# DCH REGIONAL MEDICAL CENTER

AND

# NORTHPORT MEDICAL CENTER

# 2019 COMMUNITY HEALTH NEEDS ASSESSMENT

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## and
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# INTRODUCTION

## DCH HEALTH SYSTEM

As a local, community-owned, not-for-profit organization, the DCH Health System has been providing quality health care services for more than 95 years to citizens in West Alabama. The DCH Health System operates three (3) acute care hospitals including, DCH Regional Medical Center, a 583 licensed bed cornerstone hospital, Northport Medical Center, a 204 licensed bed community hospital, and Fayette Medical Center, a 61 licensed bed rural hospital. Additionally, DCH Health System operates the Lewis and Faye Manderson Cancer Center, which is a certified member of the MD Anderson Cancer Network, located on the campus at DCH Regional Medical Center. Collectively, these health care operational centers will be referred to hereinafter as the "System." The mission of the System is to improve the health of its community and to provide high-quality, compassionate care to all the residents of West Alabama regardless of their ability to pay. The System serves residents in a seven-county area that includes Tuscaloosa, Bibb, Fayette, Green, Hale, Lamar, and Pickens counties. The hospitals within the System provide comprehensive inpatient and outpatient services, surgery, diagnostics, and emergency services as well as specialty services to include pediatrics, orthopedics, cancer, cardiology, intensive care, rehabilitation, and psychiatry. Each hospital within the System is accredited by the Joint Commission on Accreditation of Healthcare Organizations and the System hospitals have received numerous awards from independent agencies recognizing the high quality of services provided. The System employs more than 4,700 people and more than 250 physicians practice at the hospitals within the System. Many of the System's employees and physicians volunteer their time and expertise throughout the community in an effort to improve the health of the citizens within the community. These dedicated professionals work in the local schools, malls, churches, and in civic organizations providing education and information. The System sponsors health fairs and free prostate and breast screenings each year.

This report will reflect a joint Community Health Needs Assessment between DCH Regional Medical Center and Northport Medical Center. The two hospitals are located within a few miles of each other and both hospitals provide a comprehensive array of services to residents in the seven-county service area. DCH Regional Medical Center and Northport Medical Center have received the Sole Community Hospital Designation requiring both hospitals to operate under a single Medicare provider number. The regulations established under the Patient Protection and Affordable Care Act recognize and allow for collaboration under appropriate circumstances such as these.

## DCH REGIONAL MEDICAL CENTER

DCH Regional Medical Center is the largest hospital in the DCH System. It is the most advanced trauma center in West Alabama and operates several specialty units including orthopedics, cardiology, pediatrics, and cancer. The Lewis and Faye Manderson Cancer Center is located on the campus of DCH Regional Medical Center and provides a full range

of cancer treatment services with the most highly trained and experienced cancer specialists and physicians in the country in a state-of-the-art building designed for an extraordinary patient experience.

In addition, the Medical Center offers a wide range of comprehensive services including inpatient and outpatient services for pediatrics, orthopedics, oncology, intensive care, and cardiac care. It also provides neonatal services, physical and occupational therapy, endoscopy, general diagnostic services, home health, and a diabetes and nutrition education center. DCH Regional Medical Center was also the first hospital in Alabama to provide Bloodless Medicine and Surgery which is a program that provides quality care without using blood transfusions. In 2018, there were more than 22,000 patients admitted to the hospital, there were over 77,000 emergency room visits, and over 18,000 surgeries/procedures performed. The hospital provides clinical training for students in multiple health care fields and they have a Family Practice Residency Program with the University of Alabama. The hospital is a major contributor in the community as it relates to health by providing many free services and education. It is also one of the largest employers in the area.

**NORTHPORT MEDICAL CENTER**

The System purchased Northport Medical Center in 1992 and it is also a community hospital that provides a broad spectrum of comprehensive inpatient and outpatient services and several specialty services. The Women's Pavilion is a state-of-the-art, advanced obstetrical unit providing modern, comfortable, and well-equipped rooms for mothers and their babies. The hospital also has a neonatal intensive care unit with specialized physicians and staff. At Northport Medical Center, there is also a Rehabilitation Pavilion where patients can receive the most updated, high-quality care for orthopedic and neurological disorders. North Harbor offers an inpatient treatment program for adults and geriatric individuals needing psychiatric care. In 2018, there were more than 9,300 patients admitted to the hospital, there were more than 53,000 emergency room visits, and over 6,000 surgeries/procedures performed.

## EXECUTIVE SUMMARY

The System assembled a collaborative team from DCH Regional Medical Center, Northport Medical Center, Hand Arendall, Harrison, Sale, LLC, SBC Consulting, LLC and members of the identified community served by the System to conduct a Community Health Needs Assessment (CHNA) as required by the Affordable Care Act (Section 501 (r)). The team was tasked with identifying and prioritizing the issues of health within the community and developing an action plan to address those prioritized needs. As noted in the introduction, DCH Regional Medical Center and Northport Medical Center operate under the same Medicare provider number, are located in close proximity to each other, and serve the same or similar patient population; therefore, a joint CHNA was considered most appropriate. A comprehensive and diverse Stakeholder group was formed to review

pertinent data and discuss what members of the group perceived to be important issues of health in the community. The group included experts in public health, government leaders, representatives of the medically underserved, low-income, and minorities, as well as educators, religious leaders, law enforcement, business leaders, and representatives from both hospitals. This assessment is a follow-up to the System's 2016 CHNA and it defines the community served, identifies the community's health issues, includes appropriate and required input from individuals within the community and it prioritizes the needs with a plan to address those needs. This report also includes pertinent support data from The Alabama Department of Public Health, The Robert Woods Johnson Foundation, the CDC, the Alabama Rural Health Association, the US Census Bureau and others.

Facilitating the assessment was the team of Hand Arendall Harrison Sale, LLC, and SBC Consulting, LLC. The facilitators worked closely with leadership from the DCH System to develop a Stakeholder Committee that represented the communities of both hospitals. The Stakeholders considered the seven-county geographic area served by the hospitals, demographics, disease states, socio-economic, behavioral, and physical factors, as well as the low-income, minority, and medically underserved populations in the area. In order to be inclusive and diverse, the Stakeholder Committee determined the Community should be defined as the seven-county area served by DCH Regional Medical Center and Northport Medical Center. This is consistent with prior CHNAs conducted by the hospitals.

The Stakeholder Committee met as a group on April 12, 2019 with 19 participants attending. Additional telephonic interviews and focus group meetings were held in May and June 2019 to gather, review, and consider additional input and data. Public health and census data was provided to the group as was county specific information from the Robert Woods Johnson Foundation County Health Rankings and Roadmaps. The data demonstrated that multiple counties in the seven-county community (service area) ranked very poorly compared to other counties in Alabama in health outcomes, quality of life, health factors, and health behaviors. Most of the relevant counties were considered poor with lower education levels which studies indicate affect health in the community. Other issues of health that were identified included the leading causes of death in the seven-county area, obesity, diabetes, hypertension, access to care, lack of dental, mental, and primary care professionals, poverty, the uninsured, lack of resources outside of Tuscaloosa county, sexually transmitted diseases, gun violence, transportation, job training, child care, poor nutrition, Tuberculosis, the opioid crisis, and mental health. Since the first CHNA was conducted in 2013, these health issues have consistently been identified as major issues of health in the community.

After meetings and interviews guided by the facilitator team coupled with an in-depth review of pertinent data provided, it was determined that the priorities of this CHNA should be:

- Access to care

- Diabetes, obesity, and hypertension that contribute to the leading causes of death
- Mental Health

These issues were prioritized and the strategic plans to address them were determined based their effectiveness and their financial feasibility. The Stakeholder Committee and leadership from the hospitals also reviewed prior CHNAs and the established priorities, as well as the ongoing plans currently in place to address those issues.

For many years, the System has focused on its mission to improve the health of its community and to engage and collaborate with other organizations in the community to promote a healthy lifestyle where community members live, work, play, and worship. Recognizing that changing human health behaviors is challenging, the System has remained steadfast and determined to attempt to educate the general public in its service area to pursue improved health care attitudes and understandings that will have a positive impact on health care outcomes. The System and its hospitals will always strive to provide excellent, compassionate care for patients in the community without regard to race, age, or financial status.

This report will include the following:

- A description of the methodology used to identify the health needs
- A review of the 2016 CHNA
- Prioritization of identified needs with strategic plans to address
- Supplemental Data
- Existing resources available to assist in addressing the health needs
- Plans to monitor the approved CHNA to update if needed

## METHODOLOGY

The System commissioned the assistance of Hand Arendall Harrison Sale, LLC law firm in Birmingham, Alabama and SBC Consulting, LLC in Montgomery, Alabama to aid in the process of conducting and completing the CHNA. These two organizations have previously worked with the System in completing its two prior CHNAs conducted by the System. The legal expertise of Hand Arendall Harrison Sale, LLC and the healthcare consulting experience of SBC Consulting, LLC insured the System was compliant with the IRS CHNA regulations set forth in the Affordable Care Act.

In order to reflect the health needs of the entire community including the hospitals' patient populations, the System leadership and the facilitators developed a Stakeholder committee that represented the entire community including the medically underserved, minorities, and the low-income. It was important to include a broad spectrum of agencies, community leaders, and other community organization representatives to insure a comprehensive and collaborative effort designed to identify needs, prioritize

those needs, and develop a strategic, long-range plan to address those needs. Those who agreed to serve on the committee acknowledged the importance of "owning" the process, working to strengthen the partnerships in the community, and to be creative in developing a successful, meaningful course of action that not only improved the health of the community, but aimed to increase health equity within the community.

The Stakeholder Committee, consisting of community members and representatives of the DCH System, met on April 12, 2019. The meeting began with a meal blessing from Pastor David Gay. Sammy Watson, Director of Community Relations for DCH Health System welcomed and thanked the group and stressed the importance of their participation in this exercise. He then introduced consultant Stephanie Craft with SBC Consulting, LLC. Ms. Craft discussed the purpose and reason for the CHNA and the major requirements of the CHNA. Mrs. Craft moderated a roundtable discussion among the Stakeholders. The Committee's initial task was to define the System's service area. The Committee considered the patient population of the hospitals, special target populations, disease states in the area, demographics, and other factors to assist in defining the Community. It was the consensus of the group that the community should be defined as the entire seven-county area the hospitals served which included the medically underserved, minorities, and low income populations. A review of the 2013 and 2016 CHNAs were distributed and reviewed by the Committee. The initial meeting was followed by small focus group meetings and phone interviews to further identify the issues of health and potential action plans. Multiple sources of data including quantitative and qualitative data was provided and used to develop this assessment. Data used was provided by the Alabama Department of Public Health, the US Census Bureau, the Robert Woods Johnson Foundation, the CDC, the Alabama Rural Health Association, and internal data provided by the DCH Health System.

The Stakeholder Committee included the following:

- Bryan Kindred, CEO, DCH Health System
- Sammy Watson, DCH Director of Community Relations
- Brad Fisher, DCH Corporate Director of Marketing and Communications
- Marsha White, DCH Chief Nursing Officer and Vice President of Patient Care
- Donal Conway, MD, DCH Emergency Department Physician
- Cynthia Burton, Executive Director of Community Service Programs of West Alabama, Chairman of the Board of Maude Whatley Health Services
- Stacy Adams, Alabama Department of Public Health
- David Gay, Interim Executive Director of Maude Whatley Health Services, former employee of the Department of Mental Health, pastor
- Amelia de los Reyes, Director of Quality, University of Alabama Student Health Center
- Ashley Adcox, Area Agency on Aging
- Bishop Earnest Palmer, Former Superintendent of Education, retired pastor, community leader

- Chris Holloway, Tuscaloosa Fire and Rescue
- Donna Aaron, Mayor of Northport, retired school teacher
- Jim Harrison, III, DCH Board member, community leader
- Lynn Armour, Executive Director of the Good Samaritan Clinic
- Ron Abernathy, Tuscaloosa County Sheriff
- Stan Acker, County Commissioner, University of Alabama System Finance Officer
- Anne Gaddy, R.N., Manager of the DCH Diabetes and Nutrition Education Center
- Valerie Alford, North Harbor Program Director
- Jennifer Singleton, Community Education Manager of North Harbor
- Wendi Parminter, DCH Director of Volunteer Services, Doctoral student

## OBTAINING PUBLIC INPUT

The regulations in Section 501(r)(3) require input from three primary sources within the community. DCH Regional Medical Center and Northport Medical Center acquired and documented input from 1) experts in public health, 2) representatives of the medically underserved, minorities, and low-income, and 3) written comments received from the most recently conducted CHNA. (Although the report was made widely available to the public with a mechanism to make comments, to date, there have been no comments). In addition, input was received from a broad spectrum of individuals within the community to include law enforcement, educators, religious leaders, city and county government officials, other service agencies in the area, and active community leaders.

Following approval of this report by the System's governing Board, this report will be made widely available through the DCH Health System website for public access. The following is a review of the input received:

### 1. 2016 CHNA REVIEW

The 2016 CHNA identified needs, prioritized needs, and strategic plans to address those needs were presented to the Stakeholders for review. To date, no comments have been made on the System website in regards to this CHNA. Many of the action plans are long-term, ongoing plans that will be restated in this 2019 CHNA.

- The Community was defined as the seven-county area served by DCH Regional Medical Center and Northport Medical Center. Those counties include Tuscaloosa, Bibb, Lamar, Pickens, Fayette, Hale, and Green

- Identified issues of health in the 2016 CHNA were obtained from public input and national, state and local data provided to the Stakeholder group. Those needs identified included:

- ✓ Wellness – or lack thereof
- ✓ Obesity
- ✓ Diabetes
- ✓ Mental Health
- ✓ The 7-county area leading causes of death to include heart disease, cancer, stroke, accidents, and chronic lower respiratory disease
- ✓ Poor access to care
- ✓ Sexually transmitted diseases
- ✓ Gun violence
- ✓ Need for additional education on available services to the underserved and low-income
- ✓ Transportation
- ✓ Job training
- ✓ Child care
- ✓ Nutrition
- ✓ Tuberculosis
- ✓ Physical Inactivity and access to exercise opportunities
- ✓ Teen births
- ✓ Professional shortage areas in primary care, mental health, and dental care
- ✓ Unemployment
- ✓ Children in poverty

- The following three needs were considered priorities. Actions plans to address these issues were also developed.

1. Obesity and Unhealthy behaviors leading to diabetes and heart disease - Actions to achieve included:

    - ✓ Increase the collaborative efforts with various partners in the 7-county area to increase education for at risk individuals
    - ✓ Increase the United Way 211 help line partners
    - ✓ Partner with the Temporary Gardens program with the Druid City Garden Project to encourage and educate seniors as to how to grow their own healthy food
    - ✓ Continue and expand the Golden Years program for senior in the DCH System
    - ✓ Continue the DCH and Northport outreach programs
    - ✓ Start a wellness programs for DCH employees through the Diabetes Education Center
    - ✓ Expand social media and other local media outlets to educate on prevention and wellness

2. Access to Care – Actions to achieve included:

    - ✓ Promote the use of telemedicine in the rural areas

- ✓ Create a formal partnership between the DCH Health System and Community Service Programs of West Alabama to increase referral sources and education on services provided
- ✓ Create a larger collaborative education effort among all service providers
- ✓ Assist with the funding of the Alternative Response Unit of the Tuscaloosa Fire and Rescue Unit

3. Mental Health – Actions to achieve included:

- ✓ Explore funding of telepsychiatry in West Alabama
- ✓ Increase mental health awareness – especially in the younger populations
- ✓ Continue to staff a North Harbor employee in the ED to encourage compliance with medications and follow-up physician visits
- ✓ Encourage stronger partnerships with other providers in the area to insure patients are getting appropriate treatment for mental health issues
- ✓ Recruit primary care physicians and behavioral clinicians on all levels at Northport Medical Center.

After completion of the CHNA in 2016, the System's Governing Board approved the CHNA process, the prioritized needs, and the action plans to address those needs. The report was then made widely available to the public on the System website. Since 2016, DCH Regional Medical Center and Northport Medical Center have accomplished the following action plans designed to improve the overall health in the 7-county area defined as the Community."

Many of the action plans overlap within each priority and some of the action plans are on-going plans developed in the original CHNA. They include:

- Education in the area of diabetes, hypertension, mental health, substance abuse, suicide prevention and other issues of health among the 7-county area to include health fairs, school programs, community forums, sponsorships of events within the area

- DCH Health System employee contributions to the DCH Foundation which provides grants that impact the community to include scholarships/education and patient assistance. These annual grants provide patient assistance to the community that includes:

  - ✓ Air Transportation
  - ✓ Blood pressure monitors
  - ✓ Clothing
  - ✓ Breast Screenings including one specifically designed for the Latino Community
  - ✓ Diabetes Education and home supplies
  - ✓ Dialysis

- ✓ Food
- ✓ Gas cards and other transportation means
- ✓ Home Medical Equipment
- ✓ Temporary Housing for loved ones receiving cancer treatment
- ✓ Mammograms
- ✓ Wound care supplies
- ✓ Assistance with utility payments
- ✓ Smoke detectors in homes
- ✓ Prosthesis
- ✓ Medications and specialty creams for cancer patients
- ✓ Weight scales
- ✓ Wigs for cancer patients
- ✓ Toiletries
- ✓ Home oxygen concentrators
- ✓ Lymphedema supplies

- Collaboration and participation with other local agencies and providers to increase access and education especially in the rural areas

- Outreach program to educate physicians on the DCH Diabetes and Nutrition Education Center and the services provided

- Use of social media and other media outlets including radio shows in the Tuscaloosa market targeting the African American audience designed to educate listeners on various health-related issues. To date, those include information on:

  - ✓ Prostate Cancer
  - ✓ Mental Health
  - ✓ Heart Health
  - ✓ Stroke

- DCH ED physician participating on a patient discharge committee to assist with the Alternative Response Unit of the Tuscaloosa Fire and Rescue who make appointments daily with "frequent flyers" that use 911 for minor, non-emergent situations such as mental health issues, hypertension, diabetes issues, and other health issues that otherwise would result in a visit to the emergency rooms at DCH Regional Medical Center or Northport Medical Center

- DCH maintains a smoke-free environment on the campus and encourages smoking cessation programs throughout the 7-county area

- Continue the DCH Golden Years Program which is designed for individuals over the age of 50. This program includes:

- ✓ A healthy eating education program
- ✓ A heart arrhythmia education program
- ✓ A fall prevention education program
- ✓ A Medicare prescription drug education program provided in conjunction with the Tuscaloosa Council on aging that identifies available drugs and those covered by Medicare

This program provides education from physicians, therapists, nutritionists, and other clinicians from DCH Regional Medical Center and Northport Medical Center. There are more than 5,000 members in the programs to date. Meetings are hosted at the hospitals with free refreshments and parking provided.

- Continued employee contribution support of the United Way to allow for expansion of providers and services in the 2-1-1 Resource Guide which provides much needed access to education and guidance regarding multiple issues of health for residents throughout West Alabama

- Continued outreach to West Alabama residents for patients needing mental health services. Education is provided throughout the region and collaborative efforts with other providers such as Maude Whatley Health Services, Indian Rivers, and the Good Samaritan Clinic are ongoing to insure patients have access and appropriate treatment for the various mental health issues within the community

- DCH and Northport employees' participation in the Tuscaloosa Mental Health Alliance which is a 501c3 charitable organization of more than 50 agencies, businesses, and groups that provide mental health services and resources to those in need in the community

- Northport Medical Center/North Harbor sponsors the White Gala on the Black Warrior River which is a benefit that focuses on senior citizens. Proceeds help provide transportation to medical appointments, cancer treatments, dialysis, provides hot lunches, and assistance with home care

- Continued recruitment of physicians of multiple disciplines to address access to care in the entire community. Since completion of the 2016 CHNA, The System has recruited 25 physicians. Those physicians include seven (7) hospitalists, three (3) OB/GYN physicians, three (3) general surgeons, two (2) anesthesiologists, one (1) orthopedist specializing in the hand, one (1) oncologist, one (1) nephrologist, one (1) pediatrician, one (1) trauma surgeon, one (1) family medicine physicians, and one (1) emergency medicine physician.

