ALABAMA
STATE HEALTH PLAN

2014-2017

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STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
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Chapter 410-2-1
Introduction to Health Planning

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410-2-1-.01 **Statutory Authority**. The *Alabama State Health Plan* (SHP) is required by § 22-21-260(4), Code of Alabama, 1975.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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410-2-1-.02 **Health Planning Structure in Alabama**

(1) The Alabama Statewide Health Coordinating Council (SHCC) is charged by statute and the Governor to prepare a *State Health Plan* (SHP) every three years. Revisions may be accomplished as necessary, however the SHCC is required to review, and where appropriate revise, the SHP on at least an annual basis. The *State Health Plan* shall be utilized by the Certificate of Need (CON) Review Board pursuant to § 22-21-264, Code of Alabama, 1975, in the CON review process, and by other entities to guide the overall health systems development and operation in Alabama. The provisions of this plan are severable. If any part of this plan is declared invalid or unconstitutional, that declaration shall not affect the part, which remains.

(2) The SHCC shall consist of not less than 16 members, the majority of whom shall be consumers. They are appointed by the Governor for staggered terms of one (1) to three (3) years and shall serve until reappointed or a replacement is appointed.

(3) The SHCC chairman shall appoint committees and/or task forces to address specific subjects of the SHP. Committees shall be composed of only SHCC members. Task forces may have SHCC and non-SHCC members. Committee reports shall be directed to the SHCC. Task force reports may or may not be presented directly to the SHCC at the discretion of the SHCC chairman. The total SHCC shall hear and make decisions on the acceptance or adoption of the

SHP, and any amendments/adjustments thereto. Statistical updates to reflect more current population and utilization data may be accomplished by staff with the approval of the SHCC chairman.

(4) The Governor is the final approval authority for the SHP and any amendments/adjustments by the SHCC, subject to the provisions of the Alabama Administrative Procedures Act (APA).

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: §§ 22-21-260(2) and (4), 22-21-264, and 22-4-7, Code of Alabama, 1975.
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410-2-1-.03 **Alabama Health Policy Analysis**

(1) Policy is defined as a definite course or method of action selected from among alternatives and in light of given conditions to guide and determine present and future decisions. Policy may be expressed in writing or it may be implied by actions and commitments. Action policy may imply, in fact, that no policy is desired, thereby leaving the decision makers free to meet any given condition with actions that may or may not be considered as precedent setting.

(2) Basic to analyzing Alabama State Health Policy is the determination of who sets the policies and how or to what degree these policies interface to meet a general overall health policy.

(3) Health policy in Alabama finds its basis in State statutes as determined by the Legislature, State budgets, decisions and expectations of the Governor, expressions of the Statewide Health Coordinating Council in the State Health Plan, and regulatory decisions made by the State Certificate of Need Review Board.

(4) The Governor, through his cabinet and legislative programs, expresses a general health policy for maximizing a high rate of wellness for all citizens. His actions indicate a special concern for child health, infant mortality, prevention, the socio/medical problems of teenage pregnancy, the availability and accessibility of health care in the rural areas, and the special health problems of the elderly, mentally ill, and disabled. His concerns are manifested in his budget requests and funding in these areas through the various state agencies, such as the State Health Planning and Development Agency, the Alabama Medicaid Agency, the Department of Mental Health and Mental Retardation, the Department of Public Health, and the Department of Human Resources.

(5) The Governor's concern for overall health planning and development is highlighted by his appointment of providers and consumers to function in the planning and regulatory areas.

Author: Statewide Health Coordinating Council (SHCC).
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410-2-1-.04 **Data Collection and Publication**

(1) Efficient health planning and Certificate of Need decisions are dependent upon the availability of reliable health care data. Accurate inventories of existing resources and accurate utilization statistics are required in the *State Health Plan* to continue accurately projecting the need for additional health care facilities, equipment, and services that are subject to regulation herein.

(2) In 2002 SHPDA reviewed its existing data collection and processing equipment, databases and procedures. SHPDA staff concluded that improvements were needed and purchased upgraded computers and software to match the software being utilized in the private sector. During this time SHPDA staff contracted with the Finance Department Information Systems Division (ISD) to reprogram all existing databases. This reprogramming was due to several factors found in the review, such as incorrect formulas being used in the calculations on reports. The newly hired data manager for SHPDA also recommended several changes in distribution and future collection of data:

(a) Stage I, Near Term. The data department will offer reports via electronic mail (E-Mail), compact disc (CD), and other electronic means. Staff has adopted Adobe Acrobat as the software to translate all database reports. This was due to its portability and the fact that there is a free viewer for this program. Utilizing this technology has reduced the cost in disseminating data reports to the various purchasers; it has also allowed most data requests to be fulfilled in a manner that allows the purchaser to receive their data within hours instead of days. The SHPDA website was also overhauled from being a static collection of pages to a continually updated website with current information. The new site contains all meeting announcements, information on currently collected data, helpful forms, and links to other agencies.

(b) Stage I, Longer Term. Additional equipment was purchased due to the increase in data collection. The increase in data collection was due to the creation of new annual reports on Specialty Care Assisted Living Facilities (SCALF), Assisted Living Facilities (ALF), the expansion of the April Patient Origin Survey to a bi-annual survey covering April and October discharges and plans for other data collection surveys.

(c) Stage II. Once all new types of surveys have been identified and created SHPDA will consider integrating existing database structures into a data warehouse structure broken down by facility and/or survey type. This data warehouse structure will allow staff, consultants, and any other interested parties to extract historical information for use in planning of future projects.

(d) Stage III. In 2003 SHPDA received a grant from the Centers for Disease Control and Prevention (CDC) via the Alabama Department of Public Health (ADPH). This grant allowed SHPDA to purchase an additional server and a high-end workstation for data processing. SHPDA is continuously evaluating existing grants and searching for new grants to assist the department in data collection.

(e) Stage IV. SHPDA will continue to investigate future technologies to ease the burden on health care centers in complying with data requests. These technologies may include but are not limited to web based data entry forms or electronic submission of existing data reports. Due to the sensitive nature of health care data and the newly adopted HIPAA (Health Insurance Portability and Accountability Act) strict security will be implemented on any and all file sharing activities.

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410-2-1-.05 **Overview of Chapters**

(1) The Alabama State Health Plan is basically divided into five chapters.

(2) Chapter I contains the Statutory Authority, the Health Planning Structure in Alabama, the Alabama Health Policy Analysis, Data Collection and Publication, and the Overview of the State Health Plan.

(3) Chapter II provides an identification and summary of the health care priorities in Alabama. The health care priorities should be assessed each year to maintain a current reflection of issues.

(4) Chapters III and IV focus on physical resources. These chapters identify both existing and needed health care resources. The planning methodologies for such resources as assisted living beds, nursing home beds, and acute care beds are based on economic and social criteria for health care resources allocation

(5) Chapter V is the Appendix. This chapter contains support data and other information pertinent to the *State Health Plan* of such detail that it is best included in the Appendix.

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Chapter 410-2-2
Health Priorities

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410-2-2-.01 **Introduction**

(1) This section of the *Alabama State Health Plan* underscores certain health issues which warrant focused attention. These few issues have been selected for a variety of reasons, including:

(a) Unusual Severity in Our State, e.g. Infant Mortality.

(b) Special Opportunities, e.g. The Medicaid Omnibus Budget Reconciliation Act (OBRA) option.

(c) Problems of Access to Health Care, e.g. The Issue of the Uninsured and the Vulnerability of Rural Hospitals.

(2) When resources are limited and needs great, focused attention on the most pressing problems will promote optimal use of any new or additional investments. What follows is a review of the health issues and health concerns, which require priority emphasis in Alabama.

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410-2-2-.02 **Maternal and Child Health**

(1) The Problem

(a) Alabama's infant mortality was 13.3 per 1,000 live births in 1988. In 2002 the provisional rate improved to 9.1 deaths per 1,000 live births, a significant drop from the 1988 rate and is the lowest rate recorded in history. Reasons for the improvements include a number of factors related primarily to improved Medicaid coverage.

1. Medicaid has been expanded to serve more children and pregnant women who do not receive cash assistance such as Aid to Families with Dependent Children. This trend started in 1988 with expansion of eligibility to pregnant women and children up to age one with incomes under 100 percent of the federal poverty level and now up to 133 percent of the federal poverty level.

2. Medicaid's Maternity Care Program is statewide and Medicaid pays for approximately one-half of all deliveries. The Program continues to be successful in reducing the need for neonatal intensive care and hospital readmissions in the first year of life. The Program involves a primary provider that coordinates total care for the patient throughout pregnancy and until after the baby is born. Important components are case management, home visits and outreach.

3. As of September 1, 1991, Medicaid had workers out-stationed at hospitals, county health departments and other health facilities throughout the state to determine Medicaid eligibility for children and pregnant women who need help with payment for health care but who do not qualify for cash assistance.

4. Medicaid Targeted Case Management for Medically At-Risk Children was implemented through Alabama Department of Public Health (ADPH) in 1999. This program provides case management for Patient First recipients referred by private medical and dental providers in health department case managers.

5. The ADPH, in collaboration with the Alabama Department of Human Resources, implemented the Alabama Unwed Pregnancy Prevention Program (AUPPP) in 2001 and the Family Planning Teen Care Coordination Program in 2002. The AUPPP addresses adolescent pregnancy and unwed pregnancy by providing funding support to community-based projects, a statewide teen pregnancy prevention campaign, and media outreach. The teen care coordination program provides medical social support to teen's age 18 and under receiving family planning services in local health departments.

6. Other programs implemented by the ADPH that are affecting infant mortality include the Alabama Child Death Review Program legislated in 1997, a campaign addressing "back-to-sleep", a "safety for sleeping babies" brochure, and folic acid outreach.

(b) Progress has been made in Maternal and Child Health in the state. In 2001, Alabama's infant mortality rate was 9.5%, and in 2002 declined to 9.1%. In "real terms", 538 of Alabama's babies failed to reach their first birthday in 2002. Those at highest risk for infant

mortality are infants born to blacks, single mothers, teenagers, and the socio-economically disadvantaged. Almost twenty-nine percent (29%) of Alabama's population is black and other. Approximately one-third of the births in 2001 (34.4%) were to unmarried women, and 14.9 percent of infants resulted from teenage pregnancies.

(c) Infant death is not the only problem associated with high-risk birth. Research indicates that for every baby who dies, three more are born with handicapping conditions. In 2001, there were 9.6% of babies, which were low birth weight, putting them at greater risk for handicapping conditions.

(d) Alabama's women and children must receive adequate health care--health care that is primarily preventive, appropriate for the need, and available. Barriers to care include the following:

1. Outreach Efforts. Outreach efforts at the local community level are varied and sometimes nonexistent. Some children do not receive the minimal recommended number of preventive health care visits as outlined by the American Academy of Pediatrics, thus immunization rates for these infants and young children are low, and conditions that could be identified through routine screening exams go untreated.

2. Perinatal Services. Several components of the perinatal system are not available in all areas of the state. These components are obstetrical and neonatal outreach education, maternal-fetal and newborn transport systems, and high-risk infant-follow-up. Case management to include tracking and follow-up for women and infants is not available in some areas. There is a need for additional social workers at the local level to provide these services.

(2) Recommendations

(a) Improve the accessibility of services to maternity and pediatric patients through expansion and improvement of services to women and children.

1. Outreach efforts should be strengthened and targeted to maternity and pediatric patients.

2. Evaluation of case management services should be designed and implemented and management data for the Alabama Department of Public Health should be refined.

(b) Strengthen the Alabama Perinatal Program to implement programs that address recommendations issued by the State Perinatal Advisory Council (SPAC) in 2002. Provide statewide follow-up of all infants identified as high-risk. Improve maternal-fetal and neonatal transport systems.

(c) Maintain and strengthen interagency efforts directed toward decreasing the amount and effects of substance abuse in women of childbearing age and their children.

(d) Encourage access in schools for perinatal testing, counseling, prenatal education, and care.

(e) The Statewide Health Coordinating Council (SHCC) is committed to maintaining and strengthening efforts to expand and improve quality pediatric health care throughout Alabama's health care delivery system. This should be achieved through pediatric-trained personnel and systems whose expertise is to care for children--pediatric-trained physicians (family physicians, pediatricians, pediatric sub-specialists, etc.), nurses (including pediatric and family nurse practitioners), developmental specialists, mental health specialists, and other team members located in health care delivery sites and systems (physicians' offices, multi-specialty ambulatory clinics, health maintenance organizations, children's hospitals, and other service sites).

Author: Statewide Health Coordinating Council (SHCC).
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410-2-2-.03 **Care of the Elderly and Chronically Ill**

(1) The Problem

(a) The elderly comprise one of the most rapidly growing age groups in the United States. The same is true in Alabama. Since 1900, the state's total population (approximately 4.4 million people) has more than doubled and there are nearly ten times as many senior citizens. In 1900 persons 65 and older accounted for only 3% of the total population compared to 13% in 2002. This age group is expected to increase to over 22% by the year 2050.

(b) Improvements in life style, changes in diet, and development of medical technology for identification and treatment of diseases have resulted in increased life expectancy. Because of this increase, a new phenomenon is occurring, aging of the aged. More persons are living well into their 80s and even 90s. Within the ten-year period from 1990 to 2000, the 85 plus segment of the population increased by 40%. The special needs of these frail elderly will demand increased attention from service providers in the years ahead. The absolute number of people was 29,644 for females and 27,165 for males.

(c) The male population age 65 plus increased by 13.3% from 1990 to 2000 and the female population of the same age group increased by 9.3%, while one-third of the non-institutionalized elderly live alone, 80% of these are women.

(d) As age increases, the incidence of chronic disease and disability, particularly at the lower levels of severity, increases. Another factor affecting the increase of the chronically ill is the projection of an increase in the number of AIDS cases in the state.

(e) Many of our chronically ill live below the poverty level. The current census reflects, they do not always seek medical assistance because of out-of-pocket cost. Often they cannot afford required medications. Some live in substandard housing with inadequate plumbing and heating. They do not always practice proper nutrition because of economic concerns and the inability to shop.

(f) Depression, loneliness, alcohol and drug abuse, and suicide pose problems for many elderly and chronically-ill citizens.

(g) Transportation is not available to all elderly and chronically ill persons. Many who have lived alone in the past will need to be placed in a facility where they can receive assistance. Families, with both husband and wife working, need assistance with parents during work hours and at other times for respite care.

(h) Dental care and audiology are not available at affordable prices for all the elderly and chronically ill, although many more dentists are accepting Medicaid patients.

(i) Recent statistics project an increase in the need for care of the elderly and chronically ill within the next few years. However, much of this care will be linked directly to functional limitations, and only indirectly to illness.

(j) The social, economic, and cultural environment will have important bearing on how well our elderly maintain their overall health status. The support that was once provided by relatives is less feasible in today's society because of scattered families, divorce, single parents, childless couples, and two-income families.

(k) The kind of care and support needed to maintain the health of our elderly and chronically ill population cannot be sustained within the state's current medical framework.

(l) The availability of health care services has increased. Medicaid increased the payment to dentists and physicians in the last two years; the Medicaid drug formulary has been expanded and payments have been increased to nursing homes. Approximately 208 additional nursing home beds have been approved, as a result of the 10% Nursing Home Bill.

(2) Recommendations

(a) The State should strengthen its existing support services for the elderly and chronically ill and, when appropriate, develop new services, beginning at the community level. These services should include, but are not limited to, the following:

1. Adult day care facilities to assist working families;

2. Assisted living homes to provide housing for elderly and chronically ill who can no longer live alone;

3. Counseling services that deal with depression, alcohol and drug abuse, suicidal tendencies, nutrition, appropriate life styles, and self care;

4. Geriatric training and education for caregivers;

5. Homemaker and chore services;

6. Home delivered meals;

7. Transportation services;

8. Emergency alert systems;

9. Dental care, including prosthodontics;

10. Audiology, including hearing aids;

11. Optometry services, including glasses;

12. Adaptive and assistive equipment;

13. Adequate housing for persons living below the poverty level.

(b) The success or the breakdown of these support services will determine to a considerable extent the demands made on health care services by the elderly and chronically ill. However, with the success of such support services, the need for more costly health care for our elderly and chronically ill will drastically diminish.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
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410-2-2-.04 **Rural Health Care**

Alabama has a Rural Health Plan developed with the assistance of the Alabama Department of Public Health's Office of Primary Care and Rural Health and the State Health Planning and Development Agency. This plan is incorporated into this State Health Plan by reference hereto.

(1) The Problem. Trends in Alabama's rural health care parallel those of the Nation. Both are related to changes in environmental factors. A summary of the problems and possible alternatives follows.

(a) Reimbursement Factors. Reimbursement changes from the traditional cost-based system to either a prospective payment or per diem, depending on the third party payer, have had a dramatic effect on the solvency of rural hospitals. Generally speaking, hospitals in rural areas experience a higher mix of Medicare/Medicaid patients than do the facilities in urban areas; but rural hospitals receive a lower amount of reimbursement per patient from Medicare. The Centers for Medicare and Medicaid Services (CMS) implementation of the Prospective Payment System (PPS) assumes hospitals in rural areas will not experience the same labor costs for health personnel services, as do the urban hospitals. Therefore, the component parts of the prospective payment formula provides for a lower wage allowance for rural hospitals. Another factor that tends to limit reimbursement for rural hospitals is that the PPS system assigns weights related to patient attributes to each DRG. The higher the weight per DRG, the more reimbursement a hospital will receive if that hospital provides services to patients with the higher weighted/reimbursed DRGs than do the rural facilities. Therefore, the urban facilities may receive more reimbursement, in spite of the fact that the weight assignment per DRG has not been proven as accurate an indicator of the consumption of resources. The bottom line effect of Medicare reimbursement on rural hospitals is the payment rates are generally less for hospitals in rural areas, leading to a less than adequate payment system. Medicare cost reports in 2000 indicated that 34 percent of the hospitals in rural areas experienced a net loss from operations.

(b) Demographic Factors. A low population density, worsened by the emigration of the younger population in search of employment in larger communities, results in a high proportion of the elderly remaining in rural communities. Alabama's overall population density in 2000 averaged 87.6 people per square mile, ranging from a low of 14.8 persons per square mile in Wilcox County to a high of 595 persons per square mile in Jefferson County. In this case a measurement of density may not be an accurate indicator as only 22 counties experienced a density factor equal to or above the average and 45 counties were below the average. Rural facilities thus have a smaller market from which to draw patients and fewer patients who pay adequately as compared to the costs of providing the care. Rural facilities are often under utilized as well. The elderly utilized more services than other groups. The average annual healthcare expenditure during 1985 – 2000 was more than six times greater for the elderly than for the younger groups. The population 65 and older comprises 13 percent of the state population as a whole and 14.5 percent for the 45 rural counties, further emphasizing the need to develop and implement a rural health plan. Other demographic factors affecting rural health care are the farm economy, local tax base, and the number and percentage of rural Americans who lack health insurance.

(c) Utilization Factors. Overall use of inpatient services in rural areas continues to decline, while those same services are increasingly used by the elderly who are covered by decreasing Medicare reimbursement. Given that many of the rural hospitals are sole community providers, the leading industry in the community, and one of the major employers in the area, the decreasing use has caused concerns both economically and politically, and has affected the overall health status of the community. Leaders are rightly concerned that the demise of the rural hospital leaves a discontinuity of health care services for citizens in their areas.

(d) Insufficient Health Professional Supply. Data from the Bureau of Planning and Resource Development, Alabama Department of Public Health, indicated that only six Alabama counties did not have a health professional shortage area (HPSA) designation for primary care physicians. Because of the problems attracting specialized professionals and obtaining new technologies, few rural hospitals can provide special services that might increase their revenue. The migration of young people to urban communities, lack of adequate reimbursement, and limited patient resources are other problems hindering the recruitment of professional personnel and fueling the state's health professional shortages. Government reports show that Alabama, like many other parts of the South, is experiencing a physician shortage. Utilization of nurse practitioners, physician assistants, and nurse midwives meets a real need in addressing the access problem faced by many rural Alabamians. Health planners, providers, policy makers, and communities must approach the recruitment and retention of non-physician health professionals realistically. It is unrealistic to assume that every rural community will be able to recruit and retain a physician. In order to provide access to health care for the citizens of many of the state's most rural areas, the utilization of non-physician health professionals must be seriously encouraged. Also, payment for services provided by these non-physician health professionals must be made by third party payors and self-insured programs in order for their numbers to increase.

(e) No one strategy will solve the state's problems with rural health care. Policy makers must realize that rural facilities have fewer health care and political resources than do their urban counterparts and that rural hospitals may be one patient away from closing. The rural hospital of the future may, therefore, have a limited number of acute care beds with the remainder of the facility given to swing beds, outpatient services, and specialty services. In short, rural hospitals need encouragement to take advantage of diversification. The essential issue remains, however, that without some emergency strategies and relief, the only alternative for the state's rural hospitals may be closure. One new option for Alabama's rural hospitals is the "Medicare Rural Hospital Flexibility Program" found in the Balanced Budget Act of 1997, which allows rural hospitals to convert to Critical Access Hospital status.

(2) Recommendations

(a) The State should continue to strongly support additional funding toward federal Medicaid match and should support the expansion of Medicaid program eligibility and benefits, especially for low-income pregnant women and infants.

(b) Encourage medical schools in Alabama to promote rural practice and retention.

(c) Encourage the secondary school systems to coordinate medical student recruiting efforts with the medical schools.

(d) Encourage the appropriate school of higher education to develop a physician assistant training program for utilization of such personnel in rural hospital emergency departments and/or rural health clinics. Encourage the continued support and recruitment of nurse practitioners and nurse midwives and expand the number of nurse practitioner programs in the state.

(e) Encourage the development of a capital access program giving rural hospitals and rural health clinics located in underserved areas easier access to capital through a capital pool with lower interest rates and less required collateral. Encourage the State Treasurer to consider adding rural hospitals to the Linked Deposit Program.

(f) Develop and implement programs to promote the utilization of nurse practitioners, physician assistants, and nurse midwives by:

1. Licensure and physician supervision requirements should be modified where access to care is hindered.

2. Promoting third party reimbursement by insurance companies and self funded programs.

(g) The state congressional delegation should continue to support the decisions made by the Medicare Geographic Reclassification Review Board process for reclassifying rural hospitals and correcting area wage index inequities in the basic DRG payments to hospitals. The delegation should also continue to be encouraged to support congressional action to revise reimbursement inequities for Alabama hospitals.

(h) Encourage providers, physicians, and other appropriate rural health care interest groups and community leaders to develop programs through the public and private sector which:

1. Ensure increased access to comprehensive health care with fewer financial barriers.

2. Access to health care services shall be provided in accordance with federal law.

3. Ensure that local community needs are met by encouraging planning efforts in rural and otherwise underserved areas.

4. Consider the impact on the infrastructure of local communities, jobs, schools, tax bases, and community leadership.

(i) Structure an agricultural safety program to:

1. Produce and accumulate a resource for instruction and analysis.

2. Establish a delivery system to disseminate the resource base to the agricultural community and local organizations, which will receive the educational resources and interact with the individual workers and farm families.

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410-2-2-.05 **Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)**

(1) The Problem

(a) By December 2002, 859,000 cases of AIDS had been diagnosed in the United States. Of these, 849,780 have occurred in adults and adolescents and another 9,220 have been reported in children under age 13. Transmission of the AIDS virus occurs through sexual contact with an infected person, exposure to infected blood or blood products, and perinatally from mother to baby. To date, homosexual/bisexual men account for 45% of adult AIDS cases, with 6% occurring in homosexual/bisexual men who use intravenous drugs. Twenty-five percent of AIDS cases have been reported among heterosexual intravenous (IV) drug users; 1% among hemophiliacs; 1% blood transfusion recipients; and 12% among heterosexuals who have had sexual contact with infected partners. Approximately 10% fall into an "unknown" category.

(b) By October 2003, Alabama had reported 7,444 AIDS cases. Of these, 7,368 were in adults and adolescents and 76 were in children less than age 13. Alabama's AIDS cases by reported risk behavior is as follows: 47.3% homosexual/bisexual male; 8.2% homosexual/bisexual with IV drug user; 16% hetero sexual and IV drug abuse; 1.2% transfusion related; 1% hemophiliac; and 15.4% hetero sexual contact with an infected person.

(c) There are at least one million Americans silently infected with HIV. Most of them will get sick during the next decade. Nationally, the cumulative deaths as of December 2000 were 501,669. Fifty-two percent of Alabama's reported AIDS cases have died. Despite earlier diagnosis and the availability of treatment in Alabama, median survival for AIDS cases is estimated to be 18 - 20 months after diagnosis.

(d) In November 1987, the Alabama Department of Public Health designated HIV infection reportable by provider and patient name and identifiers. By October 2003, 6,180 persons who tested positive for HIV and 7,444, were reported with AIDS, had been reported to the Alabama Department of Public Health. Each one of these individuals is potentially capable of transmitting the virus to someone else and will ultimately have his/her life shortened due to virus infection.

(e) The lowest cost has been identified in areas, which have strong out-of-hospital support networks to provide services to AIDS and HIV positive patients. In addition to the obvious personal loss experienced by families and friends, the loss of productivity due to deaths of individuals with AIDS represents an economic cost to the state of more than $800 million.

(2) Recommendations

(a) The state needs to pursue three primary goals to deal with the problem of HIV/AIDS infection:

1. The elimination of HIV transmission from the infected population of Alabama to the uninfected population.

2. The provision of HIV services, both to prevent infection and to provide care in an environment free of discrimination and stigmatization.

3. The provision of appropriate and necessary health care to infected individuals.

(b) The State began participation in seroprevalence surveys with the Center for Disease Control (CDC) in 1987. Data from these surveys indicate that the State needs to continue to monitor the prevalence of infection in targeted at-risk individuals, such as homosexual/bisexual men, IV drug users, clients in Sexually Transmitted Diseases (STD) and Tuberculosis (TB) clinics, and women seeking prenatal and family planning services. Data collected in seroprevalence surveys should be used to target populations and geographic areas in need of HIV/AIDS prevention and educational efforts.

(c) The State needs to establish interventions to prevent the transmission of HIV from infected individuals to their sexual and/or needle sharing partners. This need can be addressed by HIV counseling/testing and partner notification services.

(d) Since AIDS is only the end of a spectrum of viral infection, the State needs to continue to monitor HIV infection through established reporting mechanisms. Physicians, laboratories, and others required by law to report should do so promptly to the Alabama Department of Public Health.

(e) Even if a vaccine were available for HIV/AIDS, efforts to prevent transmission of the HIV virus must rely heavily on education. Educational efforts must be targeted at the general community, as well as, to designated at-risk individuals and populations. Targeted educational messages must be specific, culturally sensitive and stress how the virus is transmitted and ways to reduce or eliminate the risk of transmission. Information directed at the general populace should not only focus on how the virus is transmitted and ways to reduce individual risk, but also stress how the virus is not transmitted so that discrimination, stigmatization and ostracism of infected individuals are eliminated. The Alabama Department of Public Health should serve as the focal point for HIV/AIDS educational and informational activities.

(f) The Alabama Department of Public Health has established a multi-agency task force (Alabama AIDS Prevention Network) which should serve to evaluate the effect of HIV/AIDS infection on the health care needs of Alabama and its impact on the state's health care resources. A system of community-based care for infected individuals must be established and maintained utilizing home health services, Medicaid waiver programs, long-term care facilities, hospice programs, and volunteer agencies.

(g) Legislation defining the right of access to HIV information for individuals who have a compelling need to know was passed in late 1991. The State needs to continue to monitor and refine this legislation in order to allow exchange of "needed" information, but in a manner, which will protect confidentiality and prevent discrimination against the HIV infected.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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410-2-2-.06 **Health Care for the Medically Indigent**

(1) The Problem

(a) There have been a number of studies and estimates to determine the number of medically uninsured and underinsured, both in Alabama and nationally. Although the statistics may vary among the various studies, the conclusions are all consistent in that a large percentage of the population has either no health insurance coverage or the coverage is inadequate. For example, the Alabama Department of Public Health in 2002 estimated that 14.6% (652,766) of Alabamians were uninsured sometime during that year. Most of the uninsured were found in families where at least one person is employed, and most of the employed worked in small businesses.

(b) Lack of health insurance coverage including mental health coverage contributes significantly to uncompensated care provided by those who deliver needed health care. The uninsured and underinsured often fail to seek needed health care services early when treatment is generally less expensive and more effective. The financial impact of the uninsured in Alabama is shown by 2001 data compiled by the Alabama Medicaid Agency. Total uncompensated care in Alabama was estimated to be $553 million.

(c) Providers should pursue collections based upon economic means based policies in order to recover part of the cost of uncompensated care, and according to generally accepted standards. Bad debt is an increasing problem for Alabama providers.

(d) Bad debt is the unpaid charges/rates for services rendered from a patient and/or third party payer, for which the provider reasonably expected payment.

(e) Charity care is defined as health services for which a provider's policies determine a patient is unable to pay. Charity care could result from a provider's policies to provide health care services free of charge to individuals who meet certain pre-established criteria. Charity care is measured as revenue forgone, at full-established rates or charges. Charity care would not include contractual write-offs, but could include partial write-offs for persons unable to pay the full amount of a particular patient's bill.

(f) Uncompensated care is the combination of charity care and bad debt.

(g) Each county is responsible for indigent residents.

(2) Recommendations

(a) The SHPDA should work with other state agencies to develop a database to determine the nature and extent of uncompensated care in Alabama and to monitor changes in the level of uncompensated care over time.

(b) The State is examining ways to encourage provision of medical insurance through employers and ways to more effectively utilize public funding sources.

(c) The State is examining establishment of a risk pool for small employers and for individuals who lose employer provided insurance.

(d) The Statewide Health Coordinating Council believes that access to care, which is mandated as a part of the Certificate of Need (CON) Review process shall include the historical and projected charity care provided by each CON applicant and the impact each CON approval will have on access to health care for the medically indigent.

(e) Counties are encouraged to provide adequate resources to fulfill obligations in accordance with the following state statutes:

1. Article 7 Title 21 Known as Hospital Service Program for Indigents (22-21-210), et seq

2. Article 10 Title 21 Financial Responsibility for Indigent Healthcare (22-21-290), et seq

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
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410-2-2-.07 **Preventable Diseases**

(1) Obesity

(a) Discussion (Sources: www.cdc.gov & www.surgeongeneral.gov)

1. In 2000, the prevalence of obesity (BMI> or = 30) among U.S. adults was 19.8 percent, which reflects a 61 percent increase since 1991.

2. An estimated 300,000 deaths per year in the United States may be attributable to obesity.

3. In 2001, Alabama had the seventh highest prevalence rate of obesity in the United States. This is an increase of over 10% since 1991.

4. Even moderate weight excess (10 to 20 pounds for a person of average height) increases the risk of death, particularly among adults aged 30 to 64 years.

5. Overweight and obesity are associated with heart disease, certain types of cancer, type 2 diabetes, stroke, arthritis, breathing problems, and psychological disorders, such as depression.

(2) Diabetes

(a) Discussion (Sources: www.adph.org & www.cdc.gov)

1. Almost 1 in 10 people in Alabama has been diagnosed with diabetes. Thousands are unaware that they have the disease.

2. Diabetes is the sixth leading cause of death for the year 2000 in Alabama. The diabetes-related death rate for Alabama and the United States has steadily increased since 1980. For 2000, the death rate in Alabama was 29.6 per 100,000 population, up from 28.0 in 1995. The Alabama rate has remained consistently above the national rate at 25.2 per 100,000 population for 1999.

3. More than 60 percent of lower limb amputations in the United States occur among people with diabetes. In 2000-2001, about 82,000 nontraumatic lower-limb amputations were performed among people with diabetes.

4. Diabetes is the leading cause of new cases of blindness among adults aged 20-74 years.

5. About 73% of adults with diabetes have blood pressure greater than or equal to 130/80 mm Hg or use prescription medications for hypertension.

(3) Hypertension (High Blood Pressure)

(a) Discussion (Sources: www.cdc.gov & www.encarta.msn.com)

1. Hypertension is a condition where the blood circulates through the arteries with too much force. Hypertension tires the heart, harms the arteries, and increases the risk of heart attack, stroke, and kidney problems.

2. Often called the "silent killer," hypertension usually causes no symptoms until it reaches a life-threatening stage.

3. Hypertension affects 20 percent of people living in the United States. Of these, almost a third are unaware of their condition.

