Tanner Medical Center/ East Alabama

COMMUNITY

Health Needs Assessment

2019

GET HEALTHY
LIVE WELL

TANNER
HEALTH SYSTEM

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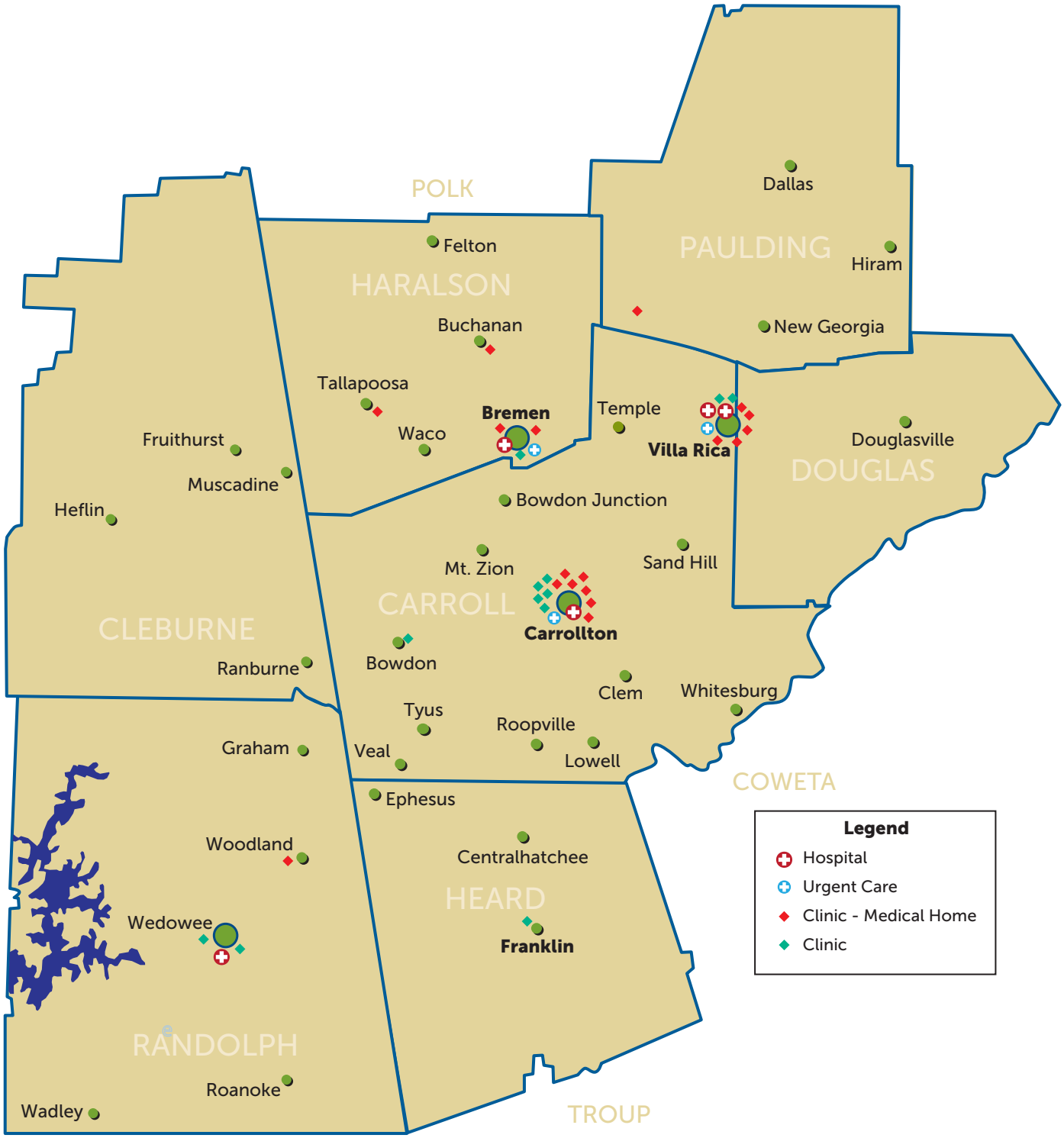
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Part I: INTRODUCTION

A. Executive Summary

Tanner Health System is a not-for-profit health system with a mission: to provide a continuum of quality healthcare services within our resource capabilities and to serve as a leader in a collaborative effort with the community to provide health education, support services and care for all of our neighbors. It is with this spirit of collaboration toward advancing community health that Tanner was established 70 years ago, when a visionary group of community leaders in west Georgia came together and sought to provide the best healthcare services for their neighbors and loved ones, close to home. Since 1949, Tanner has grown from a single community hospital to a regional comprehensive healthcare provider serving a nine-county area of more than 350,000 people in west Georgia and east Alabama. The health system's facilities include:

- The 201-bed acute care Tanner Medical Center/Carrollton
- The 40-bed acute Tanner Medical Center/Villa Rica
- The 25-bed critical access Higgins General Hospital in Bremen
- The 92-bed inpatient behavioral health facility Willowbrooke at Tanner in Villa Rica
- The 15-bed critical access Tanner Medical Center/East Alabama*

* The focus of this Community Health Needs Assessment report

Tanner also operates Tanner Medical Group, one of metro Atlanta's largest multi-specialty physician groups with about 40 medical practice locations serving the region. The health system's medical staff is composed of more than 300 physicians representing 34 unique medical specialties, from allergies and asthma to urology and vascular surgery.

At Tanner Health System, we recognize that a person's health is interwoven with the health of the community in which they live. We work to help our patients thrive under our care, as well as outside our hospital and clinic walls. A person's health is dependent on many different factors, including physical, social and economic factors such as housing, transportation and employment. As a healthcare leader in our region, we play a significant role in advancing health and partnering with others to facilitate community health improvement. Our efforts are guided in large part by the results of our Community Health Needs Assessment (CHNA), which we perform every three years.

Tanner's CHNA utilizes an organized, systematic approach to identify and address the needs and assets of underserved communities across Tanner's geographic footprint. The CHNA guides the development and implementation of a comprehensive plan to improve health outcomes for those disproportionately affected by disease as well as social, environmental and economic barriers to health. The CHNA also informs the creation of a strategy for future community health programming and how to allocate community benefit resources for fiscal years 2020-2022 across Tanner's hospitals. As a not-for-profit organization, Tanner Health System is required by the Internal Revenue Service (IRS) to conduct a CHNA every three years. Our CHNAs align with guidelines established by the Affordable Care Act and comply with IRS requirements.

Using both public health and healthcare utilization data, each hospital identified its geographic area of focus, called a Community Benefit Service Area (CBSA). Tanner Medical Center/East Alabama's CBSA, the focus of this CHNA report, is identified as its primary service area of Randolph and Cleburne counties. The CBSA serves as the geographic

target area for the CHNA and for execution of the strategies to address health needs identified. The CHNA will serve as a roadmap for targeted health promotion strategies conducted in the CBSA. The impact of the Tanner Medical Center/East Alabama's efforts in its CBSA will be tracked and evaluated over the next three-year cycle.

Tanner Medical Center/East Alabama opened in November 2017, serving as a replacement hospital for Wedowee Hospital. With dire options confronting them—including the critical realization that Wedowee Hospital was not sustainable with its current financial deficits and its inability to recruit physicians to the area—Wedowee Hospital's administrative team and board of directors prioritized keeping medical care services available to the citizens of the region as its number one mission. A referendum to support a 1 percent sales tax increase to finance the construction of a new hospital in Randolph County received wide support among voters in August 2015, with 86 percent of Randolph County voters supporting the new hospital. Local leaders enlisted the support of Tanner Health System to equip and operate the new hospital to ensure the health needs of the communities it serves are met for generations to come. Tanner has a national reputation as a leader in quality care and patient satisfaction, and a unique understanding of the vital role that community hospitals serve in our region. This relationship also gives Tanner Medical Center/East Alabama patients access to Tanner's medical staff of more than 300 physicians, including primary care and specialists.

Tanner Medical Center/East Alabama's more than 50,000-square-foot, three-story modern hospital facility provides 24-hour emergency care, critical care support, inpatient and observation beds, a state-of-the-art surgical suite and advanced diagnostic imaging services. Since it's opening in fall 2017, the hospital has received critical access hospital designation status, launched new service lines (urology, podiatry, gastrointestinal, sleep lab), and created leadership synergy across multiple areas.

Tanner Medical Center/East Alabama's CHNA process involved local residents, community partners and stakeholders, along with hospital leadership. These representatives used population-level data and feedback from a community focus group to create recommendations for the hospital's health priorities, potential implementation strategies and to identify key partners. Thirteen people were involved in the CHNA process through participation in a focus group or key informant interview.

Upon review, analysis and prioritization of the CHNA findings, the priority areas to be addressed during Tanner Medical Center/East Alabama's Fiscal Year 2020-2022 Implementation Strategy include:

- Access to Care
- Chronic Disease Education, Prevention and Management

The CHNA report is available to the community on Tanner's website: www.tanner.org. Additionally, copies will be disseminated to the hospital's board and executive leadership; the assessment team; community stakeholders who contributed to the assessment; and multiple community leaders, volunteers and organizations that could benefit from the information. Other communication efforts will include presentations of assessment findings throughout the community. Copies will also be made available for distribution upon request from the hospital. This final CHNA report for Tanner Medical Center/East Alabama was approved by the Tanner Medical Center, Inc. Board of Directors on September 2019.