DCH Regional Medical Center and Northport Medical Center are committed to improving the health of the citizens in the community through their ongoing dedication to address

the most pressing health needs identified through their Community Health Needs Assessment.

## 2. STAKEHOLDER INPUT

### A. Government Health Department Input

As required by the Affordable Care Act, DCH Regional Medical Center and Northport Medical Center enlisted Stacey Adams, the District Administrator of the Alabama Department of Public Health's West Central District of Alabama. Ms. Adams input provided essential insight to the many issues of health in west Alabama. She attended the initial meeting on March 28, 2019 and participated in the discussion on several issues of health in the community including mental health and the contributing behavioral factors that result in the leading causes of death in the area. Services provided by the Tuscaloosa Department of Public Health include but are not limited to clinical services such as ALL Kids, comprehensive dental care for children in the Alabama Medicaid program, Women Infants and Children (WIC) program, sexually transmitted disease testing, treatment, and counseling, an overall women's health program, nutrition counseling, Tuberculosis testing, and immunizations. The area office also provides the SMARTS Program which offers sexually transmitted disease infection prevention and pregnancy prevention information and services to high risk youth between the ages of 13 and 19 in areas of west Alabama. In addition, the area office provides many environmental services.

Ms. Adams indicated through her work in the area that chronic diseases and prevention of these diseases, diabetes, and mental health were major issues of health in her area. She also noted that getting appropriate and timely care for these issues was difficult for many in the area due to major transportation issues not only in the rural areas outside of Tuscaloosa County, but within the city of Tuscaloosa as well. She stated that the public transportation system was ineffective and underused. For example, she said patients needing dialysis in the rural areas could potentially spend hours on a bus trying to get to a scheduled appointment for dialysis treatment and because of that, many simply did not make their appointments. She offered the suggestion of a mobile unit that could go directly to patients at their homes for treatment of certain conditions. She said funding was an obstacle to this suggestion.

As it relates to diabetes, data provided through the Alabama Department of Public Health showed diabetes is a leading contributor to the leading causes of death in the community which include heart disease and stroke. The data showed that in several counties of the community more than 12.5% of all adults have diabetes and in one of the counties of the community, the rate was 23%. Alabama leads the nation in diabetes. The state obesity map in Appendix A shows approximately 35% of the population in the 7-county community are obese and type 2 diabetes can be a direct result of obesity. In 2012, the Alabama Department of Public Health

Tuscaloosa County Diabetes Coalition was established to increase awareness, prevent the development of diabetes, and to better manage patients who are diagnosed with diabetes. The DCH Diabetes and Nutrition Education Center partners alongside the Tuscaloosa County Health Department and other agencies in the area to provide crucial information and education in the form of flyers, health fairs, social media, and visits to doctors' offices to insure residents in the community have the information and resources to minimize the effects of diabetes and decrease the diabetes epidemic in the community.

The opioid epidemic in the area was discussed as one of the issues of health for the community. According to the CDC, Alabama has the highest prescribing rate of opioids in the country. It was discussed among the Stakeholders that access to Narcon (Naloxone), the drug used to prevent overdose deaths from opioids needs to be made more easily accessible throughout the community. Ms. Adams said the State Health Officer has a standing order that Narcan can be purchased directly from pharmacies. A list of those participating pharmacies needs to be made available to the public to increase access to this life-saving drug.

## B. Medically Underserved, Low-Income, and Minority Input

To satisfy an additional requirement, DCH Regional Medical Center and Northport Medical Center obtained and documented input from those individuals or groups representing the medically underserved, low-income, and minority populations. As reported earlier in this report, the "community" was defined as the 7-county service area of both hospitals to insure inclusion of these vulnerable groups. Those individuals who provided valuable input and expertise in working with these groups included:

- ✓ Cynthia Burton, Executive Director of Community Service Programs of West Alabama, Chairman of Maude Whatley
- ✓ Bishop Earnest Palmer, Retired Pastor, former Superintendent of Education
- ✓ David Gay, Interim Director of Maude Whatley Health Services, a retired leader in the Department of Mental Health, and a local pastor
- ✓ Lynn Armour, the Executive Director of the Good Samaritan Clinic

Each of these organizations provide comprehensive services to the underserved, uninsured, and minority populations in west Alabama and DCH Regional Medically Center and Northport Medical Center work closely with each of these organizations to insure patients are getting better overall access to care, appropriate care, and the necessary education and information to improve overall healthcare within this at-risk group. Each of these individuals attended the initial CHNA meeting. In the meeting, Ms. Burton expressed great concern regarding access to care in the rural communities outside of Tuscaloosa. She stated that many rural hospitals were closing further decreasing access to care and she pointed out that expansion of Medicaid was critical for those in the rural area because

poverty was so prevalent in the areas outside of Tuscaloosa. She also stated that lack of access to primary care often resulted in visits to the emergency departments of both hospitals for care. Bishop Palmer spoke to the issue of mental health stating there were many mental health issues among children, but because there was such a stigma associated with mental health, many children were undiagnosed and failed to receive the proper treatment further complicating the problem.

To assure there was adequate information gathered from these valuable resources, a small focus group meeting was held on Friday, April 12th in Tuscaloosa. Attending the meeting were David Gay, Lynn Armour, Cynthia Burton, Sammy Watson from the DCH System, and Stephanie Craft, one of the CHNA facilitators. A more comprehensive discussion from these valuable resources further identified issues in the community.

Mr. David Gay described his background of more than 30 years as a mental health worker in Bryce Hospital and Taylor Hardin Secure Medical Facility. He is currently the CEO of Maude Whatley Health Services which provides a full complement of health-related services to include pediatric and adolescent medicine, dental care, mental health services, chiropractic services, a full-service pharmacy, laboratory services, nutrition, health promotion and disease prevention outreach programs, HIV/AIDS primary care services, family and internal medicine, and women's healthcare services. Mr. Gay identified access to care for the medically underserved, low-income, and minority population as a concern especially in the rural areas. He said that in his opinion, there were not enough providers in the rural areas to treat patients; therefore, they typically ended up in the emergency room at both hospitals for care. He also said patients were unaware of the services provided by these organizations that serve these groups. In an attempt to address this issue, Maude Whatley provides a staff member in the DCH Regional Medical Center emergency room to educate patients as to the services provided by Maude Whatley in hopes that they will return for follow-up in a more appropriate setting. He plans to continue this service. He has also observed the steady increase in the Hispanic population in the area. Through his experience working with this vulnerable population, it was his opinion that the Hispanic population was reluctant to seek care because of language barriers and communication issues. He indicated there was a need for additional education and information in areas where these groups work, play, and worship.

Mr. Gay also pointed out that because of the lack of access to care, many mental health patients were not receiving appropriate care often resulting in arrests and time in jail or emergency room visits. He stressed the need for a more proactive instead of a reactive approach by increasing education and information on prevention especially in the rural areas to decrease the number of emergency room visits.

Lynn Armour is the Executive Director of the Good Samaritan Clinic which is the only source of free primary healthcare and dental care for residents of West Alabama. Ms. Armour stated that the most common health issues seen by her organization were diabetes, hypertension, obesity, and depression. She indicated that patients needed education on healthy eating and how and when to take their medications. Non-compliance with taking medications often resulted in chronic problems and visits to the emergency department. She pointed out that the Good Samaritan Clinic is staffed with volunteers and as such, the clinic is open only 3 days a week. She also said many patients were simply unaware of the services provided by the clinic; therefore, an increase in education to those vulnerable patients was necessary. Staff of the Good Samaritan Clinic recently began working with the DCH System hospitals by providing a social worker at discharge in the emergency room to educate patients on their services. They are also providing telemedicine to patients for follow-up visits because transportation to the clinic is a major barrier to access to their care. Many patients rely on others to take them to follow-up appointments or they simply have no transportation to get there. The local library has donated space for the set-up of equipment that is used in telemedicine. As long as patients have access to a mobile phone, they can participate.

Cynthia Burton is the Executive Director of Community Services Programs of West Alabama. Her non-profit organization provides multiple services to low-income and vulnerable populations with the goal of creating family self-sufficiency and improved quality of life. The organization provides educational programs for children designed to reach their full potential. They include Early Intervention, Early Head Start, and Head Start programs. They also provide housing assistance so that families can have safe, adequate, and affordable housing. Their support services include utility assistance, food assistance, meals on wheels, workforce development, life skills training, and emergency aid. Ms. Burton pointed out that patients in rural areas come to the hospitals' emergency departments for care because they do not have insurance or access to primary care and said that until there were additional primary care providers in the rural areas, patients would continue to come to the hospital for their primary care. She also has observed the rapid increase in the Hispanic population. She noted that typically they have no insurance and because of that, they did not seek regular primary care. To complicate matters, she also alluded to the language barrier issue facing this community. Ms. Burton said there was a need for education to residents in rural west Alabama as to what constituted a true "emergency" and she stated that expansion of Medicaid was critical in solving the access to care issue. Ms. Burton's organization is opening a Hispanic resource center in Tuscaloosa to assist with that vulnerable population by providing information on resources in west Alabama that provide health care. She suggested and encouraged the use of social media and notifications on phones and tablets to increase access to information. She also suggested public service announcements on radio and television and assistance from DCH and Northport by providing an advisor to speak to various church

groups and organizations in the area. She encouraged a stronger partnership between DCH Regional Medical Center and Northport Medical Center by assisting with education through the Saving Life Initiative, Tuscaloosa Ministerial Alliance, and The Watch Group.

Bishop Palmer, who was not in attendance sent word that he would strongly encourage participation from the DCH or Northport leadership in Leadership Tuscaloosa.

## C. Additional Stakeholder Input

In addition to the information gathered at the initial meeting, several other meetings were held to gain additional data and input from stakeholders. Information gathered from these additional stakeholders allowed the facilitators and the hospitals to get a complete picture of the health of the community. The information was comprehensive and representative of the entire community. These additional stakeholders included representatives of law enforcement, education, other local agencies, the medical community, and government officials. A summary of the information discussed is submitted below.

In the initial CHNA meeting, several community representatives discussed the major issues of health in the community.

**Amelia de los Reyes**, Director of Quality, University of Alabama Student Health Center: Ms. de los Reyes made a brief presentation to the group of her organization's CHNA conducted by her doctoral peers and herself. She identified the following issues of health:

- ✓ Perception among many in the community that wealthy people get better health care service than those who are less fortunate
- ✓ Parents views on immunization for their children
- ✓ Inability by the low-income population to access healthy food leading to poor nutrition and obesity
- ✓ Mental health, depression and the stigma attached to it
- ✓ Lack of psychologist follow up with mental health patients following the closing of Bryce and Partlow mental hospitals.
- ✓ 65% of people in the Tuscaloosa County Jail have mental illness – there is a lack of a place for them to receive appropriate treatment
- ✓ Many risk factors in certain areas of the community include drug use, lack of family planning, the increase of sexually transmitted diseases, domestic violence
- ✓ Access to healthcare and no insurance coverage
- ✓ Homeless population
- ✓ Language barriers
- ✓ Need for a community resource list

The issues of health identified by Ms. de los Reyes mirrored those issues identified by others in the Stakeholder group.

**Bryan Kindred**, CEO DCH System: Mr. Kindred identified the opioid epidemic as not only a nationwide issue, but a local community health issue as well. He noted that Tuscaloosa has the highest opioid prescribing rate in the country. He mentioned that a diverse community group is investigating the possibility of starting a local, non-profit program housed in a non-hospital based, stand-alone facility supported by other major organizations in the area designed to address the immediate needs of those affected by homelessness and substance abuse in a more appropriate, caring environment to prevent an admission to the emergency room or an arrest. Mr. Kindred and others in the community visited a similar program implemented in San Antonio, Texas for additional details called the Haven for Hope.

**Donal Conway, MD** (DCH Regional Medical Center emergency room physician): Dr. Conway added to the opioid crisis discussion by stating that Alabama as a state has the highest prescribing rate in the country and has for a few years. He also noted that Governor Kay Ivey established the Alabama Opioid and Addiction Council in August of 2017 to develop recommendations and action plans to address the opioid crisis in Alabama. This is an ongoing plan with long-range objectives to address the opioid crisis. He also noted the Alabama Department of Public Health has a prescription drug monitoring program which is used as a method to prevent patient doctor shopping and physician overprescribing of these drugs.

Although Dr. Conway agreed that the opioid crisis was indeed a major issue of health, it was his opinion that the biggest "killers" in west Alabama were coronary artery disease and cancer and one of the priorities of the CHNA should focus on the prevention of these diseases including a smoking cessation program, education on good nutrition to cut down on obesity, controlling hypertension through medication management and compliance, and management of diabetes through a more healthy lifestyle.

Finally, Dr. Conway identified mental health as a major issue of health. He suggested the need for additional resources, community education programs, and a more coordinated partnership with mental health providers in the area. He also pointed out that funding for additional personnel and equipment was a major barrier to improving the mental health issue in the community.

**Ron Abernathy**, Sheriff of Tuscaloosa County: Mr. Abernathy echoed the sentiment of many on the stakeholder panel by discussing the opioid crisis and the problem with access to care for mental health patients. As it relates to Narcon, the drug that reverses opioid overdoses, he said that his department has sufficient access to Narcon and it was easy to administer with training, but it has a fast

expiration date. He suggested that if the public had easier access to this drug, many of the overdoses they see could be avoided. As an example of easier access, he pointed out that in the past, only paramedics had access to Stop Bleed Kits in an active shooter situation, but now, it is available to the general public.

From the mental health perspective, Sheriff Abernathy said that although the Probate Judge has increased the number of mental health officers, they are not medical professionals. Most mental health patients have problems because they do not take their medications or they are not being properly managed by a physician. Because of this, many become homeless, end up in the emergency room, or jail. He indicated approximately 250 of the 600 individuals in jail are there for mental health problems and they do not belong there. They should be in treatment facilities. Finally, he pointed out that although there is a big law enforcement presence in the area, it is very hard to access the rural areas because of the size of Tuscaloosa County. Traffic and construction issues within the city are problems as is adequate staff needed to effectively serve the outlying areas. Mr. Abernathy discussed a project in San Antonio, Texas – The Haven for Hope Project which is a non-profit collaboration between several community organizations in the area with the mission of providing services to the homeless community. He suggested the possibility of a similar project in Tuscaloosa as a long-range plan that would provide services for mental health patients, those with alcohol and substance abuse issues, and the homeless in the area.

**Stan Acker,** County Commissioner: Mr. Acker agreed with the health issue of access to care in the rural area which was putting a major strain on the available resources in the city of Tuscaloosa. He stated that Tuscaloosa County was one of a very few in the nation that cross-trained their employees to be both deputies and paramedics. He said there was a need for more of these cross-trained individuals because they could deliver emergency care in the rural areas in lieu of sending an entire fire crew as a first responder.

**Chis Holloway**, EMS Chief Tuscaloosa Fire and Rescue: Mr. Holloway discussed the Tuscaloosa Fire and Rescue Department's ACTION program (Appropriate Care and Treatment in Our Neighborhood). The ACTION program is a coordinated partnership with the University of Alabama that provides a behavioral unit and a nurse practitioner unit staffed with appropriate personnel who offer at the scene care to patients who frequently call 911 for their medical needs. These patients typically have low-level emergency conditions that can be easily treated without the need for a trip to the emergency room for primary care situations. Most of these patients have chronic conditions including medication issues, hypertension depression, and other non-emergent conditions. Mr. Holloway said that due to the lack of personnel and equipment needed, it was virtually impossible to provide their services to those in the rural areas where there is a great need. He pointed out that they must have additional mid-level providers and other necessary

equipment if they are to provide services in the rural areas, but funding is a major obstacle.

The Tuscaloosa Fire & Rescue's behavioral unit sees approximately 10 patients a day who need mental health evaluations, but paramedics are not trained to perform mental health evaluations; therefore, the only option is to take these patients to Northport hospital or jail. Mr. Holloway said that unfortunately, the Tuscaloosa County jail is the largest mental health institution in the area. He suggested the development of a task force to develop a system to respond to mental health patients and appropriately care for them without sending them to the hospitals or to jail. Mr. Holloway indicated the ACTION program needed better exposure, better access to patients, and additional resources to save healthcare dollars and eliminate some of the overcrowding in the emergency department. In order to help with these issues, Dr. Conway said that the DCH Regional Medical Center emergency department is now identifying patients who are at high-risk of re-admissions. They are identified on discharge and Tuscaloosa Fire and Rescue schedules follow-up visits to check on their progress and ensure medications are refilled in a timely manner. Mr. Holloway suggested the community paramedicine model is a more cost-effective and efficient way to provide care in the rural areas and this model is gaining notoriety throughout the state.

Other Stakeholders in the initial meeting agreed that mental health, the leading causes of death and the factors that contribute to those causes of death were certainly priorities that need to be addressed. Access to care was also considered a major issue.

On June 4th, 2019, facilitator Stephanie Craft met with **Valerie Alford**, the Program Director of North Harbor at Northport Hospital and **Jennifer Singleton**, the Community Education Manager at North Harbor. Both ladies stated mental health was a problem in entire west Alabama community. Barriers to mental health care included a lack of inpatient beds, an insufficient number of mental health professionals, and other necessary resources needed to treat these patients. Ms. Alford and Ms. Singleton identified transportation as a major barrier as well. The lack of transportation for patients to attend mental health follow-up visits often creates a medication compliance issue. Many of the mental health patients need monthly anti-psychotic shots to manage their mental health problems; however, more often than not, they have no transportation to get their shots. These patients then end up in the emergency room and all gains that were previously made in the process of treating their disease are lost. They noted better access to medication is needed.

Ms. Alford and Ms. Singleton also identified suicide as an issue of health – among children and adults. North Harbor does not take patients under the age of 18 so there is a lack of access to mental healthcare for those under 18. Ms. Alford was gathering information on local volunteer programs designed to help at risk

teenagers. Also, North Harbor is part of the Tuscaloosa Mental Health Alliance which is a group of area agencies, healthcare providers, businesses, and community leaders that work together to identify problem areas within the mental health arena and find solutions to those problems. Through fundraising activities, the Alliance provides grant money to the members and associated agencies that allows for assistance with acute treatment needs, as well as programs and education materials that can benefit those affected by mental health. The Alliance has just published a book on bullying which will be provided to students in one or two schools in the area. Their hope is to get it into more and more schools in West Alabama. In addition, Ms. Singleton is receiving training in the Talks Save Lives program from the American Foundation for Suicide Prevention. Once she is trained, she will be able to go into the school systems and provide presentations on suicide prevention.

Finally, Ms. Alford and Ms. Singleton said the homeless population in Tuscaloosa is growing. Currently, there are 3 "tent" cities in the area and approximately 95% of the people living there are mentally ill. There are also approximately 400 school children in Tuscaloosa County alone that are homeless. Ms. Alford suggested North Harbor provide on-site services to those mental health patients in these tent cities maybe one day a week to deliver anti-psychotic shots to those people in need. She also suggested the development of a 3-person team to include a nurse practitioner, a social worker, and possibly someone from law enforcement to volunteer their time to assist with the homeless population.