(4) Stroke

(a) Discussion (Sources: www.cdc.gov & www.adph.org)

1. Stroke is a type of cardiovascular disease. It affects the arteries leading to and within the brain. A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts. When that happens, part of the brain cannot get the blood (and oxygen) it needs, so it starts to die.

2. Stroke is the third leading cause of death after heart disease and cancer and a leading cause of serious, long-term disability.

3. In 2000, stroke killed 167,661 people (61% of them women), accounting for about 1 out of every 14 deaths. The death rate was 61 per 100,000 population.

4. Each year about 700,000 people suffer a stroke (about 500,000 first attacks and 200,000 recurrent attacks).

5. After many years of steady decline, the stroke mortality rate among Alabamians has begun to increase. Since 1994, the rate has increased on average by more than 1 percent per year. Currently, stroke is the third leading cause of death in the state, accounting for more than 3,100 deaths in the year 2000.

(5) Summary

(a) Discussion (Source: Alabama Center for Health Statistics)

1. The Alabama age-adjusted death rate rankings for obesity related diseases are among the highest in the nation: 5^{th} for heart disease, 7^{th} for stroke, and 10^{th} for diabetes. Left unabated, overweight and obesity will cause as much preventable disease and deaths as cigarette smoking. The estimated direct and indirect costs of obesity and being overweight in the US are $117 billion and rising rapidly. This figure exceeds even the annual costs of tobacco-related illnesses.

2. Because obesity is a chronic disease, it requires long-term management. Treatment focuses on losing weight to improve or eliminate related health problems or the risk for health problems, not to attain an ideal weight. Treatment consists of modifying your eating behaviors, physical activity, and monitoring your behavior, such as tracking what triggers you to eat, medication and surgery may be used if this treatment is not effective.

Treatment also covers the psychological and social components of obesity. Stress management and counseling may be helpful. Getting family support and creating community contacts help you deal with the stereotypes and other social issues that are associated with obesity.

3. Bariatric surgery such as stomach bypass and stomach stapling increased five fold in the 1990's from about 4,900 operations in 1990 to 23,000 operations in 1999. The American Society of Bariatric Surgeons estimates 80,000 severely obese patients will get the operations in 2004. The International Bariatric Surgery Registry estimates one in 1,000 patients will die within four weeks of the surgery and three in 1,000 will die within three months. Some surgeons in the field put the fatality rate as high as one in 100 who have the surgery.

4. Americans collective weight gain leveled off in 2003 after half a decade of getting fatter, according to a new national survey of eating habits. Consumers appear to be focusing on healthier foods and more worried about the fats and additives. While fewer households were interested in dieting, 35 percent of Americans say they carefully plan to eat nutritious meals, which is a slight increase. More people are checking their food labels. 53 percent of Americans say they check food labels, up from 51 percent last year. And two-thirds of Americans say they exercise at least once a week.

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LEADING HEALTH INDICATORS FOR HEALTHY PEOPLE IN 2010

HEALTH INDICATOR	DESCRIPTION
Physical Activity	Regular physical activity throughout life is important for maintaining a healthy body, enhancing psychological well being, and preventing premature death.
Overweight and Obesity	Overweight and obesity are major contributions to many preventable causes of death. On average, higher body weights are associated with higher death rates.
Tobacco Use	Cigarette smoking is the single most preventable cause of disease and death in the United States. Smoking results in more deaths each year in the US than AIDS, cocaine, heroin, homicide, suicide, motor-vehicle crashes, and fires - - combined.
Substance Abuse	Alcohol and illicit drug use are associated with many of this country's most serious problems, including violence, injury, and HIV infection.
Responsible Sexual Behavior	Unintended pregnancies and sexually transmitted diseases (STDs), including infection with the human immunodeficiency virus that causes AIDS, can result from unprotected sexual behaviors.
Mental Health	Approximately 20 percent of the U.S. population is affected by mental illness during a given year; no one is immune. Of all mental illnesses, depression is the most common disorder.
Injury and Violence	More than 400 Americans die each day from injuries due primarily to motor vehicle crashes, firearms, poisonings, suffocation, falls, fires and drowning. The risk of injury is so great that most persons sustain a significant injury at some time during their lives.
Environmental Quality	An estimated 25 percent of preventable illnesses worldwide can be attributed to poor environmental quality. In the U.S., air pollution alone is estimated to be associated with 50,000 premature deaths and an estimated $40 billion to $50 billion in health-related costs annually.
Immunization	Vaccines are among the greatest public health achievements of the 20th Century. Immunizations can prevent disability and death from infectious disease for individuals and can help control the spread of infections within communities.
Access to Health Care	Strong predictors of quality health care included in having health insurance, a higher income level, and a regular primary care provider or other source of ongoing health care. Use of clinical preventative services, such as early prenatal care, can serve as indicators of access to quality health care.

Source: www.healthypeople.gov

410-2-2-.08 **Influenza**

(1) Problem

(a) Seasonal epidemics of influenza occur every year in the United States, beginning in the fall. Typically, the epidemics cause thousands to tens of thousands of deaths and about 200,000 hospitalizations.

(b) Since the 1940's, a vaccine has been available to prevent influenza; unfortunately, the vaccine is not used as much as it should be. To prevent the hospitalizations and deaths caused every year by influenza virus, the Center for Disease Control and Prevention has recommended that all U.S. citizens more than 6 months of age receive the influenza vaccine.

(c) The rate of vaccination is low (25-45%).

(d) The cost of vaccination is minimal ($10-$18) depending on type (injections vs. nasal).

(e) Side effects are minimal.

(f) Influenza causes children to miss school, usually up to a week, which in some cases causes parents to miss work.

(2) Recommendations

(a) The State should consider adding the influenza vaccine to the required immunization schedule 420-6-1-.03 of the Code of Alabama, 1975.

(b) Vaccinating school aged children would keep more kids in school and probably save the state millions of dollars.

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ALABAMA
STATE HEALTH PLAN
2014-2017
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

Chapter 410-2-3
Specialty Services

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410-2-3-.01 **Introduction**. This chapter of the *Alabama State Health Plan* reviews the status of certain specialty health care services and the need for additional services to address the problems cited in the Priorities section of the Plan. Specialty Services are separately identified for ease of reference and to highlight their importance in the overall planning and regulatory responsibilities. The health care system in Alabama should not be burdened by an unnecessary duplication of expensive services.

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410-2-3-.02 **Neonatal Services**

(1) Discussion

(a) A leading indicator of the health status of a state's citizens is the infant mortality rate. Alabama has one of the highest rates in the country. In order to have an impact on infant mortality, the State must make neonatal care accessible and enhance that care which is available.

(b) Maternal and Neonatal service providers are designated as Basic (Level I), Specialty (Level II), or Subspecialty (Level III), depending on their capabilities and expertise.

1. A regionally coordinated system focusing on levels of hospital-based perinatal care has been shown to be effective and to result in improved outcomes for women and their newborns. According to the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, guidelines for Perinatal Care, Fifth Edition, prenatal care can be delivered more effectively and efficiently by defining the capabilities and expertise of providers and ensuring that pregnant women receive risk-appropriate care. Basic (Level I) care should have the following capabilities and provider types:

(i) Capabilities - Risk-oriented prenatal care record, physical examination and interpretation of findings, routine laboratory assessment, assessment of gestational age and normal progress of pregnancy, ongoing risk identification, mechanisms for consultation and referral, psychosocial support, childbirth education and care coordination (including referral for ancillary services, such as transportation, food, and housing assistance).

(ii) Provider Types - Obstetricians, family physicians, certified nurse-midwives, and other advanced-practice nurses with experience, training, and demonstrated competence.

(iii) Responsibilities - Surveillance and care of all patients admitted to the obstetric service, with an established triage system for identifying high-risk patients who should be transferred to a facility that provides specialty or subspecialty care; proper detection and initial care of unanticipated maternal-fetal problems that occur during labor and delivery; capability to perform cesarean delivery within 30 minutes of the decision to do so; availability of appropriate anesthesia, radiology, ultrasound, laboratory and blood bank services on a 24-hour basis; care of postpartum conditions; resuscitation and stabilization of all neonates born in the hospital; evaluation and continuing care of healthy neonates in a nursery or with their mothers until discharge; adequate nursery facilities and support for stabilization of small or ill neonates before transfer to a specialty or subspecialty facility; consultation and transfer arrangements; parent-sibling-neonate visitation; and data collection and retrieval.

2. Specialty (Level II) providers should have:

(i) Capabilities - Basic care capabilities plus fetal diagnostic testing (eg., biophysical tests, amniotic fluid analysis, basic ultrasonography, and expertise in management of medical and obstetric complications.

(ii) Provider Types - Obstetricians.

(iii) Responsibilities - Provision of some enhanced services as well as basic care services as described in 1(iii); care of appropriate high-risk women and fetuses, both admitted and transferred from other facilities; stabilization of severely ill newborns before transfer; treatment of moderately ill larger preterm and term newborns; and data collection and retrieval.

3. Subspecialty (Level III) providers should have:

(i) Capabilities - Basic and specialty care plus advanced fetal diagnoses (eg, targeted ultrasonography, fetal echo-cardiology); advanced therapy (eg, intrauterine fetal transfusion and treatment of cardiac arrhythmias); medical, surgical, neonatal, and genetic consultation; and management of severe maternal complications.

(ii) Provider Types - Maternal-fetal medicine specialists and reproductive geneticists with experience, training and demonstrated competence.

(iii) Responsibilities - Provision of comprehensive perinatal care services for both admitted and transferred women and neonates of all risk categories, including basic and specialty care services as described previously; evaluation of new technologies and therapies; and data collection and retrieval. Neonatal services must continue to receive regional planning.

4. Regional Subspecialty Perinatal Health Care Center - Not all subspecialty perinatal health care hospitals must act as regional centers; however, regional organization of perinatal health care services requires that there be coordination in the development of specialized series, professional continuing education to maintain competency and the collection of data on long-term outcomes to evaluate both the effectiveness of delivery of perinatal health care services and the safety and efficacy of new therapies and technologies.

5. Specific responsibilities include: provision of comprehensive perinatal health care services at and above those of subspecialty care facilities; responsibility for regional perinatal health care service organization and coordination including: maternal and neonatal transport, outreach support and regional educational programs, research support and initial evaluation of new technologies and therapies, and analysis and evaluation of regional data, including those on perinatal complications and outcomes.

(2) Planning Policies

(a) In order to ensure that appropriate prenatal and neonatal services are available in Alabama:

1. Each of the five (5) designated regional perinatal centers will have a high-risk nursery.

2. The State Perinatal Advisory Committee will continue to advise the State Health Officer in the planning, organization, and evaluation of the Perinatal Program, which will address

the coordination of services to improve preconceptional, interconceptional and prenatal health for women at high risk for poor outcomes of pregnancy

3. The Alabama Perinatal Program will facilitate state, regional and local/community collaboration, interest and action regarding health care needs and services to reduce maternal, and childhood morbidity and mortality.

4. The Alabama Perinatal Program will assess the quality and effectiveness of the health care systems for women and infants through the collection, analysis and reporting of data.

5. The State should strengthen the Alabama Perinatal Program to implement programs that address recommendations issued by the State Perinatal Advisory Council (SPAC) in 2002:

(i) Public Awareness Campaigns
(ii) Smoking Cessation Interventions
(iii) Statewide Fetal Infant Mortality Review Teams
(iv) Evidence-Based Medicine/Best Practices
(v) Regionalization of Perinatal Care
(vi) Care Coordination Services
(vii) Transportation for Women and Infants
(viii) Comprehensive Care for Women of Childbearing Age
(ix) UAB MCH Program Endowed Chair

6. The State should continue to implement all sections of the federal Omnibus Budget Reconciliation Act that affect prenatal and neonatal services.

7. The State should improve the accessibility of services for maternity and pediatric patients through expansion and improvement of services to women and children.

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410-2-3-.03 **Cardiac Services**

(1) Fixed-Based Cardiac Catheterization Laboratories

(a) Discussion

1. During the past four decades, an evolution in cardiac catheterization has taken place. The role of the cardiac catheterization laboratory has progressed from study of cardiac function and anatomy for purposes of diagnosis to evaluation of candidates for surgery and finally to providing catheter-based, nonsurgical interventional treatment. This progress has stimulated an increase in demand for cardiac catheterization services.

2. From about 1982 to the present, there has been an unprecedented proliferation of cardiac catheterization services, which have now been expanded to a wider group of patients and diseases. The increase in patients and laboratories has been stimulated by the development of nonsurgical catheterization laboratory-based therapeutic procedures for palliation of both stable and unstable ischemic heart disease as well as selected valvular and congenital heart diseases, arrhythmias, and other problems. Many noncardiac diagnostic and therapeutic vascular procedures are now being performed in cardiac catheterization laboratory settings, but this area is still evolving. As newer cardiac diagnostic and treatment modalities are developed, it is highly likely that the role of cardiac catheterization will continue to evolve.

3. Fixed-based cardiac catheterization services are the only acceptable method for providing cardiac catheterization services to the people in Alabama.

4. For purposes of this section, a cardiac catheterization “procedure equivalent” is defined as a unit of measure which reflects the relative average length of time one patient spends in one session in a cardiac catheterization laboratory. One procedure equivalent equals 1.5 hours utilization time.

(b) Planning Policies

1. Planning Policy

Diagnostic catheterizations shall be weighed as 1.0 equivalents, while therapeutic/interventional catheterizations (Percutaneous Transluminal Coronary Angioplasty (PTCA), directional coronary atherectomy, rotational coronary atherectomy, intracoronary stent deployment, and intracoronary fibrinolysis, cardiac valvuloplasty, and similarly complex therapeutic procedures) and pediatric catheterizations shall be weighed as 2.0 equivalents. Electrophysiology shall be weighed as 3.0 equivalents for diagnostic and 4.0 equivalents for therapeutic procedures. For multi-purpose rooms, each special procedure which is not a cardiac catheterization procedure, performed in such rooms shall be weighed as one equivalent.

2. Planning Policy - New Institutional Service

New “fixed-based” cardiac catheterization services shall be approved only if the following conditions are met:

(i) Each facility in the county has performed at least 1,000 equivalent procedures per unit for the most recent year;

(ii) An applicant for diagnostic/therapeutic cardiac catheterization must project that the proposed service shall perform a minimum of 875 equivalent procedures (60% of capacity) annually within three years of initiation of services;

(iii) An applicant for diagnostic catheterization only must project that the proposed service shall perform a minimum of 750 procedures per room per year within three years of initiation of services;

(iv) At least two physicians, licensed in Alabama, with training and experience in cardiac catheterization shall provide coverage at the proposed facility.

3. Planning Policy - Expansion of Existing Service

Expansion of an existing cardiac catheterization service shall only be approved if:

(i) If an applicant has performed 1,000 equivalent procedures per unit (80% of capacity) for each of the past two years, the facility may apply for expansion of catheterization services regardless of the utilization of other facilities in the county;

(ii) Adult and pediatric procedures may be separated for those institutions with a dedicated pediatric catheterization lab in operation on the effective date of this section.

4. Planning Policy

Pediatric cardiac catheterization laboratories shall only be located in institutions with comprehensive pediatric services, pediatric cardiac surgery services, and a tertiary pediatric intensive care unit.

5. Planning Policy

All cardiac catheterization services without open-heart surgical capability (“OSS”) shall have written transfer agreements with an existing open-heart program located within 45 minutes by air or ground ambulance service door to door from the referring facility. Acute care hospitals providing diagnostic cardiac catheterization services may provide emergency interventional/therapeutic cardiac catheterization procedures. Notwithstanding anything in the State Health Plan to the contrary, an acute care hospital without on site open-heart surgery capability may provide elective perutaneous coronary intervention (PCI) if the following criteria are met:

1. The hospital shall maintain twenty-four (24) hour, seven (7) day a week continuous coverage by at least one interventional cardiologist and catheterization laboratory team for primary PCI treatment of ST elevation myocardial infarction;

2. The hospital shall participate in a recognized national registry for cardiac catheterizations and PCI procedures, such as the National Cardiovascular Data Registry (NCDR);

3. The hospital shall obtain informed patient consent for all elective PCI procedures, including an informed consent process in which it is clearly stated that the hospital does not offer OSS, and which clearly states that the patient may request at any time to be transferred to a hospital with OSS to undergo the PCI procedure;

4. The hospital shall conduct quarterly quality review of the elective PCI services under supervision of its serving interventional cardiologists;

5. The hospital shall demonstrate that applicable requirements in Planning Policy 2 (ii) of this subsection (Ala. Admin. Code 410-2-3-.03(1)(b)(2)) will be met; and

6. Hospitals shall use their best efforts to perform a minimum of 200 PCI cases per year. Any hospital performing less than 150 cases per year after the second full year of PCI operations must agree to an independent quality review of its program by an outside interventional cardiologist who is a member of the American College of Cardiology and to report a summary of such quality review confidentially to the Executive Director of SHPDA.

The CON Review Board shall consider the most recent recommendations/guidelines for cardiac catheterizations adopted by the American College of Cardiology Foundation, the American Heart Association Task Force on Practice Guidelines, and the Society for Cardiovascular Angiography and Interventions as an informational resource in considering any CON application for elective PCI services.

6. Planning Policy

Applicants for new or expanded cardiac catheterization services must demonstrate that sufficient numbers of qualified medical, nursing, and technical personnel will be available to ensure that quality health care will be maintained and without detrimentally affecting staffing patterns at existing programs within the same service area.

(2) Open Heart Surgery

(a) Discussion

1. "Open heart surgery" is a descriptive term for any surgical procedure that involves opening the chest to operate on the heart. But when people talk about "open-heart

surgery," they are usually referring to coronary artery bypass surgery, a procedure where the surgeon uses a blood vessel from the patient's own body to "bypass" a blockage in one of the arteries supplying blood to the heart. (www.dh.org)

2. In the last forty years, open-heart surgery has emerged from operating rooms of medical centers to become a mainstay of advanced medical treatment. In the year 2000, 686,000 open-heart surgeries were performed in the United States; and while the procedure has become commonplace, it still requires uncommon skill and the most advance technology to insure successful outcome. (www.americanheart.org)

3. Highly specialized open-heart operations require very costly, highly specialized manpower, and facility resources. Thus, every effort should be made to limit duplication and unnecessary expenditures for resources related to the performance of open-heart operations, while maintaining high quality of care.

4. Based on recommendations by various professional organizations and health planning agencies, a minimum of 200 heart operations should be performed annually to maintain quality of patient care and to minimize the unnecessary duplication of health resources. In order to prevent duplication of existing resources which may not be fully utilized, the opening of new open heart surgery units should be contingent upon existing units operating, and continuing to operate, at a level of at least 350 operations per year.

5. In units that provide services to children, lower targets are indicated because of the special needs involved. In case of units that provide services to both adults and children, at least 200 open-heart operations should be performed including 75 for children.

6. In some areas, open-heart surgical teams, including surgeons and specialized technologists, are utilizing more than one institution. For these institutions, the guidelines may be applied to the combined number of open-heart operations performed by the surgical team where an adjustment is justifiable and promotes more cost-effective use of available facilities and support personnel. In such cases, in order to maintain quality care, a minimum of 75 open-heart operations in any institution is advisable.

7. Data collection and quality assessment and control activities should be part of all open-heart surgery programs.

(b) Planning Policies

1. Planning Policy

Applicants for new and expanded adult open-heart surgery facilities shall project a minimum of 200 adult open-heart operations annually, 150 of which shall be coronary artery bypass graphs (CABG), within three years after initiation of service.

2. Planning Policy

Applicants for new and expanded pediatric open-heart surgery facilities shall project a minimum of 100 pediatric open-heart operations annually within three years after initiation of service.

3. Planning Policy

There shall be no additional adult open heart units initiated unless each existing unit in the county is operating and is expected to continue to operate at a minimum of 350 adult operations per year; provided, that to insure availability and accessibility, one adult open heart unit shall be deemed needed in each county not having an open heart surgery unit in which the current population estimate (as published from time to time by the Center for Business and Economic Research, University of Alabama) exceeds 150,000 without consideration of other facilities, wherever located.

4. Planning Policy

There shall be no additional pediatric open heart units initiated unless each existing unit in the service area is operating and is expected to continue to operate at a minimum of 130 pediatric open heart operations per year.

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410-2-3-.04 **Oncology - Radiation Therapy Services**

(1) Discussion: Radiation therapy, surgery, and medical oncology-chemotherapy combined are often the most effective treatment for cancer. Specific planning for these modes of treatment is necessary to insure proper cost and quality of care for the citizens of Alabama. Surgery is often a "one-time" service and may or may not be offered close to the patient's home. Radiation therapy and chemotherapy are generally provided on a daily basis for an extended period of time, and so are often more accessible if provided close to a patient's residence.

(2) Definition: "Radiation Therapy" is a clinical specialty in which ionizing radiation is used for treatment of cancer. The predominant form of radiation therapy involves an external source of radiation whose energy is focused on the diseased area.
"Oncology" is the discipline devoted to the delivery of specialized care to those patients afflicted with cancer. The delivery of care to these patients involves the diagnosis of cancer, the staging and determining the distribution of cancer and the treatment of cancer. Treatments involve coordination of care often with radiation oncologist and surgeons. The primary mode of treatment in these patients is with chemotherapy, hormonal therapy and immunotherapy.

(3) Surgery for cancer is usually provided in a hospital setting and may be done on an outpatient and/or inpatient basis.

(4) Medical oncology/chemotherapy is the introduction of certain chemical agents into a patient's body to inhibit or prevent the growth of cancerous cells and may be done on an inpatient or outpatient basis.

(5) Planning Policies

(a) Planning Policy: A megavoltage radiation therapy unit (which is a single megavoltage machine or energy source) shall serve a population of at least 150,000 persons and perform 6,000 treatments/patients visits annually within three years after initiation.

(b) Planning Policy: No additional megavoltage units shall receive approval unless each existing megavoltage unit in the county is performing at least 6,000 treatments/patient visits per year.

(c) Planning Policy: When applying the standard of 6,000 treatments per year, the limited specialized use of special purpose and extra high energy machines shall also receive consideration.

(d) Preference for new radiation therapy services shall be given to those applicants who combine/locate co-existent with chemotherapy treatment modalities, as these are most accessible when provided in a single location.

Note: The numerical standards contained in the above Planning Policies were obtained from Radiation Oncology in Integrated Cancer Management Report of the Inter-Society Council for Radiation Oncology, November 1986.

(6) Data on Oncology services is available from the State Health Planning and Development Agency.

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410-2-3-.05 **End Stage Renal Disease Services**

(1) Discussion. Prior to the 1972 enactment of Section 299 i of Public Law 92-603, End Stage Renal Disease services were provided almost exclusively for the general population in the Jefferson County area. Financing was derived from a number of sources, some with unpredictable reliability. Since the advent of Section 299 i, and its stable source of reimbursement, the supply of End Stage Renal Disease services in the state has dramatically increased. The supply of these services now dictates that a specific need determination is needed to guide the future development of these units.

(a) Those who suffer with End Stage Renal Disease have inadequate function to support life. Individuals with end-stage disease must rely in kidney dialysis or peritoneal dialysis to survive. End Stage Renal Disease may be caused by a number of problems including diabetes, sickle cell disease, hypertension and congenital renal disease (polycystic kidney disease).

(b) In 1991 the Legislature declared that it was in the best interest of the state and its residents for kidney disease treatment centers to be established and operated throughout the state so that any patient needing such treatment would be able to utilize a hemodialysis unit located within a reasonable distance of their home. § 22-21-278 Code of Alabama, 1975 allows kidney disease treatment centers with ten stations or less to operate in 61 of 67 counties without Certificate of Need approval. Centers in Jefferson, Madison, Limestone, Mobile, Montgomery and Shelby counties are required to receive certificate of need approval for any dialysis stations.

(c) In order to further expand access to End Stage Renal Disease treatment in rural areas, any existing kidney disease treatment center located in a county that does not contain all or any part of a Class 1, 2, or 3 municipality (as such classes are defined in sections 11-40-12 and 11-40-13, Code of Alabama, 1975) shall qualify for this exception to the need methodology set forth in 410-2-3-.05(2) to add up to six (6) stations if the existing kidney disease treatment center can demonstrate an average weekly utilization at or above the Optimal Utilization of eighty percent (80%) of Present Capacity (as such terms are defined in 410-2-3-.05(2)) for a period of ten (10) consecutive weeks within the six (6) months immediately preceding the filing of a Letter of Intent for the additional stations. Such additional stations shall be considered an exception to the need methodology set forth within 410-2-3-.05(2) and shall be considered regardless of the utilization of any other kidney disease treatment centers in the county. However, any present in-center stations developed pursuant to a CON granted under this provision will thereafter be included in future need methodology calculations in accordance with 410-2-3-.05(2).

1. In addition to such additional information that may be required by SHPDA, a kidney disease treatment center seeking a CON under this provision must provide the following information:

(i) Demonstration of compliance with the utilization rate in paragraph (1)(c);

(ii) The existing kidney disease treatment center has not been granted a CON for an increase of stations under this section within the preceding twelve (12) month period, which twelve (12) month time period begins to run upon the issuance of a license by the Alabama Department of Public Health for the additional stations in accordance with paragraph (1)(c); and

(iii) The kidney disease treatment center must have been licensed for at least one (1) year as an End Stage Renal Disease treatment center.

(d) On June 11, 2003, the Alabama Legislature passed legislation that the Alabama Department of Public Safety provide to the Alabama Organ Center (AOC) the names of all individuals who have indicated their intent to become organ donors on their license. Approximately 1,114,000 names will be added to the Legacy Organ and Tissue Donor Registry. When a potential organ donor is referred to the AOC, that information will be checked against the registry to see if the patient is listed. The information will be presented to the patient's next of kin.

(e) Other states with registries have noted increases in donation. This is the goal for Alabama.

(2) Planning Policies

(a) The determination of need for additional hemodialysis stations will be based on the utilization of present in-center hemodialysis stations (capacity at the time of application as utilized by census at the time of application) and any anticipated increases of census.

1. In calculating the present capacity, "Isolation Stations" (stations reserved for Hepatitis-B positive patients) and stations used for home hemodialysis training will be removed from the total number of stations at the facility. No further reduction of station count will be made for down-time, transients, or back-up of home patients, since provision is made for these in the Optimal Utilization Criterion.

2. Present Capacity is defined as two shifts per day, six days per week, based on the fact that most patients require three dialysis treatments per week. Third shift ("evening dialysis") will not be considered in calculating capacity since patient demand for this shift is erratic and unpredictable.

3. Optimal Utilization is defined as 80% of present capacity, thus making provision for cost-effective use of services and orderly growth, as well as reserving some capacity for downtime, transients, and back up of home patients. Optimal capacity is, therefore, 9.6 dialysis treatments per station per week (.80 x 12 dialysis treatments/station/week = 9.6 dialysis treatments/station/week).

4. Maximum Optimal Capacity is defined as the number of patients that can receive treatment under optimal capacity on a three dialysis treatment per week schedule.

EXAMPLE:

Total Stations		20	
Dialysis Treatments/Station/Week	x	12	
Capacity		240	Available Dialysis Treatments/Week
Optimal Utilization	x	.80	
Optimal Capacity		192	Available Dialysis Treatments/Week
Patient Usage	÷	3	Dialysis Treatments/Week
Maximum Optimal Census		64	Patients

(b) Projection of census will be submitted in a yearly fashion for the three years subsequent to the date of application. Note that much of the first year will be consumed by the application process (both state and federal), construction or renovation and licensure process. Calculations of anticipated census are to be based on:

1. Present In-Center Hepatitis-Negative Hemodialysis Patients.

(i) Other patients treated by the facility in the home settings [(Home Hemodialysis, Continuous Ambulatory Peritoneal Dialysis (CAPD), Continuous Cyclic Peritoneal Dialysis (CCPD)], will be excluded; Hepatitis-B positive patients will be excluded unless the application specifically addresses the need for Hepatitis-B positive stations;

(ii) Note that if more than one End Stage Renal Disease facility exists within the defined service area, all present dialysis stations and present patients in all End Stage Renal Disease facilities must be considered in developing a demonstration of need.

2. New End Stage Renal Disease patients projections shall be based on:

(i) The total population of the county in which the stations are to be located plus any contiguous county that does not have a dialysis center.

(ii) Incidence Rate: The definition of incidence rate is the rate at which new events occur in a population. The formula to determine incidence rate is as follows: The numerator is the number of new events occurring in a defined period; the denominator is the population at risk of experiencing the event during this period. Applicant will use the 2010 state average of 421/million/year or the sum of 749/million non-white population/year plus 270/million white population/year within the service area. In 2010 there were 2041 new patients.

(iii) Note that if more than one End Stage Renal Disease facility exists within the service area, the historical distribution of patients between the facilities will be used in determining the number of new patients who will seek services at the applying facility.

(iv) Loss Rate:

(I) Death: 16.2% of the sum of the in-center census at the start of each new year plus new patients during the year.

(II) Transplantation: 32.8% of the sum of the in-center census at the start of each new year plus new patients.

(III) Home Training: 8.0% of new patients.

I Incidence Rate: statewide average of 2010 421/million/year, or 749/million non-white population/year plus 270/million white population/year.

II. Loss Rate:

Death: 16% of initial census plus new patients.

Transplant: 5% of initial census plus new patients.

Home Training: 11% of new patients.

EXAMPLE:

In-Center Census Start of Year:		100 Patients
New Patients During Year:		50 Patients
		150
Less: 16% Death	24	
Less: 5% Transplant	8	
Less: 11% Home Training	6	
In-Center Census, Year End	112	

Note: Figures for incidence rates and loss rates were obtained from the 2010 Network 8, Inc. Annual Report http://www.esrdnetwork8.org.

3. A kidney transplant is a surgical procedure by which a healthy kidney is removed from one person and implanted in the ESRD patient. Transplantation is, ideally, a one-time procedure; if the donated kidney functions properly, the patient can live a relatively normal life. There is only one transplant center operating in Alabama. The University of Alabama Hospital located in Birmingham is one of the largest kidney transplant centers in the country with 331 transplants in 2002. The number of patients waiting for transplants is 1,975.

4. A free-standing licensed pediatric facility shall have the ability to make application directly to the Certificate of Need Review Board for the purpose of adding dialysis stations serving pediatric patients, provided it can clearly demonstrate that the need cannot be met by existing ESRD facilities.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended: Filed June 30, 2006; Effective: August 4, 2006. Amended: Filed January 24, 2012; Effective: February 28, 2012. Amended: Filed December 2, 2014; Effective: January 6, 2015. Statistical Update: December 3, 2012; August 11, 2014; August 4, 2015.
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410-2-3-.06 **Magnetic Resonance Imaging (MRI)**

This section repealed per Act Num….: 2003-331
Bill Num….: H-322
16 – JUN – 03

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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410-2-3-.07 **Extracorporeal Lithotresis**

This section repealed per Act Num….: 2003-331
Bill Num….: H-322
16 – JUN – 03

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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410-2-3-.08 **New Technology**

(1) Definition

(a) New technology is emerging equipment (1) intended for use in the diagnosis and/or treatment of medical conditions; (2) for which adequate data is not yet available to fully develop *State Health Plan* criteria and standards on a technology-specific basis; and (3) whose cost exceeds the thresholds established in § 22-21-263, Code of Alabama, 1975. New technologies often involve costly capital expenditures and significant increases in operational costs. Therefore, adequate standards and criteria shall be established to determine need, efficiency and appropriateness as required by § 22-21-266, Code of Alabama, 1975.

(b) Emerging equipment shall be considered new technology prior to and for eighteen (18) months following its approval by the Food and Drug Administration (FDA). After 18 months, equipment initially classified as new technology shall be treated as any other major medical equipment (§ 22-21-263, Code of Alabama, 1975) acquisition; if technology-specific criteria are made a part of the State Health Plan, they shall apply, and where no technology-specific section exists, other pertinent statutory, regulatory and State Health Plan provisions shall govern.

(c) New technology provisions do not apply to the acquisition of equipment to be used solely for research.

(2) Process

(a) Prior to approval of a new technology by the FDA, applications for certificate of need for the subject technology shall not be approved by the CON Review Board unless technology-specific criteria have been adopted by the Statewide Health Coordinating Council (SHCC) and approved by the Governor for inclusion in the *State Health Plan.*

(b) To facilitate this process (and thereby avoid unwarranted delays in equipment acquisition), providers considering acquisition of new technology shall notify the State Health Planning and Development Agency in writing of their interest at the earliest possible date. Within ten (10) days of such notification, the Chairman of the SHCC shall appoint the leader of a technology-specific task force to complete development of criteria and standards for review of the identified new technology within 60 days. At a minimum, such standards shall incorporate the Planning Policy requirements section.

