) Change % Pop with Medicare or Priv Ins	% Under 18, 11-15	% 18 to 64, 11-15	% 65 and Older, 11-15	% Pop Not Employed, 11-15 (Main Map)
Summary:		4.89 %	71.53 %	108,827	3.02 %	0.52 %	21.94 %	61.97 %	16.08 %	51.05 %
35014	Alpine	35.29 %	68.44 %	2,672	12.88 %	3.36 %	16.75 %	71.15 %	12.09 %	59.22 %
35150	Sylacauga	1.45 %	64.80 %	11,495	-8.45 %	-6.99 %	25.77 %	58.27 %	15.94 %	52.31 %
35151	Sylacauga	4.12 %	71.69 %	5,271	-0.32 %	0.09 %	17.72 %	58.79 %	23.48 %	55.45 %
35160	Talladega	13.22 %	65.68 %	15,908	4.65 %	-0.15 %	20.24 %	63.95 %	15.80 %	58.00 %
35178	Vincent	-6.81 %	79.64 %	2,700	-0.84 %	-4.18 %	25.19 %	61.94 %	12.86 %	42.16 %
35186	Wilsonville	-9.02 %	81.33 %	3,952	6.40 %	4.57 %	22.88 %	60.94 %	16.16 %	42.78 %
35032	Bon Air	18.75 %	57.37 %	35	-2.77 %	-5.40 %	40.98 %	42.62 %	16.39 %	50.00 %
35044	Childersburg	19.20 %	60.33 %	4,364	-1.99 %	-4.92 %	26.70 %	56.51 %	16.78 %	55.32 %
35051	Columbiana	-22.15 %	80.13 %	6,747	4.94 %	5.33 %	21.60 %	63.20 %	15.18 %	56.09 %
35054	Cropwell	-3.65 %	80.60 %	3,446	1.38 %	-6.63 %	14.12 %	62.24 %	23.63 %	48.47 %
35072	Goodwater	-8.66 %	65.01 %	3,185	0.00 %	0.31 %	20.57 %	62.49 %	16.93 %	58.34 %
35078	Harpersville	-5.00 %	81.60 %	1,695	0.77 %	2.41 %	25.35 %	57.45 %	17.18 %	51.07 %
35082	Hollins	0.00 %	57.14 %	4	0.00 %	0.00 %				
35096	Lincoln	9.20 %	72.68 %	5,655	0.53 %	1.34 %	20.25 %	65.88 %	13.85 %	45.21 %
36258	Delta	1.67 %	71.42 %	1,105	-3.91 %	-4.24 %	16.25 %	63.57 %	20.17 %	52.97 %
36260	Eastaboga	14.54 %	68.96 %	2,835	2.30 %	-0.35 %	26.23 %	61.11 %	12.64 %	49.33 %
36268	Munford	7.19 %	69.89 %	3,525	2.53 %	-1.03 %	22.36 %	62.12 %	15.50 %	48.44 %
36203	Oxford	9.52 %	74.73 %	14,356	16.90 %	12.21 %	22.56 %	62.77 %	14.65 %	42.52 %
36271	Ohatchee	9.81 %	75.89 %	4,909	18.06 %	5.34 %	22.31 %	63.98 %	13.69 %	46.71 %
35128	Pell City	-9.79 %	76.36 %	7,814	-1.67 %	-2.73 %	22.84 %	59.71 %	17.44 %	44.76 %
35131	Ragland	-9.60 %	76.66 %	3,006	2.41 %	-1.11 %	21.67 %	61.06 %	17.25 %	55.29 %
35135	Riverside	-15.87 %	76.43 %	1,281	1.99 %	0.31 %	18.42 %	69.50 %	12.06 %	38.57 %
35143	Shelby	-13.00 %	79.72 %	2,426	-7.51 %	-6.07 %	17.99 %	63.50 %	18.49 %	51.83 %
35149	Sycamore	44.54 %	66.51 %	441	8.62 %	0.68 %	21.61 %	56.77 %	21.61 %	67.02 %

ZCTA	Post Office Name	% Households with Limited English Proficiency, 11-15 (Main Map)	% Pop with Less Than High School Education, 11-15 (Main Map)	13-15 (2-year) Change % Total Population	14-15 (1-year) Change % Total Population	Low Birth Weight Rate, est. 12-14	Age-Adjusted Mortality Rate (per 100,000), est. 2012-2014	% Adults Ever Told They Have Diabetes, est. 09-12	% Adults Ever Told They Have High Blood Pressure, est. 07-12	% Adults Who Are Obese, est. 09-12
Summary:		0.80 %	20.13 %	0.02 %	0.43 %	9.61	948	12.14 %	37.58 %	32.92 %
35014	Alpine	0.00 %	16.72 %	-15.35 %	0.29 %	12.88	1,041	13.55 %	44.09 %	42.20 %
35150	Sylacauga	0.62 %	20.66 %	-6.80 %	-6.89 %	11.37	984	11.96 %	39.48 %	35.13 %
35151	Sylacauga	0.00 %	22.91 %	-3.60 %	0.53 %	9.87	975	10.59 %	34.75 %	29.39 %
35160	Talladega	1.94 %	23.71 %	5.55 %	0.54 %	11.85	998	12.78 %	41.83 %	38.57 %
35178	Vincent	0.00 %	22.00 %	18.64 %	-0.11 %	7.49	777	11.49 %	33.63 %	30.69 %
35186	Wilsonville	0.00 %	11.50 %	11.07 %	6.28 %	6.46	685	8.48 %	28.18 %	29.87 %
35032	Bon Air	0.00 %	8.33 %	-10.29 %	-3.17 %	12.27	1,028	12.58 %	40.98 %	38.83 %
35044	Childersburg	0.00 %	22.57 %	0.28 %	5.67 %	11.60	1,023	12.58 %	41.51 %	37.34 %
35051	Columbiana	0.36 %	23.52 %	-5.48 %	-1.42 %	6.84	689	9.01 %	29.45 %	30.09 %
35054	Cropwell	0.00 %	16.66 %	-12.17 %	-4.26 %	8.60	994	17.02 %	39.88 %	30.17 %
35072	Goodwater	0.00 %	23.52 %	0.53 %	-0.82 %	7.57	907	9.10 %	24.00 %	23.23 %
35078	Harpersville	0.00 %	18.40 %	-10.57 %	-5.26 %	6.59	672	9.05 %	29.88 %	30.70 %
35082	Hollins		0.00 %	0.00 %	0.00 %	8.20	932	15.20 %	31.45 %	35.14 %
35096	Lincoln	0.00 %	15.41 %	-5.44 %	0.38 %	10.80	1,014	12.13 %	40.45 %	34.51 %
36258	Delta	0.00 %	26.71 %	7.48 %	11.48 %	8.23	895	12.19 %	28.85 %	26.86 %
36260	Eastaboga	0.70 %	26.55 %	10.73 %	4.45 %	8.28	978	11.01 %	37.87 %	29.77 %
36268	Munford	0.00 %	21.78 %	17.93 %	11.86 %	11.02	1,010	11.64 %	38.86 %	33.39 %
36203	Oxford	2.89 %	15.86 %	-4.29 %	-2.63 %	8.72	988	11.82 %	38.27 %	31.06 %
36271	Ohatchee	0.00 %	21.94 %	0.86 %	-2.69 %	7.48	1,034	12.04 %	37.08 %	28.92 %
35128	Pell City	0.47 %	14.13 %	8.49 %	8.53 %	7.98	953	16.06 %	38.81 %	29.46 %
35131	Ragland	0.79 %	23.81 %	-0.16 %	9.60 %	7.85	975	15.99 %	38.80 %	29.62 %
35135	Riverside	0.00 %	12.52 %	7.03 %	15.27 %	7.70	966	16.60 %	39.64 %	30.07 %
35143	Shelby	0.00 %	18.06 %	3.44 %	0.09 %	6.43	674	8.52 %	28.18 %	29.49 %
35149	Sycamore	0.00 %	36.19 %	-25.07 %	-27.27 %	12.36	1,020	13.09 %	42.75 %	39.81 %

ZCTA	Post Office Name	% Adults with No Dental Visit in Past Year, est. 07-12	% Adults Who Have Delayed or Not Sought Care Due to High Cost, est. 09-12	% Adults with No Usual Source of Care, est. 09-12	% Uninsured Population Below 138% FPL, 11-15	% Uninsured Population Below 200% FPL, 11-15	% Uninsured Population at 138%-400% FPL, 11-15
Summary:		40.08 %	19.73 %	18.10 %	6.21 %	8.25 %	5.16 %
35014	Alpine	44.17 %	21.71 %	18.18 %	50.00 %	51.86 %	44.14 %
35150	Sylacauga	44.63 %	23.31 %	20.64 %	57.97 %	71.26 %	38.08 %
35151	Sylacauga	38.58 %	18.63 %	17.40 %	42.27 %	59.58 %	55.18 %
35160	Talladega	44.80 %	22.67 %	19.75 %	59.59 %	67.80 %	28.76 %
35178	Vincent	30.27 %	12.91 %	14.50 %	33.46 %	65.76 %	64.41 %
35186	Wilsonville	26.05 %	12.97 %	17.05 %	58.79 %	62.06 %	30.90 %
35032	Bon Air	43.63 %	23.03 %	19.47 %	100.00 %	100.00 %	0.00 %
35044	Childersburg	44.28 %	21.60 %	19.07 %	53.39 %	67.23 %	38.75 %
35051	Columbiana	26.64 %	12.24 %	16.67 %	41.24 %	62.56 %	54.95 %
35054	Cropwell	38.86 %	18.04 %	9.49 %	21.75 %	66.16 %	70.09 %
35072	Goodwater	27.70 %	12.59 %	11.68 %	37.94 %	64.36 %	54.96 %
35078	Harpersville	27.24 %	12.60 %	16.75 %	43.06 %	45.04 %	25.24 %
35082	Hollins	44.62 %	19.42 %	18.41 %			
35096	Lincoln	44.34 %	21.41 %	19.68 %	72.29 %	76.54 %	27.70 %
36258	Delta	41.94 %	21.09 %	19.76 %	89.22 %	89.22 %	10.77 %
36260	Eastaboga	42.24 %	20.48 %	21.32 %	46.93 %	67.34 %	48.52 %
36268	Munford	45.77 %	24.27 %	21.95 %	40.00 %	67.92 %	53.25 %
36203	Oxford	42.66 %	21.09 %	21.96 %	34.30 %	66.41 %	50.54 %
36271	Ohatchee	41.89 %	17.83 %	22.15 %	46.17 %	55.98 %	33.38 %
35128	Pell City	38.60 %	18.93 %	9.52 %	43.07 %	56.22 %	51.63 %
35131	Ragland	37.98 %	18.57 %	9.95 %	71.55 %	82.29 %	16.03 %
35135	Riverside	39.01 %	18.71 %	9.67 %	52.70 %	64.86 %	22.97 %
35143	Shelby	25.57 %	12.56 %	16.80 %	66.88 %	66.88 %	19.73 %
35149	Sycamore	44.07 %	21.46 %	18.41 %	48.27 %	48.27 %	51.72 %

ATTACHMENT D

MAPS


36279
WELLINGTON
Jacksonville
36272
PIEDMONT
36265
JACKSONVILLE
RMC Jacksonville
xandria
36250
ALEXANDRIA
36277
WEAVER
Weaver
36206
ANNISTON
36205
ANNISTON
Saks
36207
ANNISTON
RMC Anniston
36201
ANNISTON
RMC Springfellow
Oxford
36203
OXFORD
36264
HEFLIN
4 km
2 mi
UDS Mapper