On June 18th, 2019, facilitator Stephanie Craft interviewed **Anne Gaddy, R.N.** who is the Director of the DCH Diabetes and Nutrition Education Center. The Center provides education and training in self-management know-how for people with diabetes or those who are at risk for developing the disease. Ms. Gaddy confirmed that diabetes is a major issue of health in the 7-county area served by the hospitals. Diabetes data provided to the Stakeholder group also supported the growing incidence of this disease in the community. Alabama leads the nation in diabetes cases. Ms. Gaddy referred to the two types of diabetes – Type 1 which is mostly hereditary, and Type 2 which is often caused from obesity. She indicated that many people do not know they have diabetes and as such can die from complications associated with the disease. In several of the counties in the community, diabetes was one of the top 5 leading causes of death. Ms. Gaddy said that many diabetic patients do not take their medications properly, they have poor nutritional habits, and they fail to show up for physician visits. She also said that many residents in the 7-county area are not aware of the Diabetes and Nutrition Education Center. She and her staff work tirelessly to educate physicians and residents of the services they provide. The Center boasts very positive results with patients who are compliant. The Center provides services to residents in all 7-counties in the community as well as children who have been court-ordered to receive nutrition counseling. She discussed barriers in the rural areas such as transportation. Thirty percent of scheduled patients are no-shows. She sees the

need to get additional information out through the use of social media or a possible marketing campaign. One of the action plans from the 2016 CHNA was to start a wellness program for employees of the DCH System for those on the System insurance plan. This program was implemented. Employees receive meters and supplies, help with their medication and diabetes self-management training in a classroom setting at 3 month intervals. There are no co-pays for strips. So far, the programs are very successful for those who participate. It is not a mandatory program. Ms. Gaddy plans to continue and expand the program.

### 3. ADDITIONAL HEALTHCARE DATA

Refer to Appendix A and B. Data was obtained from public input and from pertinent national, state, and local data. Appendix A includes pertinent data from the Alabama Department of Public Health and Appendix B includes data from the Robert Woods Johnson Foundation County Rankings and Roadmaps.

## PRIORITIZED NEEDS AND ACTION PLANS TO ADDRESS

Following a substantial review of the Stakeholder's identified issues of health and the available quantitative data, the Stakeholders and the leadership of DCH Regional Medical Center and Northport Medical Center determined three issues of health needed to be prioritized. This decision was based on the available resources, the potential effectiveness, and the financial feasibility. Prior assessments and priorities were also considered as many of the action plans are long-term. The final intent was to build on the existing plan to improve the lives of the citizens in the community and enhance the quality of healthcare for the community. The following needs were established as priorities:

1. **Risk factors such as hypertension, diabetes, and obesity that result in the leading causes of death**
   Actions to Achieve:

   - ✓ Continue employee contributions to the DCH Foundation which provides in-house grants for outreach programs for the entire community. Those programs include free screenings and health fairs (including screenings for the Hispanic population in the community), the DCH Diabetes and Nutrition Education Center, the Help and Hope Cancer Fund, gas cards and means of transportation for families, utility payment assistance, clothing, home medical equipment, and other services

   - ✓ Expand and upgrade the DCH System employee diabetes education program by adding coverage on the System's health insurance plan to allow for Medical Nutrition Therapy which is evidenced based nutrition practice. It allows for individually tailored nutrition plans and studies show it is much

more effective than the diabetes self-management training which is currently covered on the health insurance plan for the System employees.

- ✓ Continue to market the DCH Diabetes and Nutrition Education Center. Plans include continuing free health fairs (a minimum of 3 per year) and providing flyers and additional Diabetes Center materials in areas where those in the community live, work, play, and worship including churches, assisted living facilities, nursing homes, schools, and businesses. Plans also include a continuing effort to educate physicians on the benefits of the Center to increase referrals and to continue collaborative efforts between other providers in the area such as Maude Whatley and the Good Samaritan Clinic to insure the medically underserved and low-income groups are getting the education and care they need. There are also plans to increase awareness through a local marketing campaign and through the use of an existing contract with local radio stations owned by Town Square Media. To date, there have been four segments aired, with six segments still to be aired. The plan is to renew the contract as the segments have reached a large audience, especially in the African American audience throughout the 7-county area.

- ✓ Volunteer staff of DCH Regional Medical Center and Northport Medical center to speak at churches, schools, civic clubs, and other community events to increase awareness of obesity, diabetes and unhealthy behaviors that contribute to the leading causes of death.

- ✓ Review resources (grant opportunities) and community success stories from the US Department of Health and Human Services Healthy People 2020 and 2030 to determine what successful programs could be implemented in the 7-county community of DCH Regional Medical Center and Northport Medical Center. Determination of any program implementation will depend on potential effectiveness and financial feasibility. An example would be the Healthy Family, Healthy Heart program created by the National Heart, Lung, and Blood Institute at the National Institutes of Health. This program could be implemented in a teaching environment open to the public at the hospitals.

- ✓ Renew radio health segments with the local radio stations that educate listeners on various health-related issues.

- ✓ Continue partnerships with other local providers and organizations to educate at-risk individuals in the community. DCH plans to continue their financial support of the United Way and the programs they provide as well as sponsorships of annual benefits that provide much needed services in the community.

**2. Access to Care**

Actions to Achieve:

- ✓ The DCH System will continue and expand clinics, both primary care and specialty clinics at weekly or monthly intervals in the rural areas identified as part of the community. Since the 2016 CHNA was completed, the DCH System has recruited 25 healthcare providers to include hospitalists, a pediatrician, orthopedists, obstetrics and gynecologists, anesthesiologists, general surgeons, a trauma/critical care surgeon, a nephrologist, cardiologists, and a family physician and emergency medicine physician. These efforts will continue to insure greater access to care in the community.

- ✓ Continue to explore the use of telemedicine at DCH Regional Medical Center and Northport Medical Center. The hospitals will continue to financially support other local providers such as the Good Samaritan Clinic and Maude Whatley Health Services who currently provide these services to the medically underserved and the low-income and minority groups.

- ✓ Continue partnerships with other local providers including Community Services Programs of West Alabama, Maude Whatley Health Services, The United Way, and The Good Samaritan Clinic to insure residents in the 7-county area are informed and educated on the services provided by these organizations including transportation, child care, meals, resource information, and other valuable services. Maude Whatley Health Services will continue staffing a case worker in the emergency room of DCH Regional Medical Center to increase follow-up care and medication compliance.

- ✓ DCH Regional Medical Center and Northport Medical Center will explore funding of and clinical volunteer participation for the Alternate Response Unit of the Tuscaloosa Fire and Rescue to allow for additional equipment and staff so that there is improved access in the rural communities. Currently, the ARU is limited to Tuscaloosa County due to lack of funding, equipment, and staff. DCH Regional Medical Center and Northport Medical Center, subject to HIPPA regulations and participant consent, desire to implement a community awareness plan to identify preventable and repeat visits to the emergency room and appropriately share that information with the Tuscaloosa Fire and Rescue so that Tuscaloosa Fire and Rescue can make follow-up appointments to directly communicate with citizens to assist and educate the patients and care-givers on methods to better manage the chronic conditions that often contribute to these costly and preventable trips to the System's emergency rooms.

**3. Mental Health/Substance and Alcohol Abuse**

Actions to Achieve:

- ✓ Continue to recruit behavioral clinicians to the area as the 7-county area is considered to be a mental health professional shortage area

- ✓ Continue support of other mental health providers in the area including Maude Whatley Health Services, Indian Rivers Mental Health Center, and other outpatient community mental health centers.

- ✓ Continued support of and participation in the Tuscaloosa Mental Health Alliance which is an organization of more than 50 healthcare providers, businesses, local clinicians, agencies, and concerned citizens who together are working to identify gaps in mental health services, to provide education and crisis intervention when needed, and to improve the quality of life of those impaired by mental health issues.

- ✓ North Harbor, located at Northport Medical Center is exploring providing on-site services one day a week to provide much-needed anti-psychotic shots to the growing population of homeless people in the area. Many of the homeless in the area are mental health patients who do not have access to the anti-psychotic shot that is necessary to manage their mental health conditions.

- ✓ North Harbor will continue to participate in the federal government's SBIRT program which is a screening, intervention, and referral to treatment program for individuals with substance abuse issues or who may be at risk for developing these issues.

- ✓ North Harbor plans allow for its Director of Community Education to be trained in the "Talks Saves Lives" program which will allow her to go out in the school systems and speak to the prevention of suicide.

- ✓ North Harbor will continue to provide monetary support and boots on the ground advocacy in the community to educate on mental health issues and the resources available in the community to address those issues.

- ✓ The DCH System is exploring a potential project (The Village Center Project at Tuscaloosa) which would be a collaborative effort with various community organizations to provide much needed services to the homeless, those with substance abuse issues, and those with mental health issues. Members of System leadership have visited San Antonio, Texas to see a similar program in that area. This proposed plan will provide a venue for

the homeless and those affected by mental health and substance abuse to get appropriate treatment instead of going to the emergency room or jail.

- ✓ Continue exploring the opportunity for telepsychiatry in west Alabama.
- ✓ Consideration of a marketing campaign using social media and other media outlets to reduce the stigma of abuse and to motivate opioid users to seek help.
- ✓ Establish a community volunteer mentoring program for at-risk teens.

## OTHER RECOGNIZED HEALTH CARE NEEDS

While other needs were identified by the Stakeholder committee input and national, state, and local data provided, it was deemed most appropriate to continue progress already made in the identified priorities. Many of the additional needs identified can be and are addressed through programs provided by other state agencies and organizations in Alabama. It should be noted that the DCH System was instrumental in providing substantial funding and resources to build the Safe Center of Tuscaloosa. The President and CEO of the DCH System is a member of the Board of Directors. The Safe Center is a collaborative community agency that provides a free-standing center for victims of sexual assault. There is no charge for the services provided. Although it is in its infancy, it is successfully providing a compassionate, patient-centered environment for treatment and forensic evaluation of sexual assault victims. In addition, during the past three years, members of the leadership of the DCH System team have been Board members of the following entities:

- ✓ The Good Samaritan Clinic
- ✓ Hospice of West Alabama
- ✓ Indian Rivers Mental Health Center
- ✓ Turning Point (center for abused women)
- ✓ Presbyterian Apartments (provides a safe and low-cost place for seniors)
- ✓ Area Agency on Aging Advisory Board
- ✓ Easter Seals of West Alabama
- ✓ Police Athletic League (designed to keep kids off the streets)
- ✓ Boy Scouts Black Warrior Council (character building organization)

Participation in these important organizations insures the DCH System has a vested interest in improving the quality of life and health status of the community it serves.

## DOCUMENTING RESULTS/PLANS TO MONITOR PROGRESS

Upon approval of this report by the DCH System Governing Board of Directors, the DCH System will make the report widely available to the public on the System website. There is a mechanism in place that allows comments from the public. The DCH System will diligently make every effort to implement the action plans reported in this assessment in a timely manner with the continual goal of improving the health status of the members of the 7-county community, decreasing health inequity in the community, and improving the quality of life for all citizens in the community including the medically underserved, the low-income, and the minority populations in west Alabama.

## RESOURCES AVAILABLE TO MEET THE IDENTIFIED NEEDS

In its effort to consider and evaluate the extent to which the needs of the medically underserved population were adequately considered, the CHNA Committee undertook to evaluate the public resources currently available in the hospital's service area. Many of these resources are specifically reviewed and discussed herein above in this report. Other resources noted to be available in the service area included the following:

- Alabama Cooperative Extension Services
- Alabama Department of Human Resources
- Alabama Department of Mental Health
- Alabama Department of Public Health
- Alabama Department of Senior Services
- Alabama Head Injury Foundation - Serves those disabled by brain or spinal cord injuries
- Alabama Medicaid
- American Red Cross - Disaster relief, services to military, CPR/First Aid/Safety Classes
- Alabama Rural Health Association
- The Arc of Tuscaloosa - Job skills training and placement for adults age 21 and older
- Area Agency on Aging of West Alabama- assist with needs and provides services for the elderly
- Arts 'n Autism - Provides autism services to children from preschool to young adults

- Big Brothers Big Sisters - Screened volunteers provide one-on-one friendship to at-risk children
- Boy Scouts of America-Black Warrior Council - Citizenship, fitness and leadership opportunities for young men
- Boys & Girls Club of West Alabama - Education, recreation, & leadership programs for children and youth
- Bradford Health Services – Chemical dependency treatment programs
- Caring Days Adult Day Care - Day care for adults with Alzheimer's, Parkinson's, and other forms of dementia
- Child Abuse Prevention Services - Addresses prevention and self-help
- Community Service Programs of West Alabama – Community agency dedicated to improve the quality of life for low income and vulnerable populations
- Easter Seals West Alabama - Provides assistance to children and adults with physical handicaps
- Family Counseling Services - Counseling for individuals and families
- FOCUS on Senior Citizens – Programs and services for senior citizens
- Girl Scouts of North-Central Alabama - Educational and recreational programs for girls
- Good Samaritan Clinic - Provides primary health care to the uninsured with incomes at or below 185% federal poverty guidelines
- Health InfoNet of Alabama – Consumer health information service provided by the Alabama public and medical libraries
- Hospice of West Alabama - Health care support for the terminally ill either inpatient or at home care
- 211/Information and Referral Services - Linking those needing help or information with those who can provide it
- Maude Whatley Health Center - Provides primary healthcare services to the medically underserved residents of West Alabama
- Phoenix House - Halfway house for drug and alcohol dependent men and women
- Police Athletic League of Tuscaloosa – juvenile crime prevention program
- Safe Center of Tuscaloosa – free-standing forensics center for victims of sexual assault
- Salvation Army - Emergency food and lodging for those with nowhere to turn
- The Sickle Cell Disease Association of America - West Alabama Chapter - Improves health status
- Tuscaloosa Mental Health Alliance – mental health services, support, and outreach
- Success by Six - Prepares at-risk 4 year olds for kindergarten
- Temporary Emergency Services - Help to those in need, including food, clothing and emergency medicine
- Turning Point - Safe shelter and counseling for abuse victims and their children
- Tuscaloosa's One Place – Providing support services to families and help develop skills and resources to improve the family's quality of life.

- United Cerebral Palsy of West Alabama - Serving individuals with intellectual and physical disabilities and their families
- United Way of West Alabama
- University of Alabama Community Service Center – Student advocacy program for the community
- West Alabama AIDS Outreach - HIV/AIDS education and services to those living with HIV/AIDS
- YMCA of Tuscaloosa Co. Benjamin Barnes-YMCA of Tuscaloosa County Downtown Y
- Youth, adult, and family athletics; community education and clubs

The hospital's healthcare consultants also identified several other licensed healthcare facilities that present opportunities for hospital shared community needs programs in the future including but not limited to those shown in the chart below:

**Licensed Health Care Facilities Serving the Community**

| County | Type of Facility | Facility |
|---|---|---|
| **Bibb** | **Home Health Agency** | CV Home Health of Bibb County |
| | **Hospital** | Bibb Medical Center |
| | **Independent Clinical Laboratory** | Bibb Medical Center Laboratory |
| | **Nursing Home** | Bibb Medical Center Nursing Home |
| | **Rural Health Clinics** | Bibb Medical Associates |
| | | Cahaba Medical Care, PC |
| | | |
| | | |
| **Fayette** | **Assisted Living Facility** | Morningside of Fayette |
| | **Community Mental Health Center** | Northwest Alabama Mental Health Center |
| | **End Stage Renal Disease Treatment Ctr** | Fayette Dialysis |
| | **Home Health Agency** | Fayette Medical Center HomeCare |
| | **Hospital** | Fayette Medical Center |
| | **Independent Clinical Laboratory** | Fayette Medical Center Laboratory |
| | **Nursing Home** | Fayette Med. Ctr Long Term Care Unit |
| | **Rural Health Clinic** | Fayette Medical Center |
| | | |
| **Greene** | **End Stage Renal Disease Treatment Ctr** | Greene County Dialysis |
| | **Home Health Agency** | Alabama HomeCare |
| | **Hospital** | Greene County Health System |

| | | |
|---|---|---|
| | **Independent Clinical Laboratory** | Greene County Hospital Laboratory |
| | **Nursing Home** | Greene County Residential Nursing Home |
| | **Rural Health Clinic** | Greene County Hospital Physicians Clinic |
| | | |
| **Hale** | **Community Mental Health Center** | West Al Mental Hlth Ctr – Hale County |
| | **Home Health Agency** | Hale County Hospital Home Health |
| | **Hospital** | Hale County Hospital |
| | **Independent Clinical Laboratory** | Hale County Hospital Laboratory |
| | **Nursing Homes** | Colonial Haven Care & Rehab Center |
| | | Moundville Health and Rehab, LLC |
| | **Rural Health Clinic** | Hale County Hospital Clinic |
| | | Moundville Medical Associates |
| | | |
| **Lamar** | **Community Mental Health Center** | Northwest Alabama Mental Health Center |
| | **Home Health Agencies** | Lamar County Home Care |
| | | Encompass Health Home Health |
| | **Nursing Home** | Generations of Vernon, LLC |
| | **Rural Health Clinics** | Millport Family Practice Clinic |
| | | Sulligent Medical Clinic |
| | | Fayette Medical Clinic Millport |
| | | |
| **Pickens** | **End Stage Renal Disease Treatment Ctr** | Pickens County Dialysis |
| | **Federally Qualified Health Center** | Aliceville Family Practice |
| | **Home Health Agencies** | Amedisys Home Health of Reform |
| | | Encompass Health Home Health |
| | **Hospital** | Pickens County Medical Center, Inc. |
| | **Independent Clinical Laboratory** | Pickens County Medical Center Lab |
| | **Nursing Homes** | Aliceville Manor Nursing Home |
| | | Arbor Woods Health and rehab |
| | **Rural Health Clinic** | Carrollton Primary Care |
| | | |
| **Tuscaloosa** | **Abortion or Reproductive Health Ctr** | West Alabama Women's Center, Inc. |
| | | |
| | **Ambulatory Surgical Centers** | North River Surgical Center |
| | | Tuscaloosa Endoscopy Center |
| | | Tuscaloosa Surgical Center |
| | **Assisted Living Facilities** | Brookdale Northport ALF |
| | | Crimson Village |
| | | Daffodil House Assisted Living, LLC |
| | | Hallmark Manor |
| | | Hamrick Highlands Assisted Living |

| | |
|---|---|
| | Heritage Residential Care Village – Bldg #2 |
| | Martinview Assisted Living – West |
| | Morning Pointe of Tuscaloosa |
| | North River Village, LLC |
| | Pine Valley Retirement Community |
| | Woodlands at Tannehill |
| | |
| **Assisted Living Facilities-Specialty Care** | Brookdale Northport SCALF |
| | Martinview Assisted Living – East |
| | Morning Pointe of Tuscaloosa Specialty Care |
| | Remembrance Village |
| | The Tides at Crimson Village |
| | Traditions Way |
| | |
| **Community Mental Health Centers** | Crisis Stabilization Unit |
| | Medical Health Services, Inc. |
| | Pathway Training Center – "Indian Rivers" |
| | Phillips Treatment Center |
| | |
| **End State Renal Disease Treatment Ctrs** | Northport Dialysis |
| | RRC Northridge |
| | Tuscaloosa Dialysis |
| | Crimson Dialysis |
| | Tuscaloosa University Dialysis |
| | |
| **Federally Qualified Health Centers** | West Tuscaloosa Health Center |
| | Crescent East Health Care |
| | Whatley Health services. Inc. |
| | |
| **Home Health Agencies** | Amedisys Home Health of Tuscaloosa |
| | DCH Home Health Care Agency |
| | Tuscaloosa County Home Care |
| | |
| **Hospices** | Alabama Hospice Care of Tuscaloosa |
| | Amedisys Hospice of Tuscaloosa |
| | Comfort Care Hospice of Tuscaloosa |
| | Encompass Health Hospice - Northport |
| | Hospice of West Alabama |
| | Hospice of West Alabama, Inc. - Homecare |
| | SouthernCare New Beacon Tuscaloosa |

| | | |
|---|---|---|
| | | |
| | Hospitals | Bryce Hospital |
| | | DCH Regional Medical Center |
| | | Mary S. Harper Geriatric Medical Center |
| | | Noland Hospital Tuscaloosa, LLC |
| | | Northport Medical Center |
| | | Tuscaloosa VA Medical Center |
| | | |
| | Independent Clinical Lab | Art Fertility Program of Alabama- |
| | | Choices Pregnancy Clinic |
| | | DCH Regional Medical Center Laboratory |
| | | Maude L. Whatley Health Center |
| | | Neptune Diagnostics |
| | | Northport Medical Center Laboratory |
| | | Quest Diagnostics-Tuscaloosa |
| | | The Radiology Clinic |
| | | Southern Blood Services |
| | | Talecris Plasma Resources, Inc. |
| | | University Medical Center Laboratory |
| | | |
| | Independent Physiological Labs | Clinic for Rheumatic Disease |
| | | Sav-A-Life of Tuscaloosa, Inc. |
| | | |
| | Nursing Homes | Aspire Physical Recovery Center of West Alabama |
| | | Forest Manor, Inc. |
| | | Glen Haven Health and Rehab, LLC |
| | | Heritage Health Care & Rehab, Inc. |
| | | Hunter Creek Health & Rehab, LLC |
| | | Park Manor Health & Rehab, LLC |
| | | |
| | Rehabilitation Centers | Tuscaloosa Rehabilitation & Hand Center, Inc. |
| | | Brewer-Porch Children's Center |
| | | Champion Sport Medicine & Rehab Center |
| | | Restore Therapy Services-Outpatient |
| | | |
| | Sleep Disorder Center | Snow Sleep Center, P.C. |