(c) The earliest point at which CON approval for new technology shall be granted is the point at which technology-specific criteria and standards have been adopted. However, should such criteria and standards not be in place before FDA approval is granted, then beginning with FDA approval and extending for eighteen (18) months, or until technology-specific criteria and standards are adopted and approved by the Governor, whichever comes first, the requested new technology shall be reviewable using the Planning Policy criteria incorporated as a portion of this section. Under these circumstances, a CON may be granted if the project meets the threshold requirements and discretionary provisions stated in the Planning Policy and is consistent with other

pertinent statutory, regulatory, and State Health Plan provisions for determining need, efficiency, and appropriateness of proposed equipment acquisitions.

(d) Following adoption of a technology-specific section of the State Health Plan, the Statewide Health Coordinating Council shall review the new section eighteen (18) months after approval of the specific technology by the FDA. The basis for such review may include utilization, financial, and demographic data obtained from clinical use of the equipment in Alabama, nationally, and internationally. SHCC's 18-month review may result in (1) continuation of the State Health Plan standards, (2) removal of the technology-specific section from the State Health Plan, or (3) modification of the standards for continued inclusion in the State Health Plan.

(3) Planning Policy. In addition to all other statutory, regulatory, and State Health Plan requirements, all applicants for new technology shall meet the following:

(a) Threshold Requirements

1. Applicants for new technology shall demonstrate that they will have the ability to employ staff who are adequately trained and qualified. Demonstration of operators' competence may include appropriate residency training, formal continuing medical education courses, and on-the-job training. The applicant must also demonstrate the ability to employ adequate numbers of trained technical staff and support personnel to work in conjunction with the operators.

2. Applicants requesting new technology shall demonstrate that the new technology is needed by the population of a defined geographic area. Estimates of need shall be based upon the number of patients who will use the service, classified by diagnosis and by county of residence. Institution-based data alone shall not be sufficient to meet this requirement. The effect the new technology may have on utilization of existing technology or procedure shall be considered.

3. Before acquiring new technology, the applicant shall have complementary services available for support and evaluation purposes and must show the capability for providing adequate quality assurance.

4. Applicants shall guarantee uninsured (those not covered by Medicare, Medicaid, Blue Cross/Blue Shield or commercial insurance coverage) patients equal access to the new technology.

5. A new technology must be offered in the most cost effective manner at reasonable charges (professional and facility), especially where only one or a few applicants will have an opportunity to acquire the new technology early in its development.

6. Applicants requesting the new technology must agree to report basic utilization, insurance, financial, and demographic data (including patient origin data by diagnosis and patient insurance status) in the frequency and format prescribed by the SHPDA to permit an evaluation of the technology, to facilitate regional and statewide planning for diffusion, and to monitor compliance with the provisions above.

(b) Discretionary Provisions

1. All potential patients shall have access to new technology. To the extent that is medically-indicated, a new technology shall be available 24 hours a day, seven days a week on an emergency (on-call) basis.

2. Provision shall be made for participation in research, resident training, and continuing medical education for physicians, nurses, and technicians, as appropriate.

3. Whenever possible, the applicant shall acquire new equipment in conjunction with other providers. If such sharing in acquisition is not possible, the applicant shall demonstrate efforts to establish a multi-provider referral system.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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410-2-3-.09 **Transplantation Services**

(1) Definition. Transplantation is the process in which an organ or tissue from one person is surgically implanted into another person to replace diseased, damaged, or defective organs or tissue. For purposes of this section transplantation services include kidney, heart, lung, liver, bone marrow, and pancreas transplants.

(2) General. Transplantation is a costly, specialized service due in part to the resources required to operate such a service. Resources include donated organs or tissue, medical transplant specialists, and other technical expertise. The availability of these resources are limited and as such transplant services shall be limited to ensure the quality, availability, and cost effectiveness of such services. Studies have indicated that transplant centers and surgical teams with more experience generally have fewer complications and higher survival rates.

(3) Statistics. According to The Organ Procurement & Transplantation Network (optn.org):

(a) As of July 2003, more than 83,000 people were on the national waiting list for organ transplant.

(b) In 2001 there were:

(i) 12,528 deceased and living organ donors

(ii) 24,076 life saving organ transplants

(iii) 84,798 registrations on the waiting list at the end of the year

(iv) 6,439 people who died while waiting

(4) Planning Policies.

(a) Applicants proposing to initiate a transplant service shall demonstrate that all existing similar transplant services within the state are operating at 80 percent of capacity or that those programs are unwilling to accept additional transplant patients.

(b) Applicants for transplant service shall demonstrate that qualified medical and technical personnel, licensed in Alabama, are available and that existing transplant services within the state will not be detrimentally affected.

(c) Applicants for a transplant service shall provide documentation of approved participation in an organ donor network.

(d) Facilities with existing transplant services shall be given priority consideration over the development of new transplant facilities.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004; Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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410-2-3-.10 **In Home Hospice Services**

(1) Discussion

(a) Hospice care is a choice made to enhance end of life. Hospice focuses on caring and comfort for patients and not curative care. In most cases, care is provided in the patient's place of residence. It is the intent of this section to address health planning concerns relating to hospice services provided in the patient's place of residence. For coverage of hospice services provided on an inpatient basis, please see Section 410-2-4-15.

(2) Definitions

(a) Hospice Program. A "Hospice Program" is defined as a public agency, private organization, or subsidiary of either of these that is primarily engaged in providing Hospice Care to the terminally ill individual and families and is separately licensed by the State of Alabama and certified by Centers for Medicare/Medicaid Services (CMS) for the provision of all required levels of Hospice Care.

(b) Hospice. "Hospice" is a coordinated program providing a continuum of home and inpatient care for the terminally ill patient and family and/or significant other. It employs an interdisciplinary team acting under the direction of an identifiable hospice administration. The program provides palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and bereavement. The care is available twenty-four hours a day, seven days a week.

(3) Availability and Accessibility

(a) Hospice services must be obtainable by all of the residents of the State of Alabama. The care must be available to all terminally ill persons and their families without regard to age, gender, national origin, disability, diagnosis, cost of care, ability to pay or life circumstances.

(b) Physicians and other referral sources may be unfamiliar with the total scope of services offered by hospice; accessibility may be limited due to a lack of awareness. Every provider should provide an active community informational program to educate consumers and professionals to the availability, nature, and extent of their hospice services provided.

(4) Inventory

(a) As of this date, hospice services are believed to be available in all 67 counties, Hospice programs are licensed by the Alabama Department of Public Health.

(5) Quality

(a) Quality is that characteristic which reflects professionally and technically appropriate patient services. Each provider must establish mechanisms for quality assurance

including procedures for resolving concerns identified by patients, physicians, family members, or others in patient care or referral. Providers should also develop internal quality assurance and grievance procedures.

(b) Providers are encouraged to achieve a utilization level, which promotes cost effective service delivery.

(c) Hospice programs are required to meet or exceed the current Medicare Hospice Conditions of Participation, as adopted by CMS, and codified in the Code of Federal Regulations, along with State Licensure Regulations of the Department of Public Health. Licensed programs are required to meet the data collection requirements addressed in section 6(f)(1) of this document.

(6) In Home Hospice Services Need Methodology

(a) Purpose. The purpose of this in home hospice services need methodology is to identify, by county, the number of hospice providers needed to assure the continued availability, accessibility, and affordability of quality care for residents of Alabama. A corporate entity must obtain a CON for each office, branch or parent. However, relocation, within the same county of an already established office that has previously obtained a CON and it not expanding services, does not require applying for a new CON.

(b) General. Formulation of this methodology was accomplished by a committee of the Statewide Health Coordinating Council (SHCC). The committee, which provided its recommendations to the SHCC, was composed of providers and consumers of health care, and received input from the hospice providers and other affected parties. Only the SHCC, with the Governor's final approval, can make changes to this methodology, except that SHPDA staff shall annually update statistical information to reflect more current population and utilization. Such updated information is available for a fee upon request. Adjustments are addressed in paragraph (e) below.

(c) Basic Methodology

1. The SHCC approved the following methodology with the understanding that additional data is required in order to conduct a thorough investigation of both the appropriateness an accuracy of any need projections derived from it. To properly analyze the methodology, no determination of need will be made by SHPDA until December 31, 2014. SHPDA staff will utilize this time to analyze the methodology using data obtained through all Alabama Hospice Providers who are required, through this section, to collect and provide data as required by SHPDA on an annual basis. SHPDA will present to the SHCC a preliminary finding of projected need based on the aforementioned methodology prior to the end of the aforementioned 3 year period, to allow the SHCC to assess the results and determine if the methodology should be further revised through an amendment to the SHP.

2. Need Assessment for Hospice Services[1]

[1] Obtained through all Alabama Hospice providers who are required, through this section, to collect and provide data to SHPDA on annual basis.

3. The need for additional Hospice Services shall be calculated as follows:

HPR = Hospice Deaths by County/Total Deaths by County
Where as:
HPR= The Hospice Penetration Rate

Hospice Deaths by County is defined as the total deaths of those served in hospice care for the specific county. Data shall be obtained through all licensed Alabama Hospice providers who are required, through this document, to collect and provide data to SHPDA annually,

Total Deaths by County is defined as the total deaths from all causes in the specific county. Data shall be obtained from the Alabama Department of Public Health Center for Health Statistics.

This formula is recommended by the National Hospice and Palliative Care Organization which utilizes this formula to report national hospice penetration rates. In completing the formula to establish need, SHPDA will match the year of hospice deaths with the most recent year of total deaths as provided by the Alabama Department of Public Health Center for Health Statistics.

4. Review Criteria

An application to establish or expand hospice services in a county shall be consistent with this Plan if:

(i) The Hospice penetration rate in the proposed county is less than forty (40) percent.

(ii) Each approved hospice agency in the proposed county has been operational for at least thirty six (36) months; and

(iii) Only one (1) application may be approved in each county during any approval cycle as defined by the Statewide Health Coordinating Council, or a implemented by SHPDA;

(d) Planning Policies

1. SHPDA staff shall collect data from all licensed hospice providers on an annual basis, on a survey instrument to be developed by SHDPA Staff with input from the Alabama Hospice and Palliative Organization. The survey instrument shall be designed to collect all data necessary to support the In Home Services Need methodology discussed above and in order to maintain their CON and their good standing with SHPDA, licensed hospice providers shall respond as directed.

2. Hospice need projections will be based on a three-year planning horizon.

3. Planning will be on a countywide basis.

(e) Adjustments. The need for hospice providers, as determined by the methodology, is subject to adjustments by the SHCC. SHCC may adjust the need for hospice services in an individual county or counties if an applicant documents the existence of at least one of the following conditions:

1. Absence of services by a hospice certified for Medicaid and Medicare in the proposed county, and evidence that the applicant will provide Medicaid and Medicare-certified hospice service in the county; or

2. Absence of services by a hospice in the proposed county that serves patient's ability to pay, and evidence that the applicant will provide services for patients regardless of ability to pay.

(f) 1. There was numerous in-home hospice service providers providing services under Alabama Department of Public Health ("ADPH") licensure as of the May 13, 2009 effective date of Alabama Act 2009-492 (the "Act"), which amended ALA. CODE §22-21-260(6) (1975 as amended) to include "hospice service providers" within the definition of a health care facility. The Act also amended ALA. CODE § 22-4-2(7) (1975 as amended) to include "hospice services" within the definition of a "health care facility" and amended ALA. CODE § 22-21-29 (1975 as amended) by eliminating the provision that had placed a moratorium on ADPH's licensing of hospices, except for those applicants that had obtained a letter of non-reviewability from SHPDA by July 7, 2006 and filed an application for licensure as a hospice with ADPH within twelve (12) months thereafter. On August 17, 2009 the Alabama Attorney General issued an Opinion that while existing providers are required to obtain a Certificate of Need ("CON") to continue operations, SHPDA may adopt an emergency rule allowing such providers to continue to operate within an expedited timeframe that allows consideration of their CON applications upon a finding of an immediate danger to the public health, safety or welfare.

2. On August 31, 2009 Governor Riley approved Rule 410-2-3.10ER, which had been passed by the Statewide Health Coordinating Council ("SHCC"). Pursuant to this emergency rule, in-home hospice service providers in existence as of the effective date of Alabama Act 2009-492 were allowed to obtain CONs under a non-substantive review procedure, thus preventing any unnecessary disruption of services in authorized counties. The rule also provided for the collection of data needed for the development of a long-term need methodology. Need was presumed for any provider that demonstrated that it was providing service under ADPH license in a particular county as of May 13, 2009 or during the preceding twelve months.

3. Each entity that (1) as licensed by the Department of Public Health to provide in-home hospice services in a county, based upon a non-reviewability determination letter issued to the entity by the Alabama State Health Planning and Development Agency under ALA. CODE § 22-21-29(d) (1975 as amended) listing said county, but did not provide services by May 13, 2009 or during the preceding twelve months; or (2) that established itself with the Alabama State Health Planning and Development Agency by obtaining a non-reviewability determination letter by July 7, 2006 under the former provisions of ALA. CODE § 22-21-29(d) 91975 as amended), and timely

filed its application for licensure as a hospice provider with the Alabama Department of Public Health in particular counties ("the contemplated services area") within twelve (12) months thereafter and is not deemed to have abandoned its licensure application, shall be entitled to file for a Certificate of Need for the contemplated service area under the non-substantive review process, with need presumed, using such application forms as may be required by SHPDA. Hospice providers obtaining a CON pursuant to this Section (3) shall file a single application and be granted a single CON encompassing all of the qualifying counties. For purposes of this Section only, an entity shall be considered a separate hospice provider for each Medicare Provider Number held at the time of application (e.g., if an entity has multiple hospice provider numbers, a separate application must be filed, and CON issued, for each); provided, however, that a corporate entity having multiple provider number shall not receive more than one CON per county. Such CON authority may not be subsequently divided, e.g., a hospice provider may not separate such authority into separate CONs for future disposition. All applications submitted pursuant to the non-substantive review provisions of 410-2-3-.10(2)(b) and (c) shall include an acknowledgment of this restriction. Any CON authority granted pursuant to this section shall be combined, under a single CON, with any other CON authority obtained under the same provider number under Certificate of Need Review Board emergency rule 410-1-5C-01ER.

4. Following adoption by SHCC of the Hospice Services Need Methodology, all hospice providers which did not receive a CON pursuant to the non-substantive review process are required to undergo full Certificate of Need review.

5. Any hospice services provider which obtains a CON, either pursuant to the non-substantive review process or after full Certificate of Need Review, that subsequently fails to substantially comply on a timely basis (subject to any authorized extensions) to an annual data request from SHPDA staff adopted in conjunction with long-term need methodology shall be assumed to have ceased operations as of the end of such period until such time as the provider complies full with all outstanding SHPDA data request. Any provider that is deemed to have ceased operating under this chapter shall be prohibited from submitting any CON application for additional authority or from seeking consideration by SHPDA of such facility's utilization data to oppose another provider's CON application. In accordance with Rule 410-1-11-.08(2), should such cessation of operation continue for an uninterrupted period of twelve months or longer, the provider's CON shall be deemed abandoned. SHPDA shall file a report with the Alabama Department of Public Health of any provider who is deemed to have abandoned its CON under this section.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended: Filed February 1, 2010; Effective March 8, 2010. Amended: Filed January 24, 2012; Effective: February 28, 2012. Amended: Filed February 1, 2013; Effective March 8, 2013. Amended: Filed February 13, 2014; Effective March 20, 2014. Amended: Filed: December 2, 2014; Effective: January 6, 2015.
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410-2-3-.11 **Air Ambulance**

(1) Definition:

(a) Fixed wing (FW) air ambulance is the transportation by a fixed wing aircraft that is certified by the Federal Aviation Administration (FAA) as a fixed wing air ambulance and the provision of medically necessary services and supplies.

(b) Rotary Wing (RW) air ambulance is the transportation by a helicopter that is certified by the FAA as a rotary wing ambulance, including the provision of medically necessary supplies and services.

(2) Planning Policy:

(a) An applicant applying for an air ambulance service must identify a specific service area and any/all existing providers of air ambulance services in the proposed service area.

(b) The applicant must provide documentation of the aircraft selection and the reason/s for the selection of that type of aircraft.

(c) A copy of the Federal Aviation Administration (FAA) Air Charter Certificate and documentation of the approved operations' specifications for air ambulance operations for the proposed aircraft must be provided.

(d) The applicant must project the number of estimated transports within the proposed service area and the estimated population and hospital facilities that will be served. Patient transport configurations must also be included.

(e) The applicant must give a description of the proposed base or operations center and the ability to provide air ambulance services on a 24 hour per day, seven-day per week basis, identifying the means to access and communicate with the air ambulance personnel on duty.

(f) The impact of the proposed service on existing services, and the basis for analysis should be assessed and considered. The applicant must provide a statement about the impact the proposed service is expected to have on any air ambulance service within 75 miles.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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ALABAMA
STATE HEALTH PLAN
2014-2017
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

Chapter 410-2-4
Facilities

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410-2-4-.01 **Introduction**. This chapter focuses on existing health care facilities and the need for additional facilities. Methodologies for many facilities, i.e., general hospitals, nursing homes, specialty care assisted living facilities, rehabilitation, psychiatric and substance abuse, are specific in nature and project a finite number of beds needed. Swing beds, Long Term Acute Care Hospital beds, and Critical Care Access Hospital beds are allowed for hospitals, which meet the criteria as specified in the appropriate Federal Directive. The home health methodology allows at least two active providers for each county and is based on upon a minimum level of utilization. Located in the assisted living section is a methodology for standard assisted living facilities however, this is only a recommendation as these facilities are not covered under the Certificate of Need requirements. The bed need projections contained in the adult day care sections are recommendations only and are not intended to be regulatory unless these facilities become regulated by the Certificate of Need requirements.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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410-2-4-.02 **Acute Care (Hospitals)**

(1) Introduction. In this section, the methodology for computing acute care bed need will be described, criteria for making adjustments to the computed bed need will be discussed, and bed need for 2002, based on the methodology, will be presented.

(a) Definition: Hospital

Defined as printed in Rules of Alabama State Board of Health Division of Licensure and Certification Chapter 420-5-7 (effective September 26, 1990)

"Hospital" means a health institution planned, organized and maintained for offering to the public generally facilities and beds for use in the diagnosis and/or treatment of illness, disease, injury, deformity, infirmity, abnormality, or pregnancy, when the institution offers such care or service for not less than twenty-four (24) consecutive hours in any week to two (2) or more individuals not related by blood or marriage to the owner and/or administrator. In addition, the hospital may provide for the education of patients, medical and health personnel, as well as conduct research programs to promote progress and efficiency in clinical and administrative medicine.

(2) Purpose

(a) The purpose of the bed need methodology is to identify the number of acute general hospital beds, which will be needed at least three years into the future to assure the continued availability of quality hospital, care for residents of the state of Alabama. Such number, as identified later in this section, shall be the basis for statewide health planning and certificate of need approval, except:

1. in circumstances that pose a threat to public health, and/or

2. when the SHCC makes an adjustment based on criteria specified later in this section.

(b) All Alabama's Acute Care Hospitals, which are covered by this methodology.

(3) Methodology

(a) The planning area used in this methodology is the county, except for Choctaw, Cleburne, Coosa, Henry, Lamar, Lowndes, Macon, and Perry, which are grouped with Marengo, Calhoun, Tallapoosa, Houston, Fayette, Montgomery, and Lee, respectively. There are no hospitals in Choctaw, Cleburne, Coosa, Henry, Lamar, Lowndes, Macon, or Perry counties; therefore, each of these counties is grouped with a contiguous county where the majority of its population seeks hospitalization. Russell County had a hospital, which closed on April 1, 2002; however, a CON was issued January 30, 2003 for a new hospital to be constructed.

(b) The methodology involves:

applying recent utilization data
to
projected population
and
using desired occupancy rates
to
determine needed beds.

(c) Hospital annual reports (Form BHD 134-A) for the past three years, are used in computing a three-year weighted average daily census (ADC) to provide the utilization measure. The weighted average emphasizes the most current census levels while taking into consideration census for the previous two years.

(d) Desired occupancy rates for each of eight service categories are those which were established under the National Guidelines for Health Planning. These are:

Medical/Surgical (M/S)	80%
M/S in Small Hospitals (under 4,000 total admissions/yr.)	75%
Obstetrics	75%
Pediatrics	
0-39 beds	65%
40-79 beds	70%
80 or more beds	75%
ICU-CCU	65%
Other	75%

(e) Computations by Service Category

1. Compute Average Daily Census (ADC) for each of last three years.

$$ADC = \frac{\text{Patient Days in Service Category}}{\text{Days Operational in Year; Normally 365}}$$

2. Compute Weighted Average ADC (Weighted ADC).

$$\frac{\text{(Current Year minus 2 Years ADC x 1) + (Previous Year ADC x 2) + (Current Year ADC x 3)}}{}$$

3. Compute Projected ADC.

Projected ADC = Weighted ADC x $\frac{\text{3 Years above Current Year Projected Population}}{\text{Current Year Population}}$

4. Compute Projected Beds Needed.

Beds Needed = $\frac{\text{Projected ADC in Service Category}}{\text{Desired Occupancy Rate for Service Category}}$

(f) Summation Across Service Categories

1. Compute Total Beds Needed

Beds Needed = Medical/Surgical Beds Needed
+ Obstetrical Beds Needed
+ Pediatric Beds Needed
+ ICU-CCU Beds Needed
+ Other Beds Needed

2. Compute Net Beds Needed or Excess

Net Beds Needed (Excess) = Beds Needed - Existing Beds

3. Beds currently existing, under construction, and approved for construction are assumed to be existing beds in determining excess beds or additional beds needed.

(4) Criteria for Plan Adjustments

(a) The SHCC may make adjustments to the needed beds determined by the methodology described above if evidence is introduced to the SHCC in each of the criteria, which follow, the exception to this is section 410-2-4-.02 (5):

1. Evidence that residents of an area do not have access to necessary health services. Accessibility refers to the individual's ability to make use of available health resources. Problems which might affect access include persons living more than 30 minutes travel time from a hospital, the lack of health manpower in some counties, and individuals being without the financial resources to obtain access to healthcare facilities; and

2. Evidence that a plan adjustment would result in health care services being rendered in a more cost-effective manner. The SHCC, by adopting the bed need methodology herein, has decided that beds in excess of the number computed to be needed are not cost-effective. Therefore, the burden of proof that a plan adjustment would satisfy this criteria rests with the party seeking that adjustment; and

3. Evidence that a plan adjustment would result in improvements in the quality of health care delivered to residents of an area. Many organizations, including the Division of Licensure and Certification within the Alabama Department of Public Health, the Professional

Review Organization for the State, the Joint Commission on Accreditation of Health Care, and major third-party payers, continually address the issue of the quality of hospital care. Evidence of substandard care in existing hospital(s) within a county and/or evidence that additional hospital beds would enhance quality in a cost-effective way could partially justify a plan adjustment.

(a) In applying these three plan adjustment criteria, special consideration should be given to requests from hospitals which have experienced average hospital-wide occupancy rates in excess of 80% for the most recent two-year period. It is presumed that the patients, physicians, and health plans using a hospital experiencing high occupancy rates have rendered positive judgments concerning the accessibility, cost-effectiveness, and/or quality of care of that hospital. Thus, the 80% occupancy standard adds a market-based element of validity to other evidence, which might be given in support of a plan adjustment for an area.

(b) Numbers of beds do not always reflect the adequacy of the programs available within hospitals. In applying the three plan adjustment criteria to specific services, consideration should be given to the adequacy of both numbers of beds and programs offered in meeting patient needs in a particular county.

(5) Bed Availability Assurance for Acute Care (Hospitals)

(a) In some parts of Alabama, existing acute care hospitals are experiencing inpatient census levels not seen since the 1970's and the expectation is these census levels will only increase. Typically, these existing acute care hospitals are located in counties having significant population growth and/or hospitals with broad geographical service areas/statewide missions. These existing acute care hospitals are experiencing a shortage of acute care beds due to population growth and other demographic factors such as the aging baby boomers. The shortage of acute care beds is expected to only worsen. This shortage of acute care beds is causing patient transfers to be refused and ambulances to be turned-away (diverted) to more distant facilities or causing delays in transfers from the ER to an inpatient bed, which is not in the best interests of patients or the provision of quality and cost-effective health care. The Acute Care Bed Need Methodology is on a county-wide basis and is an average of all days of the month as well as all months of the year. As such, it may not always adequately take into consideration the census level and acute care bed availability of an individual acute care hospital and the significant inpatient bed pressures on the existing hospital, its patients and its Medical Staff.

(b) Therefore, in order to assist those existing acute care hospitals that are experiencing high census levels, which cause the hospitals to close emergency rooms ("diversions") and refuse transfers from other acute care hospitals, which results in negative impacts on patients and their families, existing acute care hospitals may qualify to add acute care beds if the existing acute care hospital can demonstrate an average week day acute bed (including observation patients) occupancy rate/census (Monday through Friday at midnight, exclusive of national holidays) for two separate and distinct periods of thirty (30) consecutive calendar days of the most recent twelve month period at or above the desired average occupancy rate of eighty percent (80%) of total licensed acute care beds for that hospital.

(c) For existing acute care hospitals achieving the occupancy rate in paragraph 2, those hospitals may seek a CON to add up to ten percent of licensed bed capacity (not to exceed 50 beds), rounded to the nearest whole, or alternatively up to thirty (30) beds, whichever is greater (which shall be at the applicant's option). Such additional beds will be considered an exception to the bed methodology set forth elsewhere in this Section, provided, however, that any additional beds authorized by the CON Board pursuant to this provision shall be considered for purposes of other bed need methodology purposes. In addition to such additional information that may be required by SHPDA, a hospital seeking a CON for additional beds under this section must provide, as part of its CON application the following information:

1. Demonstration of compliance with the occupancy rate in paragraph 2 (Average of at least an 80% week day occupancy rate for two (2) separate and distinct periods of thirty (30) consecutive calendar week days of the most recent 12 month period);

2. The application for additional acute care beds does not exceed ten percent of licensed acute care bed capacity (not to exceed 50 beds), rounded to the nearest whole, or alternatively up to thirty (30) acute care beds, whichever is greater.

3. The existing acute care hospital has not been granted an increase of beds under this section within the preceding twelve month period, which time begins to run upon the issuance of a certificate of occupancy issued by the Alabama Department of Public Health; and

4. The hospital must have been licensed for at least one year as a general acute care hospital.

(d) Any acute care beds granted under this section can only be added at or/upon the existing campus of the applicant acute care hospital.

(6) Planning Policy. In a licensed general acute care hospital, the temporary utilization of inpatient rehabilitation beds, inpatient or residential alcohol and drug abuse beds, or inpatient psychiatric beds for medical/surgical purposes will not be considered a conversion of beds provided that the temporary utilization not exceed a total of twenty percent (20%) in any one specialty unit, as allowed by federal Medicare regulations in a facility's fiscal year.

(7) Beds Needed (Excess Beds). Pages 65 and 66 summarize the bed need calculations for each Alabama County. Calculations indicate that there is not a need for additional beds anywhere in the state. However, in Bullock and Jackson counties the SHCC approved adjustments for additional beds, therefore those two counties show a need for beds. Overall, there are 7,569 excess hospital beds in Alabama; Jefferson County alone has 2,051. Following the bed need summary is a complete inventory of Alabama's hospitals.

(8) Long Term Acute Care Hospitals (LTAC)

(a) According to the Federal Centers for Medicare and Medicaid Services (CMS), a hospital is an excluded [from the Prospective Payment System] long term acute care hospital if it has in effect an agreement [with CMS] to participate as a general medical surgical acute care hospital and the average inpatient length of stay is greater than 25 days. Ordinarily, the determination regarding a hospital's average length of stay is based on the hospitals most recently filed cost report. However, if the hospital has not yet filed a cost report or if there is an indication that the most recently filed cost report does not accurately reflect the hospital's current average length of stay, data from the most recent six month period is used.

(b) Long term acute care hospitals provide a hospital level of care to patients with an acute illness, injury or exacerbation of a disease process that requires intensive medical and/or functional restorative care for an extended period of time, on average 25 days or longer. Generally, high technology monitoring or complex diagnostic procedures are not required. A long-term acute care hospital's primary patient service goal is to improve a patient's medical and functional status so that they can be successfully discharged to home or to a lower level of care. These patients generally do not meet admission criteria for nursing homes, rehabilitation, or psychiatric facilities.

(c) Alabama has an excess of licensed general acute care hospital beds, some of which could be used for long-term hospital care. Therefore, a general acute care hospital may apply for a certificate of need to convert acute care beds to long-term acute care hospital beds if the following conditions are met:

1. The hospital can satisfy the requirements of a long-term acute care hospital as outlined above.

2. The long term acute care hospital can demonstrate that it will have a separate governing body, a separate chief executive officer, a separate chief medical officer, a separate medical staff, and performs basic functions of an independent hospital.

3. The long term acute care hospital has written patient transfer agreements with hospitals other than the host hospital to show that it could provide at least 75 per cent of the admissions to the long term acute care hospital, based on the total average daily census for all participating hospitals.

4. The transfer agreements are with other hospitals in the same county and/or with hospitals in a region.

(d) To assure financial feasibility, the conversion of acute care beds to long-term acute care hospital beds shall be for a minimum of 25 beds.

(e) Needs Assessment.

1. The bed need for the proposed long term acute care hospital shall be for no more than five (5) percent of the combined average daily census (ADC) of all the acute care hospitals in the region of the proposed LTACH for the most recent annual reporting period.

2. As an alternative an applicant may justify bed need based on a detailed assessment of patient discharges after stays of 25 days or more.

3. An individual hospital's ADC or discharges shall not be used more than once in the computation of need for long term acute care hospital beds.

4. Due to accessibility issues all regions regardless of need methodology shall be permitted one LTACH facility with a maximum of 25 beds; which has proven financially feasible.

(f) The hospital must also comply with all statutes, rules, and regulations governing the Certificate of Need Review Program in Alabama.

(9) Pediatric Hospitals. Any licensed freestanding pediatric hospital or wholly owned subsidiary may make application for a Certificate of Need based on the latest obtainable pediatric data. The data submitted as part of the application shall be verified by the SHPDA staff prior to consideration by the Certificate of Need Review Board.

(10) Critical Access Hospitals (CAH).

(a) An existing hospital in Alabama must meet the following criteria to be considered for certification by CMS as a CAH (a new certificate of need is not required unless the application is for a new CAH or the hospital where the CAH is to be located has been closed longer than twelve months):

1. Is a public, nonprofit, or for-profit Medicare-certified hospital currently in operation and located on one of the following:

(i) A rural area as defined by the Office of Management and Budget (i.e.; outside a Metropolitan Statistical area);

(ii) A rural census tract of an Metropolitan Statistical Area (MSA) determined under the most recent version of the Goldsmith Modification Formula;

(iii) An area designated as Rural by law or regulation of the State of Alabama or in the State's rural Health Plan as approved by the federal Centers for Medicaid and Medicare Services;

(iv) A hospital would qualify as a rural referral center or as a sole community hospital if the hospital were located in a rural area

2. Hospitals, which closed on or after November 29, 1989, or are currently licensed health clinics or health centers that were created by downsizing a hospital, may reopen as a CAH;

3. Is located more than a 35-mile drive (or, 15 mile drive in areas with mountainous terrain or with only secondary roads available) from another hospital or CAH, or is designated by the state as being a Necessary Provider of Health Care Services to area residents;

4. Makes available 24-hour emergency care services that the State determines are necessary for ensuring access to emergency care in each community served by the critical access hospital;

5. Provides not more than 25 beds for acute inpatient care (which in the case of a swing bed facility can be used interchangeably for acute or SNF-level care) and the hospital may also provide up to 10 rehabilitation and 10 psychiatric beds so long as these are operated as separate units;

6. Maintains an average annual patient stay of no more than 96 hours;

7. Meets critical access hospital staffing requirements;

8. Is a member of a rural health network and has an agreement with at least one full-service hospital (Affiliate) in the network for:

- patient referral and transfer
- development and use of communications systems
- provision of emergency and non-emergency transportation;

9. Has an agreement regarding staff credentialing and quality assurance with one of the following:

(i) a hospital that is a joint member in the rural health network,

(ii) a peer review organization or equivalent entity, or

(iii) another appropriate and qualified entity identified in the state rural health plan;

10. Federal statutes and eligibility requirements governing the CAH Program allow states to designate an existing hospital as a Necessary Provider of Health Care Services for its area residents if it meets all requirements for a CAH except the mileage between hospitals requirement. Alabama will utilize this statutory provision and designate Necessary Provider of Health Care Services for existing hospitals located in a county considered “at risk” for losing primary health care access. Alabama has reviewed numerous indicators of under-service in communities to determine criteria most appropriate for Alabama. Five criteria have been selected.