B. CHNA Approach and Process

CHNA Methodology and Data Collection

The data sources for the CHNA included quantitative secondary population-level data, and qualitative key informant interviews and a community focus group session. These data were used to broaden the types of information gathered and to engage a diverse group of internal and external stakeholders to inform the CHNA process and deliverables. The types of information gathered for each data source were as follows:

- **Secondary Data:** National, state, local health and disparity data, public health priorities and community health improvement plans. County-level ZIP code and neighborhood level data (when available).

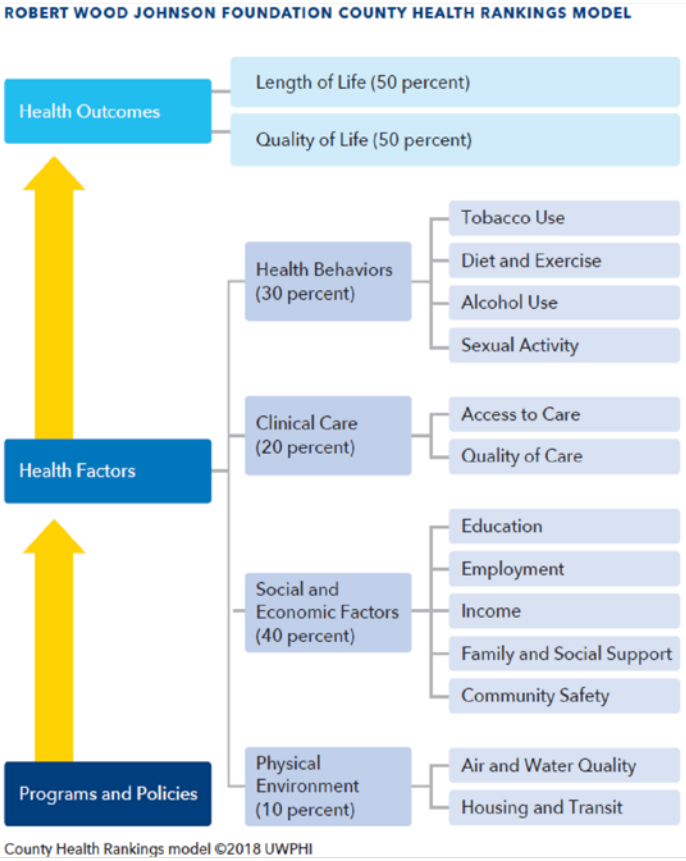
  Core Indicators: Secondary data was gathered primarily through Community Commons, a publicly available dashboard of multiple health indicators drawn from several national data sources and the Alabama Center for Health Statistics 2016 County Health profiles. US Census American Community Survey Data was also consulted for demographic, education and income statistics. Other data sources are noted in the county health profiles (as seen in Part 2).

- **Hospital Utilization Data:** Patient healthcare utilization data were used to identity the hospital's CBSA and geographic areas of focus for needs assessment and strategy implementation.

- **Community Input Session Discussions:** Tanner Medical Center/East Alabama facilitated community discussions with a diverse group of community stakeholders to identify the most important community health issues. Guided discussion areas included topics related to community health and wellness, access to care and services and the social determinants of health.

- Combined information from all of the above sources were used to:
  1. Prioritize identified needs
  2. Determine the appropriate hospital role in addressing the health issues prioritized
  3. Establish system, regional, and hospital specific approaches and outcome measures

This information was then used to develop Tanner Medical Center/East Alabama's Implementation Strategy for the next three years.



Prioritization Process and Criteria
Identification of health priorities was shaped by an understanding of the public health priorities, needs assessment data and the hospital's strengths within the context of the system's priorities. Additionally, when selecting final targeted health priorities, Tanner Medical Center/East Alabama considered additional criteria such as existing partnerships and programming. These components were used to identify priority areas.

Part II: COMMUNITY SERVED

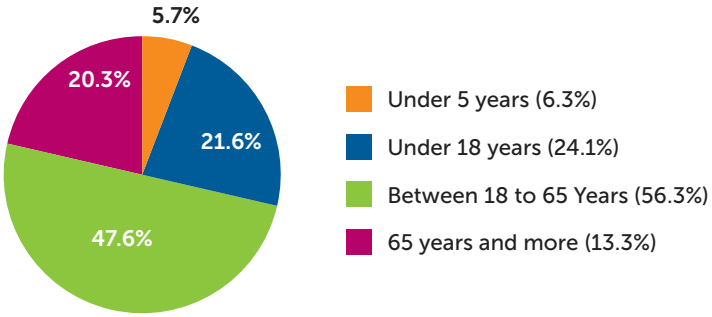
A. Geographic Area Served

For the purposes of the 2019 CHNA, Tanner Medical Center/East Alabama identified a geographic area to serve over the next three-year CHNA cycle. This Community Benefit Service Area (CBSA) was selected based on hospital patient utilization data; proximity to the hospital, and/or an existing presence of programs and partnerships within these communities.

Tanner Medical Center/East Alabama's CBSA is defined as Randolph and Cleburne counties, consisting of 1,141 square miles of predominately rural area (89 percent) with a total population of 37,570 (US Census Bureau, Population Estimates 2017).

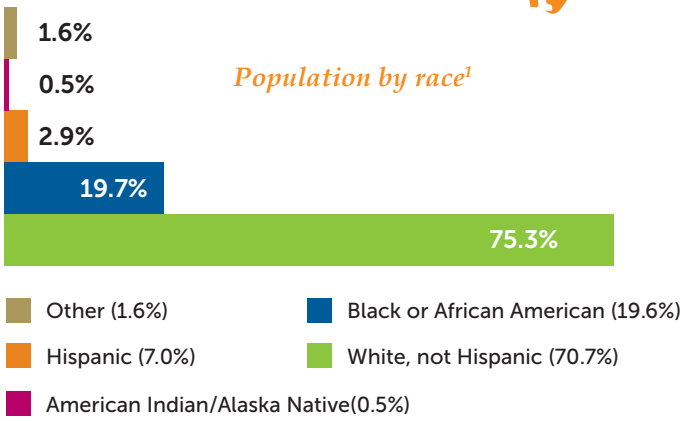
B. **County Health Profiles**

RANDOLPH COUNTY



Population by age[1]

Randolph County Total Population: 22,670

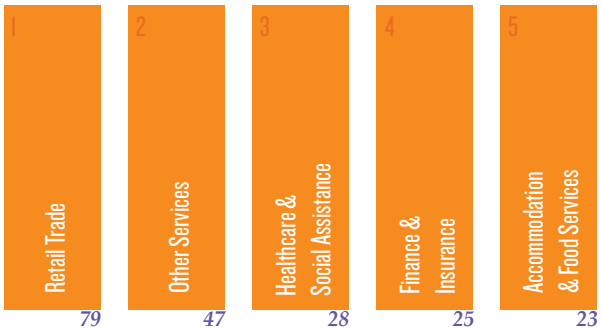


Population by race[1]

Population

The population of Randolph County was estimated at 22,670 by the 2017 US Census Bureau, reflecting a -1.1% population decrease since the 2010 Census. The population is spread out over 581 square miles, translating into a population density of 39.5 persons per square mile. Approximately 18,638 residents (81.34%) live in rural areas of the county. In 2017, Randolph County residents 65 years or older were 20.3% of the population, exceeding the state average (16.5%). Whites (75.3%) make up the majority of the population, followed by African Americans/Blacks (19.7%).

Top 5 Industries



County Health Rankings[3]

	Rank (of 67)
Health Outcomes	**47**
Mortality (Length of Life)	57
Morbidity (Quality of Life)	33
Health Factors	**24**
Health Behaviors	19
Clinical Care	50
Social and Economic Factors	25
Physical Environment	38

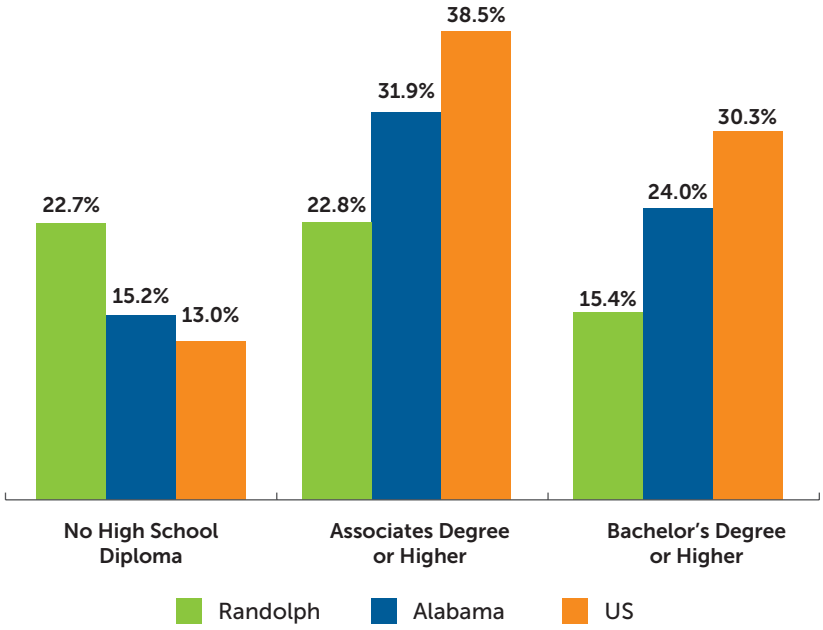
Economy

Randolph County's median household income, of $37,496 is significantly lower than the state median income of $44,758.[2] The unemployment rate (4.40%) is slightly higher than the state average (4.20%).[4] The county's percentage of children (32%), adults (18%) and seniors (15%) living in poverty exceeds the state average in all three indicators.[2]