States


Counties


ZCTAs


ZIP Codes

Medically Underserved Areas/Populations


Medically Underserved Area


Governor Designated


Medically Underserved Population


PCSAs


HCP Grantee
Administrative Locations


HCP Look-Alike
Administrative Locations


HCP Grantee
Service Access Points


HCP Look-Alike
Service Access Points

NHSC Sites

★ Less than 1 PC FTE
☆ 1-5 PC FTEs
★ 5+ PC FTEs
★ All Other Providers

Rural Health Clinics

Facility and Point HPSAs


HCP Look-Alike


Rural Health Clinic


Indian Health Service Facility


Alaskan Native Tribal Population


Native American Tribal Population


HCP Grantee

Hospitals

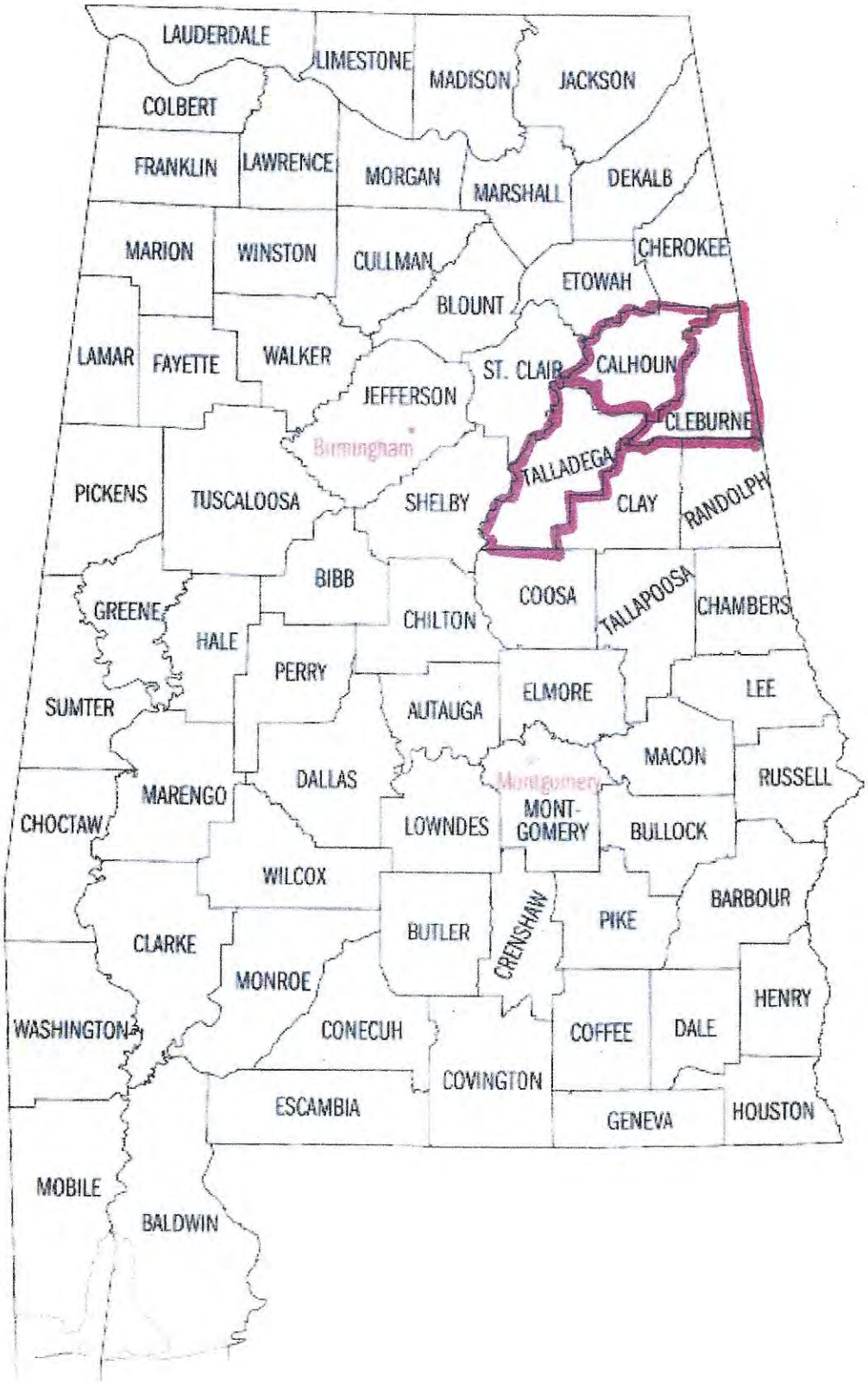

Short Term Hospitals


Critical Access Hospitals

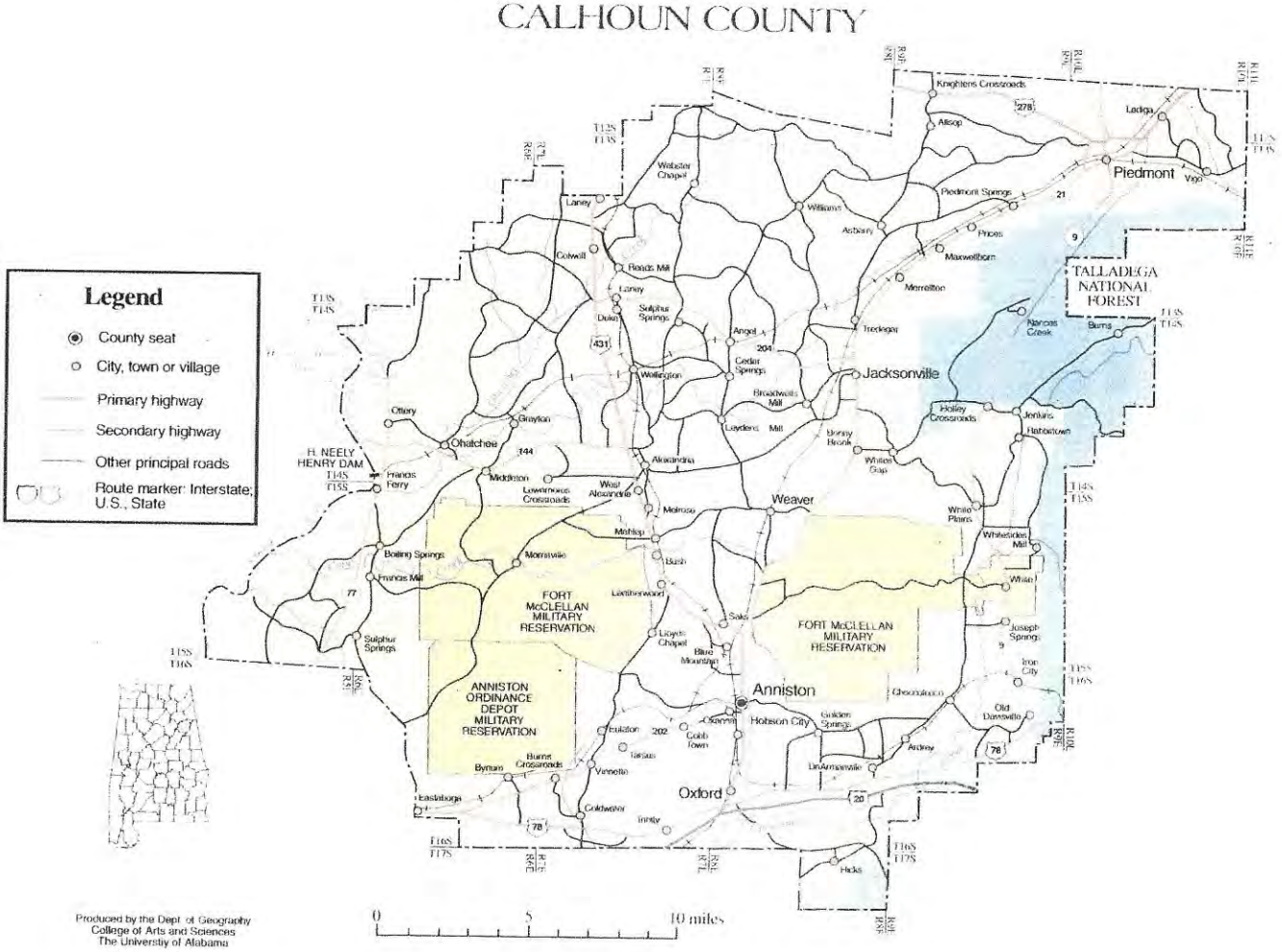
Other Hospitals


VHA Facilities

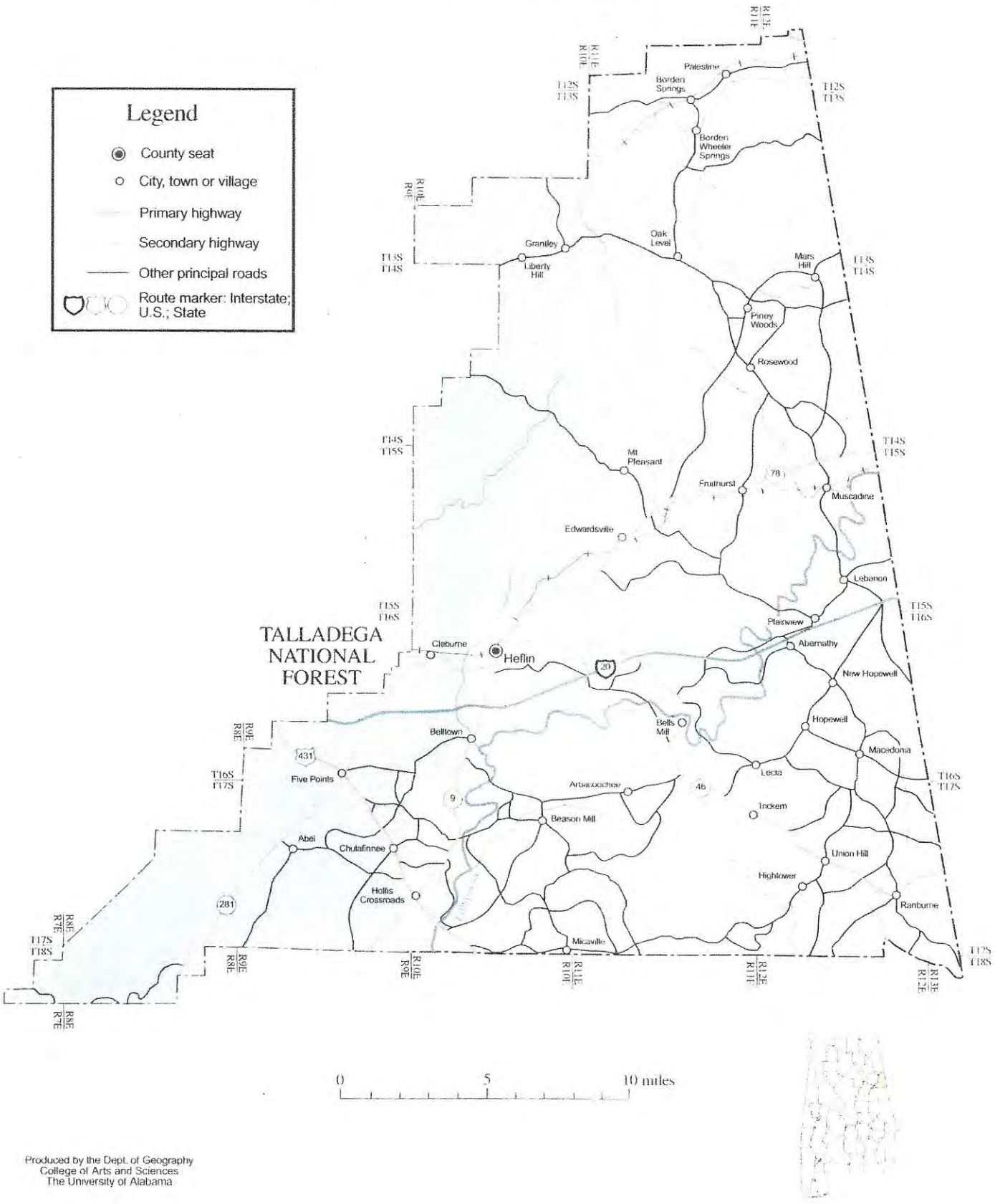
Alabama County Selection Map



CALHOUN COUNTY



CLEBURNE COUNTY



Produced by the Dept. of Geography
College of Arts and Sciences
The University of Alabama

TALLADEGA COUNTY

Produced by the Dept. of Geography
College of Arts and Sciences
The University of Alabama

Legend

- County seat
- City, town or village
- Primary highway
- Secondary highway
- Other principal roads
- Route marker: Interstate; U.S.; State

ATTACHMENT E

DATA SOURCES

Data Sources

- Internal Revenue Service (IRS) Notice 2011-52;
- IRS Instructions for Schedule H (Form 990);
- Federal Register, Vol. 79, No. 250, 12/31/2014;
- HCACA: Anniston, Jacksonville, and Stringfellow internal and external reporting information;
- U.S. Census Bureau, 2010 Census, American FactFinder, April 10, 2010 – July 1, 2016, Population Estimates, U.S. Census QuickFacts;
- American Community Survey (ACS) 2011-2015;
- American Hospital Directory – www.ahd.com;
- National Cancer Institute, SEER Cancer Statistics 2010-2014;
- Health Resources and Services Administration (HRSA) Geospatial Website – www.hrsa.gov;
- HRSA Community Fact Sheets (Calhoun, Cleburne, and Talladega Counties);
- UDS Mapper (2015 reporting) - www.udsmapper.org;
- HRSA/Shortage Designation Branch (SDB);
- Alabama Department of Public Health (ADPH) Selected Health Status Indicators (Calhoun, Cleburne, and Talladega Counties);
- Local Health Departments (Calhoun, Cleburne, and Talladega Counties);
- HRSA Community Health Status Reports;
- Centers for Disease Control and Prevention (CDC) – Behavioral Risk Factor Surveillance System (BRFSS) – www.cdc.gov 1999-2014;
- Kaiser State Health Facts, Kaiser Family Foundation - kff.org
- Alabama Cancer Facts & Figures 2015;
- Alabama Statewide Cancer Registry 2016: Data Years 2004-2103;
- Alabama Center for Health Statistics, 2015 – County Health Statistics, County Health Profiles;
- National Women's Law Center, 2010;
- KidsCount.org, Annie E. Casey Foundation 2015;
- Robert Wood Johnson Foundation (RWJF) County Health Rankings 2012-2014, 2017/other reports; and
- Patient Protection and Affordable Care Act (P.L. 111-148) of 201.50 (PPACA and ACA).

ATTACHMENT F

U.S. CENSUS BUREAU

- American Community Survey
- U.S. Census Quick Facts

DP05

ACS DEMOGRAPHIC AND HOUSING ESTIMATES

2011-2015 American Community Survey 5-Year Estimates

Supporting documentation on code lists, subject definitions, data accuracy, and statistical testing can be found on the American Community Survey website in the Data and Documentation section.

Sample size and data quality measures (including coverage rates, allocation rates, and response rates) can be found on the American Community Survey website in the Methodology section.

Tell us what you think. Provide feedback to help make American Community Survey data more useful for you.

Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census Bureau's Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities and towns and estimates of housing units for states and counties.

Subject	Calhoun County, Alabama			
	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE				
Total population	116,648	*****	116,648	(X)
Male	56,274	+/-140	48.2%	+/-0.1
Female	60,374	+/-140	51.8%	+/-0.1
Under 5 years	6,816	+/-62	5.8%	+/-0.1
5 to 9 years	7,538	+/-417	6.5%	+/-0.4
10 to 14 years	7,168	+/-410	6.1%	+/-0.4
15 to 19 years	7,780	+/-130	6.7%	+/-0.1
20 to 24 years	8,646	+/-125	7.4%	+/-0.1
25 to 34 years	14,763	+/-173	12.7%	+/-0.1
35 to 44 years	14,167	+/-169	12.1%	+/-0.1
45 to 54 years	15,887	+/-149	13.6%	+/-0.1
55 to 59 years	8,110	+/-443	7.0%	+/-0.4
60 to 64 years	7,706	+/-447	6.6%	+/-0.4
65 to 74 years	10,400	+/-87	8.9%	+/-0.1
75 to 84 years	5,777	+/-237	5.0%	+/-0.2
85 years and over	1,890	+/-234	1.6%	+/-0.2
Median age (years)	39.1	+/-0.4	(X)	(X)
18 years and over	90,567	*****	77.6%	*****
21 years and over	85,318	+/-356	73.1%	+/-0.3
62 years and over	22,277	+/-327	19.1%	+/-0.3
65 years and over	18,067	+/-104	15.5%	+/-0.1
18 years and over	90,567	*****	90,567	(X)
Male	42,776	+/-54	47.2%	+/-0.1
Female	47,791	+/-54	52.8%	+/-0.1
65 years and over	18,067	+/-104	18,067	(X)
Male	7,596	+/-70	42.0%	+/-0.2

Subject	Calhoun County, Alabama			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Female	10,471	+/-58	58.0%	+/-0.2
RACE				
Total population	116,648	*****	116,648	(X)
One race	113,902	+/-461	97.6%	+/-0.4
Two or more races	2,746	+/-461	2.4%	+/-0.4
One race	113,902	+/-461	97.6%	+/-0.4
White	87,615	+/-439	75.1%	+/-0.4
Black or African American	23,895	+/-437	20.5%	+/-0.4
American Indian and Alaska Native	223	+/-107	0.2%	+/-0.1
Cherokee tribal grouping	183	+/-102	0.2%	+/-0.1
Chippewa tribal grouping	0	+/-27	0.0%	+/-0.1
Navajo tribal grouping	0	+/-27	0.0%	+/-0.1
Sioux tribal grouping	1	+/-2	0.0%	+/-0.1
Asian	1,000	+/-142	0.9%	+/-0.1
Asian Indian	0	+/-27	0.0%	+/-0.1
Chinese	76	+/-120	0.1%	+/-0.1
Filipino	93	+/-89	0.1%	+/-0.1
Japanese	42	+/-40	0.0%	+/-0.1
Korean	345	+/-145	0.3%	+/-0.1
Vietnamese	185	+/-205	0.2%	+/-0.2
Other Asian	259	+/-216	0.2%	+/-0.2
Native Hawaiian and Other Pacific Islander	7	+/-11	0.0%	+/-0.1
Native Hawaiian	0	+/-27	0.0%	+/-0.1
Guamanian or Chamorro	0	+/-27	0.0%	+/-0.1
Samoan	7	+/-11	0.0%	+/-0.1
Other Pacific Islander	0	+/-27	0.0%	+/-0.1
Some other race	1,162	+/-424	1.0%	+/-0.4
Two or more races	2,746	+/-461	2.4%	+/-0.4
White and Black or African American	1,181	+/-362	1.0%	+/-0.3
White and American Indian and Alaska Native	896	+/-222	0.8%	+/-0.2
White and Asian	136	+/-106	0.1%	+/-0.1
Black or African American and American Indian and Alaska Native	44	+/-35	0.0%	+/-0.1
Race alone or in combination with one or more other races				
Total population	116,648	*****	116,648	(X)
White	90,106	+/-597	77.2%	+/-0.5
Black or African American	25,386	+/-196	21.8%	+/-0.2
American Indian and Alaska Native	1,309	+/-213	1.1%	+/-0.2
Asian	1,377	+/-134	1.2%	+/-0.1
Native Hawaiian and Other Pacific Islander	121	+/-104	0.1%	+/-0.1
Some other race	1,362	+/-460	1.2%	+/-0.4
HISPANIC OR LATINO AND RACE				
Total population	116,648	*****	116,648	(X)
Hispanic or Latino (of any race)	4,075	*****	3.5%	*****
Mexican	2,759	+/-358	2.4%	+/-0.3
Puerto Rican	582	+/-322	0.5%	+/-0.3
Cuban	91	+/-79	0.1%	+/-0.1
Other Hispanic or Latino	643	+/-201	0.6%	+/-0.2
Not Hispanic or Latino	112,573	*****	96.5%	*****
White alone	85,184	+/-83	73.0%	+/-0.1
Black or African American alone	23,703	+/-393	20.3%	+/-0.3
American Indian and Alaska Native alone	223	+/-107	0.2%	+/-0.1
Asian alone	1,000	+/-142	0.9%	+/-0.1
Native Hawaiian and Other Pacific Islander alone	7	+/-11	0.0%	+/-0.1

Subject	Calhoun County, Alabama			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Some other race alone	23	+/-22	0.0%	+/-0.1
Two or more races	2,433	+/-405	2.1%	+/-0.3
Two races including Some other race	63	+/-79	0.1%	+/-0.1
Two races excluding Some other race, and Three or more races	2,370	+/-403	2.0%	+/-0.3
Total housing units	53,296	+/-149	(X)	(X)
CITIZEN, VOTING AGE POPULATION				
Citizen, 18 and over population	88,612	+/-292	88,612	(X)
Male	41,783	+/-175	47.2%	+/-0.2
Female	46,829	+/-227	52.8%	+/-0.2

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Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

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ACS DEMOGRAPHIC AND HOUSING ESTIMATES

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Subject	Cleburne County, Alabama			
	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE				
Total population	15,002	*****	15,002	(X)
Male	7,334	+/-123	48.9%	+/-0.8
Female	7,668	+/-123	51.1%	+/-0.8
Under 5 years	883	+/-74	5.9%	+/-0.5
5 to 9 years	948	+/-142	6.3%	+/-0.9
10 to 14 years	1,071	+/-145	7.1%	+/-1.0
15 to 19 years	876	+/-21	5.8%	+/-0.1
20 to 24 years	804	+/-9	5.4%	+/-0.1
25 to 34 years	1,637	+/-64	10.9%	+/-0.4
35 to 44 years	1,981	+/-68	13.2%	+/-0.5
45 to 54 years	2,171	+/-70	14.5%	+/-0.5
55 to 59 years	1,042	+/-142	6.9%	+/-0.9
60 to 64 years	934	+/-140	6.2%	+/-0.9
65 to 74 years	1,575	+/-38	10.5%	+/-0.3
75 to 84 years	776	+/-91	5.2%	+/-0.6
85 years and over	304	+/-90	2.0%	+/-0.6
Median age (years)	41.3	+/-0.7	(X)	(X)
18 years and over	11,521	+/-36	76.8%	+/-0.2
21 years and over	11,073	+/-107	73.8%	+/-0.7
62 years and over	3,240	+/-131	21.6%	+/-0.9
65 years and over	2,655	+/-34	17.7%	+/-0.2
18 years and over	11,521	+/-36	11,521	(X)
Male	5,584	+/-77	48.5%	+/-0.6
Female	5,937	+/-69	51.5%	+/-0.6
65 years and over	2,655	+/-34	2,655	(X)
Male	1,177	+/-25	44.3%	+/-0.8