# Appendix A

# TUSCALOOSA 2016 HEALTH PROFILE

| SUMMARY | | |
|---|---|---|
| Total Population | | 206,102 |
| Births | | 2,589 |
| Deaths | | 1,762 |
| Median Age | | 32.6 |
| Life Expectancy at Birth | | 75.8 |
| Total Fertility Rate per 1,000 Females Aged 10-49 | | 1,499.0 |
| Marriages | Number | 1,154 |
| | Rate* | 5.6 |
| Divorces | Number | 110 |
| | Rate* | 0.5 |

*Rates are per 1,000 population.

| PREGNANCY/NATALITY | Females Aged 15-44 | | Females Aged 10-19 | |
|---|---|---|---|---|
| | Number | Rate | Number | Rate |
| Estimated Pregnancies | 3,776 | 75.4 | 304 | 20.8 |
| Births | 2,589 | 12.6 | 197 | 13.5 |
| Induced Terminations of Pregnancy | 608 | 12.1 | 61 | 4.2 |
| Estimated Total Fetal Losses | 579 | --- | 46 | --- |

Birth rates are per 1,000 population.
Estimated pregnancy and induced termination of pregnancy rates are per 1,000 females in specified age group.

| BIRTHS BY AGE GROUP OF MOTHER | Total | 10-14 | 15-17 | 18-19 | 20+ |
|---|---|---|---|---|---|
| All Births | 2,589 | 4 | 42 | 151 | 2,392 |
| Rate | --- | 0.7 | 7.8 | 42.1 | 51.3 |
| White | 1,451 | 0 | 10 | 61 | 1,380 |
| Rate | --- | 0.0 | 2.9 | 26.8 | 47.7 |
| Black and Other | 1,138 | 4 | 32 | 90 | 1,012 |
| Rate | --- | 1.7 | 16.3 | 68.6 | 57.2 |

Rates are per 1,000 females in specified age group.
Births with unknown age of mother are included in the age group "20+".

| LIVE BIRTHS | Females Aged 15-44 | | Females Aged 10-19 | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| Births to Unmarried Women | 1,226 | 47.4 | 184 | 93.4 |
| Low Weight Births | 305 | 11.8 | 32 | 16.2 |
| Multiple Births | 96 | 3.7 | 7 | 3.6 |
| Medicaid Births | 1,244 | 48.1 | 164 | 83.2 |

Percentages are of all births with known status for females in specified age group.

| INFANT RELATED MORTALITY BY RACE* AND MOTHER'S AGE GROUP | All Ages | | | Ages 10-19 | | |
|---|---|---|---|---|---|---|
| | All Races | White | Black and Other | All Races | White | Black and Other |
| Infant Deaths | 33 | 12 | 21 | 5 | 0 | 5 |
| Rate per 1,000 Births | 12.7 | 8.3 | 18.5 | 25.4 | 0.0 | 39.7 |
| Postneonatal Deaths | 11 | 4 | 7 | 2 | 0 | 2 |
| Rate per 1,000 Births | 4.2 | 2.8 | 6.2 | 10.2 | 0.0 | 15.9 |
| Neonatal Deaths | 22 | 8 | 14 | 3 | 0 | 3 |
| Rate per 1,000 Births | 8.5 | 5.5 | 12.3 | 15.2 | 0.0 | 23.8 |

*Infant deaths are by race of child; births are by race of mother.

| 2016 ESTIMATED POPULATIONS BY AGE GROUP, RACE AND SEX | All Races | | | White | | | Black and Other | | |
|---|---|---|---|---|---|---|---|---|---|
| Age Group | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| Total | 206,102 | 99,273 | 106,829 | 134,158 | 66,328 | 67,830 | 71,944 | 32,945 | 38,999 |
| 0-4 | 12,408 | 6,305 | 6,103 | 7,179 | 3,658 | 3,521 | 5,229 | 2,647 | 2,582 |
| 5-9 | 11,905 | 6,010 | 5,895 | 6,757 | 3,346 | 3,411 | 5,148 | 2,664 | 2,484 |
| 10-14 | 11,611 | 5,944 | 5,667 | 6,709 | 3,462 | 3,247 | 4,902 | 2,482 | 2,420 |
| 15-44 | 97,806 | 47,729 | 50,077 | 62,253 | 31,541 | 30,712 | 35,553 | 16,188 | 19,365 |
| 45-64 | 46,900 | 22,387 | 24,513 | 31,946 | 15,827 | 16,119 | 14,954 | 6,560 | 8,394 |
| 65-84 | 22,499 | 9,957 | 12,542 | 16,995 | 7,738 | 9,257 | 5,504 | 2,219 | 3,285 |
| 85+ | 2,973 | 941 | 2,032 | 2,319 | 756 | 1,563 | 654 | 185 | 469 |

| MORTALITY | All Races | | | White | | | Black and Other | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| Deaths | 1,762 | 878 | 884 | 1,269 | 659 | 610 | 493 | 219 | 274 |
| Rate per 1,000 Population | 8.5 | 8.8 | 8.3 | 9.5 | 9.9 | 9.0 | 6.9 | 6.6 | 7.0 |

| SELECTED CAUSES OF DEATH | Total | | Male | | Female | | White | | Black and Other | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Heart Disease | 461 | 223.7 | 230 | 231.7 | 231 | 216.2 | 333 | 248.2 | 128 | 177.9 |
| Cancer | 323 | 156.7 | 165 | 166.2 | 158 | 147.9 | 231 | 172.2 | 92 | 127.9 |
| Stroke | 83 | 40.3 | 34 | 34.2 | 49 | 45.9 | 59 | 44.0 | 24 | 33.4 |
| Accidents | 95 | 46.1 | 60 | 60.4 | 35 | 32.8 | 72 | 53.7 | 23 | 32.0 |
| CLRD* | 124 | 60.2 | 52 | 52.4 | 72 | 67.4 | 106 | 79.0 | 18 | 25.0 |
| Diabetes | 35 | 17.0 | 22 | 22.2 | 13 | 12.2 | 21 | 15.7 | 14 | 19.5 |
| Influenza and Pneumonia | 50 | 24.3 | 18 | 18.1 | 32 | 30.0 | 36 | 26.8 | 14 | 19.5 |
| Alzheimer's Disease | 79 | 38.3 | 31 | 31.2 | 48 | 44.9 | 73 | 54.4 | 6 | 8.3 |
| Suicide | 24 | 11.6 | 20 | 20.1 | 4 | 3.7 | 21 | 15.7 | 3 | 4.2 |
| Homicide | 16 | 7.8 | 14 | 14.1 | 2 | 1.9 | 6 | 4.5 | 10 | 13.9 |
| HIV Disease | 2 | 1.0 | 2 | 2.0 | 0 | 0.0 | 0 | 0.0 | 2 | 2.8 |

Rates are per 100,000 population in specified categories. *CLRD is known as Chronic Lower Respiratory Disease.

| ACCIDENTAL DEATHS | All Ages | | Ages 19 and Under | |
|---|---|---|---|---|
| | Number | Rate | Number | Rate |
| All Accidents | 95 | 46.1 | 8 | 14.9 |
| Motor Vehicle | 47 | 22.8 | 7 | 13.0 |
| Suffocation | 3 | 1.5 | 1 | 1.9 |
| Poisoning | 32 | 15.5 | 0 | 0.0 |
| Smoke, Fire and Flames | 0 | 0.0 | 0 | 0.0 |
| Falls | 3 | 1.5 | 0 | 0.0 |
| Drowning | 2 | 1.0 | 0 | 0.0 |
| Firearms | 0 | 0.0 | 0 | 0.0 |
| Other Accidents | 8 | --- | 0 | --- |

Rates are per 100,000 population in specified categories.

| DEATHS BY AGE GROUP | | |
|---|---|---|
| Age Group | Number | Rate |
| Total | 1,762 | 8.5 |
| 0 - 14 | 39 | 1.1 |
| 15 - 44 | 142 | 1.5 |
| 45 - 64 | 396 | 8.4 |
| 65 - 84 | 744 | 33.1 |
| 85 + | 441 | 148.3 |

Rates are per 1,000 population in specified age group.

| SELECTED CANCER SITE DEATHS | Total | | Male | | Female | |
|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate |
| All Cancers | 323 | 156.7 | 165 | 166.2 | 158 | 147.9 |
| Trachea, Bronchus, Lung, Pleura | 93 | 45.1 | 52 | 52.4 | 41 | 38.4 |
| Colorectal | 32 | 15.5 | 13 | 13.1 | 19 | 17.8 |
| Breast (female) | 22 | 10.7 | 0 | 0.0 | 22 | 20.6 |
| Prostate (male) | 22 | 10.7 | 22 | 22.2 | 0 | 0.0 |
| Pancreas | 24 | 11.6 | 13 | 13.1 | 11 | 10.3 |
| Leukemias | 5 | 2.4 | 3 | 3.0 | 2 | 1.9 |
| Non-Hodgkin's Lymphomas | 10 | 4.9 | 7 | 7.1 | 3 | 2.8 |
| Ovary (female) | 5 | 2.4 | 0 | 0.0 | 5 | 4.7 |
| Brain and Other Nervous System | 12 | 5.8 | 6 | 6.0 | 6 | 5.6 |
| Stomach | 7 | 3.4 | 5 | 5.0 | 2 | 1.9 |
| Uterus and Cervix (female) | 14 | 6.8 | 0 | 0.0 | 14 | 13.1 |
| Esophagus | 2 | 1.0 | 2 | 2.0 | 0 | 0.0 |
| Melanoma of Skin | 6 | 2.9 | 4 | 4.0 | 2 | 1.9 |
| Other | 69 | --- | 38 | --- | 31 | --- |

Rates are per 100,000 population in specified categories.

Measurements based on small denominators should be used with caution. Rates and ratios based on a denominator of less than 50 births or 1,000 population are shaded. Estimated pregnancies are the sum of births, induced terminations of pregnancy (abortions) and estimated total fetal losses. Estimated total fetal losses are equal to the sum of 20 percent of births and 10 percent of induced terminations of pregnancy. The total fertility rate is the sum of age-specific birth rates multiplied by the width of the intervals, i.e. five years. A total fertility rate of 2,100 births per 1,000 females aged 10-49 years would maintain the current population. Estimated populations are from the U.S. Census Bureau. See Appendix B for other definitions and formulas.

# PICKENS 2016 HEALTH PROFILE

| PREGNANCY/NATALITY | Females Aged 15-44 | | Females Aged 10-19 | |
|---|---|---|---|---|
| | Number | Rate | Number | Rate |
| **Estimated Pregnancies** | 315 | 87.9 | 23 | 20.0 |
| **Births** | 231 | 11.4 | 17 | 14.8 |
| **Induced Terminations of Pregnancy** | 34 | 9.5 | 2 | 1.7 |
| **Estimated Total Fetal Losses** | 50 | --- | 4 | --- |

Birth rates are per 1,000 population.
Estimated pregnancy and induced termination of pregnancy rates are per 1,000 females in specified age group.

| BIRTHS BY AGE GROUP OF MOTHER | Total | 10-14 | 15-17 | 18-19 | 20+ |
|---|---|---|---|---|---|
| **All Births** | 231 | 0 | 9 | 8 | 214 |
| **Rate** | --- | 0.0 | 25.9 | 34.5 | 55.3 |
| **White** | 130 | 0 | 6 | 3 | 121 |
| **Rate** | --- | 0.0 | 37.3 | 28.0 | 58.7 |
| **Black and Other** | 101 | 0 | 3 | 5 | 93 |
| **Rate** | --- | 0.0 | 16.1 | 40.2 | 51.4 |

Rates are per 1,000 females in specified age group.
Births with unknown age of mother are included in the age group "20+".

| SUMMARY | | |
|---|---|---|
| **Total Population** | | 20,324 |
| **Births** | | 231 |
| **Deaths** | | 250 |
| **Median Age** | | 41.9 |
| **Life Expectancy at Birth** | | 73.5 |
| **Total Fertility Rate per 1,000 Females Aged 10-49** | | 1,911.5 |
| **Marriages** | Number | 96 |
| | Rate* | 4.7 |
| **Divorces** | Number | 77 |
| | Rate* | 3.8 |

*Rates are per 1,000 population.

| LIVE BIRTHS | Females Aged 15-44 | | Females Aged 10-19 | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| **Births to Unmarried Women** | 125 | 54.1 | 17 | 100.0 |
| **Low Weight Births** | 33 | 14.3 | 2 | 11.8 |
| **Multiple Births** | 11 | 4.8 | 0 | 0.0 |
| **Medicaid Births** | 134 | 58.0 | 14 | 82.4 |

Percentages are of all births with known status for females in specified age group.

| INFANT RELATED MORTALITY BY RACE* AND MOTHER'S AGE GROUP | All Ages | | | Ages 10-19 | | |
|---|---|---|---|---|---|---|
| | All Races | White | Black and Other | All Races | White | Black and Other |
| **Infant Deaths** | 7 | 6 | 1 | 0 | 0 | 0 |
| **Rate per 1,000 Births** | 30.3 | 46.2 | 9.9 | 0.0 | 0.0 | 0.0 |
| **Postneonatal Deaths** | 1 | 0 | 1 | 0 | 0 | 0 |
| **Rate per 1,000 Births** | 4.3 | 0.0 | 9.9 | 0.0 | 0.0 | 0.0 |
| **Neonatal Deaths** | 6 | 6 | 0 | 0 | 0 | 0 |
| **Rate per 1,000 Births** | 26.0 | 46.2 | 0.0 | 0.0 | 0.0 | 0.0 |

*Infant deaths are by race of child; births are by race of mother.

| 2016 ESTIMATED POPULATIONS BY AGE GROUP, RACE AND SEX | All Races | | | White | | | Black and Other | | |
|---|---|---|---|---|---|---|---|---|---|
| **Age Group** | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| **Total** | 20,324 | 10,156 | 10,168 | 11,788 | 6,119 | 5,669 | 8,536 | 4,037 | 4,499 |
| **0-4** | 1,062 | 561 | 501 | 514 | 287 | 227 | 548 | 274 | 274 |
| **5-9** | 1,091 | 541 | 550 | 560 | 282 | 278 | 531 | 259 | 272 |
| **10-14** | 1,126 | 614 | 512 | 574 | 312 | 262 | 552 | 302 | 250 |
| **15-44** | 7,591 | 4,008 | 3,583 | 4,105 | 2,273 | 1,832 | 3,486 | 1,735 | 1,751 |
| **45-64** | 5,764 | 2,792 | 2,972 | 3,487 | 1,798 | 1,689 | 2,277 | 994 | 1,283 |
| **65-84** | 3,272 | 1,489 | 1,783 | 2,255 | 1,051 | 1,204 | 1,017 | 438 | 579 |
| **85+** | 418 | 151 | 267 | 293 | 116 | 177 | 125 | 35 | 90 |

| MORTALITY | All Races | | | White | | | Black and Other | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| Deaths | 250 | 116 | 134 | 154 | 76 | 78 | 96 | 40 | 56 |
| Rate per 1,000 Population | 12.3 | 11.4 | 13.2 | 13.1 | 12.4 | 13.8 | 11.2 | 9.9 | 12.4 |

| SELECTED CAUSES OF DEATH | Total | | Male | | Female | | White | | Black and Other | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Heart Disease | 65 | 319.8 | 31 | 305.2 | 34 | 334.4 | 34 | 288.4 | 31 | 363.2 |
| Cancer | 46 | 226.3 | 24 | 236.3 | 22 | 216.4 | 28 | 237.5 | 18 | 210.9 |
| Stroke | 9 | 44.3 | 3 | 29.5 | 6 | 59.0 | 7 | 59.4 | 2 | 23.4 |
| Accidents | 16 | 78.7 | 11 | 108.3 | 5 | 49.2 | 8 | 67.9 | 8 | 93.7 |
| CLRD* | 21 | 103.3 | 12 | 118.2 | 9 | 88.5 | 16 | 135.7 | 5 | 58.6 |
| Diabetes | 4 | 19.7 | 2 | 19.7 | 2 | 19.7 | 1 | 8.5 | 3 | 35.1 |
| Influenza and Pneumonia | 10 | 49.2 | 3 | 29.5 | 7 | 68.8 | 9 | 76.3 | 1 | 11.7 |
| Alzheimer's Disease | 10 | 49.2 | 2 | 19.7 | 8 | 78.7 | 9 | 76.3 | 1 | 11.7 |
| Suicide | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Homicide | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| HIV Disease | 1 | 4.9 | 1 | 9.8 | 0 | 0.0 | 0 | 0.0 | 1 | 11.7 |

Rates are per 100,000 population in specified categories. *CLRD is known as Chronic Lower Respiratory Disease.

| ACCIDENTAL DEATHS | All Ages | | Ages 19 and Under | |
|---|---|---|---|---|
| | Number | Rate | Number | Rate |
| All Accidents | 16 | 78.7 | 2 | 44.2 |
| Motor Vehicle | 11 | 54.1 | 2 | 44.2 |
| Suffocation | 0 | 0.0 | 0 | 0.0 |
| Poisoning | 3 | 14.8 | 0 | 0.0 |
| Smoke, Fire and Flames | 0 | 0.0 | 0 | 0.0 |
| Falls | 1 | 4.9 | 0 | 0.0 |
| Drowning | 0 | 0.0 | 0 | 0.0 |
| Firearms | 0 | 0.0 | 0 | 0.0 |
| Other Accidents | 1 | --- | 0 | --- |

Rates are per 100,000 population in specified categories.

| DEATHS BY AGE GROUP | | |
|---|---|---|
| Age Group | Number | Rate |
| Total | 250 | 12.3 |
| 0 - 14 | 9 | 2.7 |
| 15 - 44 | 11 | 1.4 |
| 45 - 64 | 53 | 9.2 |
| 65 - 84 | 107 | 32.7 |
| 85 + | 70 | 167.5 |

Rates are per 1,000 population in specified age group.

| SELECTED CANCER SITE DEATHS | Total | | Male | | Female | |
|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate |
| All Cancers | 46 | 226.3 | 24 | 236.3 | 22 | 216.4 |
| Trachea, Bronchus, Lung, Pleura | 17 | 83.6 | 12 | 118.2 | 5 | 49.2 |
| Colorectal | 3 | 14.8 | 2 | 19.7 | 1 | 9.8 |
| Breast (female) | 1 | 4.9 | 0 | 0.0 | 1 | 9.8 |
| Prostate (male) | 2 | 9.8 | 2 | 19.7 | 0 | 0.0 |
| Pancreas | 8 | 39.4 | 4 | 39.4 | 4 | 39.3 |
| Leukemias | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Non-Hodgkin's Lymphomas | 3 | 14.8 | 0 | 0.0 | 3 | 29.5 |
| Ovary (female) | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Brain and Other Nervous System | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Stomach | 1 | 4.9 | 0 | 0.0 | 1 | 9.8 |
| Uterus and Cervix (female) | 1 | 4.9 | 0 | 0.0 | 1 | 9.8 |
| Esophagus | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Melanoma of Skin | 2 | 9.8 | 1 | 9.8 | 1 | 9.8 |
| Other | 8 | --- | 3 | --- | 5 | --- |

Rates are per 100,000 population in specified categories.