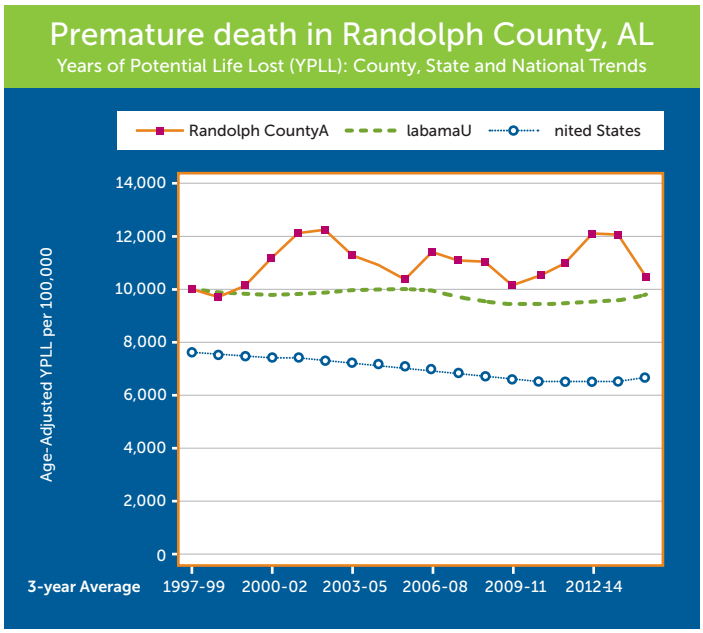
[1] US Census Bureau, Population Estimates, 2017
[2] US Census Bureau, American Community Survey, 2012-2016
[3] County Health Rankings, 2018
[4] US Department of Labor, Bureau of Labor Statistics, 2018-August
[5] US Census Bureau, County Business Patterns, 2016
[6] Alabama Center for Health Statistics, County Health Profiles 2016

Education

Poverty, unemployment and lack of educational attainment affect access to care and a community's ability to engage in healthy behaviors. Individuals with more education live longer, healthier lives than those with less education, and their children are more likely to thrive. The population age 25+ in Randolph County with no high school diploma (22.7%) exceeds state and national figures.2 Concurrently, the population age 25+ in Randolph County with an Associate's Degree or Higher (22.8%) and Bachelor's Degree or Higher (15.4%) fall significantly below state and national figures.



Health Disparities



TOP 10 CAUSES OF DEATH, 2016[6]

		mortality rate
1.	Heart Disease	432.6
2.	Cancer	242.8
3.	Chronic Lower Respiratory Disease	119.2
4.	Stroke	66.2
5.	Accidents	57.4
6.	Alzheimer's Disease	53.0
7.	Influenza and Pneumonia	35.3
8.	Suicide	22.1
9.	Diabetes	8.8

Randolph County Health Profile

Red numbers indicate parameters worse than the national average.
Green numbers indicate parameters better than the national average.

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Social and Economic Indicators					
Unemployment	4.40%	4.20%	4.00%	Percentage of population 16 years or older that is unemployed.	US Department of Labor, Bureau of Labor Statistics, 2018-June
Temporary Assistance for Needy Families (TANF)	1.71%	1.79%	2.67%	Percentage households receiving public assistance income, including TANF. Separate payments received for hospital or other medical expenses, SSI or noncash benefits such as Food Stamps.	US Census, American Community Survey, 2012-2016.
Population Receiving SNAP Benefits	16.52%	15.59%	13.05%	Percentage of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits.	US Census, American Community Survey, 2012-2016.
Adults in Poverty	18.00%	17.30%	14.20%	Percentage of adult population aged 18 to 64 years old living below the poverty line.	US Census, American Community Survey, 2012-2016.
Seniors in Poverty	15.00%	10.60%	9.30%	Percentage of population aged 65 or older living below the poverty line.	US Census, American Community Survey, 2012-2016.
Children in Poverty	32.00%	26.50%	21.17%	Percentage of population aged 0 to 17 years old living below the poverty line.	US Census, American Community Survey, 2012-2016.
Population with No High School Diploma	22.74%	15.21%	13.02%	Percentage of population 25 years and older without a high school diploma or equivalency (GED).	US Census, American Community Survey, 2012-2016.
High School Dropout Rate	5.00%	4.50%	4.00%	Percentage of youth aged 16 to 19 years old who are not in high school nor high school graduate.	Kids Count, US Census, American Community Survey, Five Year Estimates, 2012-2016.
Access to a Vehicle	6.20%	6.40%	8.70%	Percentage of occupied households with no motor vehicle.	US Census, American Community Survey, 2012-2016.
Income Inequality (GINI Index)	0.44	0.48	0.48	GINI Index score that represents "a statistical measure of income inequality ranging from 0 to 1 where a measure of 1 indicates perfect inequality and a measure of 0 indicates perfect equality". Based on the total number of households for county and state values. National value measures GINI Index income inequality ranging from 0 to 100.	US Census, American Community Survey, 2012-2016.
Substandard Housing Conditions	25.43%	27.64%	33.75%	Percentage of renter or owner occupied housing units having one or more of the following substandard conditions: lacking complete plumbing facilities, lacking complete kitchen facilities, having 1.01 or more occupants per room, selected monthly owner costs as a percentage of household income greater than 30 percent, and gross rent as a percentage of household income greater than 30 percent.	US Census, American Community Survey, 2012-2016.
Premature Death Rate	12,100	9,600	5,300	Years of potential life lost before age 75 per 100,000.	County Health Rankings 2018, National Center for Health Statistics, 2014-2016.

Randolph County Health Profile

Diabetes and Obesity					
Diabetes Prevalence	**16.00%**	14.00%	8.00%	Percentage of population over 20 years old that have been diagnosed with diabetes.	County Health Rankings 2018. CDC, National Diabetes Surveillance System, 2014.
Diabetes prevalence, Medicare population	**32.17%**	29.18%	26.55%	Percentage of Medicare fee-for-service population with diabetes.	Centers for Medicare and Medicaid Services, 2015.
Diabetes management-hemoglobin A1c test in Medicare patients	**85.60%**	85.00%	85.20%	Percentage of diabetic Medicare patients who have had hemoglobin A1c test for blood sugar levels.	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2014.
Obesity	**34%**	35%	26%	Percentage of population 20 years or older with a self reported BMI greater than 30.0.	County Health Rankings, 2018. CDC, National Diabetes Surveillance System, 2014.
Physical Inactivity	**30%**	29%	20%	Percentage of population 20 years or older that self reported no leisure time for physical activity.	County Health Rankings, 2018. CDC, National Diabetes Surveillance System, 2014.
Recreational and fitness facility access	**0**	7.89	11.01	Number of recreation and fitness facilities per 100,000 population.	US Census, County Business Patterns, 2016.
Fast-food restaurant access	**43.64**	79.96	77.06	Number of fast food restaurants per 100,000 population.	US Census, County Business Patterns, 2016.
Grocery store access	**13.09**	15.84	21.18	Number of grocery stores per 100,000 population.	US Census, County Business Patterns, 2016.
SNAP-authorized store access	**12.22**	11.4	8.25	Number of SNAP-authorized food stores per 100,000 population.	US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator, 2017.
WIC-authorized store access	**21.9**	16	15.6	Number of authorized food stores accepting WIC benefits and carry WIC foods/food categories per 100,000.	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas, 2011.
Population with low food access	**26.78%**	24.24%	22.43%	Percentage of population living in designated food deserts via census tract.	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2015.
Food Insecurity	**17%**	18%	10%	Percentage of population that experienced food insecurity in a designated year.	County Health Rankings, 2018. Map the Meal Project, Feeding America, 2015.