Subject	Cleburne County, Alabama			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Female	1,478	+/-30	55.7%	+/-0.8
RACE				
Total population	15,002	*****	15,002	(X)
One race	14,711	+/-125	98.1%	+/-0.8
Two or more races	291	+/-125	1.9%	+/-0.8
One race	14,711	+/-125	98.1%	+/-0.8
White	14,098	+/-112	94.0%	+/-0.7
Black or African American	442	+/-108	2.9%	+/-0.7
American Indian and Alaska Native	33	+/-45	0.2%	+/-0.3
Cherokee tribal grouping	33	+/-45	0.2%	+/-0.3
Chippewa tribal grouping	0	+/-18	0.0%	+/-0.2
Navajo tribal grouping	0	+/-18	0.0%	+/-0.2
Sioux tribal grouping	0	+/-18	0.0%	+/-0.2
Asian	53	+/-65	0.4%	+/-0.4
Asian Indian	0	+/-18	0.0%	+/-0.2
Chinese	0	+/-18	0.0%	+/-0.2
Filipino	39	+/-62	0.3%	+/-0.4
Japanese	0	+/-18	0.0%	+/-0.2
Korean	0	+/-18	0.0%	+/-0.2
Vietnamese	3	+/-5	0.0%	+/-0.1
Other Asian	11	+/-20	0.1%	+/-0.1
Native Hawaiian and Other Pacific Islander	0	+/-18	0.0%	+/-0.2
Native Hawaiian	0	+/-18	0.0%	+/-0.2
Guamanian or Chamorro	0	+/-18	0.0%	+/-0.2
Samoan	0	+/-18	0.0%	+/-0.2
Other Pacific Islander	0	+/-18	0.0%	+/-0.2
Some other race	85	+/-79	0.6%	+/-0.5
Two or more races	291	+/-125	1.9%	+/-0.8
White and Black or African American	116	+/-68	0.8%	+/-0.5
White and American Indian and Alaska Native	67	+/-45	0.4%	+/-0.3
White and Asian	1	+/-2	0.0%	+/-0.1
Black or African American and American Indian and Alaska Native	42	+/-51	0.3%	+/-0.3
Race alone or in combination with one or more other races				
Total population	15,002	*****	15,002	(X)
White	14,347	+/-120	95.6%	+/-0.8
Black or African American	643	+/-76	4.3%	+/-0.5
American Indian and Alaska Native	185	+/-94	1.2%	+/-0.6
Asian	54	+/-65	0.4%	+/-0.4
Native Hawaiian and Other Pacific Islander	0	+/-18	0.0%	+/-0.2
Some other race	107	+/-105	0.7%	+/-0.7
HISPANIC OR LATINO AND RACE				
Total population	15,002	*****	15,002	(X)
Hispanic or Latino (of any race)	345	*****	2.3%	*****
Mexican	283	+/-73	1.9%	+/-0.5
Puerto Rican	31	+/-52	0.2%	+/-0.3
Cuban	6	+/-14	0.0%	+/-0.1
Other Hispanic or Latino	25	+/-36	0.2%	+/-0.2
Not Hispanic or Latino	14,657	*****	97.7%	*****
White alone	13,877	+/-18	92.5%	+/-0.2
Black or African American alone	442	+/-108	2.9%	+/-0.7
American Indian and Alaska Native alone	33	+/-45	0.2%	+/-0.3
Asian alone	53	+/-65	0.4%	+/-0.4
Native Hawaiian and Other Pacific Islander alone	0	+/-18	0.0%	+/-0.2

Subject	Cleburne County, Alabama			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Some other race alone	0	+/-18	0.0%	+/-0.2
Two or more races	252	+/-103	1.7%	+/-0.7
Two races including Some other race	0	+/-18	0.0%	+/-0.2
Two races excluding Some other race, and Three or more races	252	+/-103	1.7%	+/-0.7
Total housing units	6,692	+/-37	(X)	(X)
CITIZEN, VOTING AGE POPULATION				
Citizen, 18 and over population	11,367	+/-62	11,367	(X)
Male	5,468	+/-74	48.1%	+/-0.6
Female	5,899	+/-72	51.9%	+/-0.6

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Subject	Talladega County, Alabama			
	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE				
Total population	81,437	*****	81,437	(X)
Male	39,494	+/-161	48.5%	+/-0.2
Female	41,943	+/-161	51.5%	+/-0.2
Under 5 years	4,608	+/-105	5.7%	+/-0.1
5 to 9 years	4,567	+/-419	5.6%	+/-0.5
10 to 14 years	5,794	+/-414	7.1%	+/-0.5
15 to 19 years	5,060	+/-50	6.2%	+/-0.1
20 to 24 years	5,294	+/-110	6.5%	+/-0.1
25 to 34 years	9,792	+/-172	12.0%	+/-0.2
35 to 44 years	10,744	+/-161	13.2%	+/-0.2
45 to 54 years	11,599	+/-135	14.2%	+/-0.2
55 to 59 years	6,000	+/-357	7.4%	+/-0.4
60 to 64 years	5,268	+/-358	6.5%	+/-0.4
65 to 74 years	7,637	+/-86	9.4%	+/-0.1
75 to 84 years	3,693	+/-200	4.5%	+/-0.2
85 years and over	1,381	+/-196	1.7%	+/-0.2
Median age (years)	40.9	+/-0.4	(X)	(X)
18 years and over	63,258	+/-63	77.7%	+/-0.1
21 years and over	60,334	+/-242	74.1%	+/-0.3
62 years and over	15,519	+/-319	19.1%	+/-0.4
65 years and over	12,711	+/-99	15.6%	+/-0.1
18 years and over	63,258	+/-63	63,258	(X)
Male	30,471	+/-110	48.2%	+/-0.2
Female	32,787	+/-94	51.8%	+/-0.2
65 years and over	12,711	+/-99	12,711	(X)
Male	5,534	+/-48	43.5%	+/-0.4

Subject	Talladega County, Alabama			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Female	7,177	+/-85	56.5%	+/-0.4
RACE				
Total population	81,437	*****	81,437	(X)
One race	79,978	+/-321	98.2%	+/-0.4
Two or more races	1,459	+/-321	1.8%	+/-0.4
One race	79,978	+/-321	98.2%	+/-0.4
White	52,661	+/-261	64.7%	+/-0.3
Black or African American	26,023	+/-282	32.0%	+/-0.3
American Indian and Alaska Native	284	+/-121	0.3%	+/-0.1
Cherokee tribal grouping	125	+/-71	0.2%	+/-0.1
Chippewa tribal grouping	0	+/-27	0.0%	+/-0.1
Navajo tribal grouping	0	+/-27	0.0%	+/-0.1
Sioux tribal grouping	0	+/-27	0.0%	+/-0.1
Asian	368	+/-111	0.5%	+/-0.1
Asian Indian	69	+/-80	0.1%	+/-0.1
Chinese	228	+/-161	0.3%	+/-0.2
Filipino	10	+/-20	0.0%	+/-0.1
Japanese	0	+/-27	0.0%	+/-0.1
Korean	1	+/-3	0.0%	+/-0.1
Vietnamese	60	+/-106	0.1%	+/-0.1
Other Asian	0	+/-27	0.0%	+/-0.1
Native Hawaiian and Other Pacific Islander	30	+/-37	0.0%	+/-0.1
Native Hawaiian	30	+/-37	0.0%	+/-0.1
Guamanian or Chamorro	0	+/-27	0.0%	+/-0.1
Samoan	0	+/-27	0.0%	+/-0.1
Other Pacific Islander	0	+/-27	0.0%	+/-0.1
Some other race	612	+/-281	0.8%	+/-0.3
Two or more races	1,459	+/-321	1.8%	+/-0.4
White and Black or African American	623	+/-275	0.8%	+/-0.3
White and American Indian and Alaska Native	423	+/-134	0.5%	+/-0.2
White and Asian	176	+/-91	0.2%	+/-0.1
Black or African American and American Indian and Alaska Native	15	+/-20	0.0%	+/-0.1
Race alone or in combination with one or more other races				
Total population	81,437	*****	81,437	(X)
White	53,973	+/-392	66.3%	+/-0.5
Black or African American	26,746	+/-136	32.8%	+/-0.2
American Indian and Alaska Native	783	+/-135	1.0%	+/-0.2
Asian	572	+/-29	0.7%	+/-0.1
Native Hawaiian and Other Pacific Islander	49	+/-55	0.1%	+/-0.1
Some other race	803	+/-257	1.0%	+/-0.3
HISPANIC OR LATINO AND RACE				
Total population	81,437	*****	81,437	(X)
Hispanic or Latino (of any race)	1,768	*****	2.2%	*****
Mexican	1,201	+/-172	1.5%	+/-0.2
Puerto Rican	63	+/-63	0.1%	+/-0.1
Cuban	76	+/-64	0.1%	+/-0.1
Other Hispanic or Latino	428	+/-140	0.5%	+/-0.2
Not Hispanic or Latino	79,669	*****	97.8%	*****
White alone	51,883	+/-17	63.7%	+/-0.1
Black or African American alone	25,976	+/-274	31.9%	+/-0.3
American Indian and Alaska Native alone	215	+/-93	0.3%	+/-0.1
Asian alone	348	+/-104	0.4%	+/-0.1
Native Hawaiian and Other Pacific Islander alone	30	+/-37	0.0%	+/-0.1

Subject	Talladega County, Alabama			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Some other race alone	3	+/-6	0.0%	+/-0.1
Two or more races	1,214	+/-290	1.5%	+/-0.4
Two races including Some other race	7	+/-16	0.0%	+/-0.1
Two races excluding Some other race, and Three or more races	1,207	+/-289	1.5%	+/-0.4
Total housing units	37,157	+/-208	(X)	(X)
CITIZEN, VOTING AGE POPULATION				
Citizen, 18 and over population	62,264	+/-207	62,264	(X)
Male	29,836	+/-161	47.9%	+/-0.2
Female	32,428	+/-131	52.1%	+/-0.2

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Subject	Alabama			
	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE				
Total population	4,830,620	*****	4,830,620	(X)
Male	2,341,093	+/-1,138	48.5%	+/-0.1
Female	2,489,527	+/-1,138	51.5%	+/-0.1
Under 5 years	295,054	+/-766	6.1%	+/-0.1
5 to 9 years	305,714	+/-2,742	6.3%	+/-0.1
10 to 14 years	318,437	+/-2,874	6.6%	+/-0.1
15 to 19 years	324,020	+/-1,160	6.7%	+/-0.1
20 to 24 years	348,044	+/-1,244	7.2%	+/-0.1
25 to 34 years	621,592	+/-1,482	12.9%	+/-0.1
35 to 44 years	609,415	+/-1,064	12.6%	+/-0.1
45 to 54 years	665,372	+/-1,141	13.8%	+/-0.1
55 to 59 years	326,349	+/-2,726	6.8%	+/-0.1
60 to 64 years	297,297	+/-2,812	6.2%	+/-0.1
65 to 74 years	416,983	+/-669	8.6%	+/-0.1
75 to 84 years	220,721	+/-1,861	4.6%	+/-0.1
85 years and over	81,622	+/-1,824	1.7%	+/-0.1
Median age (years)	38.4	+/-0.1	(X)	(X)
18 years and over	3,718,646	+/-445	77.0%	+/-0.1
21 years and over	3,514,202	+/-2,315	72.7%	+/-0.1
62 years and over	892,821	+/-2,115	18.5%	+/-0.1
65 years and over	719,326	+/-660	14.9%	+/-0.1
18 years and over	3,718,646	+/-445	3,718,646	(X)
Male	1,773,950	+/-656	47.7%	+/-0.1
Female	1,944,696	+/-589	52.3%	+/-0.1
65 years and over	719,326	+/-660	719,326	(X)
Male	309,311	+/-398	43.0%	+/-0.1

Subject	Alabama			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Female	410,015	+/-509	57.0%	+/-0.1
RACE				
Total population	4,830,620	*****	4,830,620	(X)
One race	4,748,974	+/-2,273	98.3%	+/-0.1
Two or more races	81,646	+/-2,273	1.7%	+/-0.1
One race	4,748,974	+/-2,273	98.3%	+/-0.1
White	3,325,464	+/-2,653	68.8%	+/-0.1
Black or African American	1,276,544	+/-2,499	26.4%	+/-0.1
American Indian and Alaska Native	23,850	+/-1,026	0.5%	+/-0.1
Cherokee tribal grouping	8,870	+/-685	0.2%	+/-0.1
Chippewa tribal grouping	172	+/-79	0.0%	+/-0.1
Navajo tribal grouping	153	+/-126	0.0%	+/-0.1
Sioux tribal grouping	252	+/-153	0.0%	+/-0.1
Asian	59,599	+/-1,379	1.2%	+/-0.1
Asian Indian	11,915	+/-1,242	0.2%	+/-0.1
Chinese	11,472	+/-1,207	0.2%	+/-0.1
Filipino	5,586	+/-759	0.1%	+/-0.1
Japanese	1,838	+/-437	0.0%	+/-0.1
Korean	10,544	+/-1,189	0.2%	+/-0.1
Vietnamese	9,212	+/-1,018	0.2%	+/-0.1
Other Asian	9,032	+/-1,074	0.2%	+/-0.1
Native Hawaiian and Other Pacific Islander	2,439	+/-742	0.1%	+/-0.1
Native Hawaiian	588	+/-211	0.0%	+/-0.1
Guamanian or Chamorro	1,246	+/-713	0.0%	+/-0.1
Samoan	161	+/-99	0.0%	+/-0.1
Other Pacific Islander	444	+/-139	0.0%	+/-0.1
Some other race	61,078	+/-2,975	1.3%	+/-0.1
Two or more races	81,646	+/-2,273	1.7%	+/-0.1
White and Black or African American	25,175	+/-1,766	0.5%	+/-0.1
White and American Indian and Alaska Native	27,134	+/-946	0.6%	+/-0.1
White and Asian	10,465	+/-1,079	0.2%	+/-0.1
Black or African American and American Indian and Alaska Native	3,705	+/-701	0.1%	+/-0.1
Race alone or in combination with one or more other races				
Total population	4,830,620	*****	4,830,620	(X)
White	3,396,662	+/-3,289	70.3%	+/-0.1
Black or African American	1,312,584	+/-1,645	27.2%	+/-0.1
American Indian and Alaska Native	58,251	+/-1,066	1.2%	+/-0.1
Asian	75,634	+/-748	1.6%	+/-0.1
Native Hawaiian and Other Pacific Islander	5,186	+/-943	0.1%	+/-0.1
Some other race	69,042	+/-2,874	1.4%	+/-0.1
HISPANIC OR LATINO AND RACE				
Total population	4,830,620	*****	4,830,620	(X)
Hispanic or Latino (of any race)	193,492	+/-582	4.0%	+/-0.1
Mexican	128,381	+/-3,118	2.7%	+/-0.1
Puerto Rican	14,524	+/-1,203	0.3%	+/-0.1
Cuban	5,155	+/-846	0.1%	+/-0.1
Other Hispanic or Latino	45,432	+/-2,987	0.9%	+/-0.1
Not Hispanic or Latino	4,637,128	+/-582	96.0%	+/-0.1
White alone	3,204,989	+/-779	66.3%	+/-0.1
Black or African American alone	1,270,064	+/-2,448	26.3%	+/-0.1
American Indian and Alaska Native alone	22,201	+/-856	0.5%	+/-0.1
Asian alone	58,969	+/-1,342	1.2%	+/-0.1
Native Hawaiian and Other Pacific Islander alone	1,579	+/-292	0.0%	+/-0.1

Subject	Alabama			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Some other race alone	5,592	+/-989	0.1%	+/-0.1
Two or more races	73,734	+/-2,165	1.5%	+/-0.1
Two races including Some other race	2,605	+/-608	0.1%	+/-0.1
Two races excluding Some other race, and Three or more races	71,129	+/-2,085	1.5%	+/-0.1
Total housing units	2,199,329	+/-508	(X)	(X)
CITIZEN, VOTING AGE POPULATION				
Citizen, 18 and over population	3,620,994	+/-2,429	3,620,994	(X)
Male	1,719,748	+/-1,773	47.5%	+/-0.1
Female	1,901,246	+/-1,444	52.5%	+/-0.1

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

For more information on understanding race and Hispanic origin data, please see the Census 2010 Brief entitled, Overview of Race and Hispanic Origin: 2010, issued March 2011. (pdf format)

While the 2011-2015 American Community Survey (ACS) data generally reflect the February 2013 Office of Management and Budget (OMB) definitions of metropolitan and micropolitan statistical areas; in certain instances the names, codes, and boundaries of the principal cities shown in ACS tables may differ from the OMB definitions due to differences in the effective dates of the geographic entities.