If the hospital meets one or more of these criteria, Alabama's Bureau of Health Provider Standards, Division of Provider Services, in consultation with the Office of Primary Care and Rural Health, will declare the facility a Necessary Provider of Health Care Services.

Criteria 1. The hospital is located in an area designated as a Health Professional Shortage Area.

Criteria 2. The hospital is located in an area designated as Medically Underserved.

Criteria 3. The hospital is located in a county with an unemployment rate higher than the statewide rate of unemployment.

Criteria 4. The hospital is located in a county with a percentage of population age 65 years and older greater than the state's average.

Criteria 5. The hospital is located in a county where the percentage of families with incomes below 200% of the federal poverty level is higher than the state average for families with incomes below 200% of the federal poverty level.

Any existing hospital, which otherwise satisfies CAH criteria except the mileage requirement but does not meet at least one of the above criteria for certification as a Necessary Provider of Health Services, may appeal to Alabama's State Health Officer. Evaluation of appeals will be based on submission of objective information, which demonstrates the presence of extenuating circumstances which may adversely impact an area's access to health care if the existing hospital is not declared a Necessary Provider of Health Services. Based on evidence presented, the State Health Officer may decide to issue a variance from established criteria and declare the appealing hospital a Necessary Provider of Health Care Services.

(b) In order to meet the federal CAH requirements as to the number of beds, an existing hospital may distinguish "authorized" and "licensed" general acute care and swing beds as in the rules established by the ADPH and SHPDA.

(c) The "Medicare Prescription Drug, Improvement and Modernization Act" (Public Law H.R. 1 and S. 1 June 27, 2003) was recently signed into law by the President. This law is a very extensive revision to the Medicare program and contains provisions relating the Critical Access Hospital Program found in Section 405 of the Act. These provisions will allow more flexibility for hospitals converting to CAH status. The provisions will not go into effect in Alabama until the rural health plan is revised/amended.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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ALABAMA
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
PROJECTED HOSPITAL BED NEED FOR 2005

COUNTY	POPULATION FACTOR 2000-2005	PROJECTED BEDS NEEDED	LICENSED BEDS EXISTING	CON ISSUED	NET NEED (EXCESS)
AUTAUGA	1.113	24	85	0	(61)
BALDWIN	1.156	191	287	0	(96)
BARBOUR	1.05	25	74	0	(49)
BIBB	1.095	5	35	0	(30)
BLOUNT	1.124	40	40	0	0
BULLOCK*	1.018	31	30	0	50
BUTLER	0.984	53	94	0	(41)
CALHOUN/CLEBURNE	1.003	306	586	0	(280)
CHAMBERS	0.995	64	115	0	(51)
CHEROKEE	1.091	15	60	0	(45)
CHILTON	1.098	10	60	0	(50)
CLARKE	1.01	33	134	0	(101)
CLAY	1.036	30	53	0	(23)
COFFEE	1.034	70	151	0	(81)
COLBERT	1.023	150	313	0	(163)
CONECUH	1.001	38	58	0	(20)
COVINGTON	1.008	78	223	0	(145)
CRENSHAW	1.001	22	65	0	(43)
CULLMAN	1.063	142	215	0	(73)
DALE	1.014	38	89	0	(51)
DALLAS	0.981	161	214	0	(53)
DEKALB	1.084	50	134	0	(84)
ELMORE	1.122	60	138	0	(78)
ESCAMBIA	1.028	106	142	0	(36)
ETOWAH	1.013	376	627	0	(251)
FAYETTE	1.008	29	61	0	(32)
FRANKLIN	1.054	62	133	0	(71)
GENEVA	1.034	34	83	0	(49)
GREENE	0.98	4	20	0	(16)
HALE	1.05	11	39	0	(28)
HOUSTON/HENRY	1.031	466	635	0	(169)
JACKSON**	1.05	60	170	0	4
JEFFERSON	1.008	3163	5214	0	(2051)
LAUDERDALE	1.042	270	366	0	(96)
LAWRENCE	1.039	21	98	0	(77)
LEE/MACON	1.09	234	314	0	(80)
LIMESTONE	1.085	63	101	0	(38)
MADISON	1.062	671	1021	0	(350)

MARENGO/CHOCTAW	0.988	55	99	0	(44)
MARION	1.019	59	128	0	(69)
MARSHALL	1.073	150	240	0	(90)
MOBILE	1.022	1266	1987	0	(721)
MONROE	1.002	29	94	0	(65)
MONTGOMERY/LOWNDES	1.03	642	977	0	(355)
MORGAN	1.044	255	543	0	(288)
PICKENS	1.007	29	56	0	(27)
PIKE	1.038	38	97	0	(59)
RANDOLPH	1.055	28	126	0	(98)
RUSSELL	1.024	56	0	70	(14)
ST. CLAIR	1.117	22	82	0	(60)
SHELBY	1.166	158	192	0	(34)
SUMTER	0.963	5	33	0	(28)
TALLADEGA	1.035	106	270	0	(164)
TALLAPOOSA/COOSA	1.027	53	127	0	(74)
TUSCALOOSA	1.033	622	814	0	(192)
WALKER	1.018	102	267	0	(165)
WASHINGTON	1.031	4	25	0	(21)
WILCOX	0.988	4	32	0	(28)
WINSTON	1.056	34	99	0	(65)
STATE TOTALS	1.041	10,923	18,565	70	(7,569)

UPDATED JANUARY 2004

* The Statewide Health Coordinating Council approved an adjustment to the *State Health Plan* that became effective on September 9, 2003 for an additional 49 beds in Bullock County.

** The Statewide Health Coordinating Council approved an adjustment to the *State Health Plan* that became effective on September 9, 2003 for a 4-bed critical access hospital in Jackson County.

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 - SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Prattville Baptist Hospital	Autauga	Prattville	85	85		6,796	18.62	21.90
Autauga County Totals			***85***	***85***		***6,796***	***18.62***	***21.90***
North Baldwin Infirmary	Baldwin	Bay Minette	55	55		4,637	12.70	23.10
Thomas Hospital	Baldwin	Fairhope	150	150		24,257	66.46	44.31
South Baldwin Regional Medical Center	Baldwin	Foley	82	82		19,844	54.37	66.30
Baldwin County Totals			***287***	***287***		***48,738***	***133.53***	***46.53***
Lakeview Community Hospital	Barbour	Eufaula	74	74		6,664	18.26	24.67
Barbour County Totals			***74***	***74***		***6,664***	***18.26***	***24.67***
Bibb Medical Center	Bibb	Centreville	35	35		1,705	4.67	13.35
Bibb County Totals			***35***	***35***		***1,705***	***4.67***	***13.35***
Medical Center Blount	Blount	Oneonta	40	40		8,550	23.42	58.56
Blount County Totals			***40***	***40***		***8,550***	***23.42***	***58.56***
Bullock County Hospital	Bullock	Union Springs	30	30		9,856	27.00	90.01
Bullock County Totals			***30***	***30***		***9,856***	***27.00***	***90.01***
Georgiana Hospital	Butler	Georgiana	22	22		5,023	13.76	62.55
L. V. Stabler Memorial Hospital	Butler	Greenville	72	59		8,646	23.69	40.15
Butler County Totals			**94**	**81**		**13,669**	***37.45***	***46.23***
Jacksonville Hospital	Calhoun	Jacksonville	89	89		5,583	15.30	17.19
Northeast AL Regional Medical Center	Calhoun	Anniston	372	352		66,448	182.05	51.72
Stringfellow Memorial Hospital	Calhoun	Anniston	125	125		17,288	47.36	37.89
Calhoun County Totals			***586***	***566***		***89,319***	***244.71***	***43.23***
George H. Lanier Memorial Hospital	Chambers	Valley	115	115		16,594	45.46	39.53

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 - SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Chambers County Totals			***115***	***115***		***16,594***	***45.46***	***39.53***
Baptist Medical Center Cherokee	Cherokee	Centre	60	60		4,481	12.28	20.46
Cherokee County Totals			***60***	***60***		***4,481***	***12.28***	***20.46***
Chilton Medical Center	Chilton	Clanton	60	60		2,264	6.20	10.34
Chilton County Totals			***60***	***60***		***2,264***	***6.20***	***10.34***
Grove Hill Memorial Hospital	Clarke	Grove Hill	50	50		3,997	10.95	21.90
Jackson Medical Center	Clarke	Jackson	35	35		3,202	8.77	25.06
Thomasville Infirmary	Clarke	Thomasville	49	49		3,511	9.62	19.63
Clarke County Totals			***134***	***134***		***10,710***	***29.34***	***21.90***
Clay County Hospital	Clay	Ashland	53	53		7,714	21.13	39.88
Clay County Totals			***53***	***53***		***7,714***	***21.13***	***39.88***
Elba General Hospital	Coffee	Elba	20	20		4,077	11.17	55.85
Medical Center Enterprise	Coffee	Enterprise	131	131		16,705	45.77	34.94
Coffee County Totals			***151***	***151***		***20,782***	***56.94***	***37.71***
Helen Keller Memorial Hospital	Colbert	Sheffield	185	165		27,768	76.08	46.11
Shoals Hospital	Colbert	Muscle Shoals	128	128		14,015	38.40	30.00
Colbert County Totals			***313***	***293***		***41,783***	***114.47***	***39.07***
Evergreen Medical Center	Conecuh	Evergreen	58	44		9,525	26.10	59.31
Conecuh County Totals			***58***	***44***		***9,525***	***26.10***	***59.31***
Andalusia Regional Hospital	Covington	Andalusia	101	101		14,489	39.70	39.30
Florala Memorial Hospital	Covington	Florala	23	23		2,221	6.08	26.46

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 - SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Mizell Memorial Hospital	Covington	Opp	99	99		8,025	21.99	22.21
Covington County Totals			***223***	***223***		***24,735***	***67.77***	***30.39***
Crenshaw Community Hospital	Crenshaw	Luverne	65	45		2,114	5.79	12.87
Crenshaw County Totals			***65***	***45***		***2,114***	***5.79***	***12.87***
Cullman Regional Medical Center	Cullman	Cullman	115	115		32,465	88.95	77.34
Woodland Medical Center	Cullman	Cullman	100	80		8,102	22.20	27.75
Cullman County Totals			***215***	***195***		***40,567***	***111.14***	***57.00***
Dale Medical Center	Dale	Ozark	89	89	-10*	9,949	27.26	30.63
Dale County Totals			***89***	***89***		***9,949***	***27.26***	***30.63***
Vaughan Regional Medical Center-Parkway	Dallas	Selma	214	151		35,125	96.23	63.73
Dallas County Totals			***214***	***151***		***35,125***	***96.23***	***63.73***
Baptist Medical Center - DeKalb	DeKalb	Fort Payne	134	134		14,504	39.74	29.65
DeKalb County Totals			***134***	***134***		***14,504***	***39.74***	***29.65***
Community Hospital, Inc.	Elmore	Tallassee	69	69	-10*	8,692	23.81	34.51
Elmore Community Hospital	Elmore	Wetumpka	69	49		2,987	8.18	16.70
Elmore County Totals			***138***	***118***		***11,679***	***32.00***	***27.12***
Atmore Community Hospital	Escambia	Atmore	51	51		7,469	20.46	40.12
D. W. McMillan Memorial Hospital	Escambia	Brewton	91	91		12,247	33.55	36.87
Escambia County Totals			***142***	***142***		***19,716***	***54.02***	***38.04***
Gadsden Regional Medical Center	Etowah	Gadsden	346	326		53,779	147.34	45.20
Riverview Regional Medical Center	Etowah	Gadsden	281	281		53,515	146.62	52.18
Etowah County Totals			***627***	***607***		***107,294***	***293.96***	***48.43***

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS		UTILIZATION DATA (OCT. 2001 - SEPT. 2002)			
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Fayette Medical Center	Fayette	Fayette	61	61		8,897	24.38	39.96
Fayette County Totals			***61***	***61***		***8,897***	***24.38***	***39.96***
Russellville Hospital	Franklin	Russellville	100	100		13,518	37.04	37.04
Red Bay Hospital	Franklin	Red Bay	33	33		4,373	11.98	36.31
Franklin County Totals			***133***	***133***		***17,891***	***49.02***	***36.85***
Wiregrass Medical Center	Geneva	Geneva	83	83		9,652	26.44	31.86
Geneva County Totals			***83***	***83***		***9,652***	***26.44***	***31.86***
Greene County Hospital	Greene	Eutaw	20	20		1,710	4.68	23.42
Greene County Totals			***20***	***20***		***1,710***	***4.68***	***23.42***
Hale County Hospital	Hale	Greensboro	39	39		2,586	7.08	18.17
Hale County Totals			***39***	***39***		***2,586***	***7.08***	***18.17***
Flowers Hospital	Houston	Dothan	235	235		55,135	151.05	64.28
Southeast Alabama Medical Center	Houston	Dothan	400	381		90,903	249.05	65.37
Houston County Totals			***635***	***616***		***146,038***	***400.10***	***64.95***
Jackson County Hospital	Jackson	Scottsboro	170	170		14,346	39.30	23.12
Jackson County Totals			***170***	***170***		***14,346***	***39.30***	***23.12***
UAB Medical Center West	Jefferson	Bessemer	300	258		45,091	123.54	47.88
Baptist Medical Center-Princeton	Jefferson	Birmingham	499	474		71,939	197.09	41.58
Baptist Medical Center Montclair	Jefferson	Birmingham	496	438		75,125	205.82	46.99
Carraway Methodist Medical Center	Jefferson	Birmingham	617	548		48,855	133.85	24.43

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 - SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Children's Hospital of Alabama (The)	Jefferson	Birmingham	225	202		58,977	161.58	79.99
Brookwood Medical Center	Jefferson	Birmingham	586	389		81,291	222.72	57.25
Medical Center East	Jefferson	Birmingham	282	262		57,858	158.52	60.50
Callahan Eye Foundation at UAB	Jefferson	Birmingham	106	106		856	2.35	2.21
Cooper Green Hospital	Jefferson	Birmingham	319	319		23,202	63.57	19.93
St. Vincent's Hospital	Jefferson	Birmingham	338	338		80,907	221.66	65.58
HealthSouth Medical Center	Jefferson	Birmingham	219	219		29,700	81.37	37.16
University of Alabama Hospital	Jefferson	Birmingham	908	761		210,338	576.27	75.73
HealthSouth Metro West Hospital	Jefferson	Fairfield	319	295		16,658	45.64	15.47
Jefferson County Totals			***5,214***	***4,609***		***800,797***	***2,193.96***	***47.60***
Eliza Coffee Memorial Hospital	Lauderdale	Florence	366	269		65,246	178.76	66.45
Lauderdale County Totals			***366***	***269***		***65,246***	***178.76***	***66.45***
Lawrence Baptist Medical Center	Lawrence	Moulton	98	98		5,643	15.46	15.78
Lawrence County Totals			***98***	***98***		***5,643***	***15.46***	***15.78***
East Alabama Medical Center	Lee	Opelika	314	276		58,253	159.60	57.82
Lee County Totals			***314***	**276**		***58,253***	***159.60***	57.82
Athens Limestone Hospital	Limestone	Athens	101	101		16,501	45.21	44.76
Limestone County Totals			***101***	***101***		***16,501***	***45.21***	***44.76***
Huntsville Hospital (The)	Madison	Huntsville	901	846		162,462	445.10	52.61
Crestwood Medical Center	Madison	Huntsville	120	108		20,408	55.91	51.77
Madison County Totals			**1,021**	**954**		182,870	***501.01***	***52.52***
Bryan W. Whitfield Memorial Hospital	Marengo	Demopolis	99	99		14,291	39.15	39.55
Marengo County Totals			***99***	***99***		***14,291***	***39.15***	***39.55***

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 - SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Marion Regional Medical Center	Marion	Hamilton	57	57		5,859	16.05	28.16
Northwest Medical Center	Marion	Winfield	71	56		10,114	27.71	49.48
Marion County Totals			***128***	***113***		***15,973***	***43.76***	***38.73***
Marshall Medical Center South	Marshall	Boaz	150	150		22,186	60.78	40.52
Marshall Medical Center	Marshall	Guntersville	90	90		18,561	50.85	56.50
Marshall County Totals			***240***	***240***		***40,747***	***111.64***	***46.51***
USA Knollwood Park	Mobile	Mobile	124	124		11,762	32.22	25.99
USA Children's and Women's Hospital	Mobile	Mobile	152	152		32,215	88.26	58.07
USA Medical Center	Mobile	Mobile	406	406		38,912	106.61	26.26
Mobile Infirmary	Mobile	Mobile	704	613		122,700	336.16	54.84
Providence Hospital	Mobile	Mobile	349	349		79,943	219.02	62.76
Springhill Memorial Hospital	Mobile	Mobile	252	252		50,584	138.59	54.99
Mobile County Totals			***1,987***	***1,896***		***336,116***	***920.87***	***48.57***
Monroe County Hospital	Monroe	Monroeville	94	94		9,507	26.05	27.71
Monroe County Totals			***94***	***94***		***9,507***	***26.05***	***27.71***
Baptist Medical Center East	Montgomery	Montgomery	150	150		28,030	76.79	51.20
Jackson Hospital and Clinic, Inc.	Montgomery	Montgomery	373	351		65,731	180.08	51.31
Baptist Medical Center South	Montgomery	Montgomery	454	422		71,525	195.96	46.44
Montgomery County Totals			***977***	***923***		***165,286***	***452.84***	***49.06***
Decatur General Hospital	Morgan	Decatur	273	273		42,617	116.76	42.77
Parkway Medical Center	Morgan	Decatur	120	120		10,677	29.25	24.38
Hartselle Medical Center	Morgan	Hartselle	150	130		6,156	16.87	12.97
Morgan County Totals			***543***	***523***		***59,450***	***162.88***	***31.14***

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS		UTILIZATION DATA (OCT. 2001 - SEPT. 2002)			
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Pickens County Medical Center	Pickens	Carrollton	56	46		7,621	20.88	45.39
Pickens County Totals			***56***	***46***		***7,621***	***20.88***	***45.39***
Edge Regional Medical Center	Pike	Troy	97	97		10,608	29.06	29.96
Pike County Totals			***97***	***97***		***10,608***	***29.06***	***29.96***
Randolph Medical Center	Randolph	Roanoke	92	92		4,612	12.64	13.73
Wedowee Hospital	Randolph	Wedowee	34	34		1,670	4.58	13.46
Randolph County Totals			***126***	***126***		***6,282***	***17.21***	***13.66***
Shelby Baptist Medical Center	Shelby	Alabaster	192	180		40,476	110.89	61.61
Shelby County Totals			***192***	***180***		***40,476***	***110.89***	***61.61***
St. Clair Regional Hospital	St. Clair	Pell City	82	82		5,619	15.39	18.77
St. Clair County Totals			***82***	***82***		***5,619***	***15.39***	***18.77***
Hill Hospital of Sumter County	Sumter	York	33	33		1,305	3.58	10.83
Sumter County Totals			***33***	***33***		***1,305***	***3.58***	***10.83***
Coosa Valley Baptist Medical Center	Talladega	Sylacauga	148	148		19,712	54.01	36.49
Citizens Baptist Medical Center	Talladega	Talladega	122	122		10,835	29.68	24.33
Talladega County Totals			***270***	***270***		***30,547***	***83.69***	***31.00***
Russell Medical Center	Tallapoosa	Alexander City	81	81		12,506	34.26	42.30
Lake Martin Community Hospital	Tallapoosa	Dadeville	46	46		3,167	8.68	18.86
Tallapoosa County Totals			***127***	***127***		***15,673***	***42.94***	***33.81***
Northport Medical Center	Tuscaloosa	Northport	204	108		27,293	74.78	69.24

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 - SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
DCH Regional Medical Center	Tuscaloosa	Tuscaloosa	610	610		129,355	354.40	58.10
Tuscaloosa County Totals			***814***	***718***		***156,648***	***429.17***	***59.77***
Walker Baptist Medical Center	Walker	Jasper	267	243		27,437	75.17	30.93
Walker County Totals			***267***	***243***		***27,437***	***75.17***	***30.93***
Washington County Infirmary	Washington	Chatom	25	25		1,271	3.48	13.93
Washington County Totals			***25***	***25***		***1,271***	***3.48***	***13.93***
J. Paul Jones Hospital	Wilcox	Camden	32	32		1,246	3.41	10.67
Wilcox County Totals			***32***	***32***		***1,246***	***3.41***	***10.67***
Burdick West Medical Center	Winston	Haleyville	99	99		8,451	23.15	23.39
Winston County Totals			***99***	***99***		***8,451***	***23.15***	***23.39***
CON Issued plus/minus					50*			
Alabama State Totals			**18,505**	**17,147**	**17,144**	**2,849,817**	***7,807.72***	***45.53***

* These beds due to CONs issued for conversion of acute beds and a CON for a 70 bed hospital to be built in Russell County.

UPDATED July 2004 SOURCE: SHPDA ANNUAL HOSPITAL REPORTS

ALABAMA'S INVENTORY OF
LONG TERM ACUTE CARE HOSPITALS

Facility	Region	City/Town	County	Exist Beds	Con Iss	Total Beds	Patient Days	ADC	Ave Length 0f Stay	% Occ
Select Specialty Hospital – Birmingham	III	Birmingham	Jefferson	38		38	7,482	20.50	29.5	53.9
Medical Center East/Lloyd Noland	III	Birmingham	Jefferson	45		45	*	*	*	*
HealthSouth Metro West/Lloyd Noland	III	Fairfield	Jefferson		55	55	*	*	*	*
The Long Term Care Hospital at Carraway – Lloyd Noland Foundation	III	Birmingham	Jefferson		27	27	*	*	*	*
Select Specialty Hospitals, Inc.	III	Birmingham	Jefferson		27	27	*	*	*	*
Total for Region				**83**	**109**	**192**				
The Long Term Care Hospital at Regional Medical Center	IV	Anniston	Calhoun	34		34	*	*	*	*
Total for Region				**34**		**34**				
The Long Term Care Hospital at DCH Regional Medical Center	V	Tuscaloosa	Tuscaloosa		27	27	*	*	*	*
Total for Region					**27**	**27**				
The Long Term Care Hospital at Jackson	VI	Montgomery	Montgomery	60	5	65	10,913	29.90	26.9	83.1
Total for Region				**60**	**5**	**65**				
USA Knollwood Park LTC Hospital	VII	Mobile	Mobile	191		191	13,317	36.48	26.7	19.1
Total for Region				**191**		**191**				
Southeast Alabama Medical Center, LLC by the Lloyd Noland Foundation, Inc.	VIII	Dothan	Houston	30		30				
Total for Region				30		**30**				
Total for State				**398**	**141**	**539**				

* Data not available

Utilization Data based upon Annual Hospital Reports (Oct. 2001-Sept. 2002) Revised as of 8/04/2004

Licensed Beds and CON Issued effective August 4, 2004

Long Term Acute Care Hospitals (LTACH)
Projected Bed Need by Region
Excluding Pediatrics
LONG TERM ACUTE CARE BED NEED STATUS AS OF August 2004

REGION	COUNTY	CON APPLICATIONS PENDING
II	Madison	AL2004-027 Select Specialty Hospital- Huntsville, Inc. construct and establish 44 bed LTACH freestanding facility.
II	Madison	AL2004-032 The Long Term Care Hospital of Huntsville, LLC, by the Lloyd Noland Foundation Inc. Construct and establish a new freestanding 49 bed LTACH facility.
II	Madison	AL2004-035 HealthSouth LTCH of Huntsville, Inc. Construct a 40 bed long-term acute care hospital in Huntsville, Alabama.
VII	Mobile	AL2003-016 Semper Care Hospital of Mobile, Inc d/b/a Mobile Infirmary. Convert 33 acute care beds to LTACH. Application denied by CONRB 4/21/04. Appealed to Circuit Court.

Long Term Acute Care Hospitals (LTACH)
Projected Bed Need by Region
Excluding Pediatrics

	Projected Beds	Existing Beds	CON Issued	Net Need
Region I				
Colbert	6			6
Franklin	2			2
Lauderdale	9			9
Lawrence	1			1
I Total	18			18
Region II				
Jackson	2			2
Limestone	2			2
Madison	24			24
Marshall	6			6
Morgan	8			8
Region II Total	42			42
Region III				
Bibb	0			0
Blount	1			1
Cullman	6			6
Jefferson	102	83	109	-90
Marion	2			2
Saint Clair	1			1
Shelby	6			6
Talladega	4			4
Walker	4			4
Winston	1			1
III Total	127	83	109	-65

	Projected Beds	Existing Beds	CON Issued	Net Need
Region IV				
Calhoun	12	34		-22
Cherokee	1			1
Clay	1			1
Cleburne	0			0
Dekalb	2			2
Etowah	15			15
Randolph	1			1
IV Total	32	34		-2
Region V				
Fayette	1			1
Greene	0			0
Hale	0			0
Lamar	0			0
Pickens	1			1
Sumter	0			0
Tuscaloosa	21		27	-6
V Total	23		27	-4

	Projected Beds	Existing Beds	CON Issued	Net Need
Region VI				
Autauga	1			1
Bullock	1			1
Butler	2			2
Chambers	2			2
Chilton	0			0
Coosa	0			0
Crenshaw	0			0
Dallas	5			5
Elmore	2			2
Lee	8			8
Lowndes	0			0
Macon	0			0
Marengo	2			2
Montgomery	21	60	5	-44
Perry	0			0
Pike	1			1
Russell	0			0
Tallapoosa	2			2
Wilcox	0			0
VI Total	47	60	5	-18

Long Term Acute Care Hospitals (LTACH)
Projected Bed Need by Region
Excluding Pediatrics

Long Term Acute Care Hospitals (LTACH)
Projected Bed Need by Region
Excluding Pediatrics

	Projected Beds	Existing Beds	CON Issued	Net Need
Region VII				
Baldwin	6			6
Choctaw	0			0
Clarke	1			1
Conecuh	1			1
Escambia	3			3
Mobile	43	191		-148
Monroe	1			1
Washington	0			0
VII Total	55	191		-136

	Projected Beds	Existing Beds	CON Issued	Net Need
Region VIII				
Barbour	1			1
Coffee	3			3
Covington	3			3
Dale	1			1
Geneva	1			1
Henry	0			0
Houston	20	30		-10
VIII Total	29	30		-1

	Projected Beds	Existing Beds	CON Issued	Net Need
State Total	**373**	**398**	**141**	**-166**

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410-2-4-.03 **Nursing Homes**

(1) Definition. Nursing homes may be identified as licensed facilities providing inpatient care for convalescents or other persons not acutely ill and not in need of acute general hospital care, but requiring skilled nursing care. Nursing home care is not to be confused with long-term hospital care. Some hospitals, however, may have nursing homes beds attached as an identifiable part which is reflected in their license. Such beds are included in this chapter. Hospital swing beds are not included.

(2) Analysis of Existing Facilities

(a) As of March 1996, there were 224 licensed nursing homes, excluding state owned and operated facilities, totaling 23,475 beds operating in the state of Alabama Average occupancy for the 224 facilities was approximately 94.8 percent for Fiscal Year 1995. Currently, there exists approximately 44.5 beds per one thousand persons 65 and older (down from 48 beds per thousand in 1980).

(b) Approximately 92 percent of nursing home beds in Alabama are occupied by persons 65 and older. This aged population represents 13.5 percent of the state's total population and is projected to increase gradually during the coming years.

(3) State Owned and Operated Facilities

(a) Five mental retardation facilities have been certified as Intermediate Care Facilities/Mental Retardation (ICF/MR). They are:

1. Albert P. Brewer Developmental Center; 210 beds; Mobile, Alabama

2. Glen Ireland II Developmental Center; 119 beds; Tarrant, Alabama

3. J. S. Tarwater Developmental Center; 107 beds; Wetumpka, Alabama

4. L. B. Wallace Developmental Center; 247 beds; Decatur, Alabama

5. William D. Partlow Developmental Center; 310 beds; Tuscaloosa, Alabama

(b) Three state-owned Intermediate Care Facilities for the mentally diseased are located in Alabama. They are:

1. Alice M. Kidd Intermediate Care Facility; 216 beds; Tuscaloosa, Alabama

2. S. D. Allen Intermediate Care Facility; 138 beds; Tuscaloosa, Alabama

3. Claudette Box Nursing Facility; 142 beds; Mt. Vernon, Alabama

(4) Alternatives to Institutionalization

(a) Efforts should be made to maintain an optimum quality of life for long-term care residents in their home for as long as possible. The types and amounts of services needed for long-term care residents vary. In order to enhance opportunities for residents needing long-term care services, which would allow them to remain in their homes for as long as possible, the health care and social needs of these residents should be evaluated by an independent multidisciplinary team, composed of a registered nurse and a social worker, prior to nursing home admission. This team should also evaluate the ability of resources within the local community to meet the needs of these residents.

(b) In an effort to encourage the development and utilization of alternatives to nursing home care, the Alabama Medicaid Agency now has a program, which reimburses certain health, social, and related services provided in the community. Individuals who might otherwise require admission to a nursing home are now able to remain in their homes because of the home and community based services provided through this program. Currently, there are nearly 8,200 residents whose long-term care needs can be met through the program.

(5) Financing

(a) The Alabama Medicaid program was started in 1970, and as a result, the nursing home industry grew rapidly during the 70s. Since the 1980 adoption of a more restrictive bed need methodology, the number of beds added tapered off considerably. Also, with the containment of health care costs as a primary concern, a moratorium on additional nursing home beds was established in August of 1984, and was not lifted until June of 1989. Medicaid patients now occupy 68 percent of the available beds (as compared to 72 percent in 1980), private pay patients 27 percent, and Medicare the remainder.

(6) Availability

(a) The 224 licensed nursing homes (excluding state owned) located in Alabama, are generally geographically well distributed and are accessible to the majority of the elderly population within 30 minutes normal driving time. Every Alabama county has a least one nursing home, with the exception of Lowndes County.

(7) Continuity

(a) Discussion

1. Nursing homes should provide care appropriate to resident needs. To ensure that comprehensive services are available and to ensure residents are at a proper level of care, nursing homes should provide, or should have agreements with other health care providers to provide, a broad range of care. When providing these services, or a part of any agreement to provide these services, transfer of residents and support service should be provided as necessary.

(b) Planning Policy

The rendering of complementary long-term care services, such as home health care adult day care, senior citizen nutrition programs, hospice, etc., to long-term care recipients should be fostered and encouraged. In areas where such services are sufficiently developed, health care facilities should be encouraged to have agreements that increase the availability of such services to residents. In areas where such services are not sufficiently available, facilities should be encouraged to develop and offer such services. The Division of Licensure and Certification is encouraged to make the appropriate changes to the licensure requirements.

(8) Quality

(a) Quality care is an obligation of all nursing homes operating in Alabama. Each facility must meet standards of care as established by the federal government (Medicare and Medicaid Conditions of Participation) and the Alabama State Board of Health Rules and Regulations. The Division of Licensure and Certification of the Alabama Department of Public Health is responsible for determining compliance. Additionally, the Professional Review Organization (PRO) now includes some nursing homes in its review.

(9) Nursing Home Bed Need Methodology

(a) Purpose. The purpose of this nursing home bed need methodology is to identify, by county, the number of nursing home beds needed to assure the continued availability, accessibility, and affordability of quality nursing home care for residents of Alabama.

(b) General. Formulation of this bed need methodology was accomplished by a committee of the Statewide Health Coordinating Council (SHCC). The committee which provided its recommendations to the SHCC, was composed of providers and consumers of health care. Only the SHCC, with the Governor's final approval, can make changes to this methodology except that the SHPDA staff shall annually update bed need projections and inventories to reflect more current population and utilization statistics. Such updated information is available for a fee upon request. Adjustments are addressed in paragraph (e).

(c) Basic Methodology. Considering the availability of more community and home based services for the elderly in Alabama, there should be a minimum of 40 beds per 1,000 population 65 and older for each county.