Measurements based on small denominators should be used with caution. Rates and ratios based on a denominator of less than 50 births or 1,000 population are shaded. Estimated pregnancies are the sum of births, induced terminations of pregnancy (abortions) and estimated total fetal losses. Estimated total fetal losses are equal to the sum of 20 percent of births and 10 percent of induced terminations of pregnancy. The total fertility rate is the sum of age-specific birth rates multiplied by the width of the intervals, i.e. five years. A total fertility rate of 2,100 births per 1,000 females aged 10-49 years would maintain the current population. Estimated populations are from the U.S. Census Bureau. See Appendix B for other definitions and formulas.

# LAMAR 2016 HEALTH PROFILE

| PREGNANCY/NATALITY | Females Aged 15-44 | | Females Aged 10-19 | |
|---|---|---|---|---|
| | Number | Rate | Number | Rate |
| **Estimated Pregnancies** | 164 | 69.4 | 20 | 23.6 |
| **Births** | 133 | 9.6 | 17 | 20.1 |
| **Induced Terminations of Pregnancy** | 4 | 1.7 | 0 | 0.0 |
| **Estimated Total Fetal Losses** | 27 | --- | 3 | --- |

Birth rates are per 1,000 population.
Estimated pregnancy and induced termination of pregnancy rates are per 1,000 females in specified age group.

| BIRTHS BY AGE GROUP OF MOTHER | Total | 10-14 | 15-17 | 18-19 | 20+ |
|---|---|---|---|---|---|
| **All Births** | 133 | 0 | 8 | 9 | 116 |
| **Rate** | --- | 0.0 | 32.9 | 55.6 | 49.2 |
| **White** | 119 | 0 | 8 | 7 | 104 |
| **Rate** | --- | 0.0 | 39.7 | 52.1 | 51.2 |
| **Black and Other** | 14 | 0 | 0 | 2 | 12 |
| **Rate** | --- | 0.0 | 0.0 | 72.5 | 36.7 |

Rates are per 1,000 females in specified age group.
Births with unknown age of mother are included in the age group "20+".

| SUMMARY | | |
|---|---|---|
| **Total Population** | | 13,918 |
| **Births** | | 133 |
| **Deaths** | | 204 |
| **Median Age** | | 44.4 |
| **Life Expectancy at Birth** | | 73.3 |
| **Total Fertility Rate per 1,000 Females Aged 10-49** | | 1,772.0 |
| **Marriages** | Number | 57 |
| | Rate* | 4.1 |
| **Divorces** | Number | 73 |
| | Rate* | 5.2 |

*Rates are per 1,000 population.

| LIVE BIRTHS | Females Aged 15-44 | | Females Aged 10-19 | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| **Births to Unmarried Women** | 53 | 39.8 | 11 | 64.7 |
| **Low Weight Births** | 15 | 11.3 | 0 | 0.0 |
| **Multiple Births** | 10 | 7.5 | 0 | 0.0 |
| **Medicaid Births** | 67 | 50.4 | 11 | 64.7 |

Percentages are of all births with known status for females in specified age group.

| INFANT RELATED MORTALITY BY RACE* AND MOTHER'S AGE GROUP | All Ages | | | Ages 10-19 | | |
|---|---|---|---|---|---|---|
| | All Races | White | Black and Other | All Races | White | Black and Other |
| **Infant Deaths** | 1 | 1 | 0 | 0 | 0 | 0 |
| **Rate per 1,000 Births** | 7.5 | 8.4 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Postneonatal Deaths** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Rate per 1,000 Births** | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Neonatal Deaths** | 1 | 1 | 0 | 0 | 0 | 0 |
| **Rate per 1,000 Births** | 7.5 | 8.4 | 0.0 | 0.0 | 0.0 | 0.0 |

*Infant deaths are by race of child; births are by race of mother.

| 2016 ESTIMATED POPULATIONS BY AGE GROUP, RACE AND SEX | All Races | | | White | | | Black and Other | | |
|---|---|---|---|---|---|---|---|---|---|
| **Age Group** | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| **Total** | 13,918 | 6,782 | 7,136 | 12,155 | 5,958 | 6,197 | 1,763 | 824 | 939 |
| **0-4** | 696 | 357 | 339 | 575 | 291 | 284 | 121 | 66 | 55 |
| **5-9** | 820 | 422 | 398 | 706 | 359 | 347 | 114 | 63 | 51 |
| **10-14** | 883 | 447 | 436 | 773 | 394 | 379 | 110 | 53 | 57 |
| **15-44** | 4,676 | 2,312 | 2,364 | 4,050 | 2,008 | 2,042 | 626 | 304 | 322 |
| **45-64** | 3,886 | 1,946 | 1,940 | 3,373 | 1,716 | 1,657 | 513 | 230 | 283 |
| **65-84** | 2,657 | 1,209 | 1,448 | 2,417 | 1,112 | 1,305 | 240 | 97 | 143 |
| **85+** | 300 | 89 | 211 | 261 | 78 | 183 | 39 | 11 | 28 |

| MORTALITY | All Races | | | White | | | Black and Other | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| Deaths | 204 | 115 | 89 | 182 | 103 | 79 | 22 | 12 | 10 |
| Rate per 1,000 Population | 14.7 | 17.0 | 12.5 | 15.0 | 17.3 | 12.7 | 12.5 | 14.6 | 10.6 |

| SELECTED CAUSES OF DEATH | Total | | Male | | Female | | White | | Black and Other | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Heart Disease | 55 | 395.2 | 32 | 471.8 | 23 | 322.3 | 48 | 394.9 | 7 | 397.1 |
| Cancer | 42 | 301.8 | 27 | 398.1 | 15 | 210.2 | 38 | 312.6 | 4 | 226.9 |
| Stroke | 11 | 79.0 | 6 | 88.5 | 5 | 70.1 | 10 | 82.3 | 1 | 56.7 |
| Accidents | 12 | 86.2 | 11 | 162.2 | 1 | 14.0 | 11 | 90.5 | 1 | 56.7 |
| CLRD* | 17 | 122.1 | 8 | 118.0 | 9 | 126.1 | 17 | 139.9 | 0 | 0.0 |
| Diabetes | 7 | 50.3 | 5 | 73.7 | 2 | 28.0 | 5 | 41.1 | 2 | 113.4 |
| Influenza and Pneumonia | 3 | 21.6 | 1 | 14.7 | 2 | 28.0 | 3 | 24.7 | 0 | 0.0 |
| Alzheimer's Disease | 6 | 43.1 | 2 | 29.5 | 4 | 56.1 | 6 | 49.4 | 0 | 0.0 |
| Suicide | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Homicide | 1 | 7.2 | 1 | 14.7 | 0 | 0.0 | 1 | 8.2 | 0 | 0.0 |
| HIV Disease | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |

Rates are per 100,000 population in specified categories.

*CLRD is known as Chronic Lower Respiratory Disease.

| ACCIDENTAL DEATHS | All Ages | | Ages 19 and Under | |
|---|---|---|---|---|
| | Number | Rate | Number | Rate |
| All Accidents | 12 | 86.2 | 0 | 0.0 |
| Motor Vehicle | 5 | 35.9 | 0 | 0.0 |
| Suffocation | 0 | 0.0 | 0 | 0.0 |
| Poisoning | 0 | 0.0 | 0 | 0.0 |
| Smoke, Fire and Flames | 1 | 7.2 | 0 | 0.0 |
| Falls | 2 | 14.4 | 0 | 0.0 |
| Drowning | 1 | 7.2 | 0 | 0.0 |
| Firearms | 0 | 0.0 | 0 | 0.0 |
| Other Accidents | 3 | --- | 0 | --- |

Rates are per 100,000 population in specified categories.

| DEATHS BY AGE GROUP | | |
|---|---|---|
| Age Group | Number | Rate |
| Total | 204 | 14.7 |
| 0 - 14 | 1 | 0.4 |
| 15 - 44 | 13 | 2.8 |
| 45 - 64 | 42 | 10.8 |
| 65 - 84 | 111 | 41.8 |
| 85 + | 37 | 123.3 |

Rates are per 1,000 population in specified age group.

| SELECTED CANCER SITE DEATHS | Total | | Male | | Female | |
|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate |
| All Cancers | 42 | 301.8 | 27 | 398.1 | 15 | 210.2 |
| Trachea, Bronchus, Lung, Pleura | 13 | 93.4 | 9 | 132.7 | 4 | 56.1 |
| Colorectal | 4 | 28.7 | 2 | 29.5 | 2 | 28.0 |
| Breast (female) | 3 | 21.6 | 0 | 0.0 | 3 | 42.0 |
| Prostate (male) | 2 | 14.4 | 2 | 29.5 | 0 | 0.0 |
| Pancreas | 3 | 21.6 | 3 | 44.2 | 0 | 0.0 |
| Leukemias | 1 | 7.2 | 1 | 14.7 | 0 | 0.0 |
| Non-Hodgkin's Lymphomas | 1 | 7.2 | 1 | 14.7 | 0 | 0.0 |
| Ovary (female) | 2 | 14.4 | 0 | 0.0 | 2 | 28.0 |
| Brain and Other Nervous System | 1 | 7.2 | 1 | 14.7 | 0 | 0.0 |
| Stomach | 3 | 21.6 | 2 | 29.5 | 1 | 14.0 |
| Uterus and Cervix (female) | 2 | 14.4 | 0 | 0.0 | 2 | 28.0 |
| Esophagus | 1 | 7.2 | 1 | 14.7 | 0 | 0.0 |
| Melanoma of Skin | 1 | 7.2 | 1 | 14.7 | 0 | 0.0 |
| Other | 5 | --- | 4 | --- | 1 | --- |

Rates are per 100,000 population in specified categories.

Measurements based on small denominators should be used with caution. Rates and ratios based on a denominator of less than 50 births or 1,000 population are shaded. Estimated pregnancies are the sum of births, induced terminations of pregnancy (abortions) and estimated total fetal losses. Estimated total fetal losses are equal to the sum of 20 percent of births and 10 percent of induced terminations of pregnancy. The total fertility rate is the sum of age-specific birth rates multiplied by the width of the intervals, i.e. five years. A total fertility rate of 2,100 births per 1,000 females aged 10-49 years would maintain the current population. Estimated populations are from the U.S. Census Bureau. See Appendix B for other definitions and formulas.

# HALE 2016
# HEALTH PROFILE

| PREGNANCY/NATALITY | Females Aged 15-44 | | Females Aged 10-19 | |
|---|---|---|---|---|
| | Number | Rate | Number | Rate |
| Estimated Pregnancies | 257 | 91.7 | 26 | 25.7 |
| Births | 182 | 12.2 | 15 | 14.9 |
| Induced Terminations of Pregnancy | 35 | 12.5 | 7 | 6.9 |
| Estimated Total Fetal Losses | 40 | --- | 4 | --- |

Birth rates are per 1,000 population.
Estimated pregnancy and induced termination of pregnancy rates are per 1,000 females in specified age group.

| SUMMARY | | |
|---|---|---|
| Total Population | | 14,952 |
| Births | | 182 |
| Deaths | | 189 |
| Median Age | | 40.4 |
| Life Expectancy at Birth | | 74.9 |
| Total Fertility Rate per 1,000 Females Aged 10-49 | | 1,944.5 |
| Marriages | Number | 82 |
| | Rate* | 5.5 |
| Divorces | Number | 25 |
| | Rate* | 1.7 |

*Rates are per 1,000 population.

| BIRTHS BY AGE GROUP OF MOTHER | Total | 10-14 | 15-17 | 18-19 | 20+ |
|---|---|---|---|---|---|
| All Births | 182 | 0 | 4 | 11 | 167 |
| Rate | --- | 0.0 | 12.7 | 52.3 | 60.4 |
| White | 67 | 0 | 0 | 4 | 63 |
| Rate | --- | 0.0 | 0.0 | 59.2 | 64.5 |
| Black and Other | 115 | 0 | 4 | 7 | 104 |
| Rate | --- | 0.0 | 18.7 | 49.0 | 58.2 |

Rates are per 1,000 females in specified age group.
Births with unknown age of mother are included in the age group "20+".

| LIVE BIRTHS | Females Aged 15-44 | | Females Aged 10-19 | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| Births to Unmarried Women | 122 | 67.0 | 13 | 86.7 |
| Low Weight Births | 26 | 14.3 | 3 | 20.0 |
| Multiple Births | 6 | 3.3 | 0 | 0.0 |
| Medicaid Births | 121 | 66.5 | 14 | 93.3 |

Percentages are of all births with known status for females in specified age group.

| INFANT RELATED MORTALITY BY RACE* AND MOTHER'S AGE GROUP | All Ages | | | Ages 10-19 | | |
|---|---|---|---|---|---|---|
| | All Races | White | Black and Other | All Races | White | Black and Other |
| Infant Deaths | 0 | 0 | 0 | 0 | 0 | 0 |
| Rate per 1,000 Births | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Postneonatal Deaths | 0 | 0 | 0 | 0 | 0 | 0 |
| Rate per 1,000 Births | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Neonatal Deaths | 0 | 0 | 0 | 0 | 0 | 0 |
| Rate per 1,000 Births | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

*Infant deaths are by race of child; births are by race of mother.

| 2016 ESTIMATED POPULATIONS BY AGE GROUP, RACE AND SEX | All Races | | | White | | | Black and Other | | |
|---|---|---|---|---|---|---|---|---|---|
| Age Group | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| Total | 14,952 | 7,060 | 7,892 | 6,133 | 3,049 | 3,084 | 8,819 | 4,011 | 4,808 |
| 0-4 | 1,044 | 536 | 508 | 382 | 205 | 177 | 662 | 331 | 331 |
| 5-9 | 924 | 481 | 443 | 361 | 183 | 178 | 563 | 298 | 265 |
| 10-14 | 928 | 466 | 462 | 333 | 171 | 162 | 595 | 295 | 300 |
| 15-44 | 5,308 | 2,504 | 2,804 | 1,885 | 954 | 931 | 3,423 | 1,550 | 1,873 |
| 45-64 | 3,979 | 1,846 | 2,133 | 1,694 | 859 | 835 | 2,285 | 987 | 1,298 |
| 65-84 | 2,410 | 1,120 | 1,290 | 1,295 | 618 | 677 | 1,115 | 502 | 613 |
| 85+ | 359 | 107 | 252 | 183 | 59 | 124 | 176 | 48 | 128 |

## HALE 2016 HEALTH PROFILE (Continued)

| MORTALITY | All Races | | | White | | | Black and Other | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| Deaths | 189 | 103 | 86 | 84 | 44 | 40 | 105 | 59 | 46 |
| Rate per 1,000 Population | 12.6 | 14.6 | 10.9 | 13.7 | 14.4 | 13.0 | 11.9 | 14.7 | 9.6 |

| SELECTED CAUSES OF DEATH | Total | | Male | | Female | | White | | Black and Other | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Heart Disease | 57 | 381.2 | 38 | 538.2 | 19 | 240.8 | 24 | 391.3 | 33 | 374.2 |
| Cancer | 40 | 267.5 | 22 | 311.6 | 18 | 228.1 | 13 | 212.0 | 27 | 306.2 |
| Stroke | 13 | 86.9 | 6 | 85.0 | 7 | 88.7 | 5 | 81.5 | 8 | 90.7 |
| Accidents | 8 | 53.5 | 6 | 85.0 | 2 | 25.3 | 4 | 65.2 | 4 | 45.4 |
| CLRD* | 6 | 40.1 | 4 | 56.7 | 2 | 25.3 | 6 | 97.8 | 0 | 0.0 |
| Diabetes | 4 | 26.8 | 1 | 14.2 | 3 | 38.0 | 1 | 16.3 | 3 | 34.0 |
| Influenza and Pneumonia | 1 | 6.7 | 1 | 14.2 | 0 | 0.0 | 0 | 0.0 | 1 | 11.3 |
| Alzheimer's Disease | 5 | 33.4 | 2 | 28.3 | 3 | 38.0 | 4 | 65.2 | 1 | 11.3 |
| Suicide | 2 | 13.4 | 2 | 28.3 | 0 | 0.0 | 1 | 16.3 | 1 | 11.3 |
| Homicide | 3 | 20.1 | 2 | 28.3 | 1 | 12.7 | 1 | 16.3 | 2 | 22.7 |
| HIV Disease | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |

Rates are per 100,000 population in specified categories.

*CLRD is known as Chronic Lower Respiratory Disease.

| ACCIDENTAL DEATHS | All Ages | | Ages 19 and Under | |
|---|---|---|---|---|
| | Number | Rate | Number | Rate |
| All Accidents | 8 | 53.5 | 0 | 0.0 |
| Motor Vehicle | 6 | 40.1 | 0 | 0.0 |
| Suffocation | 0 | 0.0 | 0 | 0.0 |
| Poisoning | 0 | 0.0 | 0 | 0.0 |
| Smoke, Fire and Flames | 0 | 0.0 | 0 | 0.0 |
| Falls | 1 | 6.7 | 0 | 0.0 |
| Drowning | 0 | 0.0 | 0 | 0.0 |
| Firearms | 0 | 0.0 | 0 | 0.0 |
| Other Accidents | 1 | --- | 0 | --- |

Rates are per 100,000 population in specified categories.

| DEATHS BY AGE GROUP | | |
|---|---|---|
| Age Group | Number | Rate |
| Total | 189 | 12.6 |
| 0 - 14 | 1 | 0.3 |
| 15 - 44 | 12 | 2.3 |
| 45 - 64 | 49 | 12.3 |
| 65 - 84 | 92 | 38.2 |
| 85 + | 35 | 97.5 |

Rates are per 1,000 population in specified age group.

| SELECTED CANCER SITE DEATHS | Total | | Male | | Female | |
|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate |
| All Cancers | 40 | 267.5 | 22 | 311.6 | 18 | 228.1 |
| Trachea, Bronchus, Lung, Pleura | 14 | 93.6 | 8 | 113.3 | 6 | 76.0 |
| Colorectal | 5 | 33.4 | 3 | 42.5 | 2 | 25.3 |
| Breast (female) | 3 | 20.1 | 0 | 0.0 | 3 | 38.0 |
| Prostate (male) | 2 | 13.4 | 2 | 28.3 | 0 | 0.0 |
| Pancreas | 2 | 13.4 | 1 | 14.2 | 1 | 12.7 |
| Leukemias | 2 | 13.4 | 1 | 14.2 | 1 | 12.7 |
| Non-Hodgkin's Lymphomas | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Ovary (female) | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Brain and Other Nervous System | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Stomach | 1 | 6.7 | 1 | 14.2 | 0 | 0.0 |
| Uterus and Cervix (female) | 3 | 20.1 | 0 | 0.0 | 3 | 38.0 |
| Esophagus | 1 | 6.7 | 1 | 14.2 | 0 | 0.0 |
| Melanoma of Skin | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Other | 7 | --- | 5 | --- | 2 | --- |

Rates are per 100,000 population in specified categories.