Estimates of urban and rural population, housing units, and characteristics reflect boundaries of urban areas defined based on Census 2010 data. As a result, data for urban and rural areas from the ACS do not necessarily reflect the results of ongoing urbanization.

Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

Explanation of Symbols:

1. An '**' entry in the margin of error column indicates that either no sample observations or too few sample observations were available to compute a standard error and thus the margin of error. A statistical test is not appropriate.
2. An '-' entry in the estimate column indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest interval or upper interval of an open-ended distribution.
3. An '-' following a median estimate means the median falls in the lowest interval of an open-ended distribution.
4. An '+' following a median estimate means the median falls in the upper interval of an open-ended distribution.
5. An '***' entry in the margin of error column indicates that the median falls in the lowest interval or upper interval of an open-ended distribution. A statistical test is not appropriate.
6. An '*****' entry in the margin of error column indicates that the estimate is controlled. A statistical test for sampling variability is not appropriate.
7. An 'N' entry in the estimate and margin of error columns indicates that data for this geographic area cannot be displayed because the number of sample cases is too small.
8. An '(X)' means that the estimate is not applicable or not available.

United States Census Bureau

QuickFacts

selected: Talladega County, Alabama; Cleburne County, Alabama; Calhoun County, Alabama; Alabama; UNITED STATES

QuickFacts provides statistics for all states and counties, and for cities and towns with a ***population of 5,000 or more***.

Table

ALL TOPICS	Talladega County, Alabama	Cleburne County, Alabama	Calhoun County, Alabama	Alabama	UNITED STATES
Population estimates, July 1, 2016, (V2016)	**80,103**	**14,924**	**114,611**	**4,863,300**	**323,127,513**
PEOPLE					
Population					
Population estimates, July 1, 2016, (V2016)	**80,103**	**14,924**	**114,611**	**4,863,300**	**323,127,513**
Population estimates base, April 1, 2010, (V2016)	82,291	14,972	118,586	4,780,131	308,758,105
Population, percent change - April 1, 2010 (estimates base) to July 1, 2016, (V2016)	-2.7%	-0.3%	-3.4%	1.7%	4.7%
Population, Census, April 1, 2010	82,291	14,972	118,572	4,779,736	308,745,538
Age and Sex					
Persons under 5 years, percent, July 1, 2016, (V2016)	5.3%	5.9%	5.6%	6.0%	6.2%
Persons under 5 years, percent, April 1, 2010	6.0%	6.3%	6.1%	6.4%	6.5%
Persons under 18 years, percent, July 1, 2016, (V2016)	21.7%	23.1%	21.8%	22.6%	22.8%
Persons under 18 years, percent, April 1, 2010	23.4%	23.7%	22.9%	23.7%	24.0%
Persons 65 years and over, percent, July 1, 2016, (V2016)	17.0%	18.8%	16.9%	16.1%	15.2%
Persons 65 years and over, percent, April 1, 2010	14.1%	15.8%	14.3%	13.8%	13.0%
Female persons, percent, July 1, 2016, (V2016)	51.6%	50.3%	51.9%	51.6%	50.8%
Female persons, percent, April 1, 2010	51.3%	50.2%	51.8%	51.5%	50.8%
Race and Hispanic Origin					
White alone, percent, July 1, 2016, (V2016) (a)	64.8%	94.9%	75.5%	69.3%	76.9%
White alone, percent, April 1, 2010 (a)	65.3%	94.0%	74.9%	68.5%	72.4%
Black or African American alone, percent, July 1, 2016, (V2016) (a)	32.6%	3.2%	21.0%	26.8%	13.3%
Black or African American alone, percent, April 1, 2010 (a)	31.7%	3.3%	20.6%	26.2%	12.6%
American Indian and Alaska Native alone, percent, July 1, 2016, (V2016) (a)	0.4%	0.4%	0.5%	0.7%	1.3%
American Indian and Alaska Native alone, percent, April 1, 2010 (a)	0.3%	0.3%	0.5%	0.6%	0.9%
Asian alone, percent, July 1, 2016, (V2016) (a)	0.6%	0.2%	0.9%	1.4%	5.7%
Asian alone, percent, April 1, 2010 (a)	0.4%	0.2%	0.7%	1.1%	4.8%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2016, (V2016) (a)	Z	0.1%	0.1%	0.1%	0.2%
Native Hawaiian and Other Pacific Islander alone, percent, April 1, 2010 (a)	Z	0.1%	0.1%	0.1%	0.2%
Two or More Races, percent, July 1, 2016, (V2016)	1.6%	1.2%	1.9%	1.6%	2.6%
Two or More Races, percent, April 1, 2010	1.3%	1.1%	1.7%	1.5%	2.9%
Hispanic or Latino, percent, July 1, 2016, (V2016) (b)	2.2%	2.5%	3.6%	4.2%	17.8%
Hispanic or Latino, percent, April 1, 2010 (b)	2.0%	2.1%	3.3%	3.9%	16.3%
White alone, not Hispanic or Latino, percent, July 1, 2016, (V2016)	63.1%	92.7%	72.6%	65.8%	61.3%
White alone, not Hispanic or Latino, percent, April 1, 2010	64.5%	93.2%	73.6%	67.0%	63.7%
Population Characteristics					
Veterans, 2011-2015	5,853	788	10,867	363,170	20,108,332
Foreign born persons, percent, 2011-2015	1.6%	1.5%	2.6%	3.5%	13.2%
Housing					
Housing units, July 1, 2016, (V2016)	37,206	6,684	53,344	2,230,185	135,697,926
Housing units, April 1, 2010	37,088	6,718	53,289	2,171,853	131,704,730
Owner-occupied housing unit rate, 2011-2015	71.1%	77.4%	69.1%	68.7%	63.9%
Median value of owner-occupied housing units, 2011-2015	$93,400	$108,000	$105,900	$125,500	$178,600
Median selected monthly owner costs -with a mortgage, 2011-2015	$986	$1,048	$1,031	$1,139	$1,492
Median selected monthly owner costs -without a mortgage, 2011-2015	$334	$330	$320	$345	$458
Median gross rent, 2011-2015	$584	$557	$637	$717	$928
Building permits, 2016	72	1	77	15,001	1,206,642

Families & Living Arrangements					
Households, 2011-2015	31,424	5,776	45,154	1,848,325	116,926,305
Persons per household, 2011-2015	2.49	2.57	2.52	2.55	2.64
Living in same house 1 year ago, percent of persons age 1 year+, 2011-2015	85.7%	88.1%	83.3%	85.3%	85.1%
Language other than English spoken at home, percent of persons age 5 years+, 2011-2015	2.8%	2.9%	4.3%	5.2%	21.0%
Education					
High school graduate or higher, percent of persons age 25 years+, 2011-2015	79.3%	75.1%	80.9%	84.3%	86.7%
Bachelor's degree or higher, percent of persons age 25 years+, 2011-2015	13.1%	12.1%	17.6%	23.5%	29.8%
Health					
With a disability, under age 65 years, percent, 2011-2015	14.6%	13.8%	15.3%	11.8%	8.6%
Persons without health insurance, under age 65 years, percent	▲ 11.2%	▲ 12.1%	▲ 11.4%	▲ 10.7%	▲ 10.1%
Economy					
In civilian labor force, total, percent of population age 16 years+, 2011-2015	54.4%	55.8%	57.9%	58.0%	63.3%
In civilian labor force, female, percent of population age 16 years+, 2011-2015	50.4%	46.7%	52.3%	53.0%	58.5%
Total accommodation and food services sales, 2012 ($1,000) (c)	D	D	199,072	7,576,462	708,138,598
Total health care and social assistance receipts/revenue, 2012 ($1,000) (c)	D	D	573,528	26,039,632	2,040,441,203
Total manufacturers shipments, 2012 ($1,000) (c)	D	269,201	2,713,200	124,809,759	5,696,729,632
Total merchant wholesaler sales, 2012 ($1,000) (c)	D	6,575	1,808,828	57,746,565	5,208,023,478
Total retail sales, 2012 ($1,000) (c)	743,404	63,984	1,463,477	58,564,965	4,219,821,871
Total retail sales per capita, 2012 (c)	$9,092	$4,314	$12,477	$12,145	$13,443
Transportation					
Mean travel time to work (minutes), workers age 16 years+, 2011-2015	24.6	33.3	24.1	24.4	25.9
Income & Poverty					
Median household income (in 2015 dollars), 2011-2015	$35,155	$38,056	$41,703	$43,623	$53,889
Per capita income in past 12 months (in 2015 dollars), 2011-2015	$19,598	$20,151	$21,374	$24,091	$28,930
Persons in poverty, percent	▲ 22.4%	▲ 18.9%	▲ 20.0%	▲ 17.1%	▲ 12.7%
BUSINESSES					
Businesses					
Total employer establishments, 2015	1,235	160	2,300	98,540[1]	7,663,938
Total employment, 2015	23,303	1,800	35,910	1,634,391[1]	124,085,947
Total annual payroll, 2015 ($1,000)	1,059,883	71,567	1,166,066	67,370,353[1]	6,253,488,252
Total employment, percent change, 2014-2015	-4.1%	2.9%	2.3%	1.9%[1]	2.5%
Total nonemployer establishments, 2015	3,994	931	6,440	322,025	24,331,403
All firms, 2012	4,812	1,185	7,513	374,153	27,626,360
Men-owned firms, 2012	2,477	784	4,113	203,604	14,844,597
Women-owned firms, 2012	1,857	317	2,570	137,630	9,878,397
Minority-owned firms, 2012	1,158	64	1,041	92,219	7,952,386
Nonminority-owned firms, 2012	3,451	1,107	6,103	272,651	18,987,918
Veteran-owned firms, 2012	434	91	938	41,943	2,521,682
Nonveteran-owned firms, 2012	4,106	1,073	6,084	316,984	24,070,685
GEOGRAPHY					
Geography					
Population per square mile, 2010	111.7	26.7	195.7	94.4	87.4
Land area in square miles, 2010	736.78	560.10	605.87	50,645.33	3,531,905.43
FIPS Code	01121	01029	01015	01	00

Value Notes

1. Includes data not distributed by county.

▲ This geographic level of poverty and health estimates are not comparable to other geographic levels of these estimates

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable. Click the Quick Info ⓘ icon to the left of each row in TABLE view to learn about sampling error.

The vintage year (e.g., V2016) refers to the final year of the series (2010 thru 2016). *Different vintage years of estimates are not comparable.*

Fact Notes

(a) Includes persons reporting only one race
(b) Hispanics may be of any race, so also are included in applicable race categories
(c) Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

Value Flags

- Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest or upper interval of an open ended distribution.
D Suppressed to avoid disclosure of confidential information
F Fewer than 25 firms
FN Footnote on this item in place of data
NA Not available
S Suppressed; does not meet publication standards
X Not applicable
Z Value greater than zero but less than half unit of measure shown

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area SHealth Insurance Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

ATTACHMENT G

HRSA COMMUNITY FACT SHEETS

HRSA Health Resources & Services Administration Data Warehouse

Community Fact Sheet

Calhoun County, Alabama, HHS Region IV

Collection	Characteristic	Population	% of Pop.	Hispanic or Latino Population	Hispanic or Latino % of Pop.
Population (U.S. Census 2010)	**Total**	118,572	---	3,893	3.28 %
Race / Ethnicity (U.S. Census 2010)	**White**	88,840	74.92 %	1,555	1.31 %
	Black or African American	24,382	20.56 %	205	0.17 %
	Asian	845	0.71 %	15	0.01 %
	American Indian or Alaskan Native	540	0.46 %	60	0.05 %
	Native Hawaiian or Other Pacific Islander	96	0.08 %	2	0.00 %
	One Race	116,597	98.33 %	3,622	3.05 %
	Two or More Races	1,975	1.67 %	271	0.23 %
Income in Relation to U.S. Federal Poverty Level Note: % is relative to known poverty status. (ACS 2011-2015)	**Family Poverty Below Poverty Level**	5,042	16.49 %		
	Family Poverty Below 150%	7,795	25.49 %		
	Family Poverty Below 200%	11,004	35.98 %		

Living Below U.S. Federal Poverty Level (USFPL) by Age (U.S. Census 2000)		
	Under 5 Years of Age	1,819
	Age 5 Years	339
	6 to 11 Years of Age	2,031
	12 to 17 Years of Age	1,787
	18 to 64 Years of Age	9,756
	65 to 74 Years of Age	961
	75 Years of Age and Greater	1,002

Median Household Income	$35,937
Estimate Living Below USFPL	
Ages 5-17	3,912
Under Age 18	5,906
All Ages	18,450
(U.S. Census 2005)	

Community Fact Sheet

Table of Sources

Data	Source
Population	U.S. Census, Population Statistics, Time Period: 2010
Income and Poverty	American Community Survey, Income and Poverty Statistics, The Census Bureau collects American Community Survey data from a sample of the population in the United States and Puerto Rico—rather than from the whole population. All ACS data are survey estimates. Time Period: 2011-2015
Age and Poverty	U.S. Census, Age and Poverty Statistics, Time Period: 2000
Age and Poverty Estimates	U.S. Census Bureau. Small Area Income and Poverty Estimates, Time Period: 2005

HRSA Health Resources & Services Administration Data Warehouse

Community Fact Sheet

Cleburne County, Alabama, HHS Region IV

Collection	Characteristic	Population	% of Pop.	Hispanic or Latino Population	Hispanic or Latino % of Pop.
Population (U.S. Census 2010)	**Total**	14,972	---	307	2.05 %
Race / Ethnicity (U.S. Census 2010)	**White**	14,079	94.04 %	123	0.82 %
	Black or African American	498	3.33 %	4	0.03 %
	Asian	23	0.15 %	0	0.00 %
	American Indian or Alaskan Native	51	0.34 %	1	0.01 %
	Native Hawaiian or Other Pacific Islander	10	0.07 %	9	0.06 %
	One Race	14,812	98.93 %	284	1.90 %
	Two or More Races	160	1.07 %	23	0.15 %
Income in Relation to U.S. Federal Poverty Level Note: % is relative to known poverty status. (ACS 2011-2015)	**Family Poverty Below Poverty Level**	432	10.60 %		
	Family Poverty Below 150%	737	18.09 %		
	Family Poverty Below 200%	1,384	33.97 %		

Living Below U.S. Federal Poverty Level (USFPL) by Age (U.S. Census 2000)				
	Under 5 Years of Age	135	**Median Household Income**	$34,287
	Age 5 Years	35		
	6 to 11 Years of Age	191	**Estimate Living Below USFPL**	
	12 to 17 Years of Age	190	**Ages 5-17**	473
	18 to 64 Years of Age	1,025	**Under Age 18**	687
	65 to 74 Years of Age	181	**All Ages**	2,217
	75 Years of Age and Greater	196	(U.S. Census 2005)	

Community Fact Sheet

Table of Sources

Data	Source
Population	U.S. Census, Population Statistics, Time Period: 2010
Income and Poverty	American Community Survey, Income and Poverty Statistics, The Census Bureau collects American Community Survey data from a sample of the population in the United States and Puerto Rico—rather than from the whole population. All ACS data are survey estimates. Time Period: 2011-2015
Age and Poverty	U.S. Census, Age and Poverty Statistics, Time Period: 2000
Age and Poverty Estimates	U.S. Census Bureau. Small Area Income and Poverty Estimates, Time Period: 2005

HRSA Health Resources & Services Administration
Data Warehouse

Community Fact Sheet
Talladega County, Alabama, HHS Region IV

Collection	Characteristic	Population	% of Pop.	Hispanic or Latino Population	Hispanic or Latino % of Pop.
Population (U.S. Census 2010)	**Total**	82,291	---	1,671	2.03 %
Race / Ethnicity (U.S. Census 2010)	**White**	53,739	65.30 %	660	0.80 %
	Black or African American	26,055	31.66 %	102	0.12 %
	Asian	339	0.41 %	10	0.01 %
	American Indian or Alaskan Native	264	0.32 %	34	0.04 %
	Native Hawaiian or Other Pacific Islander	6	0.01 %	0	0.00 %
	One Race	81,190	98.66 %	1,533	1.86 %
	Two or More Races	1,101	1.34 %	138	0.17 %
Income in Relation to U.S. Federal Poverty Level Note: % is relative to known poverty status. (ACS 2011-2015)	**Family Poverty Below Poverty Level**	4,197	19.35 %		
	Family Poverty Below 150%	6,542	30.16 %		
	Family Poverty Below 200%	8,820	40.67 %		