1. The beds need formula is as follows:

(40 beds per thousand) x (population 65 and older) =
Projected Bed Need

2. Due to budgetary limitations of the Alabama Medicaid Agency, additional nursing home beds cannot be funded by Medicaid funds. Therefore, applications for additional nursing home beds to be funded by Medicaid should not be approved. Based upon the funding shortage, projects for additional nursing home beds would not be financially feasible. Therefore, until

further action by the Statewide Health Coordinating Council, there shall be no need for additional skilled nursing beds in the State of Alabama.

(d) Planning Policies

1. The county's annual occupancy for the most recent reporting year should be at least 97 percent before additional nursing home beds are approved.

2. Conversion of existing hospital beds to nursing home beds should be given priority over new construction when the conversion is significantly less costly and the existing structure can be adapted economically to meet licensure and certification requirements. The conversion shall result in a decrease in the facility's licensed acute care beds equal to or greater than the number of beds to be converted.

3. Bed need projections will be based on a three-year planning horizon.

4. Planning will be on a county-wide basis.

5. Subject to SHCC adjustments, no beds will be added in any county where that county's projected ratio exceeds 40 beds per 1,000 population 65 and older.

6. No new free-standing nursing home should be constructed having less than 50 beds.

7. ICF/MR facilities, state and privately owned, will not be included in the application of the SHCC adopted nursing home bed need methodology.

8. When any nursing home facility relinquishes its license to operate, either voluntarily or involuntarily other than by a Certificate of Need approved transfer, or by obtaining title by a foreclosure as specified in the opinion rendered by the Alabama Attorney General, November 17, 1980, the need for the facility and its resources will automatically be eliminated from the facilities portion of the State Health Plan. The new bed need requirement in the county where the facility was located will be that number which will bring the county ratio up to 40 beds per 1,000 population 65 and older.

(d) Adjustments. The bed need, as determined by the methodology, is subject to adjustments by the SHCC. The nursing home bed need may be adjusted by the SHCC if an applicant can prove that the identified needs of a targeted population are not being met by existing nursing homes in the county of the targeted population.

For a listing of Nursing Homes or the most current statistical need projections in Alabama you may contact the Data Division as follows:

MAILING ADDRESS
(U.S. Postal Service)

PO BOX 303025
MONTGOMERY, AL 36130-3025

STREET ADDRESS
(Commercial Carrier)

100 N. UNION STREET SUITE 870
MONTGOMERY, AL 36104

TELEPHONE:
(334) 242-4103

FAX:
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EMAIL:
bradford.williams@shpda.alabama.gov

WEBSITE:
http://www.shpda.alabama.gov

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: §22-21-260(4), Code of Alabama, 1975.
History: Amended August 30, 2005; Amended: Filed August 14, 2012; Effective: September 18, 2012. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015. Amended: Filed December 18, 2015; Effective February 1, 2016.
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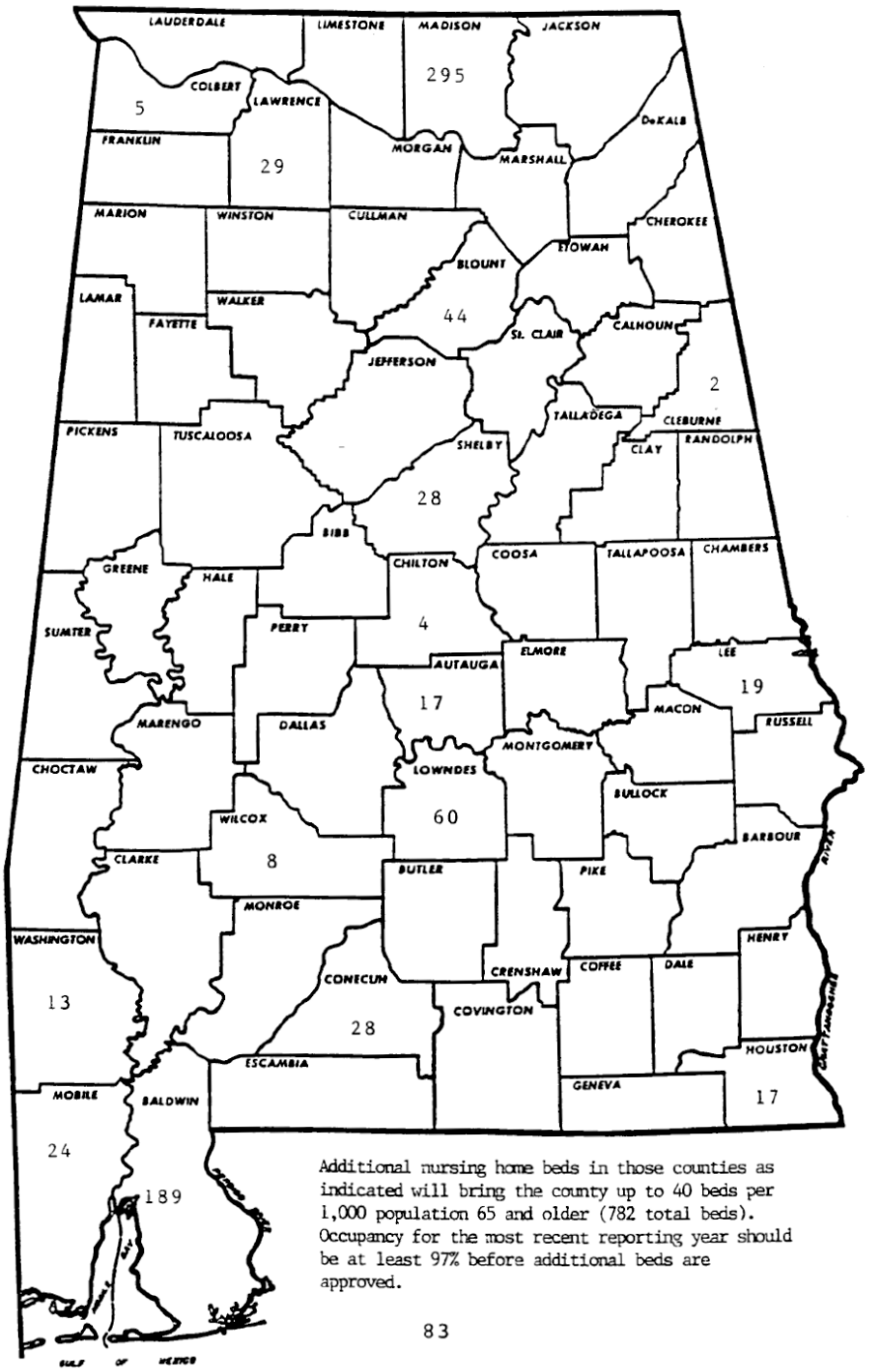
NURSING HOME BEDS NEEDED



Additional nursing home beds in those counties as indicated will bring the county up to 40 beds per 1,000 population 65 and older (782 total beds). Occupancy for the most recent reporting year should be at least 97% before additional beds are approved.

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NURSING HOME
BED NEED PROJECTIONS

COUNTY	POP 65 & OLDER (1998)	40 BEDS PER 1,000 POP 65 & OLDER	LIC BEDS		CON ISSUED	10% BILL	NET BEDS NEEDED	
AUTAUGA	3,817	153	92		44	0	17	*
BALDWIN	20,104	804	600	**	15	0	189	*
BARBOUR	3,585	143	180		0	0	-37	
BIBB	2,113	85	103		0	10	-28	
BLOUNT	5,520	221	177		0	0	44	*
BULLOCK	1,621	65	112		0	0	-47	
BUTLER	3,561	142	179		0	10	-47	
CALHOUN	15,526	621	620		30	12	-41	
CHAMBERS	5,851	234	260		0	30	-56	
CHEROKEE	3,310	132	139		0	0	-7	
CHILTON	4,888	196	119		73	0	4	*
CHOCTAW	2,251	90	101		0	0	-11	
CLARKE	3,580	143	151		0	0	-8	
CLAY	2,411	96	144		0	20	-68	
CLEBURNE	1,793	72	65		0	5	2	*
COFFEE	5,957	238	290		0	24	-76	
COLBERT	8,018	321	302		14	0	5	*
CONECUH	2,237	89	51		0	10	28	*
COOSA	1,561	62	42		29	0	-9	
COVINGTON	6,035	241	321		0	36	-116	
CRENSHAW	2,407	96	137		0	14	-55	
CULLMAN	11,078	443	486		0	32	-75	
DALE	5,339	214	237		0	23	-46	
DALLAS	6,220	249	283		0	34	-68	
DEKALB	8,346	334	406		0	12	-84	
ELMORE	6,189	248	305		0	0	-57	
ESCAMBIA	4,944	198	204		15	10	-31	
ETOWAH	16,378	655	805		0	55	-205	
FAYETTE	2,820	113	122		0	0	-9	
FRANKLIN	4,530	181	230		0	30	-79	
GENEVA	4,086	163	154		8	10	-9	
GREENE	1,458	58	52		0	10	-4	
HALE	2,361	94	160		0	20	-86	
HENRY	2,712	108	117		0	0	-9	
HOUSTON	12,044	482	415		50	0	17	*
JACKSON	6,350	254	238		20	11	-15	
JEFFERSON	92,225	3,689	3,964		0	79	-354	
LAMAR	2,493	100	144		0	14	-58	
LAUDERDALE	12,708	508	548		0	54	-94	
LAWRENCE	4,113	165	136		0	0	29	*

NURSING HOME
BED NEED PROJECTIONS

COUNTY	POP 65 & OLDER (1998)	40 BEDS PER 1,000 POP 65 & OLDER	LIC BEDS		CON ISSUED	10% BILL	NET BEDS NEEDED	
LEE	8,686	347	324		4	0	19	*
LIMESTONE	7,254	290	285		0	14	-9	
LOWNDES	1,502	60	0		0	0	60	*
MACON	3,381	135	209		0	10	-84	
MADISON	28,175	1,127	677	**	142	13	295	*
MARENGO	3,179	127	143		0	0	-16	
MARION	4,778	191	243		0	0	-52	
MARSHALL	11,572	463	484		0	33	-54	
MOBILE	48,563	1,943	1,797		122	0	24	*
MONROE	3,281	131	129		0	20	-18	
MONTGOMERY	25,943	1,038	1,222		0	60	-244	
MORGAN	13,536	541	603		0	69	-131	
PERRY	1,681	67	132		0	10	-75	
PICKENS	3,664	147	165		0	10	-28	
PIKE	3,727	149	194		0	0	-45	
RANDOLPH	3,412	136	152		0	10	-26	
RUSSELL	6,259	250	287		0	10	-47	
ST. CLAIR	7,451	298	305		0	10	-17	
SHELBY	10,228	409	248		133	0	28	*
SUMTER	2,157	86	104		0	10	-28	
TALLADEGA	10,039	402	415		0	17	-30	
TALLAPOOSA	6,586	263	506	**	0	51	-294	
TUSCALOOSA	19,855	794	809		0	25	-40	
WALKER	10,142	406	506		0	20	-120	
WASHINGTON	2,150	86	73		0	0	13	*
WILCOX	2,066	83	75		0	0	8	*
WINSTON	3,495	140	197		0	20	-77	
TOTALS	565,302	22,612	23,475		699	977	782	*

* Beds needed subject to decrease as a result of Contested Case Hearings, Fair Hearings, and Certificate of Need (CON) Review Board Decisions.

** Does not include 150 Veterans Administration beds in each of these counties.

NURSING HOME BEDS PER 1,000 POPULATION 65 AND OLDER (COUNTIES LISTED FROM LOWEST TO HIGHEST)

	COUNTY	65 & OLDER (1998)	BEDS EXISTING (*)	NH BEDS PER 1000 65 & OLDER
1	LOWNDES	1,502	0	0.00
2	CONECUH	2,237	61	27.27
3	MADISON	28,175	832	29.53
4	BALDWIN	20,104	615	30.59
5	BLOUNT	5,520	177	32.07
6	LAWRENCE	4,113	136	33.07
7	WASHINGTON	2,150	73	33.95
8	AUTAUGA	3,817	136	35.63
9	WILCOX	2,066	75	36.30
10	SHELBY	10,228	381	37.25
11	LEE	8,686	328	37.76
12	HOUSTON	12,044	465	38.61
13	CLEBURNE	1,793	70	39.04
14	CHILTON	4,888	192	39.28
15	COLBERT	8,018	316	39.41
16	MOBILE	48,563	1,919	39.52
17	LIMESTONE	7,254	299	41.22
18	CHEROKEE	3,310	139	41.99
19	TUSCALOOSA	19,855	834	42.00
20	GENEVA	4,086	172	42.09
21	CLARKE	3,580	151	42.18
22	ST. CLAIR	7,451	315	42.28
23	JACKSON	6,350	269	42.36
24	GREENE	1,458	62	42.52
25	CALHOUN	15,526	662	42.64
26	TALLADEGA	10,039	432	43.03
27	HENRY	2,712	117	43.14
28	FAYETTE	2,820	122	43.26
29	JEFFERSON	92,225	4,043	43.84
30	MARSHALL	11,572	517	44.68
31	CHOCTAW	2,251	101	44.87
32	MARENGO	3,179	143	44.98
33	MONROE	3,281	149	45.41
34	COOSA	1,561	71	45.48
35	ESCAMBIA	4,944	229	46.32
36	CULLMAN	11,078	518	46.76
37	LAUDERDALE	12,708	602	47.37

NURSING HOME BEDS PER 1,000 POPULATION 65 AND OLDER (COUNTIES LISTED FROM LOWEST TO HIGHEST)

	COUNTY	65 & OLDER (1998)	BEDS EXISTING (*)	NH BEDS PER 1000 65 & OLDER
38	RUSSELL	6,259	297	47.45
39	RANDOLPH	3,412	162	47.48
40	PICKENS	3,664	175	47.76
41	DALE	5,339	260	48.70
42	ELMORE	6,189	305	49.28
43	MONTGOMERY	25,943	1,282	49.42
44	CHAMBERS	5,851	290	49.56
45	MORGAN	13,536	672	49.65
46	DEKALB	8,346	418	50.08
47	BARBOUR	3,585	180	50.21
48	MARION	4,778	243	50.86
49	DALLAS	6,220	317	50.96
50	WALKER	10,142	526	51.86
51	PIKE	3,727	194	52.05
52	ETOWAH	16,378	860	52.51
53	COFFEE	5,957	314	52.71
54	SUMTER	2,157	114	52.85
55	BUTLER	3,561	189	53.07
56	BIBB	2,113	113	53.48
57	FRANKLIN	4,530	260	57.40
58	COVINGTON	6,035	357	59.15
59	WINSTON	3,495	217	62.09
60	CRENSHAW	2,407	151	62.73
61	LAMAR	2,493	158	63.38
62	MACON	3,381	219	64.77
63	CLAY	2,411	164	68.02
64	BULLOCK	1,621	112	69.09
65	HALE	2,361	180	76.24
66	PERRY	1,681	142	84.47
67	TALLAPOOSA	6,586	557	84.57
	TOTALS	565,302	25,151	44.49

(*) INCLUDES BEDS APPROVED BUT NOT YET LICENSED

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410-2-4-.04 Limited Care Facilities – Specialty Care Assisted Living Facilities

(1) Definition. Specialty Care Assisted Living Facilities are intermediate care facilities which provide their residents with increased care and/or supervision which is designed to address the residents' special needs due to the onset of dementia, Alzheimer's disease or similar cognitive impairment and which is in addition to assistance with normal daily activities including, but not limited to, restriction of egress for residents where appropriate and necessary to protect the resident and which require a license from the Department of Public as a Specialty Care Assisted Living Facilities pursuant to Ala. Admin. Code § 420-5-20, *et seq.*

(2) Specialty Care Assisted Living Facility Bed Need Methodology

(a) Purpose. The purpose of this specialty care assisted living facility bed need methodology is to identify, by county, the number of beds needed to assure the continued availability, accessibility, and affordability of quality care for residents of Alabama.

(b) General. Formulation of this bed need methodology was accomplished by a committee of the Statewide Health Coordinating Council (SHCC). The committee which provided its recommendations to the SHCC, was composed of providers and consumers of health care. Only the SHCC, with the Governor's final approval, can make changes to this methodology except that the SHPDA staff shall annually update bed need projections and inventories to reflect more current population and utilization statistics. Such updated information is available for a fee upon request. Adjustments are addressed in paragraph (E).

(c) Basic Methodology. Considering the availability of more community and home based services for the elderly in Alabama, there should be a minimum of 4 beds per 1,000 population 65 and older for each county.

The bed need formula is as follows:

(4 beds per thousand) x (population 65 and older) =
Projected Bed Need

(d) Planning Policies

1. Projects to develop specialty care assisted living facilities or units in areas where there exist medically underserved, low income, or minority populations should be given priority over projects not being developed in these critical areas when the project to develop specialty care assisted living facilities in areas where there exists medically underserved, low income or minority populations is not more costly to develop than other like projects.

2. Bed need projections will be based on a three-year planning horizon.

3. Planning will be on a countywide basis.

4. Subject to SHCC adjustments, no beds will be added in any county where that county's projected ratio exceeds 4 beds per 1,000 population 65 and older.

5. When any specialty care assisted living facility relinquishes its license to operate, either voluntarily or involuntarily other than by a Certificate of Need approved transfer, or by obtaining title by a foreclosure as specified in the opinion rendered by the Alabama Attorney General, November 17, 1980, the need for the facility and its resources will automatically be eliminated from the facilities portion of the State Health Plan. The new bed need requirement in the county where the facility was located will be that number which will bring the county ratio up to 4 beds per 1,000 population 65 and older.

6. Additional need may be shown in situations involving a sustained high occupancy rate either for a county of for a single facility. An applicant may apply for additional beds, and thus the establishment of need above and beyond the standard methodology, utilizing one of the following two policies. Once additional beds have been applied for under one of the policies, that applicant shall not qualify to apply for additional beds under either of these policies unless and until the established time limits listed below have passed. All CON authorized SCALF beds shall be included in consideration of occupancy rate and bed need.

(i) If the occupancy rate for a county is greater than 92% utilizing the census data in the most recent full year 'Annual Report(s) for Specialty Care Assisted Living Facilities (Form DM-1)' published by or filed with SHPDA, an additional need of the greater of either ten percent (10%) of the current total CON Authorized bed capacity of that county or sixteen (16) total beds may be approved for either the creation of a new facility or for the expansion of existing facilities within that county. However, due to the priority of providing the most cost effective health care services available, a new facility created under this policy shall only be allowed through the conversion of existing beds at an Assisted Living Facility currently in possession of a regular, non-probationary license from the Alabama Department of Public Health. Once additional need has been shown under this policy, no new need shall be shown in that county based upon this rule for twenty-four (24) months following issuance of the initial CON, to allow for the impact of those beds in that county to be analyzed. Should the initial applicant for beds in a county not apply for the total number of beds allowed to be created under this rule, the remaining beds would then be available to be applied for by other providers in the county, so long as said providers meet the conditions listed in this rule.

(ii) If the occupancy rate for a single facility is greater than 92% utilizing the census data in the last two (2) most recent full year 'Annual report(s) for Specialty Care Assisted Living Facilities (Form DM-1)' published by or filed with SHPDA, irrespective of the total occupancy rate of the county over that time period, up to sixteen (16) additional beds may be approved for the expansion of that facility only. Once additional beds have been approved under this policy, no new beds shall be approved for that facility for twenty-four (24) months following issuance of the CON, to allow for the impact of those beds at that facility to be analyzed.

7. No application for the establishment of a new, freestanding SCALF shall be approved for fewer than sixteen (16) beds, to allow for the financial feasibility and viability of a

project. Because of this, need may be adjusted by the Agency for any county currently showing a need of more than zero (0) but fewer than sixteen (16) total beds to a total need of sixteen (16) new beds, but only in the consideration of an application for the construction of a new facility in that county. Need shall not be adjusted in consideration of an application involving the expansion of a currently authorized and licensed SCALF or for the conversion of beds at an existing Assisted Living Facility.

8. Any CON Application filed by a licensed SCALF shall not be deemed complete until, and unless:

(i) The applicant has submitted all survey information requested by SHPDA prior to the application date; and

(ii) The SHPDA Executive Director determines that the survey information is complete.

9. No licensed SCALF filing an intervention notice or statement in opposition in any CON proceeding may cite or otherwise seek consideration by SHPDA of such facility's utilization data until, and unless;

(i) The intervenor or opponent has submitted all survey information requested by SHPDA prior to the application date; and

(ii) The SHPDA Executive Director determines that the survey information is complete.

(e) Adjustments. The bed need, as determined by the methodology, is subject to adjustments by the SHCC. The specialty care assisted living facility bed need may need to be adjusted by the SHCC if an applicant can prove that the identified needs of a targeted population are not being met by existing specialty care assisted living facilities in the county of the targeted population.

(f) Notwithstanding the foregoing, any application for certificate of need for specialty care assisted living facility beds for which a proper letter of intent was duly filed with SHPDA prior to the adoption of the bed need methodology shall not be bound by this bed need methodology.

(g) The determination of need for specialty care assisted living facility beds shall not be linked to the number of existing assisted living beds in the county.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended: Filed August 18, 2012; Effective September 18, 2012. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015. Return to Table of Contents

Specialty Care Assisted Living Facility
CON'S Issued

Facility Name	City	County	Type Application	Beds
Canterbury Health Care Facility	Phenix City	Russell	Conversion	35
Liveoak Village Dementia Care Facility	Foley	Baldwin	Initial	30
NIIC Place, Anniston	Anniston	Calhoun	Conversion	68
Our Southern Home West	Mobile	Mobile	Conversion	16
Our Southern Home – Three Notch	Mobile	Mobile	Conversion	54
Southern Home Place	Vernon	Lamar	Initial	10
Trinity Health Care Blount, Inc.	Not Determined	Blount	Initial	70
Trinity Health Care Talladega, Inc.	Not Determined	Talladega	Initial	150
Trinity Health Care St. Clair, Inc.	Not Determined	St. Clair	Initial	150
Trinity Health Care Morgan, Inc.	Not Determined	Morgan	Initial	150
Trinity Health Care Marshall, Inc.	Not Determined	Marshall	Initial	150
Trinity Health Care Etowah, Inc.	Not Determined	Etowah	Initial	150
Trinity Health Care Dekalb, Inc.	Not Determined	Dekalb	Initial	150
Trinity Health Care Cherokee, Inc.	Not Determined	Cherokee	Initial	150
Trinity Health Care Cullman, Inc.	Not Determined	Cullman	Initial	150
Trinity Health Care Calhoun, Inc.	Not Determined	Calhoun	Initial	150
Wesley Manor Retirement Center	Dothan	Houston	Initial	30
Wesley Gardens Retirement Center Specialty Care	Montgomery	Montgomery	Conversion	16
Capstone Village, Inc	Tuscaloosa	Tuscaloosa	Initial	16
Total Additional Beds				**1695**

SPECIALTY CARE ASSISTED LIVING BED NEED PROJECTIONS

COUNTY	Pop 65 & Older 2006	4 Per 1,000 Pop 65 & Older	Total Beds Needed	Licensed Beds	CON Issued	Net Beds Needed
AUTAUGA	5,622	22	22	80	0	-58
BALDWIN	27,411	110	110	73	30	7
BARBOUR	4,034	16	16	0	0	16
BIBB	2,817	11	11	16	0	-5
BLOUNT	7,881	32	32	50	70	-88
BULLOCK	1,530	6	6	0	0	6
BUTLER	3,490	14	14	16	0	-2
CALHOUN	16,539	66	66	43	162	-139
CHAMBERS	5,901	24	24	56	0	-32
CHEROKEE	4,677	19	19	36	150	-167
CHILTON	5,840	23	23	0	0	23
CHOCTAW	2,593	10	10	0	0	10
CLARKE	4,143	17	17	0	0	17
CLAY	2,589	10	10	0	0	10
CLEBURNE	2,188	9	9	0	0	9
COFFEE	6,799	27	27	16	0	11
COLBERT	8,986	36	36	45	0	-9
CONECUH	2,231	9	9	0	0	9
COOSA	1,897	8	8	0	0	8
COVINGTON	7,017	28	28	0	0	28
CRENSHAW	2,298	9	9	0	0	9
CULLMAN	12,563	50	50	0	150	-100
DALE	6,733	27	27	0	0	27
DALLAS	6,476	26	26	16	0	10
DEKALB	9,668	39	39	16	150	-127
ELMORE	8,319	33	33	22	0	11
ESCAMBIA	5,646	23	23	0	0	23
ETOWAH	16,620	66	66	52	150	-136
FAYETTE	3,209	13	13	8	0	5
FRANKLIN	4,939	20	20	0	0	20
GENEVA	4,539	18	18	0	0	18
GREENE	1,469	6	6	0	0	6
HALE	2,356	9	9	0	0	9
HENRY	2,784	11	11	0	0	11
HOUSTON	13,210	53	53	16	30	7
JACKSON	8,279	33	33	32	0	1
JEFFERSON	87,197	349	349	740	0	-391
LAMAR	2,702	11	11	0	10	1
LAUDERDALE	14,401	58	58	16	0	42
LAWRENCE	4,735	19	19	0	0	19
LEE	10,862	43	43	150	0	-107
LIMESTONE	8,334	33	33	32	0	1
LOWNDES	1,851	7	7	0	0	7

SPECIALTY CARE ASSISTED LIVING BED NEED PROJECTIONS

COUNTY	Pop 65 & Older 2006	4 Per 1,000 Pop 65 & Older	Total Beds Needed	Licensed Beds	Net CON Issued	Beds Needed
MACON	3,295	13	13	0	0	13
MADISON	35,374	141	141	216	0	-75
MARENGO	3,365	13	13	0	0	13
MARION	5,438	22	22	0	0	22
MARSHALL	12,936	52	52	22	150	-120
MOBILE	50,084	200	200	290	70	-160
MONROE	3,559	14	14	0	0	14
MONTGOMERY	26,974	108	108	260	16	-168
MORGAN	15,010	60	60	30	150	-120
PERRY	1,761	7	7	0	0	7
PICKENS	3,343	13	13	0	0	13
PIKE	4,193	17	17	48	0	-31
RANDOLPH	3,797	15	15	0	0	15
RUSSELL	6,794	27	27	0	35	-8
SHELBY	16,461	66	66	128	0	-62
ST. CLAIR	9,153	37	37	15	150	-128
SUMTER	1,966	8	8	0	0	8
TALLADEGA	11,409	46	46	32	150	-136
TALLAPOOSA	7,161	29	29	46	0	-17
TUSCALOOSA	19,139	77	77	32	16	29
WALKER	11,251	45	45	14	0	31
WASHINGTON	2,474	10	10	0	0	10
WILCOX	1,787	7	7	0	0	7
WINSTON	3,990	16	16	16	0	0
TOTALS	624,090	2,480	2,480	2,664	1,639	-1,823

ALABAMA'S INVENTORY OF SPECIALTY CARE ASSISTED LIVING FACILITIES

Facility		City	Beds
		City	**Beds**
AUTAUGA *County*			
001-S0109	CAMELLIA LANE I	PRATTVILLE	16
001-S0105	CAMELLIA LANE II	PRATTVILLE	16
001-S0104	GREENSPRINGS I	PRATTVILLE	16
001-S1001	HICKORY HILL	PRATTVILLE	32
	AUTAUGA County Totals:	Number Of Facilities: 4	Number Of Beds: 80
BALDWIN *County*			
003-S0110	AZALEA PLACE ASSISTED LIVING FACILITY	BAY MINETTE	9
003-S0111	JOHN MCCLURE SNOOK REGIONAL CENTER	DAPHNE	48
003-S0210	OAKLAND PLACE	FAIRHOPE	16
	BALDWIN County Totals:	Number Of Facilities: 3	Number Of Beds: 73
BIBB *County*			
007-S0112	OAKWOOD ASSISTED LIVING	CENTREVILLE	16
	BIBB County Totals:	Number Of Facilities: 1	Number Of Beds: 16
BLOUNT *County*			
009-S5001	JACOBS HOUSE I SPECIALTY CARE, THE	HAYDEN	16
009-S5002	OLIVE HOME, INC. - ONEOTA #2, LLC	ONEONTA	18
009-S5003	WARDEN MANOR ASSISTED LIVING, LLC	HAYDEN	16
	BLOUNT County Totals:	Number Of Facilities: 3	Number Of Beds: 50
BUTLER *County*			
013-S7002	HOMEWOOD OF GREENVILLE, L.L.C.	GREENVILLE	16
	BUTLER County Totals:	Number Of Facilities: 1	Number Of Beds: 16
CALHOUN *County*			
015-S8001	AUTUMN COVE MEMORY CARE	ANNISTON	27
015-S0801	EASTSIDE MANOR RETIREMENT HOME	ANNISTON	16
	CALHOUN County Totals:	Number Of Facilities: 2	Number Of Beds: 43
CHAMBERS *County*			
017-S9001	RIVER BEND	VALLEY	56

ALABAMA'S INVENTORY OF SPECIALTY CARE ASSISTED LIVING FACILITIES

Facility		City			Beds
	CHAMBERS County Totals:	Number Of Facilities:	1	Number Of Beds:	56
CHEROKEE ***County***					
019-S1001	CHEROKEE VILLAGE SPECIALTY CARE ASSISTED LIVING FACILITY	CENTRE			36
	CHEROKEE County Totals:	Number Of Facilities:	1	Number Of Beds:	36
COFFEE ***County***					
031-S1601	KELLEY PLACE (SCALF)	ENTERPRISE			16
	COFFEE County Totals:	Number Of Facilities:	1	Number Of Beds:	16
COLBERT ***County***					
033-S1786	BRENTWOOD RETIREMENT COMMUINITY II	MUSCLE			16
033-S1785	BRENTWOOD RETIREMENT COMMUNITY I	MUSCLE			16
033-S1701	WELLINGTON PLAE OF MUSCLE SHOALS SPECIALTY CARE	MUSCLE			13
	COLBERT County Totals:	Number Of Facilities:	3	Number Of Beds:	45
DALLAS ***County***					
047-S2401	HOMEWOOD OF SELMA, INC.	SELMA			16
	DALLAS County Totals:	Number Of Facilities:	1	Number Of Beds:	16
DEKALB ***County***					
049-S2501	ROSE MANOR OF GERALDINE, INC.	GERALDINE			16
	DEKALB County Totals:	Number Of Facilities:	1	Number Of Beds:	16
ELMORE ***County***					
051-S2601	RIVER RIDGE SPECIALTY CARE ASSISTED LIVING	WETUMPKA			22
	ELMORE County Totals:	Number Of Facilities:	1	Number Of Beds:	22
ETOWAH ***County***					
055-S2802	MEADOWOOD SPECIALTY CARE FACILITY	GLENCOE			40
055-S2801	ROYAL HAVEN AT REGENCY POINTE	RAINBOW CITY			12
	ETOWAH County Totals:	Number Of Facilities:	2	Number Of Beds:	52
FAYETTE ***County***					
057-S5004	MORNINGSIDE OF FAYETTE SPECIALTY CARE	FAYETTE			8
	FAYETTE County Totals:	Number Of Facilities:	1	Number Of Beds:	8

HOUSTON ***County***

ALABAMA'S INVENTORY OF SPECIALTY CARE ASSISTED LIVING FACILITIES

Facility		City				Beds
069-S3501	TERRACE AT GROVE PARK SPECIALTY CARE ASSIST LIV FACILITY	DOTHAN				16
	HOUSTON County Totals:		Number Of Facilities:	1	Number Of Beds:	16
JACKSON ***County***						
071-S3602	ROSE WOOD MANOR, INC	SCOTTSBORO				16
071-S3604	ROSE WOOD MANOR, INC II	SCOTTSBORO				16
	JACKSON County Totals:		Number Of Facilities:	2	Number Of Beds:	32
JEFFERSON ***County***						
073-S3707	BANKHEAD SPECIALTY CARE	DORA				11
073-S3710	FAIR HAVEN RETIREMENT CENTER-SPECIALTY CARE	BIRMINGHAM				64
073-S3701	GALLERIA OAKS	BIRMINGHAM				110
073-S3702	HOLLY COTTAGE AT COUNTRY COTTAGES	HOOVER				16
073-S3711	KIRKWOOD BY THE RIVER SPECIALTY CARE	BIRMINGHAM				20
073-S3712	LAKE VILLA SPECIALTY CARE ASSISTED LIVING	BIRMINGHAM				175
073-S3704	MOUNT ROYAL TOWERS SPECIALTY CARE ASST LIVING FACILITY	BIRMINGHAM				129
073-S3713	ORCHARD, THE	BIRMINGHAM				32
073-S3705	PARK AT RIVERCHASE SPECIALTY CARE, THE	HOOVER				38
073-S3715	PLANTATION MANOR ASSISTED LIVING I	MC CALLA				16
073-S3716	PLANTATION MANOR ASSISTED LIVING II	MC CALLA				16
073-S3717	PLANTATION MANOR ASSISTED LIVING III	MC CALLA				16
073-S3714	SOMBERBY AT UNIVERSITY PARK SPECIALTY CARE	BIRMINGHAM				30
073-S3706	ST MARTIN'S-IN-THE-PINES SPECIALTY CARE ASST LIVING	BIRMINGHAM				35
073-S3709	TANNEHILL HAVEN, INC. (scalf)	MCCALLA				32
	JEFFERSON County Totals:		Number Of Facilities:	15	Number Of Beds:	740