Measurements based on small denominators should be used with caution. Rates and ratios based on a denominator of less than 50 births or 1,000 population are shaded. Estimated pregnancies are the sum of births, induced terminations of pregnancy (abortions) and estimated total fetal losses. Estimated total fetal losses are equal to the sum of 20 percent of births and 10 percent of induced terminations of pregnancy. The total fertility rate is the sum of age-specific birth rates multiplied by the width of the intervals, i.e. five years. A total fertility rate of 2,100 births per 1,000 females aged 10-49 years would maintain the current population. Estimated populations are from the U.S. Census Bureau. See Appendix B for other definitions and formulas.

# GREENE 2016 HEALTH PROFILE

| SUMMARY | | |
|---|---|---|
| Total Population | | 8,422 |
| Births | | 101 |
| Deaths | | 104 |
| Median Age | | 42.3 |
| Life Expectancy at Birth | | 75.5 |
| Total Fertility Rate per 1,000 Females Aged 10-49 | | 2,082.0 |
| Marriages | Number | 40 |
| | Rate* | 4.7 |
| Divorces | Number | 4 |
| | Rate* | 0.5 |

*Rates are per 1,000 population.

| PREGNANCY/NATALITY | Females Aged 15-44 | | Females Aged 10-19 | |
|---|---|---|---|---|
| | Number | Rate | Number | Rate |
| Estimated Pregnancies | 150 | 106.8 | 18 | 34.5 |
| Births | 101 | 12.0 | 12 | 23.0 |
| Induced Terminations of Pregnancy | 26 | 18.5 | 3 | 5.8 |
| Estimated Total Fetal Losses | 23 | --- | 3 | --- |

Birth rates are per 1,000 population.
Estimated pregnancy and induced termination of pregnancy rates are per 1,000 females in specified age group.

| BIRTHS BY AGE GROUP OF MOTHER | Total | 10-14 | 15-17 | 18-19 | 20+ |
|---|---|---|---|---|---|
| All Births | 101 | 1 | 1 | 10 | 89 |
| Rate | --- | 3.7 | 6.6 | 99.2 | 62.3 |
| White | 11 | 0 | 0 | 1 | 10 |
| Rate | --- | 0.0 | 0.0 | 138.9 | 53.8 |
| Black and Other | 90 | 1 | 1 | 9 | 79 |
| Rate | --- | 4.4 | 7.1 | 96.2 | 63.6 |

Rates are per 1,000 females in specified age group.
Births with unknown age of mother are included in the age group "20+".

| LIVE BIRTHS | Females Aged 15-44 | | Females Aged 10-19 | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| Births to Unmarried Women | 76 | 75.2 | 10 | 83.3 |
| Low Weight Births | 17 | 16.8 | 2 | 16.7 |
| Multiple Births | 6 | 5.9 | 0 | 0.0 |
| Medicaid Births | 75 | 74.3 | 12 | 100.0 |

Percentages are of all births with known status for females in specified age group.

| INFANT RELATED MORTALITY BY RACE* AND MOTHER'S AGE GROUP | All Ages | | | Ages 10-19 | | |
|---|---|---|---|---|---|---|
| | All Races | White | Black and Other | All Races | White | Black and Other |
| Infant Deaths | 0 | 0 | 0 | 0 | 0 | 0 |
| Rate per 1,000 Births | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Postneonatal Deaths | 0 | 0 | 0 | 0 | 0 | 0 |
| Rate per 1,000 Births | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Neonatal Deaths | 0 | 0 | 0 | 0 | 0 | 0 |
| Rate per 1,000 Births | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

*Infant deaths are by race of child; births are by race of mother.

| 2016 ESTIMATED POPULATIONS BY AGE GROUP, RACE AND SEX | All Races | | | White | | | Black and Other | | |
|---|---|---|---|---|---|---|---|---|---|
| Age Group | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| Total | 8,422 | 4,001 | 4,421 | 1,528 | 756 | 772 | 6,894 | 3,245 | 3,649 |
| 0-4 | 498 | 242 | 256 | 63 | 32 | 31 | 435 | 210 | 225 |
| 5-9 | 547 | 272 | 275 | 51 | 26 | 25 | 496 | 246 | 250 |
| 10-14 | 543 | 285 | 258 | 63 | 38 | 25 | 480 | 247 | 233 |
| 15-44 | 2,851 | 1,446 | 1,405 | 379 | 198 | 181 | 2,472 | 1,248 | 1,224 |
| 45-64 | 2,344 | 1,055 | 1,289 | 510 | 249 | 261 | 1,834 | 806 | 1,028 |
| 65-84 | 1,392 | 624 | 768 | 393 | 189 | 204 | 999 | 435 | 564 |
| 85+ | 247 | 77 | 170 | 69 | 24 | 45 | 178 | 53 | 125 |

## GREENE 2016 HEALTH PROFILE (Continued)

| MORTALITY | All Races | | | White | | | Black and Other | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| Deaths | 104 | 50 | 54 | 22 | 10 | 12 | 82 | 40 | 42 |
| Rate per 1,000 Population | 12.3 | 12.5 | 12.2 | 14.4 | 13.2 | 15.5 | 11.9 | 12.3 | 11.5 |

| SELECTED CAUSES OF DEATH | Total | | Male | | Female | | White | | Black and Other | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Heart Disease | 31 | 368.1 | 17 | 424.9 | 14 | 316.7 | 7 | 458.1 | 24 | 348.1 |
| Cancer | 18 | 213.7 | 6 | 150.0 | 12 | 271.4 | 3 | 196.3 | 15 | 217.6 |
| Stroke | 2 | 23.7 | 0 | 0.0 | 2 | 45.2 | 0 | 0.0 | 2 | 29.0 |
| Accidents | 4 | 47.5 | 4 | 100.0 | 0 | 0.0 | 0 | 0.0 | 4 | 58.0 |
| CLRD* | 4 | 47.5 | 1 | 25.0 | 3 | 67.9 | 1 | 65.4 | 3 | 43.5 |
| Diabetes | 3 | 35.6 | 1 | 25.0 | 2 | 45.2 | 2 | 130.9 | 1 | 14.5 |
| Influenza and Pneumonia | 5 | 59.4 | 1 | 25.0 | 4 | 90.5 | 1 | 65.4 | 4 | 58.0 |
| Alzheimer's Disease | 6 | 71.2 | 3 | 75.0 | 3 | 67.9 | 3 | 196.3 | 3 | 43.5 |
| Suicide | 2 | 23.7 | 2 | 50.0 | 0 | 0.0 | 0 | 0.0 | 2 | 29.0 |
| Homicide | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| HIV Disease | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |

Rates are per 100,000 population in specified categories. *CLRD is known as Chronic Lower Respiratory Disease.

| ACCIDENTAL DEATHS | All Ages | | Ages 19 and Under | |
|---|---|---|---|---|
| | Number | Rate | Number | Rate |
| All Accidents | 4 | 47.5 | 0 | 0.0 |
| Motor Vehicle | 3 | 35.6 | 0 | 0.0 |
| Suffocation | 0 | 0.0 | 0 | 0.0 |
| Poisoning | 0 | 0.0 | 0 | 0.0 |
| Smoke, Fire and Flames | 0 | 0.0 | 0 | 0.0 |
| Falls | 0 | 0.0 | 0 | 0.0 |
| Drowning | 0 | 0.0 | 0 | 0.0 |
| Firearms | 0 | 0.0 | 0 | 0.0 |
| Other Accidents | 1 | --- | 0 | --- |

Rates are per 100,000 population in specified categories.

| DEATHS BY AGE GROUP | | |
|---|---|---|
| Age Group | Number | Rate |
| Total | 104 | 12.3 |
| 0 - 14 | 0 | 0.0 |
| 15 - 44 | 9 | 3.2 |
| 45 - 64 | 24 | 10.2 |
| 65 - 84 | 40 | 28.7 |
| 85 + | 31 | 125.5 |

Rates are per 1,000 population in specified age group.

| SELECTED CANCER SITE DEATHS | Total | | Male | | Female | |
|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate |
| All Cancers | 18 | 213.7 | 6 | 150.0 | 12 | 271.4 |
| Trachea, Bronchus, Lung, Pleura | 3 | 35.6 | 2 | 50.0 | 1 | 22.6 |
| Colorectal | 1 | 11.9 | 0 | 0.0 | 1 | 22.6 |
| Breast (female) | 4 | 47.5 | 0 | 0.0 | 4 | 90.5 |
| Prostate (male) | 3 | 35.6 | 3 | 75.0 | 0 | 0.0 |
| Pancreas | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Leukemias | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Non-Hodgkin's Lymphomas | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Ovary (female) | 1 | 11.9 | 0 | 0.0 | 1 | 22.6 |
| Brain and Other Nervous System | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Stomach | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Uterus and Cervix (female) | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Esophagus | 1 | 11.9 | 0 | 0.0 | 1 | 22.6 |
| Melanoma of Skin | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Other | 5 | --- | 1 | --- | 4 | --- |

Rates are per 100,000 population in specified categories.

Measurements based on small denominators should be used with caution. Rates and ratios based on a denominator of less than 50 births or 1,000 population are shaded. Estimated pregnancies are the sum of births, induced terminations of pregnancy (abortions) and estimated total fetal losses. Estimated total fetal losses are equal to the sum of 20 percent of births and 10 percent of induced terminations of pregnancy. The total fertility rate is the sum of age-specific birth rates multiplied by the width of the intervals, i.e. five years. A total fertility rate of 2,100 births per 1,000 females aged 10-49 years would maintain the current population. Estimated populations are from the U.S. Census Bureau. See Appendix B for other definitions and formulas.

# FAYETTE 2016 HEALTH PROFILE

| PREGNANCY/NATALITY | Females Aged 15-44 | | Females Aged 10-19 | |
|---|---|---|---|---|
| | Number | Rate | Number | Rate |
| Estimated Pregnancies | 206 | 74.3 | 13 | 13.4 |
| Births | 159 | 9.6 | 11 | 11.4 |
| Induced Terminations of Pregnancy | 14 | 5.1 | 0 | 0.0 |
| Estimated Total Fetal Losses | 33 | --- | 2 | --- |

Birth rates are per 1,000 population.
Estimated pregnancy and induced termination of pregnancy rates are per 1,000 females in specified age group.

| SUMMARY | | |
|---|---|---|
| Total Population | | 16,546 |
| Births | | 159 |
| Deaths | | 249 |
| Median Age | | 43.7 |
| Life Expectancy at Birth | | 73.9 |
| Total Fertility Rate per 1,000 Females Aged 10-49 | | 1,755.0 |
| Marriages | Number | 98 |
| | Rate* | 5.9 |
| Divorces | Number | 13 |
| | Rate* | 0.8 |

*Rates are per 1,000 population.

| BIRTHS BY AGE GROUP OF MOTHER | Total | 10-14 | 15-17 | 18-19 | 20+ |
|---|---|---|---|---|---|
| All Births | 159 | 0 | 3 | 8 | 148 |
| Rate | --- | 0.0 | 10.9 | 43.8 | 51.0 |
| White | 128 | 0 | 1 | 8 | 119 |
| Rate | --- | 0.0 | 4.3 | 51.3 | 48.1 |
| Black and Other | 31 | 0 | 2 | 0 | 29 |
| Rate | --- | 0.0 | 49.8 | 0.0 | 67.9 |

Rates are per 1,000 females in specified age group.
Births with unknown age of mother are included in the age group "20+".

| LIVE BIRTHS | Females Aged 15-44 | | Females Aged 10-19 | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| Births to Unmarried Women | 62 | 39.2 | 10 | 90.9 |
| Low Weight Births | 14 | 8.8 | 2 | 18.2 |
| Multiple Births | 4 | 2.5 | 0 | 0.0 |
| Medicaid Births | 86 | 54.1 | 8 | 72.7 |

Percentages are of all births with known status for females in specified age group.

| INFANT RELATED MORTALITY BY RACE* AND MOTHER'S AGE GROUP | All Ages | | | Ages 10-19 | | |
|---|---|---|---|---|---|---|
| | All Races | White | Black and Other | All Races | White | Black and Other |
| Infant Deaths | 1 | 0 | 1 | 0 | 0 | 0 |
| Rate per 1,000 Births | 6.3 | 0.0 | 32.3 | 0.0 | 0.0 | 0.0 |
| Postneonatal Deaths | 0 | 0 | 0 | 0 | 0 | 0 |
| Rate per 1,000 Births | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Neonatal Deaths | 1 | 0 | 1 | 0 | 0 | 0 |
| Rate per 1,000 Births | 6.3 | 0.0 | 32.3 | 0.0 | 0.0 | 0.0 |

*Infant deaths are by race of child; births are by race of mother.

| 2016 ESTIMATED POPULATIONS BY AGE GROUP, RACE AND SEX | All Races | | | White | | | Black and Other | | |
|---|---|---|---|---|---|---|---|---|---|
| Age Group | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| Total | 16,546 | 8,179 | 8,367 | 14,258 | 7,045 | 7,213 | 2,288 | 1,134 | 1,154 |
| 0-4 | 918 | 458 | 460 | 736 | 366 | 370 | 182 | 92 | 90 |
| 5-9 | 952 | 528 | 424 | 795 | 443 | 352 | 157 | 85 | 72 |
| 10-14 | 986 | 505 | 481 | 840 | 427 | 413 | 146 | 78 | 68 |
| 15-44 | 5,662 | 2,890 | 2,772 | 4,887 | 2,479 | 2,408 | 775 | 411 | 364 |
| 45-64 | 4,615 | 2,274 | 2,341 | 3,992 | 1,967 | 2,025 | 623 | 307 | 316 |
| 65-84 | 3,083 | 1,398 | 1,685 | 2,728 | 1,250 | 1,478 | 355 | 148 | 207 |
| 85+ | 330 | 126 | 204 | 280 | 113 | 167 | 50 | 13 | 37 |

## FAYETTE 2016 HEALTH PROFILE (Continued)

| MORTALITY | All Races | | | White | | | Black and Other | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| Deaths | 249 | 135 | 114 | 224 | 116 | 108 | 25 | 19 | 6 |
| Rate per 1,000 Population | 15.0 | 16.5 | 13.6 | 15.7 | 16.5 | 15.0 | 10.9 | 16.8 | 5.2 |

| SELECTED CAUSES OF DEATH | Total | | Male | | Female | | White | | Black and Other | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Heart Disease | 60 | 362.6 | 34 | 415.7 | 26 | 310.7 | 58 | 406.8 | 2 | 87.4 |
| Cancer | 61 | 368.7 | 33 | 403.5 | 28 | 334.6 | 53 | 371.7 | 8 | 349.7 |
| Stroke | 11 | 66.5 | 7 | 85.6 | 4 | 47.8 | 10 | 70.1 | 1 | 43.7 |
| Accidents | 8 | 48.4 | 6 | 73.4 | 2 | 23.9 | 7 | 49.1 | 1 | 43.7 |
| CLRD* | 19 | 114.8 | 8 | 97.8 | 11 | 131.5 | 18 | 126.2 | 1 | 43.7 |
| Diabetes | 4 | 24.2 | 3 | 36.7 | 1 | 12.0 | 3 | 21.0 | 1 | 43.7 |
| Influenza and Pneumonia | 5 | 30.2 | 1 | 12.2 | 4 | 47.8 | 5 | 35.1 | 0 | 0.0 |
| Alzheimer's Disease | 15 | 90.7 | 7 | 85.6 | 8 | 95.6 | 14 | 98.2 | 1 | 43.7 |
| Suicide | 6 | 36.3 | 5 | 61.1 | 1 | 12.0 | 5 | 35.1 | 1 | 43.7 |
| Homicide | 1 | 6.0 | 1 | 12.2 | 0 | 0.0 | 0 | 0.0 | 1 | 43.7 |
| HIV Disease | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |

Rates are per 100,000 population in specified categories.

*CLRD is known as Chronic Lower Respiratory Disease.

| ACCIDENTAL DEATHS | All Ages | | Ages 19 and Under | |
|---|---|---|---|---|
| | Number | Rate | Number | Rate |
| All Accidents | 8 | 48.4 | 0 | 0.0 |
| Motor Vehicle | 3 | 18.1 | 0 | 0.0 |
| Suffocation | 0 | 0.0 | 0 | 0.0 |
| Poisoning | 2 | 12.1 | 0 | 0.0 |
| Smoke, Fire and Flames | 1 | 6.0 | 0 | 0.0 |
| Falls | 1 | 6.0 | 0 | 0.0 |
| Drowning | 0 | 0.0 | 0 | 0.0 |
| Firearms | 0 | 0.0 | 0 | 0.0 |
| Other Accidents | 1 | --- | 0 | --- |

Rates are per 100,000 population in specified categories.

| DEATHS BY AGE GROUP | | |
|---|---|---|
| Age Group | Number | Rate |
| Total | 249 | 15.0 |
| 0 - 14 | 1 | 0.4 |
| 15 - 44 | 11 | 1.9 |
| 45 - 64 | 49 | 10.6 |
| 65 - 84 | 132 | 42.8 |
| 85 + | 56 | 169.7 |

Rates are per 1,000 population in specified age group.

| SELECTED CANCER SITE DEATHS | Total | | Male | | Female | |
|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate |
| All Cancers | 61 | 368.7 | 33 | 403.5 | 28 | 334.6 |
| Trachea, Bronchus, Lung, Pleura | 16 | 96.7 | 9 | 110.0 | 7 | 83.7 |
| Colorectal | 6 | 36.3 | 5 | 61.1 | 1 | 12.0 |
| Breast (female) | 5 | 30.2 | 0 | 0.0 | 5 | 59.8 |
| Prostate (male) | 3 | 18.1 | 3 | 36.7 | 0 | 0.0 |
| Pancreas | 5 | 30.2 | 3 | 36.7 | 2 | 23.9 |
| Leukemias | 4 | 24.2 | 4 | 48.9 | 0 | 0.0 |
| Non-Hodgkin's Lymphomas | 2 | 12.1 | 1 | 12.2 | 1 | 12.0 |
| Ovary (female) | 2 | 12.1 | 0 | 0.0 | 2 | 23.9 |
| Brain and Other Nervous System | 1 | 6.0 | 0 | 0.0 | 1 | 12.0 |
| Stomach | 1 | 6.0 | 0 | 0.0 | 1 | 12.0 |
| Uterus and Cervix (female) | 1 | 6.0 | 0 | 0.0 | 1 | 12.0 |
| Esophagus | 2 | 12.1 | 0 | 0.0 | 2 | 23.9 |
| Melanoma of Skin | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Other | 13 | --- | 8 | --- | 5 | --- |

Rates are per 100,000 population in specified categories.

Measurements based on small denominators should be used with caution. Rates and ratios based on a denominator of less than 50 births or 1,000 population are shaded. Estimated pregnancies are the sum of births, induced terminations of pregnancy (abortions) and estimated total fetal losses. Estimated total fetal losses are equal to the sum of 20 percent of births and 10 percent of induced terminations of pregnancy. The total fertility rate is the sum of age-specific birth rates multiplied by the width of the intervals, i.e. five years. A total fertility rate of 2,100 births per 1,000 females aged 10-49 years would maintain the current population. Estimated populations are from the U.S. Census Bureau. See Appendix B for other definitions and formulas.