Living Below U.S. Federal Poverty Level (USFPL) by Age (U.S. Census 2000)		
	Under 5 Years of Age	1,451
	Age 5 Years	254
	6 to 11 Years of Age	1,702
	12 to 17 Years of Age	1,433
	18 to 64 Years of Age	6,763
	65 to 74 Years of Age	1,068
	75 Years of Age and Greater	830

Median Household Income	$33,986
Estimate Living Below USFPL	
Ages 5-17	3,182
Under Age 18	5,194
All Ages	14,835
(U.S. Census 2005)	

Community Fact Sheet

Table of Sources

Data	Source
Population	U.S. Census, Population Statistics, Time Period: 2010
Income and Poverty	American Community Survey, Income and Poverty Statistics, The Census Bureau collects American Community Survey data from a sample of the population in the United States and Puerto Rico—rather than from the whole population. All ACS data are survey estimates. Time Period: 2011-2015
Age and Poverty	U.S. Census, Age and Poverty Statistics, Time Period: 2000
Age and Poverty Estimates	U.S. Census Bureau. Small Area Income and Poverty Estimates, Time Period: 2005

HRSA Data Warehouse

State: Alabama
County: Calhoun County, Cleburne County, Talladega County
MUA ID: All

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Population Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
Calhoun County	015	Calhoun County	00008	Medically Underserved Area	Medically Underserved Area	61.90	11/01/1978	11/01/1978
Cleburne County	029	Cleburne County	00015	Medically Underserved Area	Medically Underserved Area	61.10	11/01/1978	11/12/2013
Talladega County	121	Talladega County	00053	Medically Underserved Area	Medically Underserved Area	45.20	11/07/1978	11/07/1978

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Printed on: 6/26/2017

PEPAGESEX

Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2016

2016 Population Estimates

Geography: Calhoun County, Alabama

Age	April 1, 2010					
	Census			Estimates Base		
	Both Sexes	Male	Female	Both Sexes	Male	Female
Total	118,572	57,176	61,396	118,586	57,183	61,403
Under 5 years	7,204	3,705	3,499	7,204	3,705	3,499
5 to 9 years	7,521	3,881	3,640	7,521	3,881	3,640
10 to 14 years	7,719	3,936	3,783	7,719	3,936	3,783
15 to 19 years	8,607	4,343	4,264	8,607	4,343	4,264
20 to 24 years	9,022	4,474	4,548	9,022	4,474	4,548
25 to 29 years	7,601	3,711	3,890	7,601	3,711	3,890
30 to 34 years	7,186	3,517	3,669	7,186	3,517	3,669
35 to 39 years	7,232	3,524	3,708	7,232	3,524	3,708
40 to 44 years	7,395	3,637	3,758	7,395	3,637	3,758
45 to 49 years	8,291	4,086	4,205	8,293	4,087	4,206
50 to 54 years	8,695	4,172	4,523	8,695	4,172	4,523
55 to 59 years	8,024	3,858	4,166	8,024	3,858	4,166
60 to 64 years	7,085	3,372	3,713	7,085	3,372	3,713
65 to 69 years	5,337	2,470	2,867	5,340	2,473	2,867
70 to 74 years	4,100	1,849	2,251	4,102	1,850	2,252
75 to 79 years	3,374	1,336	2,038	3,378	1,338	2,040
80 to 84 years	2,375	838	1,537	2,376	838	1,538
85 years and over	1,804	467	1,337	1,806	467	1,339
Under 18 years	27,126	13,976	13,150	27,126	13,976	13,150
Under 5 years	7,204	3,705	3,499	7,204	3,705	3,499
5 to 13 years	13,799	7,080	6,719	13,799	7,080	6,719
14 to 17 years	6,123	3,191	2,932	6,123	3,191	2,932
18 to 64 years	74,456	36,240	38,216	74,458	36,241	38,217
18 to 24 years	12,947	6,363	6,584	12,947	6,363	6,584
25 to 44 years	29,414	14,389	15,025	29,414	14,389	15,025

Age	April 1, 2010					
	Census			Estimates Base		
	Both Sexes	Male	Female	Both Sexes	Male	Female
45 to 64 years	32,095	15,488	16,607	32,097	15,489	16,608
65 years and over	16,990	6,960	10,030	17,002	6,966	10,036
85 years and over	1,804	467	1,337	1,806	467	1,339
16 years and over	94,602	44,855	49,747	94,616	44,862	49,754
18 years and over	91,446	43,200	48,246	91,460	43,207	48,253
15 to 44 years	47,043	23,206	23,837	47,043	23,206	23,837
Median age (years)	38.2	36.5	39.6	38.2	36.5	39.6

Age	Population Estimate (as of July 1)					
	2010			2011		
	Both Sexes	Male	Female	Both Sexes	Male	Female
Total	118,468	57,136	61,332	117,736	56,660	61,076
Under 5 years	7,150	3,669	3,481	7,093	3,676	3,417
5 to 9 years	7,486	3,848	3,638	7,360	3,754	3,606
10 to 14 years	7,744	3,959	3,785	7,783	3,986	3,797
15 to 19 years	8,414	4,272	4,142	7,778	3,979	3,799
20 to 24 years	9,058	4,483	4,575	9,147	4,443	4,704
25 to 29 years	7,608	3,716	3,892	7,519	3,719	3,800
30 to 34 years	7,204	3,527	3,677	7,187	3,489	3,698
35 to 39 years	7,186	3,507	3,679	6,933	3,360	3,573
40 to 44 years	7,434	3,656	3,778	7,509	3,659	3,850
45 to 49 years	8,247	4,067	4,180	7,914	3,904	4,010
50 to 54 years	8,693	4,173	4,520	8,658	4,124	4,534
55 to 59 years	8,093	3,893	4,200	8,292	3,999	4,293
60 to 64 years	7,124	3,378	3,746	7,360	3,429	3,931
65 to 69 years	5,348	2,476	2,872	5,472	2,550	2,922
70 to 74 years	4,115	1,858	2,257	4,133	1,872	2,261
75 to 79 years	3,376	1,343	2,033	3,358	1,364	1,994
80 to 84 years	2,378	840	1,538	2,378	850	1,528
85 years and over	1,810	471	1,339	1,862	503	1,359
Under 18 years	27,031	13,912	13,119	26,775	13,745	13,030
Under 5 years	7,150	3,669	3,481	7,093	3,676	3,417
5 to 13 years	13,763	7,052	6,711	13,573	6,923	6,650
14 to 17 years	6,118	3,191	2,927	6,109	3,146	2,963
18 to 64 years	74,410	36,236	38,174	73,758	35,776	37,982
18 to 24 years	12,821	6,319	6,502	12,386	6,093	6,293
25 to 44 years	29,432	14,406	15,026	29,148	14,227	14,921
45 to 64 years	32,157	15,511	16,646	32,224	15,456	16,768
65 years and over	17,027	6,988	10,039	17,203	7,139	10,064
85 years and over	1,810	471	1,339	1,862	503	1,359
16 years and over	94,576	44,869	49,707	94,030	44,498	49,532
18 years and over	91,437	43,224	48,213	90,961	42,915	48,046
15 to 44 years	46,904	23,161	23,743	46,073	22,649	23,424
Median age (years)	38.3	36.6	39.8	38.6	36.9	40.2

Age	Population Estimate (as of July 1)					
	2012			2013		
	Both Sexes	Male	Female	Both Sexes	Male	Female
Total	117,208	56,408	60,800	116,475	56,188	60,287
Under 5 years	6,884	3,529	3,355	6,678	3,381	3,297
5 to 9 years	7,210	3,730	3,480	7,201	3,802	3,399
10 to 14 years	7,709	3,892	3,817	7,515	3,806	3,709
15 to 19 years	7,754	3,958	3,796	7,654	3,922	3,732
20 to 24 years	9,055	4,432	4,623	8,791	4,309	4,482
25 to 29 years	7,500	3,687	3,813	7,527	3,697	3,830
30 to 34 years	7,183	3,466	3,717	7,170	3,507	3,663
35 to 39 years	6,850	3,368	3,482	6,933	3,379	3,554
40 to 44 years	7,412	3,573	3,839	7,297	3,559	3,738
45 to 49 years	7,692	3,836	3,856	7,507	3,681	3,826
50 to 54 years	8,454	4,031	4,423	8,336	4,022	4,314
55 to 59 years	8,415	4,062	4,353	8,391	4,048	4,343
60 to 64 years	7,336	3,443	3,893	7,370	3,444	3,926
65 to 69 years	5,858	2,696	3,162	6,060	2,816	3,244
70 to 74 years	4,231	1,930	2,301	4,394	2,005	2,389
75 to 79 years	3,352	1,382	1,970	3,366	1,374	1,992
80 to 84 years	2,414	881	1,533	2,344	896	1,448
85 years and over	1,899	512	1,387	1,941	540	1,401
Under 18 years	26,319	13,473	12,846	25,932	13,322	12,610
Under 5 years	6,884	3,529	3,355	6,678	3,381	3,297
5 to 13 years	13,365	6,844	6,521	13,150	6,811	6,339
14 to 17 years	6,070	3,100	2,970	6,104	3,130	2,974
18 to 64 years	73,135	35,534	37,601	72,438	35,235	37,203
18 to 24 years	12,293	6,068	6,225	11,907	5,898	6,009
25 to 44 years	28,945	14,094	14,851	28,927	14,142	14,785
45 to 64 years	31,897	15,372	16,525	31,604	15,195	16,409
65 years and over	17,754	7,401	10,353	18,105	7,631	10,474
85 years and over	1,899	512	1,387	1,941	540	1,401
16 years and over	93,843	44,451	49,392	93,521	44,397	49,124
18 years and over	90,889	42,935	47,954	90,543	42,866	47,677
15 to 44 years	45,754	22,484	23,270	45,372	22,373	22,999
Median age (years)	38.9	37.2	40.4	39.0	37.4	40.7

Age	Population Estimate (as of July 1)					
	2014			2015		
	Both Sexes	Male	Females	Both Sexes	Male	Female
Total	115,837	55,767	60,070	115,285	55,477	59,808
Under 5 years	6,559	3,351	3,208	6,529	3,294	3,235
5 to 9 years	7,115	3,720	3,395	6,977	3,615	3,362
10 to 14 years	7,387	3,792	3,595	7,186	3,677	3,509
15 to 19 years	7,624	3,850	3,774	7,672	3,891	3,781
20 to 24 years	8,373	4,094	4,279	7,879	3,911	3,968
25 to 29 years	7,793	3,808	3,985	7,981	3,904	4,077
30 to 34 years	7,115	3,465	3,650	7,017	3,397	3,620
35 to 39 years	6,997	3,414	3,583	7,009	3,434	3,575
40 to 44 years	7,058	3,447	3,611	6,966	3,399	3,567
45 to 49 years	7,383	3,562	3,821	7,220	3,499	3,721
50 to 54 years	8,199	3,981	4,218	8,030	3,918	4,112
55 to 59 years	8,309	3,979	4,330	8,329	3,971	4,358
60 to 64 years	7,437	3,494	3,943	7,581	3,583	3,998
65 to 69 years	6,263	2,882	3,381	6,509	2,972	3,537
70 to 74 years	4,546	2,109	2,437	4,645	2,112	2,533
75 to 79 years	3,308	1,369	1,939	3,319	1,408	1,911
80 to 84 years	2,375	881	1,494	2,394	902	1,492
85 years and over	1,996	569	1,427	2,042	590	1,452
Under 18 years	25,721	13,228	12,493	25,396	12,990	12,406
Under 5 years	6,559	3,351	3,208	6,529	3,294	3,235
5 to 13 years	12,938	6,698	6,240	12,687	6,518	6,169
14 to 17 years	6,224	3,179	3,045	6,180	3,178	3,002
18 to 64 years	71,628	34,729	36,899	70,980	34,503	36,477
18 to 24 years	11,337	5,579	5,758	10,847	5,398	5,449
25 to 44 years	28,963	14,134	14,829	28,973	14,134	14,839
45 to 64 years	31,328	15,016	16,312	31,160	14,971	16,189
65 years and over	18,488	7,810	10,678	18,909	7,984	10,925
85 years and over	1,996	569	1,427	2,042	590	1,452
16 years and over	93,187	44,103	49,084	93,005	44,060	48,945
18 years and over	90,116	42,539	47,577	89,889	42,487	47,402
15 to 44 years	44,960	22,078	22,882	44,524	21,936	22,588
Median age (years)	39.3	37.6	40.9	39.6	37.9	41.1

Age	Population Estimate (as of July 1)		
	2016		
	Both Sexes	Male	Female
Total	114,611	55,138	59,473
Under 5 years	6,420	3,283	3,137
5 to 9 years	6,846	3,514	3,332
10 to 14 years	7,136	3,683	3,453
15 to 19 years	7,656	3,902	3,754
20 to 24 years	7,355	3,666	3,689
25 to 29 years	8,213	3,996	4,217
30 to 34 years	6,953	3,365	3,588
35 to 39 years	7,057	3,433	3,624
40 to 44 years	6,718	3,311	3,407
45 to 49 years	7,245	3,512	3,733
50 to 54 years	7,718	3,780	3,938
55 to 59 years	8,225	3,868	4,357
60 to 64 years	7,722	3,671	4,051
65 to 69 years	6,789	3,059	3,730
70 to 74 years	4,731	2,130	2,601
75 to 79 years	3,365	1,426	1,939
80 to 84 years	2,369	936	1,433
85 years and over	2,093	603	1,490
Under 18 years	25,020	12,871	12,149
Under 5 years	6,420	3,283	3,137
5 to 13 years	12,472	6,460	6,012
14 to 17 years	6,128	3,128	3,000
18 to 64 years	70,244	34,113	36,131
18 to 24 years	10,393	5,177	5,216
25 to 44 years	28,941	14,105	14,836
45 to 64 years	30,910	14,831	16,079
65 years and over	19,347	8,154	11,193
85 years and over	2,093	603	1,490
16 years and over	92,728	43,884	48,844
18 years and over	89,591	42,267	47,324
15 to 44 years	43,952	21,673	22,279
Median age (years)	39.8	38.1	41.4

Notes:
The estimates are based on the 2010 Census and reflect changes to the April 1, 2010 population due to the Count Question Resolution program and geographic program revisions. Median age is calculated based on single year of age. For population estimates methodology statements, see http://www.census.gov/programs-surveys/popest/technical-documentation/methodology.html.

The 6,222 people in Bedford city, Virginia, which was an independent city as of the 2010 Census, are not included in the April 1, 2010 Census enumerated population presented in the county estimates. In July 2013, the legal status of Bedford changed from a city to a town and it became dependent within (or part of) Bedford County, Virginia. This population of Bedford town is now included in the April 1, 2010 estimates base and all July 1 estimates for Bedford County. Because it is no longer an independent city, Bedford town is not listed in

this table. As a result, the sum of the April 1, 2010 census values for Virginia counties and independent cities does not equal the 2010 Census count for Virginia, and the sum of April 1, 2010 census values for all counties and independent cities in the United States does not equal the 2010 Census count for the United States. Substantial geographic changes to counties can be found on the Census Bureau website at http://www.census.gov/geo/reference/county-changes.html.