Randolph County Health Profile

HIV/AIDS and STDs					
HIV Prevalence	78.28	297.37	353.16	Prevalence rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.
HIV Screenings	63.05%	58.10%	62.79%	Percentage of adults between 18-70 years old with self reports of having not been screened for HIV.	CDC, Behavioral Risk Factor Surveillance System, 2012.
Chlamydia Incidence	396	598.6	456.08	Rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.
Gonorrhea Incidence	48.4	158.8	110.73	Rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.
Maternal and Infant Health					
Teen Births	51.5	46.7	36.6	Births to women between 15-19 years old per 1,000 of the female population between 15-19 years old.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Vital Statistics System, 2006-2012.
Low Birth Weight Babies	10.00%	10.40%	8.17%	Percentage of births with low birth weight.	OASIS. Maternal/Child Web Query. 2013-2017; CDC National Center for Health Statistics, 2016.
Infant Mortality Rate	8	8.3	5.9	Number of infant deaths per 1,000 live births.	OASIS, Morbidity/Mortality Web Query, 2013-2017; CDC National Vital Statistics, 2016.
Infant Mortality Rate	70	70	40	Number of infant deaths per 1,000 live births.	County Health Rankings, 2018. The Compressed Mortality File CDC Wonder, 2013-2016.
Premature Births	10.80%	11.70%	9.85%	Percent of births before 37 weeks of gestation.	OASIS, Morbidity/Mortality Web Query, 2013-2017; CDC National Vital Statistics, 2016.

Randolph County Health Profile

Cardiovascular Health	**10.80%**	**11.70%**			
Heart Disease Medicare Population	**36.60%**	28.47%	26.46%	Percentage of Medicare fee-for-service population with ischemic heart disease.	Centers for Medicare and Medicaid Services, 2015.
High Blood Pressure Medicare Population	**63.19%**	62.34%	54.99%	Percentage of Medicare fee-for-service population with high blood pressure.	Centers for Medicare and Medicaid Services, 2015.
High Cholesterol Medicare Population	**46.25%**	47.34%	44.61%	Percentage of Medicare fee-for-service population with hyperlipidemia which is most commonly associated with high cholesterol.	Centers for Medicare and Medicaid Services, 2015.
Heart Disease Mortality Rate	**293.30**	225.91	168.2	The age-adjusted rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population.	CDC, National Vital Statistics System, 2012-2016.
Stroke Mortality Rate	**52.90**	49.94	36.9	The age-adjusted rate of death due to cerebrovascular disease (stroke).	CDC, National Vital Statistics System, 2012-2016.
Respiratory Health					
Air Pollution-Particulate Matter	**10.1**	10.1	6.7	The average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) in a county. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers.	County Health Rankngs, 2018; CDC's National Environmental Public Health Tracking Network, 2012.
Lung Cancer Incidence	**66.6**	69.5	60.2	Annual age-adjusted incidence rates per 100,000 population.	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program, 2011-2015.
Lung Disease Mortality	**63.6**	55.24	41.3	Age adjusted death rate due to chronic lower respiratory disease per 100,000 population.	Centers for Disease Control and Prevention, National Vital Statistics System, 2012-2016.
Adult Smoking	**20%**	22%	14%	The percentage of the adult population that currently smokes every day or most days and has smoked at least 100 cigarettes in their lifetime.	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.

Randolph County Health Profile

Mental Health and Substance Misuse					
Suicide Mortality Rate	21.1	14.83	13.5	Age-Adjusted Death Rate per 100,000 population by suicide.	OASIS, Mortality Web Query, 2013-2017.CDC, National Center for Health Statistics, 2016.
Drug Overdose Deaths	15.9	16.2	10	Drug Overdose Deaths are the number of deaths due to drug poisoning per 100,000 population. ICD-10 codes used include X40-X44, X60-X64, X85, and Y10-Y14. These codes cover accidental, intentional, and undetermined poisoning by and exposure to: 1) nonopioid analgesics, antipyretics and antirheumatics, 2) antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, 3) narcotics and psychodysleptics [hallucinogens], not elsewhere classified, 4) other drugs acting on the autonomic nervous system, and 5) other and unspecified drugs, medicaments and biological substances	County Health Rankings 2018; CDC Wonder, Compressed Mortality File, 2014-2016.
Poor Mental Health Days	4.7	4.6	3	Poor Mental Health Days is based on BRFSS survey responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Frequent Mental Distress	14%	15%	10%	The percentage of adults who reported ≥14 days in response to the question, "Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Liquor Store Access	4.36	7.47	11	This indicator reports the number of beer, wine, and liquor stores per 100,000 population, as defined by North American Industry Classification System (NAICS) Code 445310	US Census Bureau, County Business Patterns, 2016.
Excessive Drinking	14%	14%	13%	The percentage of adults that report either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or 2 (men) drinks per day on average.	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Alchohol-impaired driving deaths	23%	26%	13%	The percentage of motor vehicle crash deaths with alcohol involvement.	County Health Rankings 2018; Fatality Analysis Reporting System, 2012-2016.

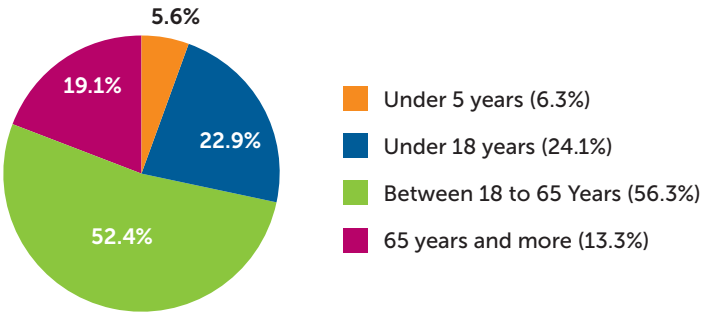
Randolph County Health Profile

Cancers					
Breast Cancer Deaths	**n/a**	21.8	20.9	Number of Age-Adjusted Breast Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Breast Cancer Incidence	**104.9**	120.9	124.7	Age-Adjusted incidence rate (cases per 100,000) population of females with breast cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Colorectal Cancer Deaths	**19.1**	16.4	14.5	Number of Age-Adjusted Colorectal Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Colorectal Cancer Incidence	**50.0**	43.5	39.2	Age-Adjusted incidence rate (cases per 100,000) population with colorectal cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Prostate Cancer Deaths	**n/a**	22.7	19.5	Number of Age-Adjusted Prostate Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Prostate Cancer Incidence	**127.0**	123.4	109	Age-Adjusted incidence rate (cases per 100,000) population with prostate cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Lung Cancer Deaths	**51.0**	53.4	43.4	Number of Age-Adjusted Lung Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Lung Cancer Incidence	**63.8**	67.7	60.2	Annual Age-Adjusted lung cancer incidence rates per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.

Randolph County Health Profile

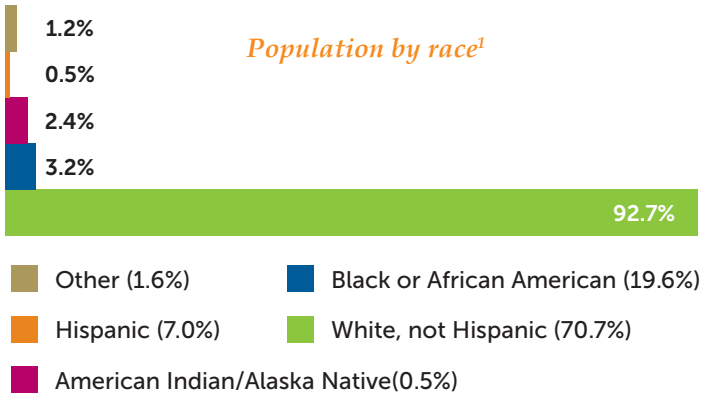
Injury Prevention and Safety					
Firearm Fatalities	22	19	7	The number of deaths due to firearms, per 100,000 population.	County Health Rankings 2018, CDC Compressed Mortality File, 2012-2016.
Violent Crime	182	436	62	The number of violent crimes reported per 100,000 population.	County Health Rankings 2018, The Uniform Crime Reporting (UCR) Program, 2012-2014.
Child Abuse and/or Neglect	11.9	7.80	n/a	Unduplicated count of children with a substantiated incident of child abuse and/or neglect, per 1,000.	Kids Count, Child Protective Services Data System, Georgia Department of Human Resources, Division of Family and Children Services, 2016.
Motor Vehicle Crash Deaths	28	19	9	The number of deaths due to traffic accidents involving a vehicle per 100,000 population.	County Health Rankings 2018, CDC Compressed Mortality File, 2010-2016.
Access to Care					
Uninsured Adults	18%	15%	7%	The percentage of the population ages 18 to 64 that has no health insurance coverage.	County Health Rankings 2018, US Census Bureau Small Area Health Insurance Estimates (SAHIE) program, 2015.
Uninsured Children	3%	3%	3%	The percentage of the population under age 19 that has no health insurance coverage.	County Health Rankings 2018, US Census Bureau Small Area Health Insurance Estimates (SAHIE) program, 2015.
Primary Care Physicians	3,780:1	1,530:1	1,030:1	The ratio of the population to total primary care physicians. 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.	County Health Rankings 2018, Area Health Resource File/ American Medical Association, 2015.
Dentists	7,550:1	2,140:1	1,280:1	The ratio of the population to total dentists.	County Health Rankings 2018, Area Health Resource File/ National Provider Identification File, 2016.
Mental Health Providers	4,530:1	1,180:1	330:1	The ratio of the population to total 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.	County Health Rankings 2018, CMS, National Provider Identification Registry, 2017.
Other Primary Care Providers	1,416:1	1,484:1	782:1	The ratio of the population to total number of other primary providers, including nurse practitioners, physician assistants and clinical nurse specialists.	County Health Rankings 2018, CMS, National Provider Identification Registry, 2017.
Preventable Hospital Stays	60	62	35	The hospital discharge rate for ambulatory care-sensitive conditions per 1,000 fee-for-service Medicare enrollees. Ambulatory care-sensitive conditions include: convulsions, chronic obstructive pulmonary disease, bacterial pneumonia, asthma, congestive heart failure, hypertension, angina, cellulitis, diabetes, gastroenteritis, kidney/urinary infection, and dehydration.	County Health Rankings 2018, CMS Dartmouth Atlas of Health Care, 2015.