# BIBB 2016
# HEALTH PROFILE

| PREGNANCY/NATALITY | Females Aged 15-44 | | Females Aged 10-19 | |
|---|---|---|---|---|
| | Number | Rate | Number | Rate |
| Estimated Pregnancies | 344 | 90.5 | 31 | 26.2 |
| Births | 273 | 12.1 | 25 | 21.2 |
| Induced Terminations of Pregnancy | 15 | 3.9 | 1 | 0.8 |
| Estimated Total Fetal Losses | 56 | --- | 5 | --- |

Birth rates are per 1,000 population.
Estimated pregnancy and induced termination of pregnancy rates are per 1,000 females in specified age group.

| BIRTHS BY AGE GROUP OF MOTHER | Total | 10-14 | 15-17 | 18-19 | 20+ |
|---|---|---|---|---|---|
| All Births | 273 | 0 | 6 | 19 | 248 |
| Rate | --- | 0.0 | 16.9 | 80.1 | 61.5 |
| White | 212 | 0 | 6 | 17 | 189 |
| Rate | --- | 0.0 | 21.5 | 91.2 | 59.7 |
| Black and Other | 61 | 0 | 0 | 2 | 59 |
| Rate | --- | 0.0 | 0.0 | 39.4 | 68.2 |

Rates are per 1,000 females in specified age group.
Births with unknown age of mother are included in the age group "20+".

| SUMMARY | | |
|---|---|---|
| Total Population | | 22,643 |
| Births | | 273 |
| Deaths | | 239 |
| Median Age | | 39.6 |
| Life Expectancy at Birth | | 74.1 |
| Total Fertility Rate per 1,000 Females Aged 10-49 | | 2,164.5 |
| Marriages | Number | 147 |
| | Rate* | 6.5 |
| Divorces | Number | 0 |
| | Rate* | 0.0 |

*Rates are per 1,000 population.

| LIVE BIRTHS | Females Aged 15-44 | | Females Aged 10-19 | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| Births to Unmarried Women | 129 | 47.3 | 21 | 84.0 |
| Low Weight Births | 26 | 9.5 | 2 | 8.0 |
| Multiple Births | 20 | 7.3 | 0 | 0.0 |
| Medicaid Births | 149 | 54.8 | 21 | 84.0 |

Percentages are of all births with known status for females in specified age group.

| INFANT RELATED MORTALITY BY RACE* AND MOTHER'S AGE GROUP | All Ages | | | Ages 10-19 | | |
|---|---|---|---|---|---|---|
| | All Races | White | Black and Other | All Races | White | Black and Other |
| Infant Deaths | 5 | 1 | 4 | 0 | 0 | 0 |
| Rate per 1,000 Births | 18.3 | 4.7 | 65.6 | 0.0 | 0.0 | 0.0 |
| Postneonatal Deaths | 1 | 0 | 1 | 0 | 0 | 0 |
| Rate per 1,000 Births | 3.7 | 0.0 | 16.4 | 0.0 | 0.0 | 0.0 |
| Neonatal Deaths | 4 | 1 | 3 | 0 | 0 | 0 |
| Rate per 1,000 Births | 14.7 | 4.7 | 49.2 | 0.0 | 0.0 | 0.0 |

*Infant deaths are by race of child; births are by race of mother.

| 2016 ESTIMATED POPULATIONS BY AGE GROUP, RACE AND SEX | All Races | | | White | | | Black and Other | | |
|---|---|---|---|---|---|---|---|---|---|
| Age Group | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| Total | 22,643 | 12,145 | 10,498 | 17,334 | 8,873 | 8,461 | 5,309 | 3,272 | 2,037 |
| 0-4 | 1,274 | 642 | 632 | 948 | 469 | 479 | 326 | 173 | 153 |
| 5-9 | 1,256 | 650 | 606 | 985 | 510 | 475 | 271 | 140 | 131 |
| 10-14 | 1,296 | 700 | 596 | 1,041 | 571 | 470 | 255 | 129 | 126 |
| 15-44 | 9,145 | 5,345 | 3,800 | 6,493 | 3,474 | 3,019 | 2,652 | 1,871 | 781 |
| 45-64 | 6,178 | 3,242 | 2,936 | 4,870 | 2,508 | 2,362 | 1,308 | 734 | 574 |
| 65-84 | 3,172 | 1,465 | 1,707 | 2,740 | 1,254 | 1,486 | 432 | 211 | 221 |
| 85+ | 322 | 101 | 221 | 257 | 87 | 170 | 65 | 14 | 51 |

| MORTALITY | All Races | | | White | | | Black and Other | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| Deaths | 239 | 139 | 100 | 203 | 114 | 89 | 36 | 25 | 11 |
| Rate per 1,000 Population | 10.6 | 11.4 | 9.5 | 11.7 | 12.8 | 10.5 | 6.8 | 7.6 | 5.4 |

| SELECTED CAUSES OF DEATH | Total | | Male | | Female | | White | | Black and Other | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Heart Disease | 63 | 278.2 | 38 | 312.9 | 25 | 238.1 | 52 | 300.0 | 11 | 207.2 |
| Cancer | 55 | 242.9 | 33 | 271.7 | 22 | 209.6 | 48 | 276.9 | 7 | 131.9 |
| Stroke | 15 | 66.2 | 8 | 65.9 | 7 | 66.7 | 15 | 86.5 | 0 | 0.0 |
| Accidents | 26 | 114.8 | 15 | 123.5 | 11 | 104.8 | 20 | 115.4 | 6 | 113.0 |
| CLRD* | 13 | 57.4 | 8 | 65.9 | 5 | 47.6 | 12 | 69.2 | 1 | 18.8 |
| Diabetes | 2 | 8.8 | 1 | 8.2 | 1 | 9.5 | 2 | 11.5 | 0 | 0.0 |
| Influenza and Pneumonia | 8 | 35.3 | 8 | 65.9 | 0 | 0.0 | 7 | 40.4 | 1 | 18.8 |
| Alzheimer's Disease | 7 | 30.9 | 1 | 8.2 | 6 | 57.2 | 7 | 40.4 | 0 | 0.0 |
| Suicide | 4 | 17.7 | 3 | 24.7 | 1 | 9.5 | 4 | 23.1 | 0 | 0.0 |
| Homicide | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| HIV Disease | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |

Rates are per 100,000 population in specified categories.

*CLRD is known as Chronic Lower Respiratory Disease.

| ACCIDENTAL DEATHS | All Ages | | Ages 19 and Under | |
|---|---|---|---|---|
| | Number | Rate | Number | Rate |
| All Accidents | 26 | 114.8 | 2 | 38.9 |
| Motor Vehicle | 10 | 44.2 | 1 | 19.5 |
| Suffocation | 1 | 4.4 | 0 | 0.0 |
| Poisoning | 7 | 30.9 | 0 | 0.0 |
| Smoke, Fire and Flames | 0 | 0.0 | 0 | 0.0 |
| Falls | 4 | 17.7 | 0 | 0.0 |
| Drowning | 1 | 4.4 | 1 | 19.5 |
| Firearms | 0 | 0.0 | 0 | 0.0 |
| Other Accidents | 3 | --- | 0 | --- |

Rates are per 100,000 population in specified categories.

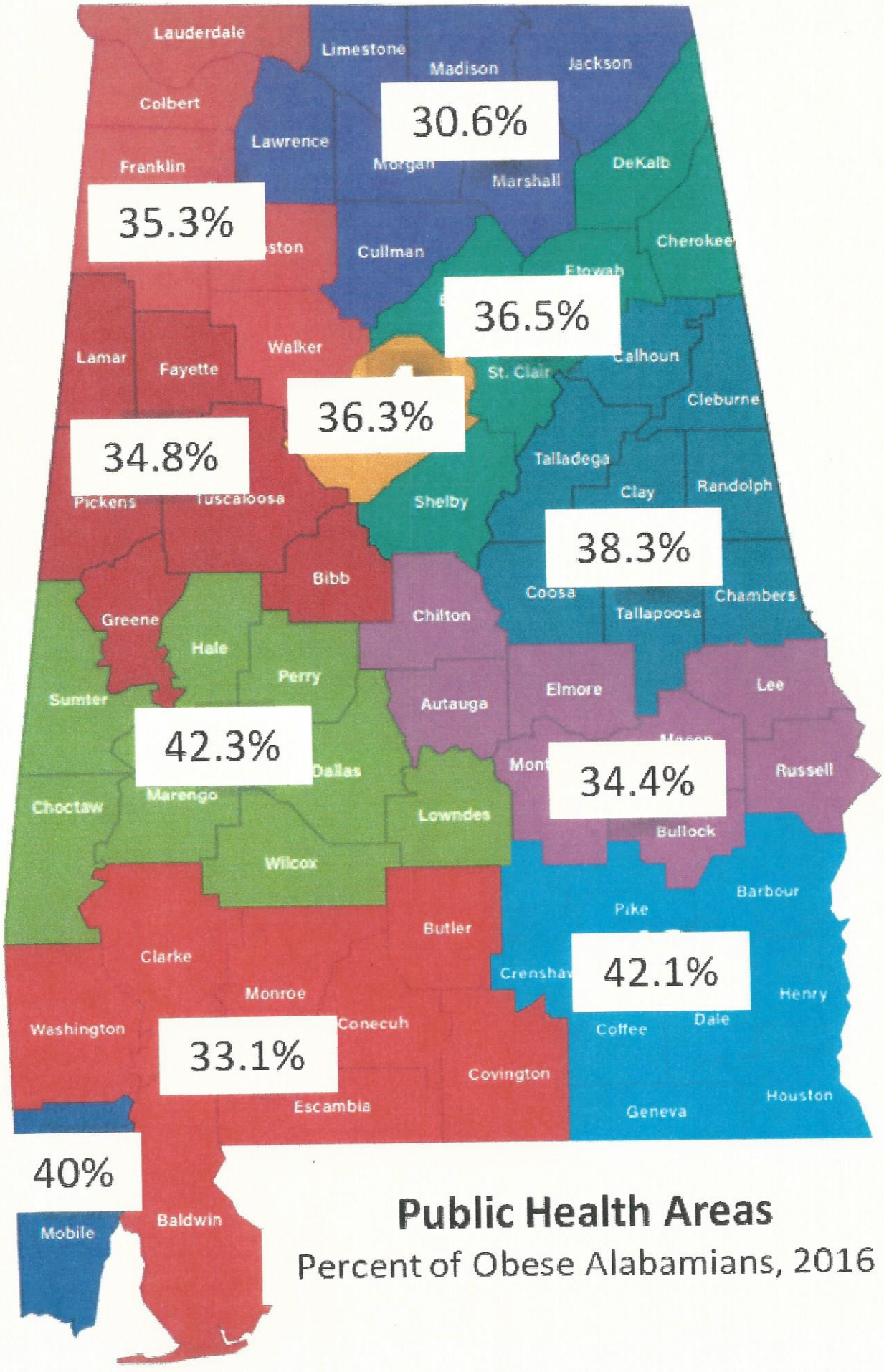
| DEATHS BY AGE GROUP | | |
|---|---|---|
| Age Group | Number | Rate |
| Total | 239 | 10.6 |
| 0 - 14 | 5 | 1.3 |
| 15 - 44 | 20 | 2.2 |
| 45 - 64 | 56 | 9.1 |
| 65 - 84 | 117 | 36.9 |
| 85 + | 41 | 127.3 |

Rates are per 1,000 population in specified age group.

| SELECTED CANCER SITE DEATHS | Total | | Male | | Female | |
|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate |
| All Cancers | 55 | 242.9 | 33 | 271.7 | 22 | 209.6 |
| Trachea, Bronchus, Lung, Pleura | 13 | 57.4 | 8 | 65.9 | 5 | 47.6 |
| Colorectal | 7 | 30.9 | 6 | 49.4 | 1 | 9.5 |
| Breast (female) | 3 | 13.2 | 0 | 0.0 | 3 | 28.6 |
| Prostate (male) | 2 | 8.8 | 2 | 16.5 | 0 | 0.0 |
| Pancreas | 1 | 4.4 | 1 | 8.2 | 0 | 0.0 |
| Leukemias | 3 | 13.2 | 3 | 24.7 | 0 | 0.0 |
| Non-Hodgkin's Lymphomas | 2 | 8.8 | 1 | 8.2 | 1 | 9.5 |
| Ovary (female) | 4 | 17.7 | 0 | 0.0 | 4 | 38.1 |
| Brain and Other Nervous System | 3 | 13.2 | 2 | 16.5 | 1 | 9.5 |
| Stomach | 2 | 8.8 | 1 | 8.2 | 1 | 9.5 |
| Uterus and Cervix (female) | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Esophagus | 1 | 4.4 | 1 | 8.2 | 0 | 0.0 |
| Melanoma of Skin | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Other | 14 | --- | 8 | --- | 6 | --- |

Rates are per 100,000 population in specified categories.

Measurements based on small denominators should be used with caution. Rates and ratios based on a denominator of less than 50 births or 1,000 population are shaded. Estimated pregnancies are the sum of births, induced terminations of pregnancy (abortions) and estimated total fetal losses. Estimated total fetal losses are equal to the sum of 20 percent of births and 10 percent of induced terminations of pregnancy. The total fertility rate is the sum of age-specific birth rates multiplied by the width of the intervals, i.e. five years. A total fertility rate of 2,100 births per 1,000 females aged 10-49 years would maintain the current population. Estimated populations are from the U.S. Census Bureau. See Appendix B for other definitions and formulas.



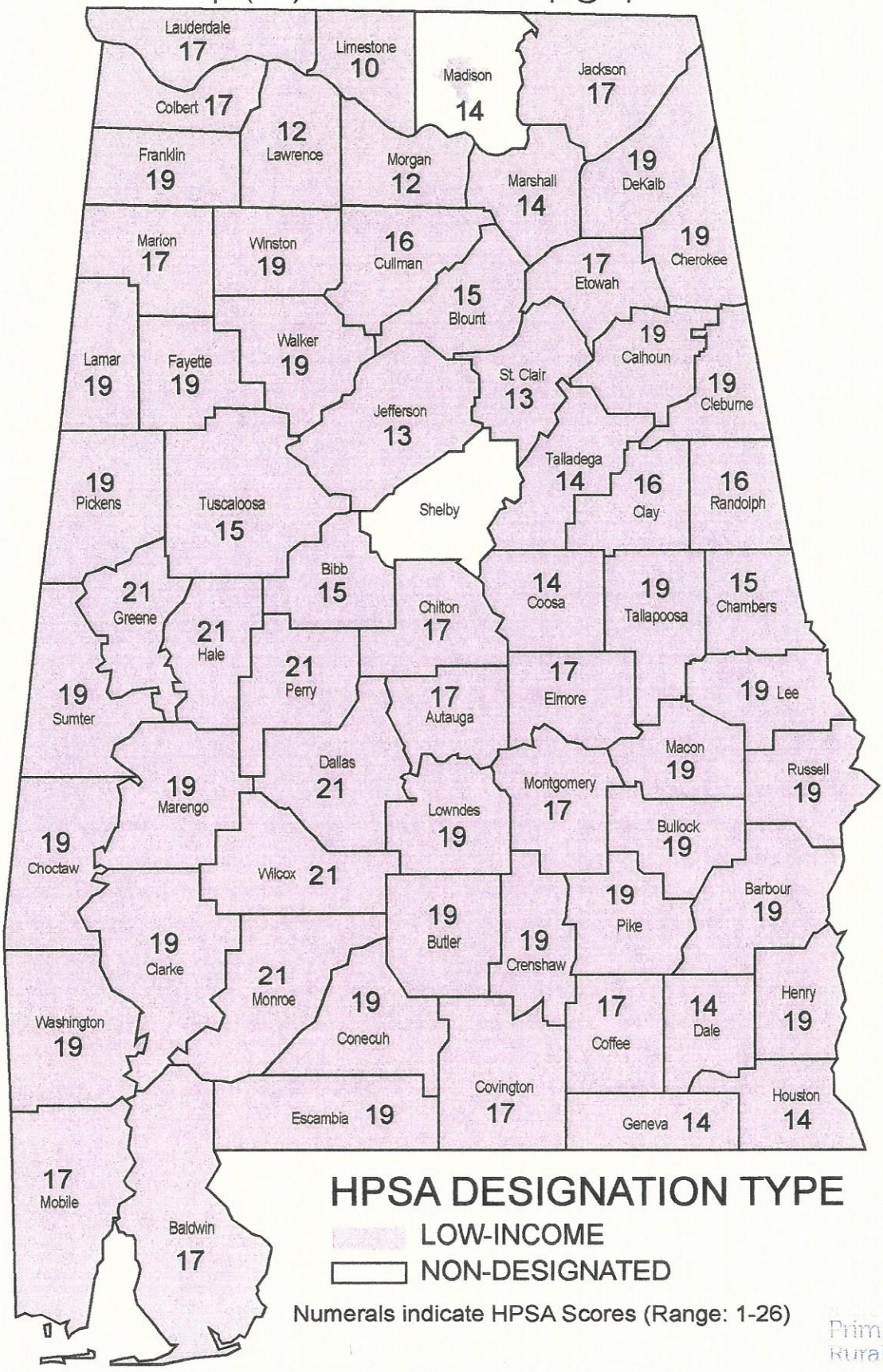

# Public Health Areas

Percent of Obese Alabamians, 2016

# Medically Underserved Areas/Populations (MUA/Ps)

# Dental Health Professional Shortage Areas
## October 2017

Niko Phillips (334) 206-3807 or Niko.Phillips@adph.state.al.us




## HPSA DESIGNATION TYPE

LOW-INCOME

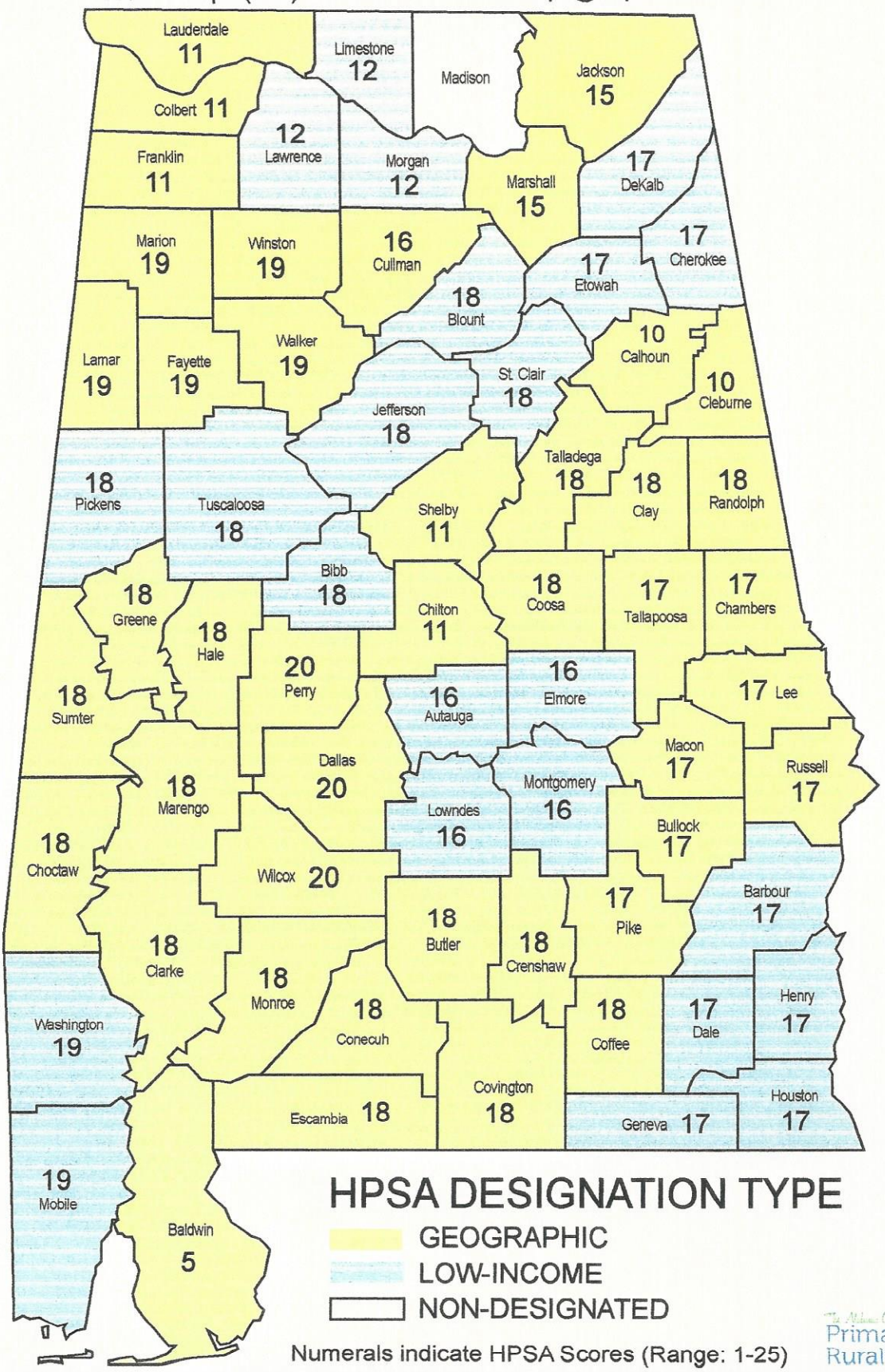
NON-DESIGNATED

Numerals indicate HPSA Scores (Range: 1-26)