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U.S. Census Bureau

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Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2016

2016 Population Estimates

Geography: Cleburne County, Alabama

Age	April 1, 2010				
	Census			Estimates Base	
	Both Sexes	Male	Female	Both Sexes	Male
Total	14,972	7,453	7,519	14,972	7,453
Under 5 years	938	469	469	938	469
5 to 9 years	942	522	420	942	522
10 to 14 years	997	522	475	997	522
15 to 19 years	1,080	540	540	1,080	540
20 to 24 years	769	406	363	769	406
25 to 29 years	859	421	438	859	421
30 to 34 years	764	379	385	764	379
35 to 39 years	1,014	514	500	1,014	514
40 to 44 years	1,048	511	537	1,048	511
45 to 49 years	1,109	573	536	1,109	573
50 to 54 years	1,040	509	531	1,040	509
55 to 59 years	1,030	534	496	1,030	534
60 to 64 years	1,021	507	514	1,021	507
65 to 69 years	817	409	408	817	409
70 to 74 years	568	262	306	568	262
75 to 79 years	470	204	266	470	204
80 to 84 years	267	99	168	267	99
85 years and over	239	72	167	239	72
Under 18 years	3,551	1,857	1,694	3,551	1,857
Under 5 years	938	469	469	938	469
5 to 13 years	1,764	947	817	1,764	947
14 to 17 years	849	441	408	849	441
18 to 64 years	9,060	4,550	4,510	9,060	4,550
18 to 24 years	1,175	602	573	1,175	602
25 to 44 years	3,685	1,825	1,860	3,685	1,825
45 to 64 years	4,200	2,123	2,077	4,200	2,123
65 years and over	2,361	1,046	1,315	2,361	1,046
85 years and over	239	72	167	239	72
16 years and over	11,887	5,830	6,057	11,887	5,830
18 years and over	11,421	5,596	5,825	11,421	5,596
15 to 44 years	5,534	2,771	2,763	5,534	2,771
Median age (years)	40.6	39.5	41.5	40.6	39.5

Age	April 1, 2010 Estimates Base	Population Estimate (as of July 1)			
		2010			2011
	Female	Both Sexes	Male	Female	Both Sexes
Total	7,519	14,975	7,460	7,515	14,976
Under 5 years	469	949	474	475	915
5 to 9 years	420	937	520	417	951
10 to 14 years	475	1,005	529	476	1,006
15 to 19 years	540	1,047	523	524	973
20 to 24 years	363	785	412	373	832
25 to 29 years	438	870	427	443	838
30 to 34 years	385	763	385	378	773
35 to 39 years	500	1,007	508	499	942
40 to 44 years	537	1,047	508	539	1,032
45 to 49 years	536	1,115	577	538	1,085
50 to 54 years	531	1,044	512	532	1,078
55 to 59 years	496	1,032	532	500	1,031
60 to 64 years	514	1,025	513	512	1,031
65 to 69 years	408	810	403	407	833
70 to 74 years	306	571	266	305	632
75 to 79 years	266	460	199	261	472
80 to 84 years	168	270	101	169	308
85 years and over	167	238	71	167	244
Under 18 years	1,694	3,546	1,856	1,690	3,489
Under 5 years	469	949	474	475	915
5 to 13 years	817	1,754	944	810	1,752
14 to 17 years	408	843	438	405	822
18 to 64 years	4,510	9,080	4,564	4,516	8,998
18 to 24 years	573	1,177	602	575	1,188
25 to 44 years	1,860	3,687	1,828	1,859	3,585
45 to 64 years	2,077	4,216	2,134	2,082	4,225
65 years and over	1,315	2,349	1,040	1,309	2,489
85 years and over	167	238	71	167	244
16 years and over	6,057	11,885	5,833	6,052	11,915
18 years and over	5,825	11,429	5,604	5,825	11,487
15 to 44 years	2,763	5,519	2,763	2,756	5,390
Median age (years)	41.5	40.6	39.5	41.5	41.2

Age	Population Estimate (as of July 1)				
	2011		2012		
	Male	Female	Both Sexes	Male	Female
Total	7,451	7,525	14,928	7,424	7,504
Under 5 years	462	453	904	459	445
5 to 9 years	512	439	983	513	470
10 to 14 years	517	489	983	508	475
15 to 19 years	503	470	938	492	446
20 to 24 years	439	393	839	433	406
25 to 29 years	400	438	803	382	421
30 to 34 years	407	366	804	422	382
35 to 39 years	475	467	920	469	451
40 to 44 years	495	537	1,027	501	526
45 to 49 years	558	527	1,060	544	516
50 to 54 years	534	544	1,083	537	546
55 to 59 years	517	514	999	496	503
60 to 64 years	522	509	996	500	496
65 to 69 years	409	424	889	438	451
70 to 74 years	307	325	659	330	329
75 to 79 years	204	268	467	203	264
80 to 84 years	114	194	317	111	206
85 years and over	76	168	257	86	171
Under 18 years	1,820	1,669	3,464	1,790	1,674
Under 5 years	462	453	904	459	445
5 to 13 years	920	832	1,781	936	845
14 to 17 years	438	384	779	395	384
18 to 64 years	4,521	4,477	8,875	4,466	4,409
18 to 24 years	613	575	1,183	615	568
25 to 44 years	1,777	1,808	3,554	1,774	1,780
45 to 64 years	2,131	2,094	4,138	2,077	2,061
65 years and over	1,110	1,379	2,589	1,168	1,421
85 years and over	76	168	257	86	171
16 years and over	5,855	6,060	11,859	5,839	6,020
18 years and over	5,631	5,856	11,464	5,634	5,830
15 to 44 years	2,719	2,671	5,331	2,699	2,632
Median age (years)	40.1	42.1	41.4	40.3	42.3

Age	Population Estimate (as of July 1)				
	2013			2014	
	Both Sexes	Male	Female	Both Sexes	Male
Total	15,031	7,440	7,591	15,076	7,467
Under 5 years	888	456	432	916	471
5 to 9 years	1,003	495	508	980	486
10 to 14 years	996	545	451	1,029	562
15 to 19 years	902	455	447	882	445
20 to 24 years	892	446	446	876	435
25 to 29 years	804	392	412	835	416
30 to 34 years	809	418	391	835	418
35 to 39 years	905	464	441	868	436
40 to 44 years	1,031	502	529	1,037	526
45 to 49 years	1,031	528	503	1,001	510
50 to 54 years	1,075	545	530	1,084	538
55 to 59 years	990	468	522	958	459
60 to 64 years	1,007	516	491	1,002	518
65 to 69 years	900	436	464	926	446
70 to 74 years	713	353	360	728	347
75 to 79 years	484	203	281	495	227
80 to 84 years	327	131	196	347	138
85 years and over	274	87	187	277	89
Under 18 years	3,455	1,785	1,670	3,521	1,808
Under 5 years	888	456	432	916	471
5 to 13 years	1,799	944	855	1,781	923
14 to 17 years	768	385	383	824	414
18 to 64 years	8,878	4,445	4,433	8,782	4,412
18 to 24 years	1,226	612	614	1,162	591
25 to 44 years	3,549	1,776	1,773	3,575	1,796
45 to 64 years	4,103	2,057	2,046	4,045	2,025
65 years and over	2,698	1,210	1,488	2,773	1,247
85 years and over	274	87	187	277	89
16 years and over	11,962	5,861	6,101	11,949	5,850
18 years and over	11,576	5,655	5,921	11,555	5,659
15 to 44 years	5,343	2,677	2,666	5,333	2,676
Median age (years)	41.6	40.5	42.6	41.6	40.5

Age	Population Estimate (as of July 1)				
	2014	2015			2016
	Females	Both Sexes	Male	Female	Both Sexes
Total	7,609	14,996	7,412	7,584	14,924
Under 5 years	445	891	466	425	883
5 to 9 years	494	939	462	477	932
10 to 14 years	467	996	542	454	999
15 to 19 years	437	922	479	443	931
20 to 24 years	441	860	422	438	793
25 to 29 years	419	826	421	405	854
30 to 34 years	417	841	419	422	842
35 to 39 years	432	823	406	417	810
40 to 44 years	511	1,013	514	499	969
45 to 49 years	491	1,013	508	505	1,008
50 to 54 years	546	1,066	531	535	1,049
55 to 59 years	499	999	473	526	1,045
60 to 64 years	484	986	498	488	1,001
65 to 69 years	480	946	469	477	940
70 to 74 years	381	741	345	396	723
75 to 79 years	268	501	234	267	521
80 to 84 years	209	336	132	204	306
85 years and over	188	297	91	206	318
Under 18 years	1,713	3,452	1,784	1,668	3,446
Under 5 years	445	891	466	425	883
5 to 13 years	858	1,727	894	833	1,743
14 to 17 years	410	834	424	410	820
18 to 64 years	4,370	8,723	4,357	4,366	8,670
18 to 24 years	571	1,156	587	569	1,092
25 to 44 years	1,779	3,503	1,760	1,743	3,475
45 to 64 years	2,020	4,064	2,010	2,054	4,103
65 years and over	1,526	2,821	1,271	1,550	2,808
85 years and over	188	297	91	206	318
16 years and over	6,099	11,941	5,817	6,124	11,899
18 years and over	5,896	11,544	5,628	5,916	11,478
15 to 44 years	2,657	5,285	2,661	2,624	5,199
Median age (years)	42.7	42.0	40.9	43.3	42.3

Age	Population Estimate (as of July 1)	
	2016	
	Male	Female
Total	7,421	7,503
Under 5 years	459	424
5 to 9 years	461	471
10 to 14 years	548	451
15 to 19 years	489	442
20 to 24 years	401	392
25 to 29 years	451	403
30 to 34 years	389	453
35 to 39 years	431	379
40 to 44 years	496	473
45 to 49 years	511	497
50 to 54 years	506	543
55 to 59 years	509	536
60 to 64 years	495	506
65 to 69 years	477	463
70 to 74 years	337	386
75 to 79 years	244	277
80 to 84 years	116	190
85 years and over	101	217
Under 18 years	1,802	1,644
Under 5 years	459	424
5 to 13 years	894	849
14 to 17 years	449	371
18 to 64 years	4,344	4,326
18 to 24 years	556	536
25 to 44 years	1,767	1,708
45 to 64 years	2,021	2,082
65 years and over	1,275	1,533
85 years and over	101	217
16 years and over	5,840	6,059
18 years and over	5,619	5,859
15 to 44 years	2,657	2,542
Median age (years)	41.1	43.6

Notes:
The estimates are based on the 2010 Census and reflect changes to the April 1, 2010 population due to the Count Question Resolution program and geographic program revisions. Median age is calculated based on single year of age. For population estimates methodology statements, see http://www.census.gov/programs-surveys/popest/technical-documentation/methodology.html.
The 6,222 people in Bedford city, Virginia, which was an independent city as of the 2010 Census, are not included in the April 1, 2010 Census enumerated population presented in the county estimates. In July 2013, the legal status of Bedford changed from a city to a town and it became dependent within (or part of) Bedford County, Virginia. This population of Bedford town is now included in the April 1, 2010 estimates base and all July 1 estimates for Bedford County. Because it is no longer an independent city, Bedford town is not listed in this table. As a result, the sum of the April 1, 2010 census values for Virginia counties and independent cities does not equal the 2010 Census count for Virginia, and the sum of April 1, 2010 census values for all counties and independent cities in the United States does not equal the 2010 Census count for the United States. Substantial geographic changes to counties can be found on the Census Bureau website at http://www.census.gov/geo/reference/county-changes.html.

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Source: U.S. Census Bureau, Population Division
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Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2016

2016 Population Estimates

Geography: Talladega County, Alabama

Age	April 1, 2010				
	Census			Estimates Base	
	Both Sexes	Male	Female	Both Sexes	Male
Total	82,291	40,077	42,214	82,291	40,077
Under 5 years	4,941	2,438	2,503	4,941	2,438
5 to 9 years	5,199	2,584	2,615	5,199	2,584
10 to 14 years	5,645	2,831	2,814	5,645	2,831
15 to 19 years	5,747	2,927	2,820	5,747	2,927
20 to 24 years	4,857	2,328	2,529	4,857	2,328
25 to 29 years	4,867	2,381	2,486	4,867	2,381
30 to 34 years	5,113	2,622	2,491	5,113	2,622
35 to 39 years	5,613	2,813	2,800	5,613	2,813
40 to 44 years	5,623	2,844	2,779	5,623	2,844
45 to 49 years	5,973	3,026	2,947	5,973	3,026
50 to 54 years	6,261	3,060	3,201	6,261	3,060
55 to 59 years	5,704	2,784	2,920	5,704	2,784
60 to 64 years	5,157	2,498	2,659	5,157	2,498
65 to 69 years	3,817	1,813	2,004	3,817	1,813
70 to 74 years	2,917	1,326	1,591	2,917	1,326
75 to 79 years	2,154	886	1,268	2,154	886
80 to 84 years	1,505	563	942	1,505	563
85 years and over	1,198	353	845	1,198	353
Under 18 years	19,285	9,671	9,614	19,285	9,671
Under 5 years	4,941	2,438	2,503	4,941	2,438
5 to 13 years	9,732	4,871	4,861	9,732	4,871
14 to 17 years	4,612	2,362	2,250	4,612	2,362
18 to 64 years	51,415	25,465	25,950	51,415	25,465
18 to 24 years	7,104	3,437	3,667	7,104	3,437
25 to 44 years	21,216	10,660	10,556	21,216	10,660
45 to 64 years	23,095	11,368	11,727	23,095	11,368
65 years and over	11,591	4,941	6,650	11,591	4,941
85 years and over	1,198	353	845	1,198	353
16 years and over	65,376	31,643	33,733	65,376	31,643
18 years and over	63,006	30,406	32,600	63,006	30,406
15 to 44 years	31,820	15,915	15,905	31,820	15,915
Median age (years)	39.3	38.5	40.1	39.3	38.5

Age	April 1, 2010	Population Estimate (as of July 1)			
	Estimates Base	2010			2011
	Female	Both Sexes	Male	Female	Both Sexes
Total	42,214	82,077	40,002	42,075	81,847
Under 5 years	2,503	4,881	2,420	2,461	4,722
5 to 9 years	2,615	5,161	2,565	2,596	5,092
10 to 14 years	2,814	5,621	2,819	2,802	5,580
15 to 19 years	2,820	5,666	2,885	2,781	5,442
20 to 24 years	2,529	4,903	2,359	2,544	5,150
25 to 29 years	2,486	4,839	2,374	2,465	4,771
30 to 34 years	2,491	5,079	2,592	2,487	5,018
35 to 39 years	2,800	5,562	2,803	2,759	5,287
40 to 44 years	2,779	5,640	2,843	2,797	5,731
45 to 49 years	2,947	5,941	3,008	2,933	5,821
50 to 54 years	3,201	6,232	3,053	3,179	6,148
55 to 59 years	2,920	5,736	2,794	2,942	5,834
60 to 64 years	2,659	5,200	2,521	2,679	5,398
65 to 69 years	2,004	3,840	1,818	2,022	3,940
70 to 74 years	1,591	2,917	1,331	1,586	2,970
75 to 79 years	1,268	2,138	890	1,248	2,172
80 to 84 years	942	1,513	569	944	1,532
85 years and over	845	1,208	358	850	1,239
Under 18 years	9,614	19,130	9,596	9,534	18,743
Under 5 years	2,503	4,881	2,420	2,461	4,722
5 to 13 years	4,861	9,669	4,836	4,833	9,533
14 to 17 years	2,250	4,580	2,340	2,240	4,488
18 to 64 years	25,950	51,331	25,440	25,891	51,251
18 to 24 years	3,667	7,102	3,452	3,650	7,243
25 to 44 years	10,556	21,120	10,612	10,508	20,807
45 to 64 years	11,727	23,109	11,376	11,733	23,201
65 years and over	6,650	11,616	4,966	6,650	11,853
85 years and over	845	1,208	358	850	1,239
16 years and over	33,733	65,289	31,628	33,661	65,368
18 years and over	32,600	62,947	30,406	32,541	63,104
15 to 44 years	15,905	31,689	15,856	15,833	31,399
Median age (years)	40.1	39.4	38.6	40.2	39.9

Age	Population Estimate (as of July 1)				
	2011		2012		
	Male	Female	Both Sexes	Male	Female
Total	39,792	42,055	81,941	39,852	42,089
Under 5 years	2,323	2,399	4,684	2,340	2,344
5 to 9 years	2,530	2,562	5,060	2,495	2,565
10 to 14 years	2,818	2,762	5,536	2,803	2,733
15 to 19 years	2,761	2,681	5,316	2,666	2,650
20 to 24 years	2,470	2,680	5,301	2,586	2,715
25 to 29 years	2,320	2,451	4,745	2,311	2,434
30 to 34 years	2,538	2,480	5,047	2,554	2,493
35 to 39 years	2,689	2,598	5,063	2,582	2,481
40 to 44 years	2,860	2,871	5,790	2,853	2,937
45 to 49 years	2,927	2,894	5,750	2,889	2,861
50 to 54 years	2,986	3,162	6,000	2,914	3,086
55 to 59 years	2,841	2,993	5,987	2,941	3,046
60 to 64 years	2,626	2,772	5,265	2,548	2,717
65 to 69 years	1,860	2,080	4,313	2,023	2,290
70 to 74 years	1,364	1,606	3,026	1,420	1,606
75 to 79 years	921	1,251	2,235	942	1,293
80 to 84 years	583	949	1,508	589	919
85 years and over	375	864	1,315	396	919
Under 18 years	9,358	9,385	18,625	9,298	9,327
Under 5 years	2,323	2,399	4,684	2,340	2,344
5 to 13 years	4,784	4,749	9,454	4,721	4,733
14 to 17 years	2,251	2,237	4,487	2,237	2,250
18 to 64 years	25,331	25,920	50,919	25,184	25,735
18 to 24 years	3,544	3,699	7,272	3,592	3,680
25 to 44 years	10,407	10,400	20,645	10,300	10,345
45 to 64 years	11,380	11,821	23,002	11,292	11,710
65 years and over	5,103	6,750	12,397	5,370	7,027
85 years and over	375	864	1,315	396	919
16 years and over	31,586	33,782	65,523	31,648	33,875
18 years and over	30,434	32,670	63,316	30,554	32,762
15 to 44 years	15,638	15,761	31,262	15,552	15,710
Median age (years)	39.0	40.7	40.2	39.2	41.1