ALABAMA'S INVENTORY OF SPECIALTY CARE ASSISTED LIVING FACILITIES

Facility		City				Beds
LAUDERDALE ***County***						
077-S3901	GREEN OAKS INN-CREEL HOUSE	FLORENCE				16
	LAUDERDALE County Totals:		Number Of Facilities:	1	Number Of Beds:	16
LEE ***County***						
081-S4103	CAMBRIDGE PLACE	OPELIKA				36
081-S4101	CAMELLIA PLACE AT AUBURN MEDICAL PARK	AUBURN				58
081-S4102	MAGNOLIA PLACE SPECIALTY CARE	AUBURN				40
081-S4104	NORTHRIDGE	OPELIKA				16
	LEE County Totals:		Number Of Facilities:	4	Number Of Beds:	150
LIMESTONE ***County***						
083-S4201	LIMESTONE LODGE EAST	ATHENS				16
083-S4202	LIMESTONE LODGE WEST	ATHENS				16
	LIMESTONE County Totals:		Number Of Facilities:	2	Number Of Beds:	32
MADISON ***County***						
089-S4503	AGAPE VILLAGE	HAZEL GREEN				16
089-S4502	AGAPE VILLAGE II (SCALF)	HAZEL GREEN				16
089-S4501	EDENBROOK OF HUNTSVILLE, KEEPSAKE GARDENS	HUNTSVILLE				38
089-S4506	HAVEN FOR GREATER LIVING, INC., THE	NEW MARKET				16
089-S4504	PINE CREST ESTATE, INC.	HUNTSVILLE				16
089-S3754	REGENCY MANOR ASSISTED LIVING FACILITY	GURLEY				16
089-S4507	REMEMBRANCES CENTER AT WYNDHAM PARK, THE	HUNTSVILLE				16
089-S4508	VENONA ACRES NORTH	HUNTSVILLE				16
089-S4506	VENONA ACRES SOUTH	HUNTSVILLE				16
089-S4505	WELLINGTON PLACE AT HAMPTON COVE	HAMPTON				50
	MADISON County Totals:		Number Of Facilities:	10	Number Of Beds:	216
MARSHALL ***County***						
095-S4801	MERRILL GARDENS AT ALBERTVILLE GARDEN HOUSE	ALBERTVILLE				22
	MARSHALL County Totals:		Number Of Facilities:	1	Number Of Beds:	22
MOBILE ***County***						
097-S4950	ASHBURY MANOR	MOBILE				16

ALABAMA'S INVENTORY OF SPECIALTY CARE ASSISTED LIVING FACILITIES

Facility		City	Beds
097-S4903	ATRA ASSISTED LIVING REGENCY SPECIALTY CARE	MOBILE	20
097-S4902	BROOKSIDE ASSISTED LIVING	MOBILE	32
097-S4914	GORDON OAKS CONVALESCENT CENTER INC.	MOBILE	34
097-S4905	GORDON OAKS SCALF	MOBILE	100
097-S4901	LAKEFRONT SPECIALTY CARE ASSISTED LIVING	MOBILE	16
097-S4906	NORTH MOBILE RETIREMENT CENTER	SATSUMA	40
097-S4904	OUR SOUTHERN HOME	MOBILE	16
097-S4918	TAY-CON MAGNOLIA HOUSE-DAUPHIN	MOBILE	16
	MOBILE County Totals:	Number Of Facilities: 9	Number Of Beds: 290
MONTGOMERY ***County***			
101-S5101	ANGELS FOR THE ELDERLY II, INC.	MONTGOMERY	16
101-S5102	ANGELS FOR THE ELDERLY III, INC	MONTGOMERY	16
101-S5110	ANGELS FOR THE ELDERLY IV INC	MONTGOMERY	16
101-S5102	BETH MANOR	MONTGOMERY	16
101-S5113	CEDARS, THE	MONTGOMERY	61
101-S5127	Country Cottage-Holly	MONTGOMERY	16
101-S5128	EAST HAVEN ASSISTED II	MONTGOMERY	16
101-S5129	ELMCROFT OF HALCYON SPECIALTY CARE	MONTGOMERY	16
101-S5104	GOD'S GRACE SPECIALTY CARE ASSISTED LIVING FACILITY	MONTGOMERY	13
101-S5122	MON PETITE MAISON	MONTGOMERY	8
101-S5106	ROSEWOOD TERRACE, INC.	MONTGOMERY	16
101-S5103	WATERFORD PLACE	MONTGOMERY	50
	MONTGOMERY County Totals:	Number Of Facilities: 12	Number Of Beds: 260

ALABAMA'S INVENTORY OF SPECIALTY CARE ASSISTED LIVING FACILITIES

Facility		City				Beds
MORGAN ***County***						
	SUNSHINE HAVEN ASSISTED LIVING	HARTSELLE				30
	MORGAN County Totals:	Number Of Facilities:	1	Number Of Beds		30
PIKE ***County***						
109-S5503	MAGNOLIA WOOD LODGE II	TROY				16
109-S5504	MAGNOLIA WOOD LODGE III	TROY				16
109-S5505	MAGNOLIA WOOD LODGE IV	TROY				16
	PIKE County Totals:	Number Of Facilities:	3	Number Of Beds:		48
SHELBY ***County***						
117-S5911	LAKE VIEW ESTATES ASSISTED LIVING	BIRMINGHAM				64
117-S5913	SHANGRI-LA ASSISTED LIVING, LLC	COLUMBIA				16
117-S5912	SPRINGS MANOR SPECIALTY CARE	BIRMINGHAM				48
	SHELBY County Totals:	Number Of Facilities:	3	Number Of Beds:		128
ST. CLAIR ***County***						
115-S5801	SPRINGS MANOR SPECIALTY CARE	COOK SPRINGS				15
	ST. CLAIR County Totals:	Number Of Facilities:	1	Number Of Beds:		15
TALLADEGA ***County***						
121-S6101	AUTUMN TRACE	TALLADEGA				16
121-S6102	MOUNTAIN VIEW LAKE RETIREMENT VILLAGE	SYLACAUGA				16
	TALLADEGA County Totals:	Number Of Facilities:	2	Number Of Beds:		32
TALLAPOOSA ***County***						
123-S6201	CHAPMAN SPECIALTY CARE ASSISTED LIVING FACILITY	ALEXANDER				46
	TALLAPOOSA County Totals:	Number Of Facilities:	1	Number Of Beds:		46
TUSCALOOSA ***County***						
125-S6301	MARTINVIEW EAST	NORTHPORT				16
125-S6302	MERRILL GARDENS AT NORTHPORT GARDEN HOUSE	NORTHPORT				16
	TUSCALOOSA County Totals:	Number Of Facilities:	2	Number Of Beds:		32
WALKER ***County***						
127-S6401	TERRACE AT JASPER SPECIALTY CARE ASSISTED LIVING FACILITY	JASPER				14

ALABAMA'S INVENTORY OF SPECIALTY CARE ASSISTED LIVING FACILITIES

Facility	City				Beds
WALKER County Totals:		Number Of Facilities:	1	Number Of Beds:	14
WINSTON ***County***					
133-S6701 ROSE MANOR OF HALEYVILLE	HALEYVILLE				16
WINSTON County Totals:		Number Of Facilities:	1	Number Of Beds:	16
State Totals:		Number Of Facilities:	98	Number Of Beds:	2680

Revised as of: 07/28/2004

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410-2-4-.05 **Assisted Living Facilities**

(1) Definition. Assisted living facilities are licensed facilities that consist of permanent buildings, portions of buildings, or groups of buildings (not to include mobile homes and trailers) in which room, board, meals, laundry, assistance with personal care, and other services are provided for not less than twenty-four hours in any week to a minimum of two ambulatory adults not related by blood or marriage to the owner and/or administrator.

(2) Existing Assisted Living Facilities. As of January 2004, there were 247 licensed assisted living facilities totaling 7,572 beds operating in the state of Alabama, or approximately 12.1 beds per 1,000 persons 65 and older. Assisted living is available in Alabama on a private-pay basis only.

(3) Availability. The 247 licensed assisted living facilities are concentrated in the more populated counties. Three counties contain 35% of the assisted living beds and 10 counties contain 65% of the assisted living beds. Fifty-four of the 67 counties have assisted living facilities and 13 counties have no assisted living facilities. Generally, these facilities are distributed geographically; however, there are two counties in northwest Alabama, and ten counties in central and south Alabama that have no assisted living facilities. Cherokee and Cleburne are the only northeast Alabama counties without an assisted living facility.

(4) Continuity

(a) Discussion. Assisted living facilities should provide assistance appropriate to resident needs. To insure that comprehensive services are available and to be certain residents are at a proper level of care, assisted living facilities should provide, or should have agreements with health care providers to provide, a broad range of care. When providing these services, transfer of residents and support services should be provided as necessary.

(b) Self-Help Program. Assisted living providers will be encouraged to provide a level of assistance that would help and encourage the residents to be self-sufficient for as long as possible before requiring a change to a more dependent home.

(5) Quality. Quality assistance is an obligation of all assisted living facilities operating in Alabama. Each facility must meet standards established by the Alabama Department of Public Health (see paragraph 4 above). The Division of Licensure and Certification of the Alabama Department of Public Health is responsible for determining compliance.

(6) Assisted Living Facilities Bed Need Methodology.

(a) Purpose. The purpose of this assisted living bed need methodology is to identify, by county, the number of assisted living beds needed to assure the continued availability, accessibility, and affordability of quality supervised assistance for residents of Alabama. Bed need projections contained in this section are recommendations only and are not intended to be regulatory.

(b) Basic Methodology. When reviewing the existing nursing homes and assisted living facilities, it was found that the total combined beds came to approximately 54.7 beds/1,000 sixty-five and older. The adjacent states combined totals were: 53.7 for Mississippi, 83.7 for Georgia, 68.3 for Tennessee, and 51.7 for Florida. Considering the availability of community and home based services and nursing homes for the elderly in Alabama, the methodology in determining the number of beds needed is based on the following formula which will bring Alabama up to 55 combined beds/1,000 sixty-five and older.

Formula

(16 beds per 1,000) x (population 65 and older) = Projected Bed Need.

(c) Planning Policies

1. Population projections will be based on a three-year planning horizon.

2. Planning will be on a countywide basis.

3. Subject to SHCC adjustments, beds should not be added in any county where that county's projected ratio exceeds 16 beds per 1,000 populations 65 and older.

4. No new freestanding assisted living facility should be constructed having less than eight beds.

5. When any assisted living facility relinquishes its license to operate, either voluntarily or involuntarily, the facility and its resources will automatically be eliminated from this section of the State Health Plan. The new bed need in the county where the facility was located will be that number which will bring the county ratio up to 16 beds per 1,000 population 65 and older.

For a listing of Assisted Living Facilities of the most current statistical need projections in Alabama you may contact the State Division as follows:

MAILING ADDRESS (U.S. Postal Service)	STREET ADDRESS (Commercial Carrier)
PO BOX 303025 MONTGOMERY, AL 36130-3025	100 N. UNION STREET SUITE 870 MONTGOMERY, AL 36104
TELEPHONE: (334) 242-4103	FAX: (334) 242-4113
EMAIL: Bradford.williams@shpda.alabama.gov	WEBSITE: http://www.shpda.alabama.gov

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended: Filed August 18, 2012; Effective September 18, 2012. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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410-2-4-.06 **Adult Day Care Programs**

(1) Definition. Adult day care programs may be identified as structured, comprehensive programs designed to offer lower cost alternative to institutionalization for newly or chronically disabled adults who cannot stay alone during the day, but who do not need 24-hour inpatient care. Designed to promote maximum independence, participants usually attend on a scheduled basis. Services may include nursing, counseling, social services, restorative services, medical and health care monitoring, exercise sessions, field trips, recreational activities, physical, occupational and speech therapy, medication administration, well balanced meals, and transportation to and from the facility. Adult day care can provide the respite family members require to sustain healthy relationships while caring for their elderly loved one at home. Adult day care programs provide services to one or more adults not related by blood or marriage to the owner and/or administrator.

(2) Analysis of Existing Adult Day Care Programs. Adult day care programs do not currently have to be licensed by any department of the State of Alabama. As a consequence, it is extremely difficult to ascertain the actual number of such programs within Alabama. However, Adult Day Care Centers are approved through ADPH, ADSS and Medicaid. Mental Health also uses adult day care. It has also been reported that the Birmingham area has numerous private Adult Day Care Centers. Because there is no regulation it is difficult to develop an accurate methodology.

(3) Adult Day Care Programs as Alternatives to Nursing Home Admission.

(a) Efforts should be made to maintain an optimum quality of life for individuals who require extended or long-term care. The types and amounts of services needed for these individuals vary. In order to enhance opportunities for individuals needing extended or long-term care services, the needs of these individuals should be evaluated prior to admission to any extended care or long-term care program, including nursing homes, assisted living homes, and adult day care programs.

(b) In an effort to encourage the development and utilization of alternatives to nursing home and assisted living (domiciliary) care, adult day care programs and services for the elderly should be utilized to the greatest extent possible. It is the intent to provide for the establishment of additional adult day care programs in order that: (i) the elderly will be given the opportunity to remain with their families and in their communities, rather than being placed in nursing homes or state institutions; (ii) families, particularly those with one or more members working outside of the home, may keep their elderly parents and relatives with them, instead of having to place them in impersonal institutions; and (iii) the State of Alabama can deal more effectively and economically with the needs of its elderly citizens.

(4) Financing. Historically, all adult day care programs have been private pay with some assistance coming from public and community sources.

(5) Availability. Adult day care programs are concentrated in the more populated counties. Many counties have no adult day care programs and a number are without assisted living facilities.

(6) Continuity.

(a) Discussion. Adult day care programs should provide care appropriate to the needs of their participants. To insure that comprehensive services are available and that certain participants receive a proper level of care, adult day care programs should provide, or should have agreements with other health care providers to provide, a broad range of care. When providing these services, transportation and support services for participants should be provided as necessary.

(b) Self-Help Program. Adult day care program providers should be encouraged to provide a level of care that will help maintain and improve function and encourage participants to be as independent as they can for as long as possible before the condition of such participants requires a change to a more dependent level of care.

(7) Quality. Quality care is an obligation of all adult day care programs operating in Alabama. Each program should comply with applicable state and local building regulations, and zoning, fire, and health codes or ordinances. In addition, each program must comply with all requirements of its funding sources, including requirements with respect to a Medicaid Waiver, if applicable.

(8) Promotion of adult day care programs. The alternate special affordable care offered by adult day care programs should be publicized by responsible agencies using some or all of the following:

(a) Public Service Announcements
(b) Physicians (provide literature)
(c) Hospitals (discharge planners)
(d) Nursing Homes
(e) The Alabama Commission on Aging
(f) The American Association of Retired Persons
(g) Community Service Agencies/Projects
(h) Religious Organizations
(i) The Department of Human Resources

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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410-2-4-.07 **Home Health**

(1) Definitions

(a) Home Health Agency. A home health agency is an organization that is primarily engaged in providing skilled nursing services and other therapeutic services. Services are provided on an intermittent basis. Each visit must be less than four hours in duration. Any visit made to or procedures performed on a patient at their home must only be made upon a physician's written order. Home health providers shall provide at least the following services, including, but not limited to, skilled nursing care, personal care, physical therapy, speech therapy, medical social services, and medical supplies services.

(b) Home Health Care. Home health care is that component of a continuum of comprehensive health care whereby intermittent health services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining or restoring health, or of maximizing the level of independence, while minimizing the effects of disability and illness, including terminal illness. Services appropriate to the needs of the individual patient and family are planned, coordinate, and made available by providers organized for the delivery of home health care through the use of employed staff, contractual arrangements, or a combination of employed staff and contractual arrangements. There is no licensure requirement for home health agencies in Alabama.

(c) Home Health Services. Home health services are made available based upon patient care needs as determined by an objective patient assessment administered by a multidisciplinary team or a single health professional. Centralized professional coordination and case management are included. These services are provided under a plan of treatment certified by a physician that may include, but are not limited to, appropriate service components, such as medical, nursing, social work, respiratory therapy, physical therapy, occupational therapy, speech therapy, nutrition, homemaker home health aide service, and provision of medical equipment and supplies.

(d) Section 22-21-265, Code of Alabama 1975, allows an existing home health agency to accept referrals from a county which is contiguous to the county where the CON is held (see the referenced section above for restrictions as provided in the section with regard to contiguous counties; also this information is posted on the SHPDA website at http://www.shpda.alabama.gov.)

(2) Inventory of Existing Resources

The State Health Planning and Development Agency annually compiles several home health agency reports and identifies counties which are in need of an additional agency. These publications are available for a fee upon request. A current listing of home health agencies is located at http://www.shpda.alabama.gov or http://www.adph.org.

(3) Planning Policy – (Availability)

Home health visits are scheduled on an intermittent basis and must be available seven days a week at such times as may be ordered by referring physicians. While availability must include provision for weekend and evening services, emergency services are not within the scope or purpose of home health providers.

(4) Accessibility

(a) Home health service must be obtainable by the general public in every county in the state.

(b) Because physicians and other referral sources are sometimes unfamiliar with the total scope of services offered by home health providers, patients' accessibility is also limited by failure to refer appropriately to home health services. Every agency should provide an active community information program to educate consumers and professionals to the availability, nature, and extent of home health services.

(c) Because services are provided in patients' own homes, accessibility to services is not dependent upon physical or geographic accessibility to the home health provider's offices. The essential characteristics are location of home health visiting staff in proximity to patients' places of residence and telephone accessibility of the provider to patients, physicians, and other referral sources.

(5) Acceptability and Continuity

(a) Acceptability is the willingness of consumers, physicians, discharge planners, and others to use home health services as a distinct component of the health care continuum.

(b) Continuity reflects a case management approach that allows patient entry into the health care continuum at the point that ensures delivery of appropriate services. Home health care provides a balanced program of clinical and social services, and may serve as a transitional level of care between inpatient treatment and infrequent physician office visits. Home health also extends certain intensive, specialized treatments into the home setting.

(c) Planning Guides and Policies

1. Planning Guide

Home health providers shall maintain referral contacts with appropriate community providers of health and social services, to facilitate continuity of care and to coordinate services not provided directly by the home health provider.

2. Planning Policy

Home health providers must furnish discharge-planning services for all patients.

(6) Quality

(a) Quality is that characteristic, which reflects professionally appropriate and technically adequate patient services.

(b) The state home health industry, through development of ethical standards and a peer review process, can foster provision of quality home health care services. Each provider must establish mechanisms for quality assurance, including procedures for resolving concerns identified by patients, physicians, families or others involved in patient referral or patient care.

(c) Planning Policies

1. Planning Policy

The county will be the geographic unit for need determination, based upon population.

2. Planning Policy – (New Providers)

When a new provider is approved for a county, that provider will have eighteen months from the date of the Certificate of Need to meet the identified need in the county before a new provider may apply for a Certificate of Need to serve a county.

3. Planning Policy – (Existing Providers)

If an existing provider ceases to operate in a county, once the Certificate of Need is deemed null and void then a provider can apply under the current published statistical need.

4. Planning Policy – Favorable Consideration

Home health agencies that achieve or agree to achieve Charity Care plus Self Pay at the statewide average percent for all home health providers shall be given favorable CON consideration over home health applicants that do not achieve the statewide average for Charity Care plus Self Pay, but not less than one (1) percent. The latest published SHPDA data report HH-11 shall be used to determine the assets to governmental and non-profit organizations at the individual county level that may be considered. See section 410-2-2-.06 for the definition of charity care.

5. Planning Policy – CON Intervention/Opposition

(a) Any CON application filed by a health care facility shall not be deemed complete until, and unless:

i. The applicant has submitted all survey information requested by SHPDA prior to the application date; and

ii. The SHPDA Executive Director determines that the survey information is substantially complete.

(b) No Home Health Agency or Hospice Agency filing an intervention notice or statement in opposition in any CON proceeding may cite or otherwise seek consideration by SHPDA of such facility's utilization data until, and unless:

i. the intervenor or opponent has submitted all survey information requested by SHPDA prior to the application date; and

ii. the SHPDA Executive Director determines that the survey information is substantially complete.

6. Home Health Need Methodology

(i) Purpose. The purpose of this home health need methodology is to identify, by county, the number of home health agencies needed to assure the continued availability, accessibility, and affordability of quality home health care for residents of Alabama.

(ii) Basic Methodology.

The SHCC finds that the current home health methodology, set forth below, is in need of review prior to the grant or consideration of new home health agencies. Consequently, no new home health applications shall be accepted until the earlier of (1) January 1, 2016; or (2) the adoption of a revised home health need methodology.

In order to perform the calculations for this methodology, population data from the Center for Business and Economic Research (CBER) was used. All time frames are based on the year of the latest reported data.

Step 1:

1. Data required to perform the calculations in this methodology are: population data for the current reporting year, the two reporting years immediately prior to the current reporting year, and the projected data for three years immediately following the current reporting year.
2. Persons served data for the current reporting year, and the two reporting years immediately prior to the current reporting year, are required to perform the calculations in this methodology. This information can be gathered off the HH-2 report as generated by SHPDA.
3. The ratio for the change in population for two age cohorts, Population under 65 and Population age 65 and over, needs to be determined per county. The ratio for the change will be for a three year period. Therefore, the current reporting year will be compared to the year three years following the current reporting year. The year immediately prior to the current reporting year will be compared to the year two years following the current reporting year. The year two year prior to the current reporting year will be compared to the year immediately following the current reporting year. To show this another way:

Current Reporting Year	--	Current Reporting Year + 3
Current Reporting Year	--	Current Reporting Year + 2
Current Reporting Year	--	Current Reporting Year + 1

4. Projected patients served under the age of 65 for future reporting years are calculated on a county basis by: multiplying the year's total persons served by 25% (0.25) to determine the approximate number of persons served under the age of 65. This number is divided by the county population under the age of 65 to determine a utilization rate. To determine the *projected patients served under the age of 65*, this total is then multiplied by the total projected population for the target year for each county.
5. Projected patients served age 65 and older for future reporting years are calculated on a county basis by: multiplying the year's total persons served by 75% (0.75) to determine the approximate number of persons served age 65 and older. This number is divided by the county population 65 and older to determine a utilization rate. To determine the *projected patients served age 65 and older*, this total is then multiplied by the total projected population for the target year for each county.
6. To determine the *total number of projected persons served per county*, add the totals from steps 4 and 5.
7. Add the *total number of projected persons served*, by county, to determine the *statewide projected total persons served*.
8. Multiply the target year's *projected total persons served* for the target year by 25% (0.25) to reflect the *projected statewide total persons served* under the age of 65.
9. Divide the total statewide population under the age of 65 for the target year by 1000.
10. Divide the numeric result from step 8 by the numeric result in step 9.
11. Multiply the target year's *projected total persons served* by 75% (0.75) to reflect the projected statewide total persons served ages 65 and over.

12. Divide the total statewide population age 65 and over for the target year by 1000.
13. Divide the numeric result from step 11 by the numeric result in step 12.
14. Add the results from steps 10 and 13. This is the *projected average statewide persons served per 1000 population*, by county, for the target year.
15. Repeat steps 4 through 14 for the second target year.
16. Repeat steps 4 through 14 for the third target year.
17. To determine the *projected weighted statewide average persons served*, perform the following calculation: multiply the *projected statewide average persons served per 1000 population* for 3 years after the current reporting year by 3; multiply the *projected statewide average persons served per 1000 population* for 2 years after the current reporting year by 2; and multiply the *projected statewide average persons served per 1000 population* for 1 year after the current reporting year by 1.
18. Add the three results determined in step 17 and divide the total by 6 for the *projected statewide average persons served per 1000 population.*
19. To determine the *Current Home Health Comparative Value,* multiply the number derived in step 18 by 85% (0.85). This is the value that will be utilized in the comparisons in step 2.

Step 2:

1. Using the data created above for the target year (the year three years after the current reporting year), follow the steps below to determine the future projected need for Home Health Services by county.
2. Multiply the target year's total persons served by 25% (0.25) to reflect the *county wide total persons served under the age of 65*.
3. Divide the total county wide population under the age of 65 by 1000.
4. Divide the numeric result from step 2 by the numeric result in step 3.
5. Multiply the current year's total persons served by 75% (0.75) to reflect the *county wide total persons served ages 65 and over*.
6. Divide the total county wide population age 65 and over by 1000.
7. Divide the numeric result from step 5 by the numeric result in step 6.
8. Add the results from steps 4 and 7. This is the *projected total persons served per 1000 population* used to determine need for Home Health Services in a county.
9. Subtract the result from step 8, by county, from the *Current Home health Comparative Value.* If this number is negative, there is no need for a new Home Health provider in a county. If the number is positive, continue to step 10.
10. This number is then divided by the SUM of 0.75 (75%) times 1000 divided by the county population aged 65 and over AND 0.25 (25%) times 1000 divided by the county population under the age of 65. This number is the number of new persons required to be served in a county to bring the county persons served per 1000 value up to the statewide comparative value.
11. A threshold level of 100 new patients needed to be served is required for a determination of need in a county. If the number of new patients needed to be served is less than 100, there is no need for a new Home Health provider in a county. If the

number is equal to or greater than 100, there is a need for a new Home Health Care provider in a county.

Step 1:
For each target year by county:

(reported year persons served * 0.25) / (reported year population under 65)

= utilization rate population under 65

Utilization rate * target year population under 65 = projected persons served under 65

(reported year persons served * 0.75) / (reported year population age 65 and over)

=utilization rate population age 65 and over

Utilization rate * target year population age 65 and over = projected persons served age 65 and over

Projected persons served under 65 + projected persons served age 65 and over

= Target year projected persons served by county

For each target year:

Sum of all Target year projected persons served by county = Target year projected total persons served

(Target year projected total persons served * 0.25) / (Projected population under 65/1000) + (Target year projected total persons served * 0.75) / (Projected population age 65 and over/1000)

=Projected Statewide Average Persons Served per 1000 Population

To Determine Current Home Health Comparative Value for Step 2:

$$\frac{\begin{array}{l}(\text{3 Years after Current Reporting Year Projected Average Persons Served} * 3) + \\ (\text{2Years after Current Reporting Year Projected Average Persons Served} * 2) + \\ (\text{1 year after Current Reporting Year Projected Average Persons Served} * 1))\end{array}}{6}$$

= Projected Weighted Average Persons Serviced per 1000 Population

Projected Weighted Average Persons Served per 1000 Population * 0.85

= Current Home Health Comparative Value

Step 2: *(Using population and persons served for 3 years after current reporting year)*

$$\frac{\text{(countywide total persons served * 0.25)}}{\text{(countywide population under 65/1000)}} + \frac{\text{(countywide total persons served * 0.75)}}{\text{(county population 65 and over/1000)}}$$

= County Persons Served per 1000 Population

Current Home Health Comparative Value – County Persons Served per 1000 Population

=County Projected Persons Per 1000 Population in need of Home Health Services.

$$\frac{\text{County Projected Persons Per 1000 Population in need of Home Health Services}}{\text{(0.75 * 100/Population age 65 and over) + (0.25 * 1000/Population under 65)}}$$

= New persons required to be served in county to equal Current Home Health Comparative Value

If number is negative, there is no need in a county.
If number is less than 100, there is no need in a county.
If number is 100 or more, there is a need for a new Home Health provider in a county.

For a listing of Home Health Agencies or the most current statistical need projections in Alabama you may contact the Data Division as follows:

MAILING ADDRESS
(U.S. Postal Service)

PO BOX 303025
MONTGOMERY AL 36130-3025

STREET ADDRESS
(Commercial Carrier)

100 NORTH UNION STREET
SUITE 870
MONTGOMERY AL 36104

TELEPHONE:
(334) 242-4103

FAX:
(334) 242-4113

E-Mail:
info@shpda.alabama.gov

Website:
http://www.shpda.alabama.gov

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Repealed Filed December 12, 2006; Effective January 16, 2008. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015. Amended: Filed February 10, 2015; Effective March 17, 2015.
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COUNTY ASSESSMENT OF NEED FOR HOME HEALTH AGENCIES

	VISITS	PERS SERV	POP 65 + 2003	VISITS PER 1,000 65 +	PERS SERV/ 1,000 65 +	PERS NEEDED TO = 138	METHODOLOGY CONCLUSION
AUTAUGA	30,298	860	5,007	6,051	172		
BALDWIN	66,015	2,532	24,392	2,706	104	829	Possibly Underserved
*BARBOUR	24,984	797	3,928	6,360	203		
*BIBB	9,424	380	2,593	3,634	147		
BLOUNT	20,796	704	7,183	2,895	98	287	Possibly Underserved
*BULLOCK	5,937	200	1,525	3,893	131	21	**
*BUTLER	16,709	599	3,481	4,800	172		
CALHOUN	52,671	1,719	16,169	3,258	106	517	Possibly Underserved
*CHAMBERS	12,589	653	5,874	2,143	111	188	Possibly Underserved
*CHEROKEE	6,645	323	4,225	1,573	76	262	Possibly Underserved
*CHILTON	31,257	861	5,435	5,751	158		
*CHOCTAW	24,677	640	2,449	10,076	261		
*CLARKE	16,463	521	3,939	4,179	132	24	**
*CLAY	20,292	531	2,467	8,225	215		
*CLEBURNE	2,536	125	2,045	1,240	61	27	**
*COFFEE	26,980	859	6,470	4,170	133	52	**
COLBERT	53,686	1,404	8,711	6,163	161		
*CONECUH	27,740	621	2,213	12,535	281		
*COOSA	3,152	142	1,824	1,728	78	109	Possibly Underserved
*COVINGTON	28,479	906	6,871	4,145	132	41	**
*CRENSHAW	9,755	282	2,308	4,227	122	95	**
*CULLMAN	56,261	1,586	11,920	4,720	133	60	**
DALE	17,995	665	6,260	2,875	106	232	Possibly Underserved
*DALLAS	37,655	1,188	6,445	5,843	184		
*DEKALB	34,977	1,195	9,238	3,786	129	83	**
ELMORE	24,232	1,367	7,665	3,161	178		
*ESCAMBIA	20,281	696	5,428	3,736	128	54	**
ETOWAH	64,290	1,784	16,549	3,885	108	496	Possibly Underserved
*FAYETTE	9,901	431	3,084	3,210	140		
*FRANKLIN	40,091	944	4,786	8,377	197		
*GENEVA	18,784	627	4,358	4,310	144		
*GREENE	11,019	276	1,465	7,522	188		
*HALE	21,480	450	2,324	9,243	194		
*HENRY	5,215	226	2,710	1,924	83	149	Possibly Underserved
HOUSTON	44,638	1,531	12,630	3,534	121	215	Possibly Underserved
*JACKSON	39,214	1,123	7,720	5,080	145		
JEFFERSON	286,078	12,400	88,407	3,236	140		
*LAMAR	22,473	539	2,617	8,587	206		
LAUDERDALE	30,957	1,414	13,785	2,246	103	620	Possibly Underserved
LAWRENCE	34,648	861	4,436	7,811	194		
LEE	27,481	1,188	10,037	2,738	118	351	Possibly Underserved
LIMESTONE	39,301	1,140	7,771	5,057	147		
*LOWNDES	6,392	209	1,745	3,663	120	58	**
*MACON	13,279	596	3,303	4,020	180		

COUNTY ASSESSMENT OF NEED FOR HOME HEALTH AGENCIES

	VISITS	PERS SERV	POP 65 + 2003	VISITS PER 1,000 65 +	PERS SERV/ 1,000 65 +	PERS NEEDED TO = 138	METHODOLOGY CONCLUSION
MADISON	82,481	3,537	32,677	2,524	108	980	Possibly Underserved
*MARENGO	15,882	480	3,319	4,785	145		
*MARION	35,104	1,022	5,171	6,789	198		
*MARSHALL	62,023	1,916	12,290	5,047	156		
MOBILE	492,952	7,142	48,819	10,098	146		
*MONROE	33,695	608	3,446	9,778	176		
MONTGOMERY	93,382	3,734	26,553	3,517	141		
MORGAN	57,857	1,884	14,305	4,045	132	86	**
*PERRY	6,477	195	1,762	3,676	111	48	**
*PICKENS	21,370	637	3,316	6,445	192		
*PIKE	28,289	945	3,805	7,435	248		
*RANDOLPH	19,512	607	3,674	5,311	165		
RUSSELL	32,406	1,145	6,658	4,867	172		
ST. CLAIR	25,025	771	8,293	3,018	93	373	Possibly Underserved
SHELBY	26,537	1,270	14,140	1,877	90	679	Possibly Underserved
*SUMTER	17,090	478	2,006	8,519	238		
*TALLADEGA	66,798	1,993	10,985	6,081	181		
*TALLAPOOSA	18,785	857	6,973	2,694	123	300	Possibly Underserved
TUSCALOOSA	101,008	3,589	18,783	5,378	191		
*WALKER	72,028	1,839	10,828	6,652	170		
*WASHINGTON	16,668	462	2,349	7,096	197		
*WILCOX	5,950	171	1,791	3,322	95	77	**
*WINSTON	31,169	869	3,744	8,325	232		
TOTALS	2,760,215	84,246	599,479	4,604	141		

*Designated as Rural by the Health Care Financing Administration.