PrimaryCare RuralHealth

# Mental Health Professional Shortage Areas
## August 2018

Niko Phillips (334) 206-3807 or Niko.Phillips@adph.state.al.us




## HPSA DESIGNATION TYPE

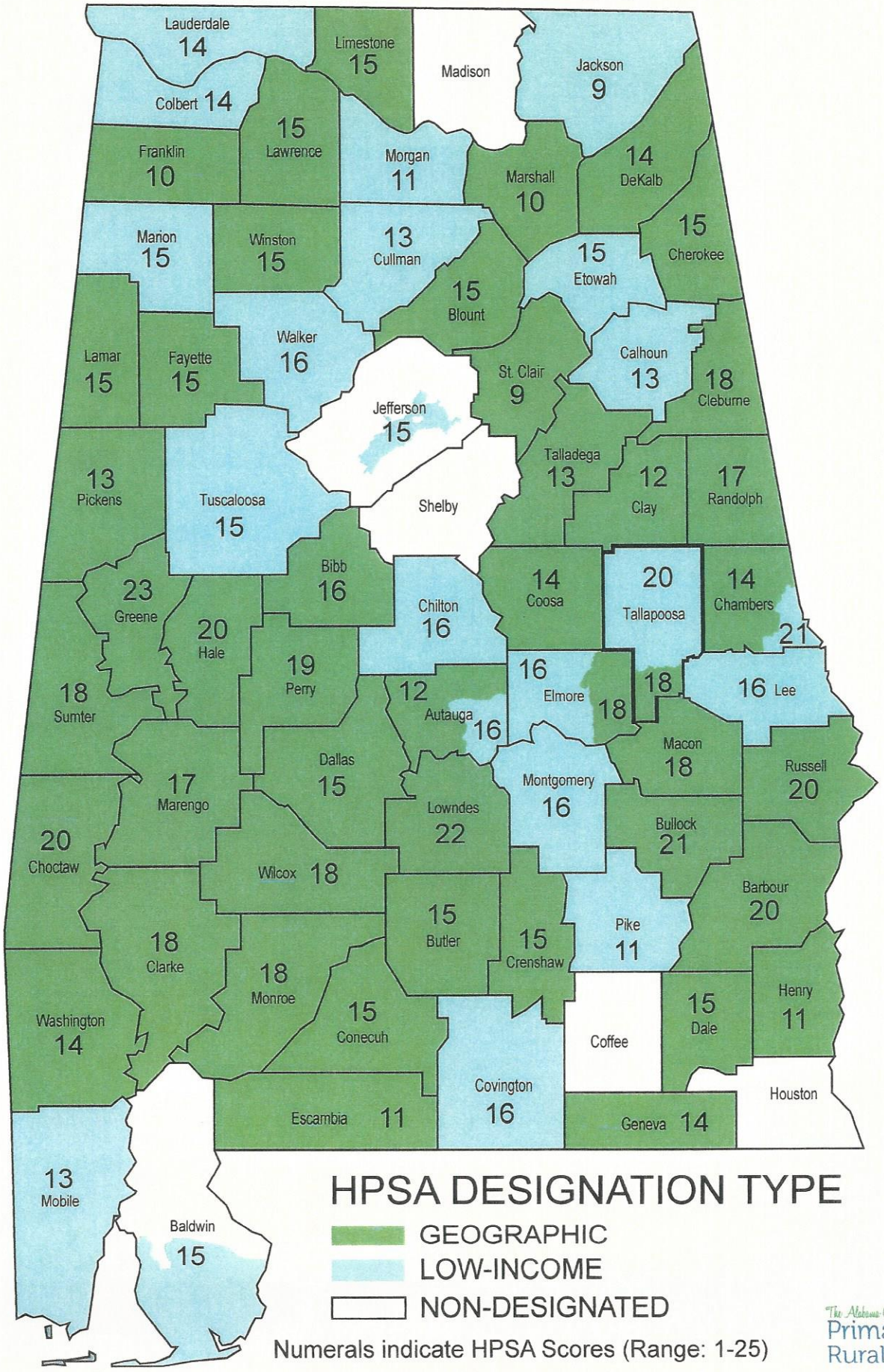
- GEOGRAPHIC
- LOW-INCOME
- NON-DESIGNATED

Numerals indicate HPSA Scores (Range: 1-25)

The National Office of Primary Care & Rural Health

# Primary Care Health Professional Shortage Areas
## January 2019

Danita Crear (334) 206-2925 or Danita.Crear@adph.state.al.us




## HPSA DESIGNATION TYPE

- GEOGRAPHIC
- LOW-INCOME
- NON-DESIGNATED

Numerals indicate HPSA Scores (Range: 1-25)

The Alabama Office of Primary Care & Rural Health

# Appendix B

County Health
Rankings & Roadmaps
Building a Culture of Health, County by County

# Compare Counties

## 2018 Rankings

| | Alabama | Fayette (FA), AL X | Lamar (LA), AL X | Bibb (BI), AL X | Greene (GR), AL X | Hale (HA), AL X | Tuscaloosa (TU), AL X | Pickens (PI), Al X |
|---|---|---|---|---|---|---|---|---|
| Health Outcomes | | 23 | 37 | 41 | 66 | 54 | 15 | 52 |
| Length of Life | | 31 | 22 | 53 | 63 | 35 | 9 | 40 |
| Premature death | 9,600 | 10,300 | 9,700 | 11,700 | 14,000 | 10,600 | 8,400 | 10,700 |
| Quality of Life | | 27 | 46 | 25 | 67 | 60 | 38 | 51 |
| Poor or fair health | 21% | 20% | 25% | 20% | 34% | 27% | 21% | 25% |
| Poor physical health days | 4.4 | 4.6 | 4.9 | 4.4 | 5.6 | 5.2 | 4.5 | 5.0 |
| Poor mental health days | 4.6 | 4.6 | 5.0 | 4.3 | 5.3 | 5.0 | 4.7 | 4.8 |
| Low birthweight | 10% | 10% | 10% | 11% | 15% | 14% | 11% | 13% |
| Health Factors | | 27 | 33 | 37 | 64 | 59 | 11 | 46 |
| Health Behaviors | | 34 | 30 | 39 | 65 | 59 | 22 | 42 |
| Adult smoking | 22% | 20% | 21% | 20% | 24% | 22% | 20% | 21% |
| Adult obesity** | 35% | 36% | 34% | 38% | 42% | 41% | 33% | 35% |
| Food environment index** | 5.6 | 7.7 | 7.6 | 7.6 | 3.0 | 6.0 | 6.9 | 6.8 |
| Physical inactivity** | 29% | 37% | 34% | 38% | 32% | 34% | 28% | 29% |
| Access to exercise opportunities | 63% | 46% | 18% | 49% | 6% | 30% | 68% | 6% |
| Excessive drinking | 14% | 15% | 14% | 16% | 10% | 13% | 19% | 14% |
| Alcohol-impaired driving deaths | 26% | 33% | 31% | 28% | 24% | 26% | 28% | 38% |
| Sexually transmitted infections** | 543.6 | 456.3 | 362.1 | 302.1 | 853.5 | 955.0 | 615.2 | 545.1 |
| Teen births | 36 | 44 | 44 | 47 | 43 | 39 | 24 | 38 |
| Clinical Care | | 36 | 56 | 42 | 29 | 38 | 4 | 45 |
| Uninsured | 12% | 12% | 13% | 12% | 12% | 12% | 10% | 13% |
| Primary care physicians | 1,530:1 | 990:1 | | 1,880:1 | 1,700:1 | 5,020:1 | 1,380:1 | 2,980:1 |
| Dentists | 2,140:1 | 3,310:1 | 4,640:1 | 4,530:1 | 8,420:1 | 7,480:1 | 2,040:1 | 10,160:1 |
| Mental health providers | 1,180:1 | 8,270:1 | 6,960:1 | 11,320:1 | 8,420:1 | 14,950:1 | 860:1 | 6,770:1 |
| Preventable hospital stays | 62 | 86 | 77 | 93 | 75 | 72 | 66 | 85 |
| Diabetes monitoring | 85% | 80% | 83% | 82% | 87% | 82% | 85% | 88% |
| Mammography screening | 63% | 56% | 53% | 61% | 59% | 67% | 71% | 59% |
| Social & Economic Factors | | 30 | 21 | 42 | 65 | 54 | 16 | 49 |
| High school graduation** | 89% | 93% | 88% | 85% | 88% | 86% | 85% | 90% |
| Some college | 60% | 52% | 53% | 50% | 42% | 47% | 64% | 54% |
| Unemployment | 6.0% | 7.0% | 5.7% | 6.6% | 10.1% | 7.8% | 5.8% | 6.9% |
| Children in poverty | 25% | 29% | 27% | 28% | 49% | 35% | 22% | 37% |
| Income inequality | 5.3 | 5.1 | 4.6 | 4.2 | 5.3 | 6.0 | 5.0 | 6.3 |
| Children in single-parent households | 38% | 30% | 30% | 31% | 69% | 56% | 39% | 50% |
| Social associations | 12.3 | 11.3 | 8.6 | 10.6 | 11.8 | 6.0 | 11.6 | 12.9 |
| Violent crime** | 436 | 179 | 162 | 147 | 886 | 194 | 415 | 221 |
| Injury deaths | 77 | 95 | 71 | 96 | 86 | 67 | 60 | 92 |
| Physical Environment | | 12 | 53 | 29 | 21 | 62 | 36 | 18 |

| | Alabama | Fayette (FA), AL X | Lamar (LA), AL X | Bibb (BI), AL X | Greene (GR), AL X | Hale (HA), AL X | Tuscaloosa (TU), AL X | Pickens (PI), Al X |
|---|---|---|---|---|---|---|---|---|
| Air pollution - particulate matter | 10.1 | 10.0 | 9.7 | 10.5 | 9.6 | 9.9 | 10.7 | 9.9 |
| Drinking water violations | | No | Yes | No | No | No | No | No |
| Severe housing problems | 15% | 11% | 13% | 12% | 15% | 20% | 17% | 17% |
| Driving alone to work | 86% | 85% | 84% | 85% | 84% | 90% | 85% | 82% |
| Long commute - driving alone | 33% | 36% | 37% | 49% | 51% | 45% | 24% | 46% |

** Compare across states with caution
Note: Blank values reflect unreliable or missing data

# The Burden of Diabetes in Alabama

American Diabetes Association.

**Diabetes is an epidemic in the United States.** According to the Centers for Disease Control and Prevention (CDC), over 30 million Americans have diabetes and face its devastating consequences. What's true nationwide is also true in Alabama.

## ALABAMA'S DIABETES EPIDEMIC:

Approximately **634,000 people in Alabama,** or 15.4% of the adult population, **have diabetes.**

- Of these, an estimated **127,000 have diabetes but don't know it,** greatly increasing their health risk.
- In addition, **1,334,000 people in Alabama,** 37% of the adult population, **have prediabetes** with blood glucose levels higher than normal but not yet high enough to be diagnosed as diabetes.
- **Every year** an estimated **31,000 people in Alabama** are diagnosed with diabetes.

**Diagnosed diabetes costs an estimated $5.9 billion in Alabama each year.**
The serious complications include heart disease, stroke, amputation, end-stage kidney disease, blindness—and death.

## DIABETES IS EXPENSIVE:

People with diabetes have **medical expenses approximately 2.3 times higher** than those who do not have diabetes.

- Total **direct medical expenses** for diagnosed diabetes in Alabama were estimated at **$4.2 billion in 2017.**
- In addition, another **$1.7 billion** was spent on **indirect costs** from lost productivity due to diabetes.

## IMPROVING LIVES, PREVENTING DIABETES AND FINDING A CURE:

In 2018, the **National Institute of Diabetes and Digestive and Kidney Diseases** at the National Institutes of Health invested **$26,840,952** in diabetes-related research projects in Alabama.

The **Division of Diabetes Translation** at the CDC provided **$1,821,128** in diabetes prevention and educational grants in Alabama in 2018.


Sources include:

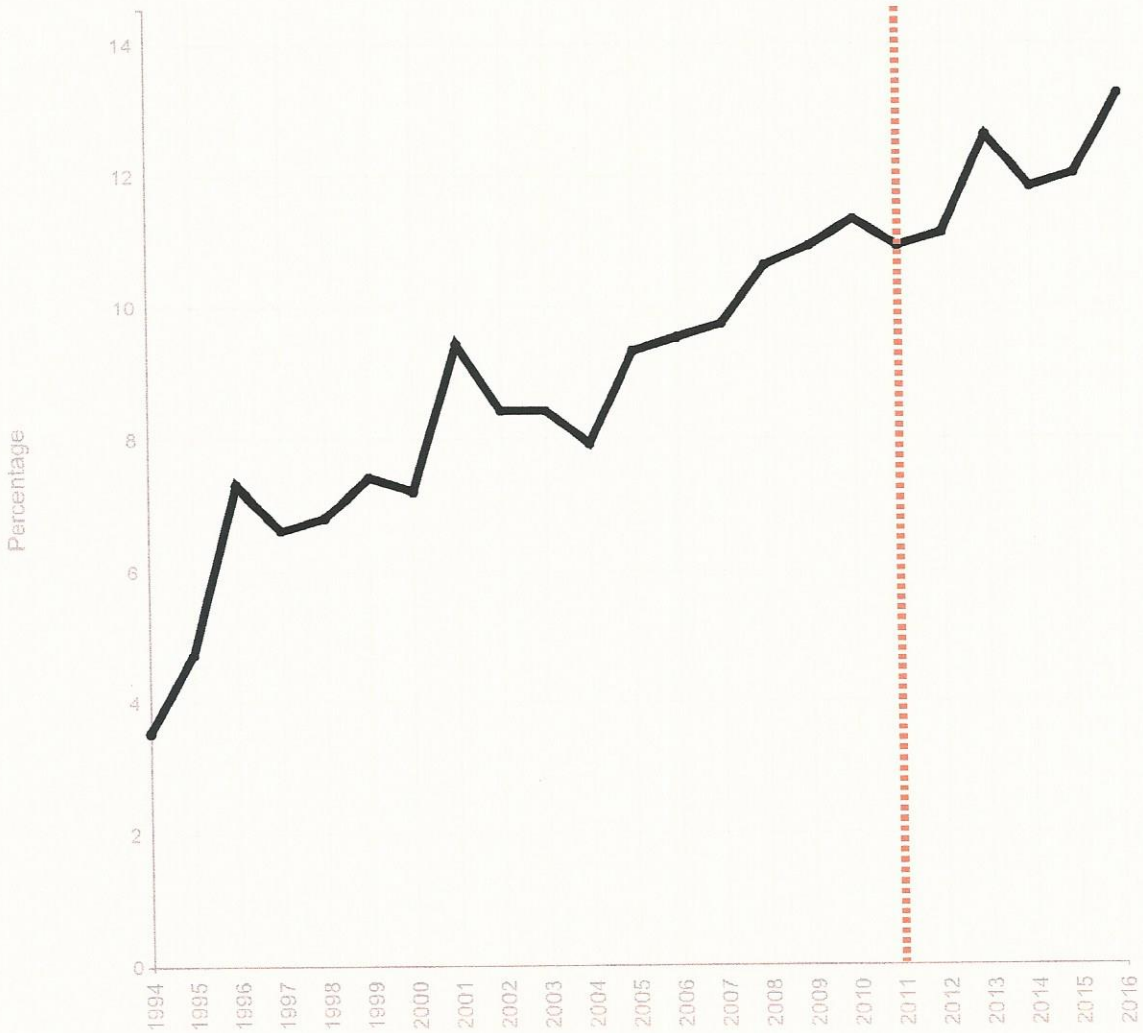
- Diabetes Prevalence: 2015 state diagnosed diabetes prevalence, cdc.gov/diabetes/data; 2012 state undiagnosed diabetes prevalence, Dall et al., "The Economic Burden of Elevated Blood Glucose Levels in 2012", Diabetes Care, December 2014, vol. 37.
- Diabetes Incidence: 2015 state diabetes incidence rates, cdc.gov/diabetes/data
- Cost: American Diabetes Association, "Economic Costs of Diabetes in the U.S. in 2017", Diabetes Care, May 2018.
- Research expenditures: 2018 NIDDK funding, projectreporter.nih.gov; 2018 CDC diabetes funding, www.cdc.gov/fundingprofiles

## Diagnosed Diabetes Read more...

Search Geography... Alabama Indicators Data Filters

TOTAL AGE GENDER EDUCATION

Diagnosed Diabetes,
Total, Adults with Diabetes, Age-Adjusted Percentage, Alabama




Vertical dotted line indicates major changes to the survey methods in 2011
(http://www.cdc.gov/SurveillancePractice/reports/brfss/brfss.html)
Horizontal dotted line indicates "No Data", "Suppressed Data" or both.

Diagnosed Diabetes,
Total, Adults with Diabetes, Age-Adjusted Percentage, Alabama

| Year | Total | | |
|---|---|---|---|
| | Percentage | LL | UL |
| 2004 | 7.9 | 7.0 | 8.8 |
| 2005 | 9.3 | 8.3 | 10.4 |
| 2006 | 9.5 | 8.5 | 10.6 |
| 2007 | 9.7 | 9.0 | 10.6 |
| 2008 | 10.6 | 9.7 | 11.5 |
| 2009 | 10.9 | 10.0 | 11.9 |
| 2010 | 11.3 | 10.4 | 12.3 |
| 2011 | 10.9 | 10.1 | 11.7 |
| 2012 | 11.1 | 10.3 | 11.9 |
| 2013 | 12.6 | 11.7 | 13.7 |

Showing 11 to 20 of 23 entries Previous 1 2 3 Next

Major changes to the survey methods in 2011
(http://www.cdc.gov/SurveillancePractice/reports/brfss/brfss.html)
* indicates 'No Data', ** indicates 'Suppressed Data', LL - Lower Limit, UL - Upper Limit

| Year | Total | | |
|---|---|---|---|
| | Percentage | LL | UL |
| 2014 | 11.8 | 11.0 | 12.6 |
| 2015 | 12.0 | 11.2 | 12.9 |
| 2016 | 13.2 | 12.2 | 14.2 |

Showing 21 to 23 of 23 entries Previous 1 2 3 Next

Major changes to the survey methods in 2011
(http://www.cdc.gov/SurveillancePractice/reports/brfss/brfss.html)
* indicates 'No Data', ** indicates 'Suppressed Data', LL - Lower Limit, UL - Upper Limit