Age	Population Estimate (as of July 1)				
	2013			2014	
	Both Sexes	Male	Female	Both Sexes	Male
Total	81,277	39,536	41,741	81,216	39,473
Under 5 years	4,513	2,339	2,174	4,382	2,245
5 to 9 years	4,992	2,436	2,556	5,036	2,435
10 to 14 years	5,400	2,698	2,702	5,346	2,667
15 to 19 years	5,118	2,555	2,563	5,089	2,568
20 to 24 years	5,367	2,590	2,777	5,340	2,635
25 to 29 years	4,693	2,325	2,368	4,840	2,383
30 to 34 years	5,107	2,591	2,516	4,973	2,500
35 to 39 years	4,922	2,494	2,428	4,883	2,443
40 to 44 years	5,663	2,786	2,877	5,595	2,773
45 to 49 years	5,610	2,849	2,761	5,489	2,785
50 to 54 years	5,897	2,878	3,019	5,840	2,861
55 to 59 years	6,079	2,927	3,152	6,037	2,865
60 to 64 years	5,210	2,531	2,679	5,313	2,582
65 to 69 years	4,432	2,076	2,356	4,581	2,166
70 to 74 years	3,237	1,523	1,714	3,377	1,574
75 to 79 years	2,252	962	1,290	2,268	996
80 to 84 years	1,479	572	907	1,508	563
85 years and over	1,306	404	902	1,319	432
Under 18 years	18,170	9,091	9,079	18,027	9,020
Under 5 years	4,513	2,339	2,174	4,382	2,245
5 to 13 years	9,296	4,569	4,727	9,215	4,519
14 to 17 years	4,361	2,183	2,178	4,430	2,256
18 to 64 years	50,401	24,908	25,493	50,136	24,722
18 to 24 years	7,220	3,527	3,693	7,166	3,530
25 to 44 years	20,385	10,196	10,189	20,291	10,099
45 to 64 years	22,796	11,185	11,611	22,679	11,093
65 years and over	12,706	5,537	7,169	13,053	5,731
85 years and over	1,306	404	902	1,319	432
16 years and over	65,280	31,510	33,770	65,378	31,564
18 years and over	63,107	30,445	32,662	63,189	30,453
15 to 44 years	30,870	15,341	15,529	30,720	15,302
Median age (years)	40.5	39.5	41.5	40.7	39.7

Age	Population Estimate (as of July 1)				
	2014	2015			2016
	Females	Both Sexes	Male	Female	Both Sexes
Total	41,743	80,749	39,200	41,549	80,103
Under 5 years	2,137	4,358	2,225	2,133	4,265
5 to 9 years	2,601	4,940	2,428	2,512	4,817
10 to 14 years	2,679	5,148	2,551	2,597	5,054
15 to 19 years	2,521	5,055	2,545	2,510	5,046
20 to 24 years	2,705	5,145	2,587	2,558	4,882
25 to 29 years	2,457	5,105	2,501	2,604	5,315
30 to 34 years	2,473	4,885	2,409	2,476	4,774
35 to 39 years	2,440	4,814	2,400	2,414	4,753
40 to 44 years	2,822	5,373	2,639	2,734	5,026
45 to 49 years	2,704	5,486	2,760	2,726	5,562
50 to 54 years	2,979	5,680	2,811	2,869	5,567
55 to 59 years	3,172	5,970	2,807	3,163	5,939
60 to 64 years	2,731	5,398	2,608	2,790	5,479
65 to 69 years	2,415	4,763	2,267	2,496	4,904
70 to 74 years	1,803	3,390	1,579	1,811	3,401
75 to 79 years	1,272	2,373	1,039	1,334	2,411
80 to 84 years	945	1,538	601	937	1,566
85 years and over	887	1,328	443	885	1,342
Under 18 years	9,007	17,698	8,853	8,845	17,406
Under 5 years	2,137	4,358	2,225	2,133	4,265
5 to 13 years	4,696	8,971	4,427	4,544	8,805
14 to 17 years	2,174	4,369	2,201	2,168	4,336
18 to 64 years	25,414	49,659	24,418	25,241	49,073
18 to 24 years	3,636	6,948	3,483	3,465	6,658
25 to 44 years	10,192	20,177	9,949	10,228	19,868
45 to 64 years	11,586	22,534	10,986	11,548	22,547
65 years and over	7,322	13,392	5,929	7,463	13,624
85 years and over	887	1,328	443	885	1,342
16 years and over	33,814	65,169	31,433	33,736	64,868
18 years and over	32,736	63,051	30,347	32,704	62,697
15 to 44 years	15,418	30,377	15,081	15,296	29,796
Median age (years)	41.7	40.9	39.9	42.0	41.2

Age	Population Estimate (as of July 1)	
	2016	
	Male	Female
Total	38,778	41,325
Under 5 years	2,188	2,077
5 to 9 years	2,374	2,443
10 to 14 years	2,510	2,544
15 to 19 years	2,518	2,528
20 to 24 years	2,475	2,407
25 to 29 years	2,586	2,729
30 to 34 years	2,335	2,439
35 to 39 years	2,320	2,433
40 to 44 years	2,488	2,538
45 to 49 years	2,745	2,817
50 to 54 years	2,741	2,826
55 to 59 years	2,808	3,131
60 to 64 years	2,644	2,835
65 to 69 years	2,334	2,570
70 to 74 years	1,545	1,856
75 to 79 years	1,083	1,328
80 to 84 years	635	931
85 years and over	449	893
Under 18 years	8,712	8,694
Under 5 years	2,188	2,077
5 to 13 years	4,360	4,445
14 to 17 years	2,164	2,172
18 to 64 years	24,020	25,053
18 to 24 years	3,353	3,305
25 to 44 years	9,729	10,139
45 to 64 years	10,938	11,609
65 years and over	6,046	7,578
85 years and over	449	893
16 years and over	31,162	33,706
18 years and over	30,066	32,631
15 to 44 years	14,722	15,074
Median age (years)	40.2	42.3

Notes:
The estimates are based on the 2010 Census and reflect changes to the April 1, 2010 population due to the Count Question Resolution program and geographic program revisions. Median age is calculated based on single year of age. For population estimates methodology statements, see http://www.census.gov/programs-surveys/popest/technical-documentation/methodology.html.
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Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2016

2016 Population Estimates

Geography: Alabama

Age	April 1, 2010					
	Census			Estimates Base		
	Both Sexes	Male	Female	Both Sexes	Male	Female
Total	4,779,736	2,320,188	2,459,548	4,780,131	2,320,479	2,459,652
Under 5 years	304,957	155,265	149,692	304,961	155,268	149,693
5 to 9 years	308,229	157,340	150,889	308,232	157,343	150,889
10 to 14 years	319,655	163,417	156,238	319,655	163,417	156,238
15 to 19 years	343,471	175,151	168,320	343,475	175,155	168,320
20 to 24 years	335,322	167,520	167,802	335,342	167,536	167,806
25 to 29 years	311,034	153,716	157,318	311,080	153,760	157,320
30 to 34 years	297,888	146,424	151,464	297,930	146,465	151,465
35 to 39 years	308,430	151,078	157,352	308,462	151,110	157,352
40 to 44 years	311,071	152,707	158,364	311,099	152,734	158,365
45 to 49 years	346,369	169,103	177,266	346,402	169,130	177,272
50 to 54 years	347,485	168,725	178,760	347,516	168,752	178,764
55 to 59 years	311,906	149,633	162,273	311,928	149,645	162,283
60 to 64 years	276,127	131,603	144,524	276,142	131,610	144,532
65 to 69 years	209,637	97,893	111,744	209,651	97,903	111,748
70 to 74 years	160,864	72,143	88,721	160,883	72,148	88,735
75 to 79 years	122,836	51,927	70,909	122,866	51,945	70,921
80 to 84 years	88,771	33,684	55,087	88,793	33,694	55,099
85 years and over	75,684	22,859	52,825	75,714	22,864	52,850
Under 18 years	1,132,459	578,649	553,810	1,132,467	578,656	553,811
Under 5 years	304,957	155,265	149,692	304,961	155,268	149,693
5 to 13 years	564,204	288,212	275,992	564,207	288,215	275,992
14 to 17 years	263,298	135,172	128,126	263,299	135,173	128,126
18 to 64 years	2,989,485	1,463,033	1,526,452	2,989,757	1,463,269	1,526,488
18 to 24 years	479,175	240,044	239,131	479,198	240,063	239,135
25 to 44 years	1,228,423	603,925	624,498	1,228,571	604,069	624,502

Age	April 1, 2010					
	Census			Estimates Base		
	Both Sexes	Male	Female	Both Sexes	Male	Female
45 to 64 years	1,281,887	619,064	662,823	1,281,988	619,137	662,851
65 years and over	657,792	278,506	379,286	657,907	278,554	379,353
85 years and over	75,684	22,859	52,825	75,714	22,864	52,850
16 years and over	3,781,800	1,810,745	1,971,055	3,782,187	1,811,029	1,971,158
18 years and over	3,647,277	1,741,539	1,905,738	3,647,664	1,741,823	1,905,841
15 to 44 years	1,907,216	946,596	960,620	1,907,388	946,760	960,628
Median age (years)	37.9	36.4	39.1	37.9	36.4	39.1

Age	Population Estimate (as of July 1)					
	2010			2011		
	Both Sexes	Male	Female	Both Sexes	Male	Female
Total	4,785,492	2,323,202	2,462,290	4,799,918	2,328,923	2,470,995
Under 5 years	304,294	155,038	149,256	302,865	154,622	148,243
5 to 9 years	307,288	156,793	150,495	305,079	155,452	149,627
10 to 14 years	320,134	163,617	156,517	321,496	164,208	157,288
15 to 19 years	340,891	174,028	166,863	329,551	168,416	161,135
20 to 24 years	337,926	168,744	169,182	346,602	172,830	173,772
25 to 29 years	311,214	153,755	157,459	310,271	153,043	157,228
30 to 34 years	299,479	147,299	152,180	304,263	149,537	154,726
35 to 39 years	306,645	150,157	156,488	296,640	144,867	151,773
40 to 44 years	311,640	152,968	158,672	314,460	154,263	160,197
45 to 49 years	345,441	168,670	176,771	337,130	164,574	172,556
50 to 54 years	347,925	168,894	179,031	349,028	169,118	179,910
55 to 59 years	314,039	150,689	163,350	320,406	153,702	166,704
60 to 64 years	278,297	132,697	145,600	289,677	137,954	151,723
65 to 69 years	210,523	98,257	112,266	215,082	100,347	114,735
70 to 74 years	161,436	72,487	88,949	164,855	74,227	90,628
75 to 79 years	123,046	52,134	70,912	124,807	53,361	71,446
80 to 84 years	89,122	33,895	55,227	90,014	34,456	55,558
85 years and over	76,152	23,080	53,072	77,692	23,946	53,746
Under 18 years	1,130,540	577,607	552,933	1,123,918	573,806	550,112
Under 5 years	304,294	155,038	149,256	302,865	154,622	148,243
5 to 13 years	564,083	288,012	276,071	562,957	286,988	275,969
14 to 17 years	262,163	134,557	127,606	258,096	132,196	125,900
18 to 64 years	2,994,673	1,465,742	1,528,931	3,003,550	1,468,780	1,534,770
18 to 24 years	479,993	240,613	239,380	481,675	241,722	239,953
25 to 44 years	1,228,978	604,179	624,799	1,225,634	601,710	623,924
45 to 64 years	1,285,702	620,950	664,752	1,296,241	625,348	670,893
65 years and over	660,279	279,853	380,426	672,450	286,337	386,113
85 years and over	76,152	23,080	53,072	77,692	23,946	53,746
16 years and over	3,788,923	1,814,499	1,974,424	3,807,194	1,822,370	1,984,824
18 years and over	3,654,952	1,745,595	1,909,357	3,676,000	1,755,117	1,920,883
15 to 44 years	1,907,795	946,951	960,844	1,901,787	942,956	958,831
Median age (years)	37.9	36.5	39.2	38.1	36.6	39.4

Age	Population Estimate (as of July 1)					
	2012			2013		
	Both Sexes	Male	Female	Both Sexes	Male	Female
Total	4,815,960	2,336,346	2,479,614	4,829,479	2,342,350	2,487,129
Under 5 years	298,917	152,506	146,411	294,312	149,939	144,373
5 to 9 years	305,756	155,918	149,838	307,005	156,524	150,481
10 to 14 years	319,572	162,913	156,659	315,973	160,897	155,076
15 to 19 years	323,244	165,208	158,036	320,703	163,309	157,394
20 to 24 years	352,325	175,954	176,371	355,021	178,015	177,006
25 to 29 years	310,563	153,221	157,342	311,638	153,743	157,895
30 to 34 years	306,809	150,662	156,147	308,817	151,854	156,963
35 to 39 years	292,472	142,568	149,904	291,981	142,425	149,556
40 to 44 years	316,509	155,014	161,495	315,911	154,438	161,473
45 to 49 years	327,862	160,177	167,685	319,251	156,073	163,178
50 to 54 years	347,168	168,263	178,905	345,879	167,701	178,178
55 to 59 years	327,770	157,301	170,469	332,817	159,532	173,285
60 to 64 years	287,603	136,581	151,022	289,600	137,289	152,311
65 to 69 years	232,160	108,624	123,536	240,466	112,597	127,869
70 to 74 years	169,972	76,808	93,164	178,189	80,753	97,436
75 to 79 years	126,665	54,396	72,269	129,836	55,778	74,058
80 to 84 years	90,381	35,107	55,274	90,435	35,680	54,755
85 years and over	80,212	25,125	55,087	81,645	25,803	55,842
Under 18 years	1,115,829	569,205	546,624	1,108,102	564,663	543,439
Under 5 years	298,917	152,506	146,411	294,312	149,939	144,373
5 to 13 years	560,927	285,873	275,054	559,072	284,982	274,090
14 to 17 years	255,985	130,826	125,159	254,718	129,742	124,976
18 to 64 years	3,000,741	1,467,081	1,533,660	3,000,806	1,467,076	1,533,730
18 to 24 years	483,985	243,294	240,691	484,912	244,021	240,891
25 to 44 years	1,226,353	601,465	624,888	1,228,347	602,460	625,887
45 to 64 years	1,290,403	622,322	668,081	1,287,547	620,595	666,952
65 years and over	699,390	300,060	399,330	720,571	310,611	409,960
85 years and over	80,212	25,125	55,087	81,645	25,803	55,842
16 years and over	3,828,132	1,832,373	1,995,759	3,847,909	1,842,171	2,005,738
18 years and over	3,700,131	1,767,141	1,932,990	3,721,377	1,777,687	1,943,690
15 to 44 years	1,901,922	942,627	959,295	1,904,071	943,784	960,287
Median age (years)	38.3	36.8	39.6	38.4	37.0	39.8

Age	Population Estimate (as of July 1)					
	2014			2015		
	Both Sexes	Male	Females	Both Sexes	Male	Female
Total	4,843,214	2,348,033	2,495,181	4,853,875	2,352,474	2,501,401
Under 5 years	293,454	149,609	143,845	293,325	149,582	143,743
5 to 9 years	306,038	155,966	150,072	304,981	155,371	149,610
10 to 14 years	313,669	159,808	153,861	308,972	157,459	151,513
15 to 19 years	317,723	161,228	156,495	319,238	161,858	157,380
20 to 24 years	352,504	177,373	175,131	343,773	173,095	170,678
25 to 29 years	316,871	156,726	160,145	324,676	160,727	163,949
30 to 34 years	308,608	151,353	157,255	306,717	150,445	156,272
35 to 39 years	293,141	142,658	150,483	296,523	144,354	152,169
40 to 44 years	311,974	152,227	159,747	304,981	148,540	156,441
45 to 49 years	311,893	152,358	159,535	309,232	151,092	158,140
50 to 54 years	344,696	167,288	177,408	340,236	164,883	175,353
55 to 59 years	334,878	160,749	174,129	337,002	161,848	175,154
60 to 64 years	294,125	139,133	154,992	300,087	141,782	158,305
65 to 69 years	250,657	117,248	133,409	260,550	121,789	138,761
70 to 74 years	184,486	83,754	100,732	189,540	86,179	103,361
75 to 79 years	133,599	57,528	76,071	135,969	58,679	77,290
80 to 84 years	91,073	36,261	54,812	92,446	37,128	55,318
85 years and over	83,825	26,766	57,059	85,627	27,663	57,964
Under 18 years	1,104,700	562,949	541,751	1,101,434	561,091	540,343
Under 5 years	293,454	149,609	143,845	293,325	149,582	143,743
5 to 13 years	553,900	282,204	271,696	549,572	279,939	269,633
14 to 17 years	257,346	131,136	126,210	258,537	131,570	126,967
18 to 64 years	2,994,874	1,463,527	1,531,347	2,988,309	1,459,945	1,528,364
18 to 24 years	478,688	241,035	237,653	468,855	236,274	232,581
25 to 44 years	1,230,594	602,964	627,630	1,232,897	604,066	628,831
45 to 64 years	1,285,592	619,528	666,064	1,286,557	619,605	666,952
65 years and over	743,640	321,557	422,083	764,132	331,438	432,694
85 years and over	83,825	26,766	57,059	85,627	27,663	57,964
16 years and over	3,866,079	1,850,154	2,015,925	3,880,726	1,856,495	2,024,231
18 years and over	3,738,514	1,785,084	1,953,430	3,752,441	1,791,383	1,961,058
15 to 44 years	1,900,821	941,565	959,256	1,895,908	939,019	956,889
Median age (years)	38.6	37.1	40.0	38.7	37.3	40.2