CLEBURNE COUNTY



Population by age[1]

Haralson County Total Population: 14,900

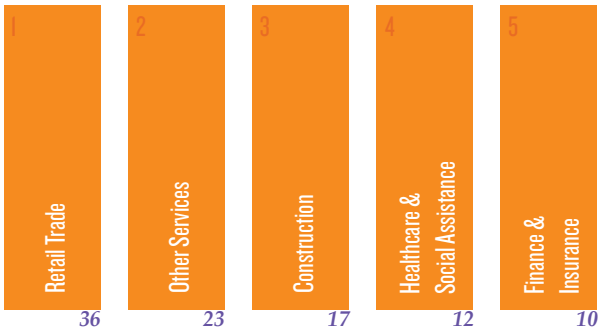


Population by race[1]

Population

The population of Cleburne County was estimated at 14,900 by the 2017 US Census Bureau, reflecting a -0.5% population decrease since the 2010 Census. The population is spread out over 560 square miles, translating into a population density of 26.7 persons per square mile. Cleburne County is designated as a 100% rural county. In 2017, Cleburne County residents 65 years or older were 19.1% of the population, exceeding the state average (16.5%). Whites (92.7%) make up the majority of the population, followed by African Americans/Blacks (3.2%).

Top 5 Industries



County Health Rankings[3]

	Rank (of 67)
Health Outcomes	**27**
Mortality (Length of Life)	44
Morbidity (Quality of Life)	10
Health Factors	**20**
Health Behaviors	21
Clinical Care	58
Social and Economic Factors	14
Physical Environment	20

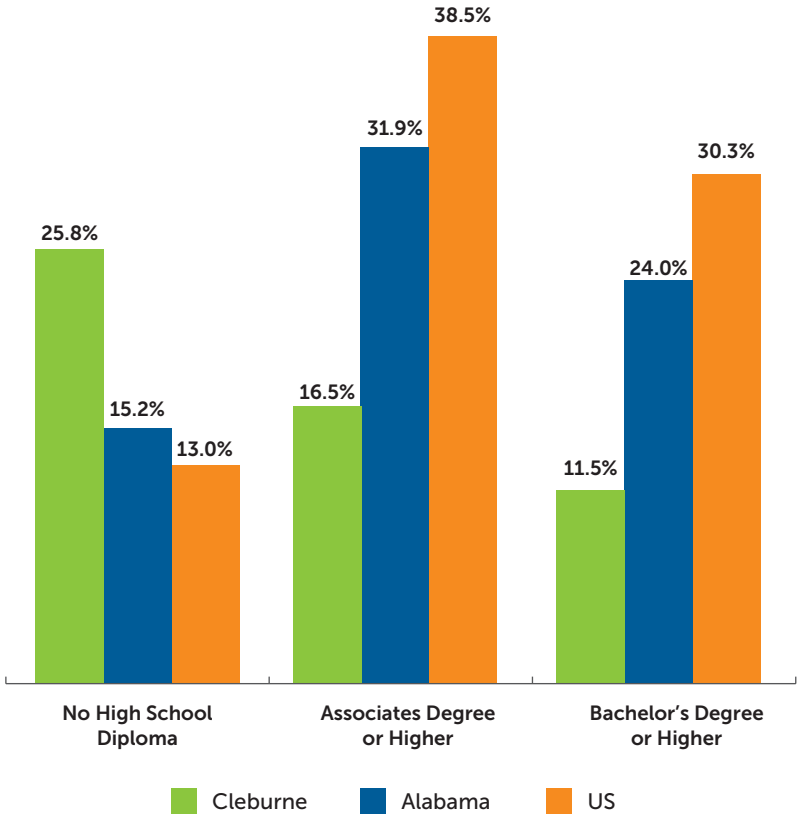
Economy

Cleburne County's median household income, of $36,316 is significantly lower than the state median income of $44,758.[2] The unemployment rate (4.5%) is slightly higher than the state average (4.2%).4 The county's percentage of children (31.2%), adults (16.9%) and seniors (13.6%) living in poverty exceeds the state average in all three indicators.[2]

[1] US Census Bureau, Population Estimates, 2017
[2] US Census Bureau, American Community Survey, 2012-2016
[3] County Health Rankings, 2018
[4] US Department of Labor, Bureau of Labor Statistics, 2018-August
[5] US Census Bureau, County Business Patterns, 2016
[6] Alabama Center for Health Statistics, County Health Profiles 2016

Education

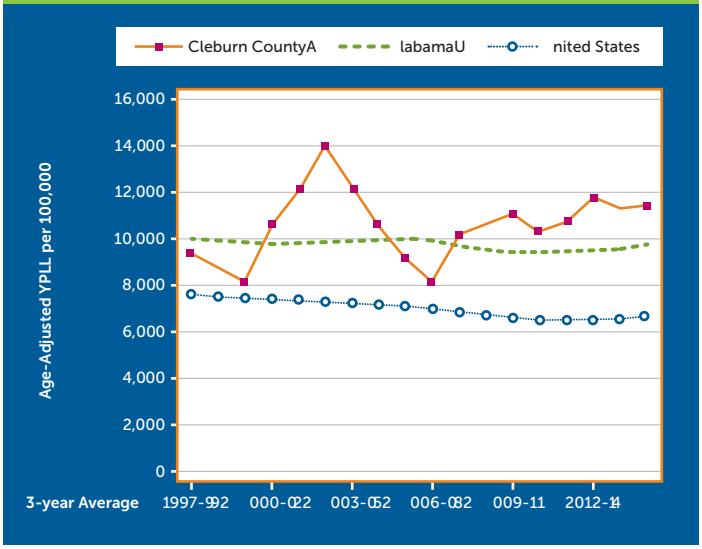
Poverty, unemployment and lack of educational attainment affect access to care and a community's ability to engage in healthy behaviors. Individuals with more education live longer, healthier lives than those with less education, and their children are more likely to thrive. The population age 25+ in Cleburne County with no high school diploma (25.8%) exceeds state and national figures.2 Concurrently, the population age 25+ in Cleburne County with an Associate's Degree or Higher (16.5%) and Bachelor's Degree or Higher (11.5%) fall significantly below state and national figures.



Health Disparities

Premature death in Cleburne County, AL

Years of Potential Life Lost (YPLL): County, State and National Trends



TOP 10 CAUSES OF DEATH, 2016[6]

		mortality rate
1.	Heart Disease	422.1
2.	Cancer	241.2
3.	Chronic Lower Respiratory Disease	127.3
4.	Accidents	93.8
5.	Alzheimer's Disease	46.9
6.	Stroke	26.8
7.	Influenza and Pneumonia	20.1
8.	Diabetes	13.4
9.	Suicide	13.4

Cleburne County Health Profile

Red numbers indicate parameters worse than the national average.
Green numbers indicate parameters better than the national average.

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Social and Economic Indicators					
Unemployment	**4.50%**	4.20%	4.00%	Percentage of population 16 years or older that is unemployed.	US Department of Labor, Bureau of Labor Statistics, 2018-June
Temporary Assistance for Needy Families (TANF)	**1.71%**	1.79%	2.67%	Percentage households receiving public assistance income, including TANF. Separate payments received for hospital or other medical expenses, SSI or noncash benefits such as Food Stamps.	US Census, American Community Survey, 2012-2016.
Population Receiving SNAP Benefits	**16.52%**	15.59%	13.05%	Percentage of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits.	US Census, American Community Survey, 2012-2016.
Adults in Poverty	**16.90%**	17.30%	14.20%	Percentage of adult population aged 18 to 64 years old living below the poverty line.	US Census, American Community Survey, 2012-2016.
Seniors in Poverty	**13.60%**	10.60%	9.30%	Percentage of population aged 65 or older living below the poverty line.	US Census, American Community Survey, 2012-2016.
Children in Poverty	**31.20%**	26.50%	21.17%	Percentage of population aged 0 to 17 years old living below the poverty line.	US Census, American Community Survey, 2012-2016.
Population with No High School Diploma	**22.74%**	15.21%	13.02%	Percentage of population 25 years and older without a high school diploma or equivalency (GED).	US Census, American Community Survey, 2012-2016.
High School Dropout Rate	**25.82%**	5.20%	4.00%	Percentage of youth aged 16 to 19 years old who are not in high school nor high school graduate.	Kids Count, US Census, American Community Survey, Five Year Estimates, 2012-2016.
Access to a Vehicle	**1.80%**		8.70%	Percentage of occupied households with no motor vehicle.	US Census, American Community Survey, 2012-2016.
Income Inequality (GINI Index)	**0.44**	0.48	0.48	GINI Index score that represents "a statistical measure of income inequality ranging from 0 to 1 where a measure of 1 indicates perfect inequality and a measure of 0 indicates perfect equality". Based on the total number of households for county and state values. National value measures GINI Index income inequality ranging from 0 to 100.	US Census, American Community Survey, 2012-2016.
Substandard Housing Conditions	**25.43%**	27.64%	33.75%	Percentage of renter or owner occupied housing units having one or more of the following substandard conditions: lacking complete plumbing facilities, lacking complete kitchen facilities, having 1.01 or more occupants per room, selected monthly owner costs as a percentage of household income greater than 30 percent, and gross rent as a percentage of household income greater than 30 percent.	US Census, American Community Survey, 2012-2016.
Premature Death Rate	**11,400**	9,600	5,300	Years of potential life lost before age 75 per 100,000.	County Health Rankings 2018, National Center for Health Statistics, 2014-2016.