**Under Section 410-2-4-.07(8) a county will be considered for an additional agency only when the number required to bring the county up to the set number of persons served per 1,000 population 65 and older equals, at a minimum, 100 new person.

Note: Counties below 138 persons served per 1,000 population 65 and older are possibly underserved, utilizing the three year weighted average methodology.

Note: Methodology per *Alabama State Health Plan* 2004-2007
Section 410-2-4-.07.

Source: SHPDA HH-2 report for period ending September 30, 2003

20-Jun-04

ALABAMA
Home Health Care Agencies

Facility Name	City
BALDWIN *County*	
AMEDISYS HOME HEALTH INC. OF ALABAMA	FAIRHOPE
MERCY MEDICAL HOME HEALTH	FAIRHOPE
MID SOUTH HOME HEALTH AGENCIES, INC.	DAPHNE
SOUTH BALDWIN HOSP HOME HEALTH AGENCY	FOLEY
THOMAS HOSPITAL HOME HEALTH	DAPHNE
BALDWIN County Totals:	Number Of Facilities: 5
BARBOUR *County*	
LAKEVIEW COMMUNITY HOSPITAL HOME HEALTH	EUFAULA
BARBOUR County Totals:	Number Of Facilities: 1
BIBB *County*	
BIBB MEDICAL CENTER HOME HEALTH	CENTREVILLE
BIBB County Totals:	Number Of Facilities: 1
BLOUNT *County*	
MEDICAL CENTER BLOUNT HOME HEALTH	ONEONTA
BLOUNT County Totals:	Number Of Facilities: 1
BULLOCK *County*	
ASSOCIATES HOME HEALTH	UNION SPRINGS
BULLOCK County Totals:	Number Of Facilities: 1
BUTLER *County*	
LVSMH HOME HEALTH AGENCY	GREENVILLE
RELIABLE HOME HEALTH SERVICES, INC.	GEORGIANA
BUTLER County Totals:	Number Of Facilities: 2
CALHOUN *County*	
AMEDISYS HOME HEALTH OF ANNISTON	ANNISTON
GENTIVA HEALTH SERVICES Calhoun	ANNISTON
NORTHEAST AL REG MEDICAL CENTER HOME HEALTH	ANNISTON
CALHOUN County Totals:	Number Of Facilities: 3

ALABAMA
Home Health Care Agencies

Facility Name	City
CHAMBERS*County*	
LANIER HOME HEALTH SERVICES	VALLEY
CHAMBERS County Totals:	Number Of Facilities: 1
CHEROKEE *County*	
CHEROKEE BMC HOME HEALTH	CENTRE
CHEROKEE County Totals:	Number Of Facilities: 1
CHILTON *County*	
CHILTON MEDICAL CENTER HOME HEALTH	CLANTON
CHILTON County Totals:	Number Of Facilities: 1
CHOCTAW *County*	
PRIMARY HOME CARE	GILBERTOWN
CHOCTAW County Totals:	Number Of Facilities: 1
CLARKE *County*	
INFIRMARY HOME HEALTH AGENCY	GROVE HILL
JACKSON HOME HEALTH	JACKSON
CLARKE County Totals:	Number Of Facilities: 2
CLAY *County*	
CLAY COUNTY HOSPITAL HOME HEALTH	ASHLAND
CLAY County Totals:	Number Of Facilities: 1
COLBERT *County*	
TRI-COUNTY HOME HEALTH CARE AGENCIES	SHEFFIELD
COLBERT County Totals:	Number Of Facilities: 1
CONECUH *County*	
EVERGREEN HOME CARE	EVERGREEN
CONECUH County Totals:	Number Of Facilities: 1

ALABAMA
Home Health Care Agencies

Facility Name	City
COVINGTON ***County***	
GENTIVA HEALTH SERVICES Covington	ANDALUSIA
HOME CARE SERVICE OF OPP	OPP
MIZELL MEMORIAL HOSPITAL HOME HEALTH CARE AGENCIES	OPP
COVINGTON County Totals:	Number Of Facilities: 3
CRENSHAW ***County***	
CRENSHAW BAPTIST HOME HEALTH SERVICES	LUVERNE
CRENSHAW County Totals:	Number Of Facilities: 1
CULLMAN ***County***	
CULLMAN REG MEDICAL CENTER HOME CARESERVICES	CULLMAN
WOODLAND MEDICAL HOSPITAL HOME HEALTH	CULLMAN
CULLMAN County Totals:	Number Of Facilities: 2
DALE ***County***	
DALE MEDICAL CENTER HOME HEALTH	OZARK
DALE County Totals:	Number Of Facilities: 1
DALLAS ***County***	
AMEDISYS HOME HEALTH, INC. OF SELMA	SELMA
MID SOUTH HOME HEALTH	SELMA
DALLAS County Totals:	Number Of Facilities: 2
DEKALB ***County***	
BAPTIST DEKALB HOME CARE	COLLINSVILLE
DEKALB County Totals:	Number Of Facilities: 1
ELMORE ***County***	
COMMUNITY HOME CARE	TALLASSEE
IVY CREEK HOME HEALTH OF ELMORE	WETUMPKA
ELMORE County Totals:	Number Of Facilities: 2

ALABAMA
Home Health Care Agencies

Facility Name	City
ESCAMBIA*County*	
ATMORE COMMUNITY HOSPITAL HOME HEALTH	ATMORE
D. W. MCMILLAN HOME HEALTH	BREWTON
ESCAMBIA County Totals:	Number Of Facilities: 2
ETOWAH *County*	
GADSDEN REGIONAL MEDICAL CENTER (HH)	ATTALLA
RIVERVIEW REGIONAL MED CTR HOME HEALTH	GADSDEN
ETOWAH County Totals:	Number Of Facilities: 2
FAYETTE *County*	
FAYETTE MEDICAL CENTER HOME HEALTH AGENCY	FAYETTE
FAYETTE County Totals:	Number Of Facilities: 1
FRANKLIN *County*	
COMMUNITY HOME HEALTH (Franklin)	RED BAY
NORTHWEST HOME HEALTH	RUSSELLVILLE
SOUTHERN RURAL HEALTH CARE CONSORTIUM (Franklin)	RUSSELLVILLE
FRANKLIN County Totals:	Number Of Facilities: 3
GREENE *County*	
GREENE COUNTY HOSPITAL HOME HEALTH	EUTAW
GREENE County Totals:	Number Of Facilities: 1
HALE *County*	
HALE COUNTY HOSPITAL HOME HEALTH	GREENSBORO
HALE County Totals:	Number Of Facilities: 1
HOUSTON *County*	
CARESOUTH-DOTHAN	DOTHAN
HORIZON HOME CARE OF DOTHAN	DOTHAN
MEDICAL CENTER HH SERVICES II	DOTHAN
MEDICAL CENTER HH SERVICES, I	DOTHAN
HOUSTON County Totals:	Number Of Facilities: 4

ALABAMA
Home Health Care Agencies

Facility Name	City
JACKSON ***County***	
HOSPITAL HOME HEALTH	SCOTTSBORO
JACKSON County Totals:	Number Of Facilities: 1
JEFFERSON ***County***	
ABLE HOME HEALTH INC	BESSEMER
ALACARE HOME HEALTH SERVICES, INC.	BIRMINGHAM
Alacare Home Health Services, Inc. (Troy) 0	BIRMINGHAM
AMEDISYS HOME HEALTH OF BIRMINGHAM	BIRMINGHAM
BAPTIST HOME CARE SERVICES	BIRMINGHAM
BROOKWOOD HOME HEALTH AGENCY	BIRMINGHAM
CARE FIRST, INC.	BIRMINGHAM
GENTIVA HEALTH SERVICES	BIRMINGHAM
HEALTH SERVICES EAST, INC.	BIRMINGHAM
HOME CARE PLUS, INC.	BIRMINGHAM
JEFFERSON COUNTY HEALTH DEPARTMENT	BIRMINGHAM
MIDSOUTH HOME HEALTH - SHELBY	PELHAM
SOLEUS HC SERVICE OF NC AL, INC.	BIRMINGHAM
ST MARTINS HOME HEALTH, INC.	BIRMINGHAM
JEFFERSON County Totals:	Number Of Facilities: 14 0
LAMAR ***County***	
LAMAR HOME CARE, INC.	VERNON
LAMAR County Totals:	Number Of Facilities: 1
LAWRENCE ***County***	
LAWRENCE BAPTIST MEDICAL CENTER HOME HEALTH	MOULTON
MID SOUTH HOME HEALTH AGENCY INC.	MOULTON
LAWRENCE County Totals:	Number Of Facilities: 2

ALABAMA
Home Health Care Agencies

Facility Name	City
LEE *County*	
EAST AL MEDICAL CENTER HOME CARE	OPELIKA
SOUTHERN HOME HEALTH SERVICES	OPELIKA
LEE County Totals:	Number Of Facilities: 2
LIMESTONE *County*	
ATHENS LIMESTONE HOSPITAL HOME HEALTH	ATHENS
LIMESTONE County Totals:	Number Of Facilities: 1
MADISON *County*	
AMEDISYS HOME HEALTH OF HUNTSVILLE	HUNTSVILLE
HGA - HOME HEALTH GROUP - HUNTSVILLE	HUNTSVILLE
SPECTRUM HOME HEALTH AGENCY	HUNTSVILLE
MADISON County Totals:	Number Of Facilities: 3
MARENGO *County*	
B. W. WHITFIELD MEM HOME HEALTH CARE AGENCIES	DEMOPOLIS
MARENGO County Totals:	Number Of Facilities: 1
MARION *County*	
MARION REGIONAL HOME HEALTH SERVICES	HAMILTON
NORTHWEST HOME HEALTH-WINFIELD	WINFIELD
MARION County Totals:	Number Of Facilities: 2
MARSHALL *County*	
MEDICAL CENTER HOME HEALTH (Marshall)	ALBERTVILLE
MARSHALL County Totals:	Number Of Facilities: 1
MOBILE *County*	
AMEDISYS HOME HEALTH INC. OF AL MOBILE	MOBILE
GENTIVA HEALTH SERVICES	MOBILE
INFIRMARY HOME HEALTH AGENCY	MOBILE
KARE IN HOME HEALTH SERVICES OF ALA, INC	MOBILE
SAAD'S HEALTH CARE SERVICES	MOBILE

ALABAMA
Home Health Care Agencies

Facility Name	City
MOBILE ***County***	
SPRINGHILL HOME HEALTH AGENCY	MOBILE
VANGUARD HOME HEALTH OF MOBILE	MOBILE
MOBILE County Totals:	Number Of Facilities: 7
MONROE ***County***	
MONROE COUNTY HOSPITAL PROGRESSIVE HOME CARE	MONROEVILLE
VANGUARD HOME HEALTH OF MONROEVILLE	MONROEVILLE
MONROE County Totals:	Number Of Facilities: 2
MONTGOMERY ***County***	
AMEDISYS HOME HEALTH	MONTGOMERY
BAPTIST HOME HEALTH SERVICES MONTGOMERY	MONTGOMERY
GENTIVA HEALTH SERVICES MONTGOMERY	MONTGOMERY
MID SOUTH HOME HEALTH AGENCY	MONTGOMERY
MONTGOMERY HOME CARE	MONTGOMERY
MONTGOMERY County Totals:	Number Of Facilities: 5
MORGAN ***County***	
ALACARE HOME HEALTH & HOSPICE	DECATUR
HEALTH GROUP-HOME HEALTH GROUP-DECATUR	DECATUR
MORGAN County Totals:	Number Of Facilities: 2
PICKENS ***County***	
AMEDISYS HOME HEALTH INC. OF AL PICKENS	REFORM
MEDICAL CENTER HOME HEALTH (Pickens)	CARROLLTON
PICKENS County Totals:	Number Of Facilities: 2
PIKE ***County***	
TROY REGIONAL MEDICAL CENTER (HH)	TROY
PIKE County Totals:	Number Of Facilities: 1
RUSSELL ***County***	
CHATTAHOOCHEE VALLEY HHC, INC.	PHENIX CITY
RUSSELL County Totals:	Number Of Facilities: 1

ALABAMA
Home Health Care Agencies

Facility Name	City
SHELBY *County*	
COMFORT CARE HOME HEALTH SERVICES	ALABASTER
SHELBY County Totals: Number Of Facilities: 1	
ST. CLAIR *County*	
ST CLAIR REGIONAL HOME HEALTH	PELL CITY
ST. CLAIR County Totals: Number Of Facilities: 1	
SUMTER *County*	
HILL HOSPITAL HOME HEALTH	YORK
SUMTER County Totals: Number Of Facilities: 1	
TALLADEGA *County*	
COOSA VALLEY BMC HOME HEALTH	SYLACAUGA
GENTIVIA HEALTH SERVICES	SYLACAUGA
TALLADEGA County Totals: Number Of Facilities: 2	
TALLAPOOSA *County*	
COMMUNITY HOME CARE (Tallapoosa)	DADEVILLE
TALLAPOOSA County Totals: Number Of Facilities: 1	
TUSCALOOSA *County*	
AMEDISYS HOME HEALTH OF TUSCALOOSA	TUSCALOOSA
COMMUNITY HOME HEALTH (Tuscaloosa)	TUSCALOOSA
DCH HOME HEALTH CARE AGENCIES AGENCY	TUSCALOOSA
TUSCALOOSA County Totals: Number Of Facilities: 3	
WALKER *County*	
WALKER BMC HOME CARE SERVICES	JASPER
WALKER County Totals: Number Of Facilities: 1	
WILCOX *County*	
J PAUL JONES HOME HEALTH AGENCY	CAMDEN
WILCOX County Totals: Number Of Facilities: 1	
WINSTON *County*	
NORTHWEST HOME HEALTH - HALEYVILLE	HALEYVILLE
WINSTON County Totals: Number Of Facilities: 1	
State Totals: Number Of Facilities: 109	

ALABAMA

ALABAMA HEALTH DEPARTMENT COUNTY HOME HEALTH AGENCIES

Facility	City
AUTAUGA COUNTY HEALTH DEPARTMENT	PRATTVILLE
BARBOUR COUNTY HEALTH DEPARTMENT	CLAYTON
CHOCTAW COUNTY HEALTH DEPARTMENT	LINDEN
CLAY COUNTY HEALTH DEPARTMENT	LINEVILLE
COFFEE COUNTY HEALTH DEPARTMENT	ENTERPRISE
NORTHWEST AL REGION HOME HEALTH DEPT	TUSCUMBIA
CONECUH COUNTY HEALTH DEPARTMENT	EVERGREEN
CULLMAN COUNTY HEALTH DEPARTMENT	CULLMAN
DALLAS COUNTY HEALTH DEPARTMENT	SELMA
DEKALB COUNTY HEALTH DEPARTMENT	FORT PAYNE
ETOWAH COUNTY HEALTH DEPARTMENT	GADSDEN
GENEVA COUNTY HEALTH DEPARTMENT	GENEVA
HOUSTON COUNTY HEALTH DEPARTMENT	DOTHAN
JACKSON COUNTY HEALTH DEPARTMENT	SCOTTSBORO
LAMAR COUNTY HEALTH DEPARTMENT	VERNON
LAWRENCE COUNTY HEALTH DEPARTMENT	MOULTON
LIMESTONE COUNTY HEALTH DEPARTMENT	ATHENS
MARION COUNTY HEALTH DEPARTMENT	HAMILTON
MARSHALL COUNTY HEALTH DEPARTMENT	GUNTERSVILLE
MOBILE COUNTY HEALTH DEPARTMENT	MOBILE
MONROE COUNTY HEALTH DEPARTMENT	MONROEVILLE
MONTGOMERY COUNTY HEALTH DEPARTMENT	MONTGOMERY
MORGAN COUNTY HEALTH DEPARTMENT	DECATUR
PIKE COUNTY HEALTH DEPARTMENT	TROY

ALABAMA
ALABAMA HEALTH DEPARTMENT COUNTY HOME HEALTH AGENCIES

Facility	City
RANDOLPH COUNTY HEALTH DEPARTMENT	ROANOKE
RUSSELL COUNTY HEALTH DEPARTMENT	PHENIX CITY
SUMTER COUNTY HEALTH DEPARTMENT	LIVINGSTON
TALLEDEGA/COOSA COUNTY HEALTH DEPARTMENT	SYLACAUGA
TUSCALOOSA COUNTY HEALTH DEPARTMENT	TUSCALOOSA
WASHINGTON COUNTY HEALTH DEPARTMENT	CHATOM
WINSTON COUNTY HEALTH DEPARTMENT	HAMILTON

State Totals: Number Of Facilities: 31

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410-2-4-.08 **Inpatient Physical Rehabilitation**

(1) Definition. Inpatient physical rehabilitation services are those designed to be provided on an integrated basis by a multidisciplinary rehabilitation team to restore the disabled individual to the highest physical usefulness of which he is capable. These services may be provided in a distinct part unit of a hospital, as defined in the Medicare and Medicaid Guidelines, or in a free-standing rehabilitation hospital.

(2) General. Rehabilitation can be viewed as the third phase of the medical care continuum, with the first being the prevention of illness, the second, the actual treatment of disease, and the third, rehabilitation or a constructive system of treatment designed to enable individuals to attain their highest degree of functioning. In many cases, all three phases can occur simultaneously. For the purposes of this section of the State Health Plan, only the need and inventory of inpatient rehabilitation facilities will be addressed.

(3) Need Determination. The Statewide Health Coordinating Council (SHCC) has determined that there is a need for 12 rehabilitation beds per 100,000 population for each region (see Table I).

(4) Planning Policies

(a) Planning Policy

Regional occupancy for the most recent reporting year should be at least 75% before the SHCC gives consideration to any requests for plan adjustments for additional bed capacity.

(b) Planning Policy

Conversion of existing hospital beds to rehabilitation beds should be given priority consideration over new construction when the conversion is significantly less costly and the existing structure can meet licensure and certification requirements.

(5) Accessibility-Distribution. Inpatient Rehabilitation services appear to be well distributed in the most populous regions of Alabama, with the exception of Region V, the largest of the seven planning regions. The SHCC, though the adjustment process in August of 2005, recognized the need for 5 additional rehabilitation beds to be located in Houston County. Future consideration should be given to locating a unit in Dallas County to serve the western counties of Region V.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004: Filed June 30, 2006; Effective August 4, 2006. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.

INPATIENT REHABILITATION BED REGIONS

REGION I

Lauderdale
Limestone
Madison
Jackson
Colbert
Franklin
Lawrence
Morgan
Marshall

REGION II

Lamar
Fayette
Pickens
Tuscaloosa
Sumter
Greene
Hale
Bibb

REGION III

Marion
Winston
Cullman
Blount
Walker
Jefferson
Shelby
Chilton
Coosa
Talladega
St. Clair

REGION IV

DeKalb
Etowah
Cherokee
Calhoun
Cleburne
Clay
Randolph

REGION V

Perry
Marengo
Wilcox
Dallas
Autauga
Lowndes
Butler
Crenshaw
Pike
Montgomery
Elmore
Macon
Bullock
Lee
Russell
Tallapoosa
Chambers

REGION VI

Choctaw
Washington
Mobile
Baldwin
Escambia
Conecuh
Monroe
Clarke

REGION VII

Covington
Coffee
Dale
Geneva
Houston
Barbour
Henry

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TABLE I

INPATIENT PHYSICAL REHABILITATION
PROJECTION OF BED NEED
(Based on 12 Beds Per 100,000 Population)

Region	Population (2006)	Beds Needed	Beds Existing	CON Issued	Net Need (Excess)
I	851,208	102	70	20	12
II	292,599	35	42	0	(7)
III	1,327,358	159	268	0	(109)
IV	368,285	44	0	40	4
V	825,755	99	87	31	(19)
VI	718,313	86	75	0	11
VII	299,847	36	34	12	(10)

TABLE II

REHABILITATION BEDS AUTHORIZED

COUNTY	FACILITY	TYPE LIC	BEDS	OCC (2002)
Baldwin	Mercy Medical, A Corporation	REH	25	65.6%
Etowah	HealthSouth Rehabilitation Hospital of Gadsden	REH	40	*
Houston	HealthSouth Rehabilitation Hospital	REH	34	95.5%
Jefferson	Baptist Medical Center Montclair	GEN	17	72.2%
	Bessemer Carraway Medical Center	GEN	31	51.1%
	Carraway Methodist Medical Center	GEN	17	84.0%
	HealthSouth Lakeshore Rehabilitation Hospital	REH	100	90.6%
	Medical Center East	GEN	20	80.8%
	University of Alabama Hospital	GEN	78	50.0%
Madison	Huntsville Hospital	GEN	20	45.5%
	HealthSouth Rehabilitation Hospital of North Alabama	REH	50	99.0%
Mobile	Mobile Infirmary	REH	50	66.3%
Montgomery	HealthSouth Rehabilitation Hospital of Montgomery	REH	80	96.4%
Tuscaloosa	Northport Hospital DCH	REH	50	74.2%
	Totals		600	

Utilization Source: Annual Report for Hospitals & Related Facilities (Form BHD-134-A)

* Facility opened in October 2003 no occupancy data available.

CON 2014-H issued August 2, 2002 to HealthSouth Regional Rehabilitation Hospital for construction and operation of a 38 bed rehabilitation hospital in Phenix City, Russell County. Seven of these beds would be relocated from Montgomery County.

CON 2072-H issued October 29, 2003 to Andalusia Regional Hospital for the construction and operation of a patient wing to house 12 rehabilitation beds in Andalusia, Covington County.

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410-2-4-.09 **Swing Beds**

(1) Definition. A swing bed is a licensed hospital bed that can be used for either a hospital or skilled nursing home patient. A swing bed program is authorized in Alabama to include hospitals that meet the criteria as specified in Federal laws and regulations. In accordance with the appropriate directive and this State Health Plan, a swing bed hospital must meet the following requirements:

(a) must meet the federal requirements addressing the facility size, location, and utilization factors;

(b) must have a valid provider agreement under Medicare;

(c) must meet the discharge planning and social services standards applicable to participating skilled nursing facilities;

(d) must not have a waiver for 24-hour nursing coverage;

(e) must be granted a certificate of need by the State Health Planning and Development Agency to provide skilled nursing facility services;

(f) each participating hospital is limited to 10 swing beds;

(g) the average length of stay for swing bed patients must not exceed 30 days;

(h) beds authorized as swing beds will remain licensed as general hospital beds and be included in the general acute care inventory and bed need methodology;

(i) critical access hospitals shall be given special consideration in any application for a certificate of need for swing beds.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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ALABAMA HOSPITALS WITH CERTIFICATE OF NEED FOR SWING BEDS

	Hospital	County	Date Issued
1.	Greenlawn Hospital, Atmore	Escambia	8-14-1985
2.	Abernethy Memorial Hospital, Flomaton **	Escambia	11-21-1985
3.	Bullock County Hospital, Union Springs	Bullock	11-21-1985
4.	Georgiana Doctors Hospital, Georgiana	Butler	11-21-1985
5.	Perry County Hospital, Marion **	Perry	11-21-1985
6.	Wedowee Hospital, Wedowee	Randolph	11-21-1985
7.	Bibb Medical Center Hospital, Centreville	Bibb	1-24-1986
8.	Clay County Hospital, Ashland	Clay	1-24-1986
9.	Pickens County Medical Center, Carrollton	Pickens	1-24-1986
10.	Red Bay Hospital, Red Bay	Franklin	1-24-1986
11.	Elba General Hospital, Elba	Coffee	1-24-1986
12.	J. Paul Jones Hospital, Camden	Wilcox	3-27-1986
13.	Enterprise Hospital, Enterprise	Coffee	3-27-1986
14.	Hill Hospital of York, York	Sumter	5-29-1986
15.	Grove Hill Memorial Hospital, Grove Hill	Clarke	7-25-1986
16.	Thomasville Hospital, Thomasville	Clarke	2-11-1987
17.	Greene County Hospital, Eutaw	Greene	10-26-1987
18.	D.W. McMillian Memorial Hospital, Brewton	Escambia	5-25-1988
19.	Mizell Memorial Hospital, Opp	Covington	5-25-1988
20.	Clay County Hospital, Ashland	Clay	5-25-1988
21.	Wiregrass Hospital, Geneva	Geneva	5-26-1988
22.	Andalusia Hospital, Andalusia	Covington	5-26-1988
23.	Woodland Community Hospital, Cullman	Cullman	5-26-1988
24.	Washington County Infirmary, Chatom	Washington	5-26-1988
25.	Lakeview Community Hospital, Eufaula	Barbour	5-26-1988
26.	Evergreen Hospital, Evergreen	Conecuh	5-26-1988
27.	Clarke Hospital, Inc., Jackson	Clarke	5-26-1988
28.	Burdick-West Memorial Hospital, Haleyville	Winston	5-26-1988
29.	Humana Hospital, Russellville	Franklin	5-26-1988
30.	Lamar Regional Hospital, Vernon **	Lamar	5-26-1988
31.	Crenshaw County Hospital, Luverne	Crenshaw	5-26-1988
32.	Russell Hospital, Alexander City	Tallapoosa	5-26-1988
33.	Randolph County Hospital, Roanoke	Randolph	5-26-1988
34.	Central Alabama Community Hospital, Clanton	Chilton	5-26-1988
35.	Guntersville Hospital, Guntersville	Marshall	5-26-1988
36.	Arab Hospital, Arab	Marshall	5-26-1988
37.	Monroe County Hospital, Monroeville	Monroe	5-26-1988
38.	Marion County General Hospital, Hamilton	Marion	5-26-1988
39.	Bryan W. Whitfield Memorial Hospital, Demopolis	Marengo	5-26-1988
40.	Athens Limestone Hospital, Athens	Limestone	5-26-1988
41.	Baptist Medical Center – Cherokee, Centre	Cherokee	6-17-1988
42.	Fayette County Hospital, Fayette	Fayette	6-17-1988
43.	Winfield Carraway Hospital, Winfield	Marion	8-11-1988
44.	George H. Lanier Memorial Hospital, Valley	Chambers	9-15-1988
45.	Edge Regional Medical Center, Troy	Pike	1-11-1989
46.	Citizens Hospital, Talladega	Talladega	7-6-1989
47.	Coosa Valley Medical Center, Sylacauga	Talladega	7-6-1989
48.	Rush Hospital – Butler Inc., Butler **	Choctaw	6-25-1990
49.	Cullman Medical Center, Cullman	Cullman	10-29-1990
50.	Lakeview Community Hospital, Eufaula	Barbour	1-5-1999*
51.	L.V. Stabler Memorial Hospital, Greene	Butler	11-2-2001
52.	South Baldwin Regional Medical Center, Foley	Baldwin	5-2-2002
53.	Baptist Medical Center – Cherokee, Centre	Cherokee	9-5-2002*
54.	Jackson Medical Center	Clarke	7-19-2004

* These facilities had to have a new CON reissued because the initial CON expired. Return to Table of Contents

** Facility is closed.

410-2-4-.10 **Psychiatric Care**

(1) Background

(a) In the early 1990s, the Alabama Department of Mental Health and Mental Retardation developed a psychiatric bed need methodology that provided for an inventory of 37.1 beds per 100,000 population. Originally, the methodology was calculated using regions; however, in 2003 it was changed to reflect a statewide need methodology. Although the statewide need methodology was helpful in the early years to ensure access to care, it resulted in an uneven distribution of psychiatric beds, with higher concentrations of beds in some regions and shortages of psychiatric beds in other regions of the state.

(b) Over time, the number of psychiatric beds, both private beds and state beds, has declined. States have transitioned funding for mental health services from institutional care to community-based services, as state budgets have been cut and as more is known about the benefits of providing care in a non-institutional, community setting. Alabama mirrors these national trends, as it has closed three state facilities and downsized from 4,000 beds in 2009 to approximately 1,600 beds in 2017. In some areas, community-based services include crisis stabilization and access to timely follow-up care. In other areas, community resources may be limited, and those with psychiatric emergencies often present to a general acute care hospital emergency room for care; some of the more severely mentally ill remain for extended periods of time in private psychiatric facilities, waiting on a state bed to become available.

(2) Methodology

(a) Discussion.

The Statewide Health Coordinating Council (SHCC) developed a proposal for a new methodology based on the increasing need for psych beds and a better distribution of those beds. Approved by the full SHCC, the purpose of this inpatient psychiatric services need methodology is to identify, by region and by bed type, the number of inpatient psychiatric beds needed to ensure the continued availability, accessibility, and affordability of quality inpatient psychiatric care for residents of Alabama. Only the SHCC, with the Governor's approval, can make changes to this methodology. The State Health Planning and Development Agency (SHPDA) staff shall annually update statistical information to reflect more current utilization through the Hospital Annual Survey. Such updated information is available for a fee upon request.

(b) Bed Need Determined by Region and by Category of Bed.

The new methodology is based upon the regional needs of the state as opposed to a statewide need methodology. It also addresses need based on the category of patients served in the beds being used; the bed categories include: 1. Child/Adolescent; 2. Adult; and 3. Geriatric. Calculation of beds needed will be based on utilization of those beds by category and by region as reported annually in the Hospital Annual Report. The Hospital Annual Report must be amended to accomplish the purposes of this new methodology. This new methodology will become effective after the certification by the Healthcare Information and Data Advisory Council of the

first new Hospital Annual Report following the passage of this amendment. All providers will report their licensed beds, operating beds and patient days by inpatient psychiatric category each year via the new Hospital Annual Report. Operating beds may be the same as or fewer than the total number of licensed psychiatric beds. Providers with unrestricted psychiatric beds obtained prior to the effective date of this new methodology shall be allowed to change the categories of their beds during the first two reporting periods. The bed allocation by category reported on the third Hospital Annual Report following the passage of this amendment shall be considered final for operating beds. Thereafter, any permanent change to a different inpatient psychiatric bed category for an existing operating bed or beds will require the approval of a new CON. This requirement will not apply to licensed beds not currently in use; however once beds are put into use, the provider will have to declare the category(ies) of the beds.

After this methodology becomes effective, applicants for new inpatient psychiatric beds will be required to select a category (Child/Adolescent, Adult, Geriatric) for which they are seeking inpatient psychiatric beds. Applicants may apply for more than one inpatient psychiatric category if a need is shown. See Section (3)(c), below regarding new beds.

Note: This new methodology is intended for planning purposes. The declaration of psychiatric beds by category on the Hospital Annual Report is not intended to preclude providers from using their psychiatric beds as necessary to address seasonal needs and surge situations. If a hospital determines that it needs to permanently change its psychiatric bed allocation, a new CON will be required. This new methodology, however, does not apply to pediatric specialty hospital providers, and is not intended: to preclude pediatric specialty hospital providers from using their pediatric specialty beds to provide pediatric psychiatric services, as necessary; to require such providers to report or declare via the SHPDA Hospital Annual Report their pediatric specialty beds used for pediatric psychiatric services as psychiatric beds, with related patient days, by inpatient category; or require such providers to obtain a CON for any new or additional use of their pediatric specialty beds for the provision of any pediatric specialty services, including pediatric psychiatric services.