Age	Population Estimate (as of July 1)		
	2016		
	Both Sexes	Male	Female
Total	4,863,300	2,355,586	2,507,714
Under 5 years	292,565	148,982	143,583
5 to 9 years	303,617	154,858	148,759
10 to 14 years	306,381	156,164	150,217
15 to 19 years	320,546	162,538	158,008
20 to 24 years	333,330	168,033	165,297
25 to 29 years	332,135	164,389	167,746
30 to 34 years	305,352	149,455	155,897
35 to 39 years	301,057	146,597	154,460
40 to 44 years	294,656	143,268	151,388
45 to 49 years	312,055	152,255	159,800
50 to 54 years	331,963	160,957	171,006
55 to 59 years	338,734	162,491	176,243
60 to 64 years	306,358	144,608	161,750
65 to 69 years	271,310	126,603	144,707
70 to 74 years	193,359	87,833	105,526
75 to 79 years	138,956	60,166	78,790
80 to 84 years	94,173	38,120	56,053
85 years and over	86,753	28,269	58,484
Under 18 years	1,096,823	558,628	538,195
Under 5 years	292,565	148,982	143,583
5 to 13 years	548,306	279,603	268,703
14 to 17 years	255,952	130,043	125,909
18 to 64 years	2,981,926	1,455,967	1,525,959
18 to 24 years	459,616	231,947	227,669
25 to 44 years	1,233,200	603,709	629,491
45 to 64 years	1,289,110	620,311	668,799
65 years and over	784,551	340,991	443,560
85 years and over	86,753	28,269	58,484
16 years and over	3,896,337	1,862,731	2,033,606
18 years and over	3,766,477	1,796,958	1,969,519
15 to 44 years	1,887,076	934,280	952,796
Median age (years)	38.9	37.4	40.3

Notes:
The estimates are based on the 2010 Census and reflect changes to the April 1, 2010 population due to the Count Question Resolution program and geographic program revisions. Median age is calculated based on single year of age. For population estimates methodology statements, see http://www.census.gov/programs-surveys/popest/technical-documentation/methodology.html.

The 6,222 people in Bedford city, Virginia, which was an independent city as of the 2010 Census, are not included in the April 1, 2010 Census enumerated population presented in the county estimates. In July 2013, the legal status of Bedford changed from a city to a town and it became dependent within (or part of) Bedford County, Virginia. This population of Bedford town is now included in the April 1, 2010 estimates base and all July 1 estimates for Bedford County. Because it is no longer an independent city, Bedford town is not listed in

this table. As a result, the sum of the April 1, 2010 census values for Virginia counties and independent cities does not equal the 2010 Census count for Virginia, and the sum of April 1, 2010 census values for all counties and independent cities in the United States does not equal the 2010 Census count for the United States. Substantial geographic changes to counties can be found on the Census Bureau website at http://www.census.gov/geo/reference/county-changes.html.

Suggested Citation:
Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2016
Source: U.S. Census Bureau, Population Division
Release Date: June 2017

ATTACHMENT H

INTERVIEW TEST INSTRUMENT EXAMPLE

The Health Care Authority of the City of Anniston (HCA-A)
Regional Medical Center – Anniston (RMC-A)
Community Health Needs Assessment
Community Member Interview Guide

November, 2017

executive resources

1. How many years have you lived in the Calhoun County area?

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

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

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

_____ Very attentive
_____ Moderately attentive
_____ Moderately inattentive
_____ Emergency situation only
_____ Not at all

5. **Which of the following health related issues have you observed or encountered within the community:**

_____ **Mental illness**
_____ **Drug/Alcohol abuse**
_____ **HIV related illness**
_____ **Malnutrition**
_____ **Respiratory**
_____ **Cardiac**
_____ **Cancer**
_____ **Diabetes**
_____ **Vision**
_____ **Dental**
_____ **Physical abuse**
_____ **Poverty**
_____ **Health disparities**

6. Do you believe that the community has adequate access to the following healthcare services?

a. Preventive programs (screenings, education)	Yes	No	Not Sure
b. Women's Health services	Yes	No	Not Sure
c. Surgical Services	Yes	No	Not Sure
d. Mental Health Services	Yes	No	Not Sure
e. Drug and Alcohol Treatment	Yes	No	Not Sure
f. Dental	Yes	No	Not Sure
g. Cancer	Yes	No	Not Sure
h. Cardiac	Yes	No	Not Sure
i. Diabetes	Yes	No	Not Sure
j. Primary Care Physicians	Yes	No	Not Sure
k. Geriatric Services	Yes	No	Not Sure
l. Physical Rehab Services	Yes	No	Not Sure
m. Referrals to Specialty Care Physicians	Yes	No	Not Sure

7. It is commonly accepted that health care organizations have three major objectives: 1) Highest quality, 2) Widest access, and 3) Lowest costs. Most health care economists believe that only two of the three are achievable at any one time. Which two would you pursue? Why?

8. How familiar are you with the following characteristics of RMC-A?

a. Location and facilities	Very	Somewhat	Not Familiar
b. Leadership (Board of Directors, CEO, Physicians)	Very	Somewhat	Not Familiar
c. Mission	Very	Somewhat	Not Familiar
d. Programs and Services	Very	Somewhat	Not Familiar
e. Community Involvement	Very	Somewhat	Not Familiar

9. We would like to know and understand your perception of RMC-A. 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 services:

a. Women's Health Services	5	4	3	2	1	Can't Rate
b. Mental Health Services	5	4	3	2	1	Can't Rate
c. Emergency Services	5	4	3	2	1	Can't Rate
d. Surgical Services	5	4	3	2	1	Can't Rate
e. Clinic and Outreach Programs	5	4	3	2	1	Can't Rate
f. Radiology Services	5	4	3	2	1	Can't Rate
g. Cardiac Programs and Services	5	4	3	2	1	Can't Rate
h. Cancer Programs and Services	5	4	3	2	1	Can't Rate
i. Diabetes Programs and Services	5	4	3	2	1	Can't Rate
j. Children's Services	5	4	3	2	1	Can't Rate
k. Geriatric Services	5	4	3	2	1	Can't Rate
l. Services to All Individuals	5	4	3	2	1	Can't Rate

10. **Do you believe that the continuation of RMC-A is vital to the health and welfare of the community?**

Yes **No**

11. **If RMC-A did not exist, do you believe the community's healthcare needs would be met?**

Yes **No**

12. **Do you think that RMC-A adequately addresses the needs of the community and is successful in improving health indicators and reducing health disparities?**

Yes **No**

13. **Do you think there is a need for more primary care physicians in the community? Specialty care physicians?**

14. **How can RMC-A better meet the needs of the community?**

The Health Care Authority of the City of Anniston (HCA-A)
Regional Medical Center – Anniston (RMC-A)
Community Health Needs Assessment
Board of Directors Interview Guide

November, 2017

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Mission

To provide advanced health care of the highest quality with compassion and integrity to every patient.

Vision

To be the region's first choice for health care by providing:

- **Quality care;**
- **Broad scope of medical specialties;**
- **Advanced technology;**
- **Skill, teamwork and compassion of employees and physicians; and**
- **Convenient and attractive facilities and services.**

1. Is the hospital achieving its mission and vision?

2. Does the mission need to be revised, expanded, changed?

3. What are the barriers/risks that threaten the hospital's ability to achieve its mission, vision?

4. In your opinion, do you think that RMC-A as a local hospital system is the key in the marketplace in meeting the needs of the community?

5. In your opinion, do you think that RMC-A is doing a good job in meeting the needs of the community?

6. How do you envision the impact of health reform will affect RMC-A's ability to meet its mission?

7. If a health care 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?

8. In your opinion, what are the strengths of RMC-A? Have they changed in the last 5 years? Describe changes if any.

9. What *external* factor or factors (rank them) poses the greatest challenge to the viability of RMC-A over the next five years?

_____ Competition from other hospitals? If so which ones?
_____ Competition from other health care providers? Be specific (doctors groups, ASC's, urgent care) Niche providers
_____ Cutbacks in Medicare payments
_____ Cutbacks in state support
_____ Demographic changes in Calhoun County that predict changing demand for Services
_____ Inability to recruit physicians, nurses and other skilled staff?
_____ Keeping pace with changing technology and adequate facilities
_____ Federal and state regulations
_____ The economy
_____ Health reform, conversion of uninsured market
_____ Aging population, growth in safety net cost (uninsured/underinsured)
_____ Demographic changes
_____ Changing needs of the community, i.e., chronic disease

10. In your opinion, what *internal* factors pose the greatest challenge to the visibility of RMC-A over the next 5 years?

_____ Employee retention
_____ Physician retention
_____ Physician recruitment – primary care, subspecialty care, surgical
_____ Maintaining adequate staffing levels
_____ Hiring quality staff to support physician staff and programs and services at RMC-A
_____ Working within budgetary constraints, ability to manage cost
_____ Desire/need to expand services – what services
_____ Range and scope of services offered

11. What do you consider the top THREE strategic priorities for RMC-A?

_____ Physician recruitment and retention, practice acquisitions
_____ Physician recruitment
_____ Program expansion – inpatient and/or outpatient
_____ Facility improvement/expansion
_____ Improving current medical technology
_____ Clinical information systems and HER
_____ Strengthening the hospital's current financial position
_____ Service area expansion for inpatient and outpatient services
_____ Increasing current market share
_____ Cost reduction
_____ Improve quality of clinical services/patient satisfaction

12. Based on your perception of the health care industry do you expect RMC-A to experience increased pressure or decreased pressure from the following issues over the next five years?

_____ Medicare/Medicaid reimbursement
_____ HMO payment rates/payment denials
_____ Health reform, conversion of uninsured market
_____ Inpatient service volume
_____ Outpatient service volume (local market)
_____ Government regulation (federal and state)
_____ Competition (local market)
_____ Mergers/affiliations (regional)
_____ Physician practice acquisitions/consolidations
_____ Employee recruitment
_____ For-profit health care

13. **Do you think RMC-A should get more involved in addressing the following, and if so how?**

_____ **Public health issues**
_____ **Health indicators**
_____ **Health disparities**
_____ **Special population group health issues**
_____ **Chronic diseases**

The Health Care Authority of the City of Anniston (HCA-A)
Regional Medical Center – Anniston (RMC-A)
Community Health Needs Assessment
Physician Interview Guide

November, 2017

executive resources

1. Physician practice description – primary care, subspecialty care, surgery (specialty)

2. What do you view as your service area relative to your specialty?

3. What do you view as the service area of RMC-A?

4. Has RMC-A been able to support your practice regarding the service area? To what extent?

5. Has RMC-A been able to meet the needs of the community and to what extent?

6. What distinguishes your practice from those of other physicians at RMC-A or elsewhere? Why did you choose to practice at RMC-A? Relationship with hospital?

7. What do you think are the worse health indicators and worst health disparities in the community?

8. What quality measures do you use in your practice?

9. What are current wait times for appointments for new patients in your office? Do you accept Medicare, Medicaid, Private Pay, Commercial, and Uninsured?

10. How do you obtain the majority of your patients – referral from other physicians, RMC-A, ER call, "word of mouth", other?

11. How do you communicate to referring physicians? Does your office have an EMR? If so, is it linked to RMC-A? Lab? Do you plan to comply with the standards for meaningful use?

12. What opportunities do you see for practice growth? Hospital growth?

13. **Do you think there is a need for more primary care physicians in the community? Specialty care physicians?**

14. **View of RMC-A's role in practice expansion? How does this fit with your practice business plan? Identify practice/hospital competitors?**

15. **What are your current Calhoun County relationships (physicians/hospital affiliations) outside Calhoun County? Other?**

16. **If hospital growth initiative is launched, what resources/time would you devote to effort? (Include hours, willingness to lease space, marketing dollars, other)**

17. Is your practice on EHR platform – does it link with RMC-A? What value has this added to your practice?

18. Identify your competitors in Calhoun County or greater service area.

19. Define success factors for practice expansion. Near term? Long term?

20. Are you considering becoming a patient certified medical home accredited practice?

21. Willingness to participate in physician oversight group to help hospital position itself for the future?

22. What value does RMC-A affiliation add to your practice? Value proposition for expansion?

23. What would motivate you to change existing referral patterns?

24. How do you measure patient satisfaction?

25. Describe practice experience at RMC-A. User friendly, welcoming MD friendly?

26. How can RMC-A better meet the needs of the community?

The Health Care Authority of the City of Anniston (HCA-A)
Regional Medical Center – Anniston (RMC-A)
Community Health Needs Assessment
Senior Management Interview Guide

November, 2017

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1. Describe the mission and vision of RMC-A. Is the RMC-A currently achieving its mission?

2. Do you think the mission needs to be revised, expanded, changed and why?

3. What are the barriers/risks that threaten the hospital's ability to achieve its mission, vision?

4. How do you envision the impact of health reform will affect RMC-A's ability to meet its mission? What steps has management taken to address these issues?

5. What do you think is RMC-A's service area for inpatient and outpatient programs and services?

6. Do you think RMC-A does a good job of providing inpatient and outpatient programs and services to its service area and meeting the needs of the community?

7. Do you think RMC-A's service area for its inpatient and outpatient programs should be expanded and if so, how do you think they should be expanded? If so, where should they be expanded and what programs and services?

8. How does RMC-A differentiate itself in its service area? Service, Quality, Patient Satisfaction, Technology? Other?

9. **Does RMC-A do an adequate job on improving upon health indicators and reducing health disparities?**

10. **What best describes the organizational culture of RMC-A?**

11. In your opinion, what *external* threats that post greatest challenges to RMC-A's future. What steps should be taken to address those challenges?

_____ Market consolidation
_____ Ability to recruit physicians – primary care, specialty care, surgical care
_____ Hospital financial pressures
_____ Physician financial pressures
_____ Competitor program expansion
_____ Health reform
_____ Increased regulations
_____ Decreased payments from government programs
_____ Demographics, population changes
_____ Changing needs of the community, i.e., chronic disease

12. In your opinion, what *internal* factors that pose the greatest challenge to RMC-A's future? What steps should be taken to address these challenges?

_____ Employee retention
_____ Physician retention
_____ Physician recruitment – primary care, subspecialty care, surgical
_____ Maintaining adequate staffing levels
_____ Hiring quality staff to support physician staff and programs and services at RMC-A
_____ Working within budgetary constraints, ability to manage cost
_____ Desire/need to expand services – what services
_____ Range and scope of services offered

13. **What do you consider the top THREE strategic priorities for RMC-A (identify 1, 2, and 3)?**

_____ **Physician recruitment and retention**
_____ **Program and service expansion**
_____ **Increase market share**
_____ **Improve available medical technology**
_____ **Strengthen hospital's financial position**
_____ **Merger, affiliation or other**
_____ **Quality service delivery**
_____ **Meeting community need**

14. Based on your perception of the healthcare industry, do you expect RMC-A to experience increased pressure or decreased pressure from the following issues over the next five years?

_____ Medicare/Medicaid reimbursement
_____ Health reform and conversion of uninsured – RMC-A's readiness?
_____ HMO payment rates/payment denials
_____ Inpatient service volume
_____ Outpatient service volume (local market)
_____ Specialty niches
_____ Government regulation (federal and state)
_____ Competition (local market) – hospitals, physicians, others
_____ Mergers/affiliations (regional)
_____ Physician practice acquisitions/consolidations
_____ Employee recruitment

15. **Do you think that RMC-A should get more involved in addressing the following, and if so, how?**

_____ **Public health issues**
_____ **Health indicators**
_____ **Health disparities**
_____ **Special population group health issues**
_____ **Chronic diseases**