Cleburne County Health Profile

Diabetes and Obesity					
Diabetes Prevalence	**13.00%**	14.00%	8.00%	Percentage of population over 20 years old that have been diagnosed with diabetes.	County Health Rankings 2018. CDC, National Diabetes Surveillance System, 2014.
Diabetes prevalence, Medicare population	**29.52%**	29.18%	26.55%	Percentage of Medicare fee-for-service population with diabetes.	Centers for Medicare and Medicaid Services, 2015.
Diabetes management-hemoglobin A1c test in Medicare patients	**83.00%**	85.00%	85.20%	Percentage of diabetic Medicare patients who have had hemoglobin A1c test for blood sugar levels.	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2014.
Obesity	**35%**	35%	26%	Percentage of population 20 years or older with a self reported BMI greater than 30.0.	County Health Rankings, 2018. CDC, National Diabetes Surveillance System, 2014.
Physical Inactivity	**32%**	29%	20%	Percentage of population 20 years or older that self reported no leisure time for physical activity.	County Health Rankings, 2018. CDC, National Diabetes Surveillance System, 2014.
Recreational and fitness facility access	**0**	7.89	11.01	Number of recreation and fitness facilities per 100,000 population.	US Census, County Business Patterns, 2016.
Fast-food restaurant access	**33.40**	79.96	77.06	Number of fast food restaurants per 100,000 population.	US Census, County Business Patterns, 2016.
Grocery store access	**13.36**	15.84	21.18	Number of grocery stores per 100,000 population.	US Census, County Business Patterns, 2016.
SNAP-authorized store access	**12.69**	11.40	8.25	Number of SNAP-authorized food stores per 100,000 population.	US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator, 2017.
WIC-authorized store access	**40.4**	16	15.6	Number of authorized food stores accepting WIC benefits and carry WIC foods/food categories per 100,000.	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas, 2011.
Population with low food access	**5.27%**	24.24%	22.43%	Percentage of population living in designated food deserts via census tract.	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2015.
Food Insecurity	**14%**	18%	10%	Percentage of population that experienced food insecurity in a designated year.	County Health Rankings, 2018. Map the Meal Project, Feeding America, 2015.

Cleburne County Health Profile

HIV/AIDS and STDs					
HIV Prevalence	111.43	297.37	353.16	Prevalence rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.
HIV Screenings	54.61%	58.10%	62.79%	Percentage of adults between 18-70 years old with self reports of having not been screened for HIV.	CDC, Behavioral Risk Factor Surveillance System, 2012.
Chlamydia Incidence	213.42	598.6	456.08	Rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.
Gonorrhea Incidence	40.02	158.8	110.73	Rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.
Maternal and Infant Health					
Teen Births	57.4	46.7	36.6	Births to women between 15-19 years old per 1,000 of the female population between 15-19 years old.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Vital Statistics System, 2006-2012.
Low Birth Weight Babies	8.00%	10.40%	8.17%	Percentage of births with low birth weight.	OASIS. Maternal/Child Web Query. 2013-2017; CDC National Center for Health Statistics, 2016.
Infant Mortality Rate	0	8.3	5.9	Number of infant deaths per 1,000 live births.	OASIS, Morbidity/Mortality Web Query, 2013-2017; CDC National Vital Statistics, 2016.
Premature Births	10.40%	11.70%	9.85%	Percent of births before 37 weeks of gestation.	OASIS, Morbidity/Mortality Web Query, 2013-2017; CDC National Vital Statistics, 2016.
Cardiovascular Health					
Heart Disease Medicare Population	33.22%	28.47%	26.46%	Percentage of Medicare fee-for-service population with ischemic heart disease.	Centers for Medicare and Medicaid Services, 2015.
High Blood Pressure Medicare Population	61.45%	62.34%	54.99%	Percentage of Medicare fee-for-service population with high blood pressure.	Centers for Medicare and Medicaid Services, 2015.
High Cholesterol Medicare Population	46.11%	47.34%	44.61%	Percentage of Medicare fee-for-service population with hyperlipidemia which is most commonly associated with high cholesterol.	Centers for Medicare and Medicaid Services, 2015.
Heart Disease Mortality Rate	282.60	225.91	168.2	The age-adjusted rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population.	CDC, National Vital Statistics System, 2012-2016.
Stroke Mortality Rate	22.70	49.94	36.9	The age-adjusted rate of death due to cerebrovascular disease (stroke).	CDC, National Vital Statistics System, 2012-2016.

Cleburne County Health Profile

Respiratory Health					
Air Pollution-Particulate Matter	**10.3**	10.1	6.7	The average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) in a county. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers.	County Health Rankngs, 2018; CDC's National Environmental Public Health Tracking Network, 2012.
Lung Cancer Incidence	**82.5**	67.7	60.2	Annual age-adjusted incidence rates per 100,000 population.	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program, 2011-2015.
Lung Disease Mortality	**101.2**	55.24	41.3	Age adjusted death rate due to chronic lower respiratory disease per 100,000 population.	Centers for Disease Control and Prevention, National Vital Statistics System, 2012-2016.
Adult Smoking	**20%**	22%	14%	The percentage of the adult population that currently smokes every day or most days and has smoked at least 100 cigarettes in their lifetime.	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.

Cleburne County Health Profile

Mental Health and Substance Misuse					
Suicide Mortality Rate	17.4	15.26	13.5	Age-Adjusted Death Rate per 100,000 population by suicide.	OASIS, Mortality Web Query, 2013-2017.CDC, National Center for Health Statistics, 2016.
Drug Overdose Deaths	22	15	10	Drug Overdose Deaths are the number of deaths due to drug poisoning per 100,000 population. ICD-10 codes used include X40-X44, X60-X64, X85, and Y10-Y14. These codes cover accidental, intentional, and undetermined poisoning by and exposure to: 1) nonopioid analgesics, antipyretics and antirheumatics, 2) antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, 3) narcotics and psychodysleptics [hallucinogens], not elsewhere classified, 4) other drugs acting on the autonomic nervous system, and 5) other and unspecified drugs, medicaments and biological substances	County Health Rankings 2018; CDC Wonder, Compressed Mortality File, 2014-2016.
Poor Mental Health Days	4.6	4.6	3	Poor Mental Health Days is based on BRFSS survey responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Frequent Mental Distress	14%	15%	10%	The percentage of adults who reported ≥14 days in response to the question, "Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Liquor Store Access	6.68	7.47	11	This indicator reports the number of beer, wine, and liquor stores per 100,000 population, as defined by North American Industry Classification System (NAICS) Code 445310	US Census Bureau, County Business Patterns, 2016.
Excessive Drinking	16%	14%	13%	The percentage of adults that report either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or 2 (men) drinks per day on average.	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Alchohol-impaired driving deaths	25%	26%	13%	The percentage of motor vehicle crash deaths with alcohol involvement.	County Health Rankings 2018; Fatality Analysis Reporting System, 2012-2016.

Cleburne County Health Profile

Cancers					
Breast Cancer Deaths	**n/a**	21.8	20.9	Number of Age-Adjusted Breast Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Breast Cancer Incidence	**108.2**	120.9	124.7	Age-Adjusted incidence rate (cases per 100,000) population of females with breast cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Colorectal Cancer Deaths	**18.8**	16.4	14.5	Number of Age-Adjusted Colorectal Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Colorectal Cancer Incidence	**55.1**	43.5	39.2	Age-Adjusted incidence rate (cases per 100,000) population with colorectal cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Prostate Cancer Deaths	**n/a**	22.7	19.5	Number of Age-Adjusted Prostate Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Prostate Cancer Incidence	**103.6**	123.4	109	Age-Adjusted incidence rate (cases per 100,000) population with prostate cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Lung Cancer Deaths	**60.3**	53.4	43.4	Number of Age-Adjusted Lung Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Lung Cancer Incidence	**82.5**	67.7	60.2	Annual Age-Adjusted lung cancer incidence rates per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.

Cleburne County Health Profile

Injury Prevention and Safety					
Firearm Fatalities	**23**	19	7	The number of deaths due to firearms, per 100,000 population.	County Health Rankings 2018, CDC Compressed Mortality File, 2012-2016.
Violent Crime	**150**	436	62	The number of violent crimes reported per 100,000 population.	County Health Rankings 2018, The Uniform Crime Reporting (UCR) Program, 2012-2014.
Child Abuse and/or Neglect	**17.0**	7.8	n/a	Unduplicated count of children with a substantiated incident of child abuse and/or neglect, per 1,000.	Kids Count, Child Protective Services Data System, Georgia Department of Human Resources, Division of Family and Children Services, 2016.
Motor Vehicle Crash Deaths	**26**	19	9	The number of deaths due to traffic accidents involving a vehicle per 100,000 population.	County Health Rankings 2018, CDC Compressed Mortality File, 2010-2016.
Access to Care					
Uninsured Adults	**15%**	15%	7%	The percentage of the population ages 18 to 64 that has no health insurance coverage.	County Health Rankings 2018, US Census Bureau Small Area Health Insurance Estimates (SAHIE) program, 2015.
Uninsured Childrenww	**4%**	3%	3%	The percentage of the population under age 19 that has no health insurance coverage.	County Health Rankings 2018, US Census Bureau Small Area Health Insurance Estimates (SAHIE) program, 2015.
Primary Care Physicians	**3,750:1**	1,530:1	1,030:1	The ratio of the population to total primary care physicians. 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.	County Health Rankings 2018, Area Health Resource File/ American Medical Association, 2015.
Dentists	**14,920:1**	2,140:1	1,280:1	The ratio of the population to total dentists.	County Health Rankings 2018, Area Health Resource File/ National Provider Identification File, 2016.
Mental Health Providers	**2,490:1**	1,180:1	330:1	The ratio of the population to total 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.	County Health Rankings 2018, CMS, National Provider Identification Registry, 2017.
Other Primary Care Providers	**4,975:1**	1,484:1	782:1	The ratio of the population to total number of other primary providers, including nurse practitioners, physician assistants and clinical nurse specialists.	County Health Rankings 2018, CMS, National Provider Identification Registry, 2017.
Preventable Hospital Stays	**68**	62	35	The hospital discharge rate for ambulatory care-sensitive conditions per 1,000 fee-for-service Medicare enrollees. Ambulatory care-sensitive conditions include: convulsions, chronic obstructive pulmonary disease, bacterial pneumonia, asthma, congestive heart failure, hypertension, angina, cellulitis, diabetes, gastroenteritis, kidney/urinary infection, and dehydration.	County Health Rankings 2018, CMS Dartmouth Atlas of Health Care, 2015.

C. SUMMARY OF KEY SECONDARY FINDINGS

The leading causes of death in Randolph and Cleburne counties, in order, are heart disease, cancer and chronic lower respiratory disease, according to the latest data from the Alabama Department of Public Health. Because heart disease accounts for substantial morbidity and mortality, reduction of risk factors is of particular importance in improving the health of the community. The major risk factors are associated with lifestyle; they include elevated blood pressure, high blood cholesterol levels, obesity, smoking, diabetes and a sedentary lifestyle. Furthermore, extensive research from the National Cancer Institute indicates that nearly two-thirds of cancer deaths can be linked to modifiable risk factors such as tobacco use, diet, obesity and lack of physical activity.

Obesity prevalence has reached epidemic proportions both locally and nationally. According to a 2018 Trust for America's Health Report, Alabama is the 5th most obese state in the nation for adults, and the 12th most obese for children. County area figures, based on the 2018 County Health Rankings report, reveal that Randolph County has an adult obesity rate of 34 percent and Cleburne County a rate of 35 percent—highly exceeding the national benchmark of 25 percent. Additional data (Table 2) indicate that the percentages of adults who report getting insufficient leisure physical activity—such as walking and other recreation—are higher than state and national figures in both Randolph and Cleburne counties.

According to a 2018 Trust for America's Health Report, Alabama ranks 3rd in the nation for the prevalence of diabetes. Randolph County has an adult diabetes rate of 16 percent and Cleburne County a rate of 13 percent, with Randolph County exceeding the state rate of 14 percent. Diabetes complications are debilitating, costly, deadly and are most prevalent among underserved populations—leading to increased emergency room utilization and acute care hospitalization. Concernedly, according to 2018 County Health Rankings data, the preventable hospital stays rate in Cleburne (68) and Randolph (60) counties highly surpass national (35) statistics. The preventable hospital stays rate indicator reports the discharge rate (per 1,000 Medicare enrollees) for conditions that are ambulatory care sensitive (ACS). ACS conditions include pneumonia, dehydration, asthma, diabetes, and other conditions which could have been prevented if adequate primary care resources were available and accessed by those patients.

According to the National Institute of Mental Health, one in four adults across the nation experience a mental health disorder in any given year. It is estimated that 45 percent of those with a diagnosed mental disorder suffer from two or more disorders; co-occurring mental health and substance abuse disorders are common among this population. A 2015 Behavioral Health Barometer report from SAMSHA states that about 170,000 adults aged 18 or older (4.6 percent of all adults) in Alabama had a serious mental illness (SMI) within the year prior to being surveyed. Additionally, data from the Center for Mental Health Services indicate that approximately two thirds of young people in the U.S. with psychiatric disorders are not getting the help they need, as a result of a myriad of factors often relating to financial and physical access and increased societal stigmas. State figures second these discouraging figures, as a 2018 Commonwealth Fund State Scorecard report reveals that Alabama ranks 35th in the nation for the percentage of children (ages 2-17) with emotional, developmental or behavioral problems who did not receive needed mental health services, with 19 percent not receiving services. Suicide is a significant and preventable public health problem. Rates of suicide in Randolph (21.1) and Cleburne (17.4) counties exceed the state rate (15.26) and the Healthy People 2020 goal (10.2).

Lack of access to medical care services is a significant problem for many east Alabamians. The 2018 County Health Rankings report notes that uninsured rates for both adults and children in Randolph and Cleburne counties highly exceeds national figures. Having access to care requires not only having financial coverage but also access to providers. Distressingly, the 2018 County Health Rankings data indicate that Randolph and Cleburne counties significantly surpass state and national rates for the population per primary care physician and the population per mental health professional. A 2017 report from the Association of American Medical Colleges ranks Alabama the 42nd state in the nation with the fewest physicians. Supplementary data from the U.S. Department of Health and Human Services Administration reveal that Randolph and Cleburne counties, in their entirety, are designated as Medically Underserved Areas (MUA's).

D. EXISTING HEALTHCARE FACILITIES AND RESOURCES TO ADDRESS NEEDS

Tanner Medical Center/East Alabama recognizes that there are additional healthcare resources within the community that are available to respond to the health needs of residents, including but not limited to:

Tanner/East Alabama: In May 2013, Tanner Health System opened Tanner/East Alabama, a new 26,000-square-foot, two-story medical office building in Wedowee, AL that houses Tanner Primary Care of Wedowee, a Tanner Medical Group practice that provides preventive care, health screenings, acute and chronic illness care, DOT and sports physical exams, men's and women's wellness, chronic disease management, including hypertension, diabetes and weight management, immunizations and more. The second floor of Tanner/East Alabama includes space for various specialists from Tanner's medical staff—including cardiologists, cancer specialists, obstetrics and gynecology specialists and others—to rotate through on a limited basis, bringing specialties to east Alabama that have not previously been available.

Woodland Family Healthcare: A Tanner Medical Group practice, Woodland Family Healthcare combines experience, compassion and comprehensive medical care for the whole family. Services include: general medical care, minor surgery, screenings for depression and other behavioral disorders; women's wellness; men's wellness; sick visits; children's care; geriatric care.

Tanner Primary Care of Roanoke: A Tanner Medical Group practice, Tanner Primary Care of Roanoke provides a wide range of primary care services, including: chronic disease management, cardiac testing, wellness appointments, employment and sports physicals, health screenings, weight management services and worker's compensation services.

Social Service, Faith-Based, And Other Community-Based Organizations: Faith-based organizations, community centers, senior centers, schools and other social services are just some of the organizations that will continue to be a major asset for the community as safety net providers working to reach out and engage communities in primary care and other needed health promotion services.

Additional nearby Hospitals include: Tanner Medical Center/Carrollton, Carrollton, GA; Regional Medical Center, Anniston, AL; East Alabama Medical Center, Opelika, AL; and West Georgia Medical Center, LaGrange, GA.

Part III: COMMUNITY INPUT

A. KEY INFORMANT INTERVIEWS AND FOCUS GROUP

Qualitative data were gathered during one focus group (11 participants) and two key informant interviews (2 participants) conducted with community leaders in Wedowee, Alabama at Tanner Medical Center/East Alabama on May 30, 2019. Participants were identified and recruited by Tanner Health System's Community Benefit (CB) Department.

Interview and Focus Group Participants:

- 7 Females, 6 Males
- Sectors: academia, business, county and city government, education, economic development, healthcare, public safety, and non-profit.
- Majority of the CHNA participants have lived in east Alabama for 10+ years.

The focus group and key informant interviews were conducted by a Georgia Health Policy Center (GHPC) representative using discussion guides drafted by GHPC and reviewed by Tanner Health System's CB Department. Participants were informed about the Internal Revenue Service requirement for non-profit health systems to conduct a community health needs assessment every three years noting this would be the first such assessment for Tanner Medical Center/East Alabama. The purpose for the project was explained to participants noting that Tanner is seeking input from community leaders on the ways to improve the health of residents in the community. More than just determining what the problems are, it was noted that Tanner wants to hear what solutions the leaders have to address the needs and what they would be willing to support in terms of new initiatives or opportunities.

Two key informant interviews were conducted with community leaders on May 30, 2019. Both interviewees had lived in the community in excess of 20 years and had been medical professionals: the female started her career as a surgical nurse but transitioned to community service and the male had been a physician assistant for more than 40 years.

One focus group was conducted, also on May 30, 2019, with 11 diverse community leaders representing education, healthcare, city and county government, public safety, and private business. The leaders were from different geographic areas of Randolph County.

Interviewees and focus group participants completed an informed consent approved by the Institutional Review Board of Georgia State University. Focus group participants were provided a meal. Each interview lasted approximately 60 minutes. The focus group lasted just over 90 minutes.

Both interviewees and focus group members expressed appreciation to Tanner Health System for working with community leaders to establish a hospital and primary care office in Randolph County, Alabama. They also commented on the outpouring of support from residents who voted to support the construction of the hospital with their tax dollars.

Key Health Issues and Concerns:

Key informants and focus group participants identified several health issues or challenges that need to be addressed in Randolph County and the area served by the Tanner Medical Center/East Alabama. Bulleted below are the key health issues and concerns impacting residents in the region.

- **Mental Health Services:** The lack of mental health services in the county and surrounding areas was noted as the critical concern by all participants. Contract mental health professionals (from Pell City) are providing services in Roanoke City Schools. Both interviewees and focus group members acknowledged that the local police officers often serve as the "trained mental health" provider in times of need or emergency. One person noted the presence of a mental health nurse practitioner with her own practice in Roanoke, but time and location were limiting factors.
- **Chronic Diseases:** Diabetes was identified by both key informants and the focus group as a critical concern. Hypertension and heart disease were also identified as chronic conditions of concern. The ratio of primary care physicians to residents was named as a barrier to addressing chronic conditions.
- **Overweight and Obesity:** There are a high percentage of overweight and obese adults and children in Randolph County. Specific contributing factors named included fast food, "junk food", screen time and limited physical activity.
- **Substance Misuse/Drugs:** Both the interviewees and focus group participants noted that substance misuse and drug abuse was a critical concern for the area. The public safety representatives in the focus group were particularly concerned about this issue noting there are approximately three times as many drug arrests compared to alcohol. Manufactured drugs such as "meth" as well as prescription drug misuse were specifically named. One interviewee noted, "Alcohol is not that big of a problem, Randolph County went "wet" in November 2011." The data suggests this comment to be true as Randolph County's excessive drinking (14%) and alcohol-impaired driving deaths (28%) from the 2019 County Health Rankings are the same or lower than the state and lower than surrounding counties.
- **Jobs/Employment:** The focus group noted that jobs in the county are limited and that residents often work and shop elsewhere. The advent of Tanner Hospital has resulted in stable jobs for the community and is seen as a positive economic driver contributing to a healthier and better community. It was noted by one participant that most of the available employment in the region is in low wage positions, which makes family stability difficult.

Other Concerns:

- **Access to primary care, dental care, and vision care:** Access to care was of concern especially to the two key informants. The two informants commented on this challenge prior to seeing the data summary noting that limited days, hours, and care providers made it difficult for those employed in manufacturing to schedule medical appointments. Residents will often wait until their condition is worsened before accessing care so as not to miss work or, potentially, because they cannot afford the co-payment or deductible.
- **Access to and affordability of medicines:** This theme came out in the interviews but focus group participants were more specific in their concerns including ensuring patients know there are cheaper generic drugs or inmates who are using street drugs to cope because they do not have health insurance and in order to continue medications they must see a provider "on the outside."
- **Elder care:** Interviewees and focus group participants expressed concern for elderly residents suggesting that many were on fixed incomes and affording their medicine, transportation and monthly bills is difficult. Reports of senior citizens having to use the ambulance service as their transportation were noted.

What's causing these health conditions and concerns?

According to the participant feedback, root causes for these health concerns and challenges include

1. Poverty/Limited income – Poverty was considered the key cause to many of the health issues plaguing residents in Randolph County. This social determinant impacted certain areas of the county. Participants reported that Roanoke and the county have several "pockets of poverty" and many residents are working in low wage jobs.
2. Housing – 27% of residents are renters but participants report few rental properties are available, especially for low income families.
3. Poor diet quality and physical inactivity – limited time and dollars result in residents buying fast food or less healthy food. Despite having Lake Wedowee, Flat Rock Park, and the Piedmont Plateau Birding Trail as recreation spaces along with the sports complexes at schools, many residents are sedentary and spend a great deal of time on screens. Wedowee was praised for having sidewalks in their downtown corridor. Few public parks were reported near low-income, high poverty areas of the county.

Part IV: SIGNIFICANT HEALTH NEEDS

A. Prioritized Description Of Significant Health Needs

As mentioned previously, the identification of health priorities was shaped by an understanding of the public health priorities, needs assessment data and the hospital's strengths within the context of the system's priorities. Additionally, when selecting final targeted health priorities, Tanner considered additional criteria such as availability of evidence-based approaches and existing partnerships and programming. These components were used to identify priority areas.

Through this process of evaluation, two priority health issues were selected from the broader list of priorities identified in the CHNA as specific areas of focus for Tanner Medical Center/East Alabama's Community Health Implementation Strategy, including:

1. Access to Care
2. Chronic Disease Education, Prevention and Management

Over the next three years (fiscal year's 2020-2022), Tanner Medical Center/East Alabama will execute the Implementation Strategy. Plans will focus on the execution of programming for identified priority areas, systematic measurement and tracking of program effectiveness, as well as reporting progress and outcomes.

B. NEEDS NOT ADDRESSED

As an outcome of the prioritization process and taking existing hospital and community resources into consideration, mental/behavioral health and substance misuse were both identified as significant health needs flowing from the primary and secondary data but were not advanced for consideration for the Implementation Strategy. While Tanner is committed to providing behavioral/mental health services and substance abuse services to adults, adolescents and children in the region through Willowbrooke at Tanner's many programs and services, the addition of these services in TMC/East Alabama's service area to address these identified needs is currently outside of Tanner's scope of resources. Tanner will continue to work collaboratively with various community organizations and agencies in the local region to further address gaps in the provision of mental/behavioral health and substance misuse services and continue to connect individuals to Willowbrooke at Tanner's existing mental health and substance services in west Georgia.

Part V: COMMUNITY HEALTH IMPLEMENTATION STRATEGY

A. IMPLEMENTATION STRATEGY

1. Access to Care

Improve Access to Care

» Expand the continuum of care

- Develop new clinical programs to expand treatment capabilities, including but not limited to a focus on general surgery, orthopedics, ENT, pain procedures, telehealth for neurology and mobile MRI services
- Extend access to specialist coverage at TMC/East Alabama and the Tanner/East Alabama medical office building

» Increase access to care for the uninsured and underinsured

- Continually evaluate and broadly communicate financial assistance and self-pay discount policies and practices to ensure optimal access for qualifying patients

» Utilize health information technology to improve population health outcomes and healthcare quality

- Transition to a new, single-database electronic medical record — EPIC — for both acute and ambulatory environments
  - ◊ Utilize EPIC capabilities to provide patients with the ability to access MyChart to view medical history, schedule appointments and receive reminders for healthcare follow-ups
  - ◊ Enable physicians in all service areas to access EPIC through Community Connect, raising the standard of care and level of information available

» Increase awareness of existing resources

- Utilize educational outreach and enhanced networking/partnerships to raise awareness of services and resources in the community to overcome barriers to care

2. Chronic Disease Education, Prevention and Management

Increase Access to and Utilization of Clinical and Community-based Services for Chronic Disease Prevention, Risk Reduction and Management

» Increase access to chronic disease preventive services and self-management programs in the community

- ◊ Implement outpatient nutrition counseling and diabetes self-management education programming in the community

» Provide outreach to increase use of clinical preventive services by the population

- Hold community screening opportunities (i.e., prostate cancer) to ensure underserved individuals are aware of and have access to available screenings
- Provide community-wide CPR education/trainings
- Tanner's "Mammography on the Move" digital mammography unit to provide mammograms and bone density screenings in the community
- Expand targeted and culturally appropriate media and education efforts through a variety of communication channels and formats to raise awareness of health information and services in the community, empower individuals to take an active role in their health and health care and overcome barriers to care
- Continually develop and engage collaborative partnerships at the local, regional, and statewide levels to address chronic disease and environmental factors that contribute to health risks and the overall health of the community


GET HEALTHY
LIVE WELL
TANNER
HEALTH SYSTEM