(3) Planning Policies

(a) Planning on a Regional Basis

Planning will be on a regional basis. Please see attached listing for the counties in each region as designated by the SHCC.*

(b) Planning Policies for applicants.

1. An applicant for an inpatient psychiatric bed must be either: 1) an established and licensed hospital provider that has been operational for at least twelve (12) months; or, 2) a new inpatient psychiatric hospital seeking a minimum of at least twenty (20) inpatient psychiatric beds. (Specialty, Free-Standing Psychiatric Hospitals must have at least twenty (20) inpatient beds pursuant to Rule 420-5-7-.03 Classification of Hospitals; found in Chapter 420-5-7 of the Alabama Department of Public Health Administrative Code.)

2. An applicant for inpatient psychiatric beds in a particular category must demonstrate the ability to comply with state law.

3. In certificate of need decisions concerning psychiatric services, the extent to which an applicant proposes to serve all patients in an area should be considered. The problem of indigent care should be addressed by certificate of need applicants.

(c) Applying for Additional beds.

Applicants may apply for new psychiatric beds using one of the following occupancy need determinations:

1. Regional occupancy calculation.

Any region that shows an occupancy rate of 75 percent (75%) or greater in any one of the three (3) bed categories would be eligible for additional beds in that category. The number of additional beds needed would be calculated by dividing the average daily census for the region by the desired occupancy rate of 70 percent (70%) and then subtracting from this number the current beds in operation. Information for this calculation will be obtained from the most recent Hospital Annual Report as compiled by SHPDA. Beds granted under the regional methodology shall be deemed part of the official regional bed inventory at time of issuance. See formula below:

To calculate regional occupancy:

Total patient days/(Beds operating x days in Reporting Period)

To calculate beds needed to get the region to 70 percent (70%) occupancy:

a. (Total patient days/days in Reporting Period)/.70 = total beds needed for the region to have a 70 percent (70%) occupancy rate.

b. To calculate additional beds needed for the region:

Total beds needed to reach 70 percent (70%) occupancy rate minus current beds in operation.

The total patient days and the beds in operation used for the calculations would come from the information reported to SHPDA through the most recent Hospital Annual Report.

The following is an example of how the regional methodology would be calculated if a single region had 25,000 adult patient days and 90 adult beds:

To calculate the regional occupancy:

25,000 adult days/(90 beds operating x days in Reporting Period) = 76 percent regional occupancy

To calculate beds needed to have a 70-percent occupancy:

(25,000 adult days/ days in Reporting Period)/.70 = 98 total beds needed for that occupancy level

Beds needed (98) minus current beds (90) = 8 additional adult beds needed for the region.

2. Individual Provider Occupancy Calculation.

If the average occupancy rate for a single facility within a region is 80 percent (80%) or greater for a continuous period of twelve (12) months in any of the three (3) bed categories, as calculated by the SHPDA using data reported on the most recent Hospital Annual Report, that facility may apply for up to 10 percent (10%) additional beds or six (6) beds, whichever is greater. An individual facility may demonstrate a need based on occupancy irrespective of the total occupancy for the region in that bed category. Information for this calculation will be obtained from the most recent Hospital Annual Report as compiled by SHPDA.

Any beds obtained through the Individual Provider Occupancy Calculation will not be included in the regional bed calculation for a period of three years after the beds are brought into service. After this three-year period the beds would be included in the regional count. Any provider obtaining beds through this provision will not be eligible to use the 10 percent rule for 24 months from the date the CON is granted.

(4) Plan Adjustments

The psychiatric bed need for each region as determined by the methodology is subject to adjustments by the SHCC. The psychiatric bed need may be adjusted by the SHCC if an applicant can prove that the identified needs of a target population are not being met by the current bed need methodology.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015. Amended: Filed June 21, 2018; Effective: August 5, 2018.

***REGIONS:**

North Central Region
Blount
Calhoun
Cherokee
Chilton
Clay
Cleburne
Coosa
DeKalb
Etowah
Jefferson
Randolph
Shelby
St. Clair
Talladega
Tallapoosa
Walker

Southeast Region
Autauga
Barbour
Bullock
Butler
Chambers
Coffee
Covington
Crenshaw
Dale
Dallas
Elmore
Geneva
Henry
Houston
Lee
Lowndes
Macon
Montgomery
Pike
Russell
Wilcox

North Region
Colbert
Cullman
Franklin
Jackson
Lauderdale
Lawrence
Limestone
Madison
Marshall
Morgan

Southwest Region
Baldwin
Clarke
Conecuh
Escambia
Mobile
Monroe
Washington

West Region
Bibb
Choctaw
Fayette
Greene
Hale
Lamar
Marengo
Marion
Perry
Pickens
Sumter
Tuscaloosa
Winston

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410-2-4-.11 **Substance Abuse**

(1) Discussion

(a) The National Household Survey on Drug Abuse (NHSDA) estimated 16.6 million Americans age 12 or older in 2001 were classified with dependence on or abuse of either alcohol or illicit drugs, a figure significantly higher than in 2000 – about 14.5 million. Most of these persons (11.0 million) were dependent on or abused alcohol only. Another 2.4 million were dependent on or abused both alcohol and illicit drugs, while 3.2 million were dependent on or abused illicit drugs but not alcohol. Persons age 18 to 25 had the highest rates of alcohol dependence or abuse (14.8 percent). (Source: www.samhsa.gov)

(b) There are more deaths and disabilities each year in the United States from Substance Abuse than from any other cause. One-quarter of all emergency room visits, one-third of all suicides, and more than one half of all homicides and incidents of domestic violence are alcohol-related. (Source: www.ncadd.org)

(c) Alcohol and drug abuse costs the American economy an estimated $276 billion per year in lost productivity, health care expenditures, crime, motor vehicle crashes and other conditions. (Source: www.ncadd.org)

(2) Background

(a) Substance abuse services for persons with both dependence and abuse problems is provided through an array of private and public providers throughout the state. The array of services ranges from inpatient medical detoxification services to residential treatment services to a variety of outpatient types of services including various affiliated support groups.

(b) In the past few years the technology for treating individuals with dependence and abuse problems has changed rather dramatically from a traditional inpatient/residential mode to outpatient treatment. This has occurred for a variety of reasons including financial considerations. These phenomena can be verified through analysis of current utilization of both inpatient and residential services.

(3) Methodology

(a) The Alabama Department of Mental Health/Mental Retardation (DMH/MR) has developed a substance abuse bed need methodology, which is based upon a formula utilized in other states, commonly referred to as the “Mardin Formula”. This prevalence base formula was selected in lieu of utilization-based formulas due to the lack of comprehensive statistical information on the current utilization of residential treatment centers. Calculation of needed beds is performed as follows:

(b) Step 1: Multiply the population ages 10-17 by 19%, which is the proportion, assumed to have problems with chemical dependency;

(c) Step 2: Multiply the population ages 18 and over by 7%, which is the proportion assumed to have problems with chemical dependency;

(d) Step 3: Multiply the sum of steps 1 and 2 by 12%, which is the proportion who will seek treatment annually;

(e) Step 4: Multiply the product in step 3 by 60% which is the proportion of those seeking treatment who will require detoxification services for 3 days. Calculate total number of patient days;

(f) Step 5: Multiply those receiving detoxification services by 50%, which is the proportion who will need residential treatment for 10 days. Calculate total number of patient days;

(g) Step 6: Add the patient days in steps 4 and 5 to arrive at total patient days;

(h) Step 7: Divide by 365 to determine average daily census (ADC);

(i) Step 8: Divide by 80% occupancy to arrive at total needed beds;

(j) Step 9: Subtract existing public beds to arrive at total private bed need;

(k) Step 10: Subtract existing private beds to determine need or excess.

BED NEED CALCULATIONS
2005

Population		Persons with SA Problems	Persons Seeking Help	Detoxification Days	Residential Days	Total Days
531,145	3,507,562	346,447	41,574	74,832	124,720	199,552

Average Daily Census	80% Occupancy	Public Beds	Private Beds	Beds Needed
547	684	616	432	(364)

SUBSTANCE ABUSE BEDS AUTHORIZED

COUNTY	FACILITY	BEDS
	Hospitals	
Colbert	Helen Keller Memorial Hospital	13
Crenshaw	Crenshaw Baptist Hosptial	5
Jefferson	Carraway Methodist Medical Center	18
	Brookwood Medical Center	14
	University of Alabama Hospital	12
	Subtotal:	62
	Residential	
Jefferson	Bradford Parkside Lodge at Warrior	100
	Salvation Army Adult Rehabilitation Center	84
Madison	Bradford at Huntsville	84
Shelby	Bradford Adolescent	102
	Subtotal:	370
	State Total:	432

Updated September 2003
Alabama 2002 Hospital H-5 Report

(4) Methadone Treatment

(a) Definition. Methadone is an opioid agonist medication used to treat heroin and other opiate addiction. Methadone reduces the craving for heroin and other opiates by blocking receptor sites that are affected by heroin and other opiates.

(b) Background

1. Prior to June 1991 Alabama operated two methadone clinics in Birmingham and in Mobile, both of which were operated through a DMH/MR contract. These clinics are part of the UAB Mental Health Center and the Mobile Mental Health Center. The average number of clients served in any given month never exceeded 380 of which fewer than 5% were clients from out of state.

2. As of April 2015, Alabama has twenty two (22) certified methadone treatment programs.

(c) Recommendations

1. A methadone treatment program should provide adequate medical, counseling, vocational, educational, mental health assessment, and social services to patients enrolled in the opioid treatment program with the goal of the individual becoming free of opioid dependency, with oversight by the Alabama Department of Mental Health.

2. The Methadone Advisory Committee suggests the following information be submitted with Certificate of Need applications:

(i) The number of arrests for the previous year regarding the sale and possession of opioids by county for the area to be served.

(ii) Data from the Medical Examiner regarding all deaths related to overdose from opioids by county for the area to be served during the previous year.

(iii) Data from all hospital emergency rooms regarding the number of persons diagnosed and treated for an overdose of opioids by county for the area to be served.

(iv) The number of clients within specific geographic areas who, out of necessity, must travel in excess of 50 miles round-trip for narcotic treatment services.

(v) The name and number of existing narcotic treatment programs within 50 miles of the proposed sight.

(vi) Number of persons to be served by the proposed program and the daily dosing fee.

(vii) Applicant shall submit evidence of the ability to comply with all applicable rules and regulations of designated governing authorities.

(d) Need

1. Basic Methodology

(i) The purpose of this need methodology is to identify, by region, need for additional treatment facilities to ensure the continued availability, accessibility, and affordability of quality opioid replacement treatment services for residents of Alabama.

(ii) A multi-county region shall be the planning area for methadone treatment facilities. A listing of the counties in each region is attached as part of this section. These were derived from the regions used by the Alabama Department of Mental Health (ADMH), Division of Mental Health and Substance Abuse Services.

(iii) The Center for Business and Economic Research, University of Alabama, (CBER) population data shall be used in any determination of need for methadone treatment facilities in Alabama.

(iv) Data from the National Survey on Drug Use and Health (NSDUH) shall be used in the calculation of national rates of dependency on heroin or prescription pain relievers in Alabama.

(v) Data from ADMH shall be used in the determination of the number of current patients seen by each clinic within a region. ADMH shall supply, on an annual basis, an Annual Report to SHPDA with rates of prevalence, service utilization and epidemiological data to assist with implementation of the methodology and publication of statistical updates to this plan.

(vi) For each region, need shall be calculated using the following methodology:

a. For each county in the region, list the population, ages 18 and over, as reported by CBER, for the year matching the year for which need is being projected.

b. Using NSDUH data for the same time period, determine the rate of dependency on heroin and prescription pain relievers nationally.

c. For each county in the region, multiply the population from step (a) above by the dependency rate in step (b) above to determine the projected number of residents in that county addicted to heroin or prescription pain relievers.

d. Multiply the estimate from step (c) above by 20% (0.2) to determine the projected number of residents of that county likely to seek Medication Assisted Therapy for opioid dependency.

e. Add the county totals determined in step (d) above to determine the regional totals.

f. Using data supplied by ADMH, determine the current census of each treatment center in the region on the last day of the year matching the year of population and NSDUH dependency data used in step (a) and step (b) respectively.

g. Add the facility census totals determined in step (f) above to determine regional totals.

h. If the number of residents projected to seek treatment in a region as determined in step (e) is greater than the current census of all treatment centers in the region as determined in step (g) by more than 10%, a need shall be shown for a new methadone treatment facility in that region.

i. Only one methadone treatment facility may be approved in any region showing a need under this methodology during any application cycle, defined here as the period of time between the date of publication of one statistical update and the date of publication of a successive update.

j. Upon the issuance of a Certificate of Need for a new methadone treatment facility in a region, no additional CONs shall be issued for the development of a new methadone treatment facility in that region for a period of eighteen (18) months to allow for the impact of a new provider in the region to be shown and reflected in the next statistical update.

2. The provisions of subsection 1 above shall not prohibit the grant of a certificate of need for the relocation and replacement of an existing methadone treatment facility within the same planning region.

3. All methadone clinic applications shall be site specific. No CON shall be granted for a new methadone treatment facility to be located within fifty (50) linear miles of an existing methadone treatment facility.

(e) Adjustments – Need for additional methadone treatment facilities, as determined by the in subsection 1 above, is subject to adjustment by the SHCC as provided below. The SHCC may adjust the need for a new methadone treatment facility only upon demonstration of one or more of the following conditions listed in 1 through 3 below. Applicants seeking an adjustment under this section shall include, as part of the application, supporting documentation from ADMH.

1. The opioid-related arrest or death rate in the region exceeds the national average, and there are no methadone treatment facilities within fifty (50) miles of the county for which the proposed adjustment applies.

2. Hospital emergency room admissions for opioid-overdose related conditions in the region exceed the national average, and there are no methadone treatment facilities within fifty (50) miles of the county for which the proposed adjustment applies.

3. Admissions to drug-free programs specifically treating opioid dependency in the region exceed the national average, and there are no methadone treatment facilities within fifty (50) miles of the county for which the proposed adjustment applies.

(f) Preference for Indigent Patients: In considering CON applications filed under this section, whether pursuant to the regular need methodology or an adjustment, preference shall be given to those applicants demonstrating the most comprehensive plan for treating patients regardless of their ability to pay.

Methadone Treatment Facility Regional County Listings

Region I	Region II	Region III	Region IV
Cherokee	Bibb	Autauga	Baldwin
Colbert	Blount	Bullock	Barbour
Cullman	Calhoun	Chambers	Butler
DeKalb	Chilton	Choctaw	Clarke
Etowah	Clay	Dallas	Coffee
Fayette	Cleburne	Elmore	Conecuh
Franklin	Coosa	Greene	Covington
Jackson	Jefferson	Hale	Crenshaw
Lamar	Pickens	Lee	Dale
Lauderdale	Randolph	Lowndes	Escambia
Lawrence	Shelby	Macon	Geneva
Limestone	St. Clair	Marengo	Henry
Madison	Talladega	Montgomery	Houston
Marion	Tuscaloosa	Perry	Mobile
Marshall		Pike	Monroe
Morgan		Russell	Washington
Walker		Sumter	
Winston		Tallapoosa	
		Wilcox	

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended: Filed August 16, 2012; Effective September 20, 2012. Amended: Filed November 20, 2013; Effective December 25, 2013. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015. Amended: Filed: September 9, 2015; Effective October 14, 2015.
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AUTHORIZED METHADONE TREATMENT PROGRAMS

COUNTY	PROGRAM	EXECUTIVE DIRECTOR
Calhoun	Calhoun Treatment 118 Choccolocco Street Oxford, AL 35203	Wendy Sprayberry
Colbert	Shoals Treatment 520 Louisa Avenue Muscle Shoals, AL 35661	Becky Clayton James Beverly
Cullman	Cullman County Treatment 1912 Commerce Ave. NW Cullman, AL 35055	Brenda Heatherly
Etowah	Gadsden Treatment 1107 West Meighan Blvd. Gadsden, AL 35901	Becky Clayton
Houston	Houston Treatment 9283 West US 84 Newton, AL 36352	Dr. Henry Born
Jefferson	Birmingham Metro Treatment 151 Industrial Drive Birmingham, AL 35211	Norm Huggins, M.D. Bill Garrett
Jefferson	Northwest Treatment 709 Memorial Drive Bessemer, AL 35022	Susan Sidwell
Jefferson	Tri-County Treatment 1101 East Park Drive Birmingham, AL 35235	Brent Hamer
Jefferson	UAB 401 West Beacon Parkway Birmingham, AL 35209	Norm Huggins, M.D. Bill Garrett
Madison	Huntsville Metro Treatment 2227 Drake Avenue, Suite 19 Huntsville, AL 35805	Bill Pierce
Madison	Huntsville Recovery, Inc. 1300 Putman Drive Huntsville, AL 35816	C.E. Payne

COUNTY	PROGRAM	EXECUTIVE DIRECTOR
Marion	Marion County Treatment 1879 Military Street South Hamilton, AL 35570	Pat Waldrop Steven Kiser
Mobile	ECD P O Box 7395 Mobile, AL 36670	Brenda Heatherly Sharon Gibbs
Mobile	Gulf Coast Treatment 12271 Interchange Drive Grand Bay, AL 36541	Brenda Heatherly Linda Waite
Mobile	Mobile MH (Gateway) 4211 Government Blvd. Mobile, AL 36693	Susan Case
Mobile	Mobile Metro Treatment 3367 Dauphin Island Parkway Mobile, AL 36605	Amber Ellis
Montgomery	Montgomery Metro Treatment 4303 Norman Bridge Road Montgomery, AL 36105	Mark Shaw
Sumter	Sumter County Treatment 106 Hospital Road, Suite 101 Livingston, AL 35470	Steve Nippert
Tuscaloosa	Tuscaloosa Treatment 1001 Mimosa Park Road Tuscaloosa, AL 35405	Steve Nippert Tina McWilliams
Walker	Walker Recovery P O Box 2030 Jasper, AL 35501	T. Camp, M.D. Steven Kiser

* CON 2098-ORF was issued September 2, 2004 for the operation of an Opiate Replacement Center in Chambers County.

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410-2-4-.12 **Ambulatory Surgery**

(1) Discussion. During the last two decades, an evolution in the provision of surgical care has taken place. As a result of cost containment measures and advances in medical technology, many surgical procedures which previously required inpatient care (both before and after the procedure) are now done on an outpatient basis.

(2) Definition. Ambulatory surgery centers (ASC) are any health care facility, licensed by the Alabama Department of Public Health, with the primary purpose of providing medically necessary or elective surgical care on an outpatient basis and in which the patient stays less than 24 hours. Excluded from this definition are the offices of private physicians and dentists, including those organized as professional corporations, professional associations, partnerships, or individuals in sole proprietorship. Also excluded from this definition are health care facilities licensed as hospitals. Ambulatory surgery centers may be multi-specialty in which more than one surgical specialty is represented or a specialized ambulatory surgery center in which a single, exclusive surgical specialty is provided.

(3) Inventory of Existing Resources. Before meaningful planning policies can be developed, the SHCC must have at its disposal outpatient surgical utilization data for both licensed acute care hospitals and ambulatory surgery centers.

SHDPA shall survey annually all licensed and/or Medicare certified hospitals and ambulatory surgery centers, as defined herein, regarding outpatient surgical utilization. The SHCC recommends that SHPDA promulgate the following CON regulations:

(a) Any CON application filed by a licensed hospital or an ambulatory surgery center shall not be deemed complete until, and unless:

1. the applicant has submitted all survey information requested by SHPDA prior to the application date; and

2. the SHPDA Executive Director determines that the survey information is substantially complete.

(b) No licensed hospital or ambulatory surgery center filing an intervention notice or statement in opposition in any CON proceeding may cite or otherwise seek consideration by SHPDA of such facility's utilization data until, and unless:

1. the intervenor or opponent has submitted all survey information requested by SHPDA prior to the application date; and

2. the SHPDA Executive Director determines that the survey information is substantially complete.

The SHCC recommends that the Certificate of Need Review Board adopt this and other CON regulations to further support and enforce SHPDA's survey of outpatient surgical utilization data as required under this Section.

The SHCC, upon receipt of meaningful utilization data from all licensed hospitals and ambulatory surgery centers, shall amend this section to include further definitions and planning policies as appropriate and applicable. Any amendment adopted as result of this provision shall be considered to have been generated by the SHCC and shall not be subject to any fees that may later be imposed on parties seeking a *State Health Plan* amendment or adjustment.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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ALABAMA
AMBULATORY SURGERY CENTERS

BALDWIN ***County***

INFIRMARY EASTERN SHORE AMBULATORY SURGERY CENTER	DAPHNE
THOMAS MEDICAL CENTER AMBULATORY SURGERY CTR/DAPHN	DAPHNE

BALDWIN County Totals: Number Of Facilities: 2

CALHOUN ***County***

Surgery Center, The	OXFORD

CALHOUN County Totals: Number Of Facilities: 1

COFFEE ***County***

SOUTH ALABAMA OUTPATIENT SERVICES	ENTERPRISE

COFFEE County Totals: Number Of Facilities: 1

DALE ***County***

DALE MEDICAL CENTER AMBULATORY SURGERY CENTER	OZARK

DALE County Totals: Number Of Facilities: 1

ETOWAH ***County***

GADSDEN SURGERY CENTER	GADSDEN
NORTHEAST ALABAMA EYE SURGERY CENTER INC	GADSDEN

ETOWAH County Totals: Number Of Facilities: 2

HOUSTON ***County***

AMERICAN SURGERY CENTER	DOTHAN
DOTHAN SURGERY CENTER	DOTHAN

HOUSTON County Totals: Number Of Facilities: 2

JEFFERSON ***County***

BIRMINGHAM ENDO-SURGICAL CENTER	HOMEWOOD
CHILDREN'S SOUTH OUTPATIENT CENTER	BIRMINGHAM
HEALTHSOUTH OUTPATIENT CARECENTER	BIRMINGHAM
KIRKLIN CLINIC AMBULATORY SURGICAL CENTER, THE	BIRMINGHAM
OUTPATIENT SERVICES EAST INC	BIRMINGHAM

JEFFERSON County Totals: Number Of Facilities: 5

ALABAMA
AMBULATORY SURGERY CENTERS

LAMAR ***County***

LAMAR HEALTHCARE SERVICES	SULLIGENT
LAMAR County Totals:	Number Of Facilities: 1

LAUDERDALE ***County***

FLORENCE SURGERY CENTER	FLORENCE
VALLEY SURGERY CENTER LLC	FLORENCE
LAUDERDALE County Totals:	Number Of Facilities: 2

MADISON ***County***

HUNTSVILLE ENDOSCOPY CENTER INC	HUNTSVILLE
SURGERY CENTER OF HUNTSVILLE, THE	HUNTSVILLE
MADISON County Totals:	Number Of Facilities: 2

MOBILE ***County***

DAUPHIN WEST SURGERY CENTER	MOBILE
HEALTHSOUTH MOBILE SURGERY CENTER	MOBILE
HEALTHSOUTH SURGICARE OF MOBILE	MOBILE
MOBILE County Totals:	Number Of Facilities: 3

MONTGOMERY*County*

42 MEDICAL GROUP 0	MONTGOMERY
MONTGOMERY EYE SURGERY CENTER	MONTGOMERY
MONTGOMERY SURGICAL CENTER, LTD	MONTGOMERY
MONTGOMERY County Totals:	Number Of Facilities: 3 0

MORGAN ***County***

DECATUR AMBULATORY SURGERY CENTER	DECATUR
MORGAN County Totals:	Number Of Facilities: 1

SHELBY ***County***

MEDPLEX OUTPATIENT SURGERY CENTER	BIRMINGHAM
SHELBY County Totals:	Number Of Facilities: 1

ALABAMA
AMBULATORY SURGERY CENTERS

TUSCALOOSA ***County***

HEALTHSOUTH SURGICAL CENTER OF TUSCALOOSA	TUSCALOOSA
NORTH RIVER SURGICAL CENTER INC	TUSCALOOSA
TUSCALOOSA ENDOSCOPY CENTER	TUSCALOOSA

TUSCALOOSA County Totals: Number Of Facilities: 3

State Totals: Number Of Facilities: 30

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410-2-4-.13 **Renovations**

(1) Renovation is defined as a project for modernization, improvement, alteration and/or upgrading of an existing physical plant and/or equipment. Renovation does not include the modernization or construction of a non clinical building, parking facility, or any other non institutional health services capital item on the existing campus of a health care facility, provided that construction or modernization does not allow the health care facility to provide new institutional health services subject to review and not previously provided on a regular basis.

(2) Planning Policies

(a) The applicant must demonstrate that the proposed renovation is the most cost effective or otherwise most appropriate alternative to provide patients with needed health care services and/or facility improvements.

(b) The applicant must provide evidence that the proposed square footage, construction cost per square foot, and cost of fixed equipment is appropriate and reasonable for the types and volumes of patients to be served.

(c) The applicant must demonstrate how the disruption of normal operations will be minimized during the period of construction.

(3) Needs Assessment.

(a) For the renovation of a health care facility an applicant must submit significant evidence of need for the project. Evidence of need for the project should include, but is not limited to, one or more of the following:

1. The service being provided by the applicant requires additional space or the facility requires renovation to meet minimum licensure and certification requirements.

2. There are operating problems, which can best be corrected by renovation of the existing facility.

3. The renovation will correct deficiencies that place the health and safety of patients and/or employees at significant risk.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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410-2-4-.14 **Replacements**

(1) Replacement is defined as a project for the erection, construction, creation or other acquisition of a physical plant or facility where the proposed new structure will replace an existing structure and will be located in the same county and market area. Replacement does not include the modernization or construction of a non clinical building, parking facility, or any other non institutional health services capital item on the existing campus of a health care facility, provided that construction or modernization does not allow the health care facility to provide new institutional health services subject to review and not previously provided on a regular basis.

(2) Planning Policies

(a) The applicant must demonstrate that the proposed replacement is the most cost effective or otherwise most appropriate alternative to provide patients with needed health care services and/or facility improvements.

(b) The applicant must provide evidence that the proposed square footage, construction cost per square foot, and cost of fixed equipment is appropriate and reasonable for the types and volumes of patients to be served.

(c) The applicant for the proposed replacement must be the same as the owner of the facility to be replaced.

(3) Needs Assessment

(a) For replacement of a health care facility an applicant must submit significant evidence of need for the project. Evidence of need for the project should include, but is not limited to, one or more of the following:

1. The existing structure requires replacement to meet minimum licensure and certification requirements.

2. There are operating problems, which can best be corrected by replacement of the existing facility.

3. The replacement of the existing structure will correct deficiencies that place the health and safety of patients and/or employees at significant risk.

(b) For replacement of hospitals, the occupancy rate for the most recent annual reporting period should have been at least 60 percent. If this occupancy level was not met, the hospital should agree to a reduction in bed capacity that will increase its occupancy rate to 60 percent. For example, if a 90-bed hospital had an average daily census (ADC) of 45 patients, its occupancy rate was 50 percent. (The ADC of 45 patients divided by 90 beds equals 50 percent). To determine a new bed capacity that would increase the hospital's occupancy rate to 60 percent, simply divide the ADC of 45 patients by .60 (A fraction of a bed should be rounded upward to the next whole bed) The hospital's new capacity should be 75 beds, a 15 bed reduction to its original capacity of 90 beds.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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410-2-4-.15 Inpatient Hospice Services

(1) Discussion

(a) Hospice care is a choice made to enhance end of life. Hospice focuses on caring and comfort for patients and not curative care. In most cases, care is provided in the patient's place of residence.

(b) It is the intent of this section to address health planning concerns relating to hospice services provided on an inpatient basis. For coverage of hospice services provided primarily in the patient's place of residence, please see Section 410-2-3-.10.

(c) A hospice program is required by federal statutes as a Condition of Participation for hospice care (Title 42- Public Health; Chapter IV – CMS, Department of Health and Human Services; Part 418 – Hospice care; Section 418.98 or successors) and state statutes and regulations (Alabama State Board of Health, Department of Public Health; Administrative Code, Chapter 420-5-17; Section 420-5-17-.01 or successors) to provide general inpatient level of care and inpatient respite level of care as two of the four levels of hospice care. As per the Medicare Condition of Participation (418.108), the total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12-month period in a particular hospice may not exceed twenty (20) percent of the total number of hospice days consumed in total by this group of beneficiaries.

(d) A hospice program per federal statute **must** provide the inpatient levels of care that meets the conditions of participation specified. The approved locations for inpatient hospice care are a hospital, a skilled nursing facility ("SNF") or an inpatient hospice facility.

(e) A hospice program may provide the inpatient levels of care in a freestanding inpatient facility/unit which the hospice program owns and manages, through beds owned by either a hospital or a skilled nursing facility ("SNF") but leased and managed by a hospice program or through contracted arrangements with another hospice program's inpatient facility/unit.

(2) Definitions.

(a) All definitions included in Section 410-2-3-.10 are incorporated herein by reference.

(b) Inpatient hospice facility. An "Inpatient Hospice Facility" is defined as a freestanding hospice facility or a designated unit, floor or specific number of beds located in a skilled nursing facility or hospital that is leased or under the management of a hospice services provider.

(c) General Inpatient Level of Care: The general inpatient ("GIP") level of hospice care is intended for short term acute care for pain control and symptomatic management. It is not intended for long term care, residential or rehabilitation.

(d) Inpatient Respite Level of Care: The inpatient respite level of care is limited per Medicare and Medicaid to a maximum of 5 days per episode for the purpose of family respite.

(3) Availability and Accessibility

(a) Hospice services must be obtainable by all of the residents of the State of Alabama.

(b) Physicians and other referral sources may be unfamiliar with the total scope of services offered by hospice; accessibility may be limited due to lack of awareness. Every provider should provide an active community informational program to educate consumers and professionals to the availability, nature, and extent of their hospice services provided.

(c) In order for a SNF to provide the inpatient levels of care for hospice patients, the SNF must meet the standards specified by CMS regarding items such as required staffing facilities.

(d) Hospice agencies are limited in establishing contracts with hospitals for the inpatient levels of care. This is due to (a) the increased number of hospice providers that request contracts from the same hospitals in the same service areas and (b) the reimbursement hospitals receive from the hospice providers for the hospice inpatient levels of care.

(4) Inventory

(a) The establishment of an inpatient hospice facility does not eliminate the need for contractual arrangements with hospitals or SNF for inpatient levels of care. If the inpatient hospice facility is at full capacity and a hospice patient is eligible for/requires inpatient care, the hospice remains responsible to provide that level of care at a contracted facility.

(5) Quality

(a) Quality is that characteristic which reflects professionally and technically appropriate patient services. Each provider must establish mechanisms for quality assurance, including procedures for resolving concerns identified by patients, physicians, family members, or others in patient care or referral. Providers should also develop internal quality assurance and grievance procedures.

(b) Providers are encouraged to achieve a utilization level, which promotes cost effective service delivery.

(c) Hospice programs are required to meet the most stringent or exceed the current Medicare Hospice Conditions of Participation, as adopted by CMS, and codified in the Code of Federal Regulations, along with State Licensure Regulations of the Department of Public Health.

(6) Inpatient Hospice Facility Need Methodology

(a) Purpose. The purpose of this inpatient hospice services need methodology is to identify, by region, the number of inpatient hospice needed to assure the continued availability, accessibility, and affordability of quality of care for residents of Alabama.

(b) General. Formulation of this methodology was accomplished by a committee of the Statewide Health Coordinating Council (SHCC). The committee, which provided its recommendations to the SHCC, was composed of providers and consumers of health care, and received input from hospice providers and other affected parties. Only the SHCC, with the Governor's final approval, can make changes to this methodology, except that SHPDA staff shall annually update statistical information to reflect more current population and utilization. Such updated information is available for a fee upon request. Adjustments are addressed in paragraph (e) below.

(c) Basic Methodology.

1. The purpose of this need methodology is to identify, by region, the number of inpatient hospice beds needed to assure the continued availability, accessibility, and affordability of quality hospice care for residents of Alabama.

2. The need methodology shall be calculated by aggregating the reported average daily censuses (ADC) for all licensed hospices in the designated Region, as reported annually to SHPDA, and multiplying that aggregate regional ADC by 3%. The resulting figure shall be the regional need. The need cannot be established or updated until after the most current year's completed annual report is received and compiled by SHPDA.

3. Any increase in regional need shall be limited to no more than five percent (5%) per year with the sole exclusion of any need determined under Planning Policy 7 of this section.

(d) Planning Policies

1. Planning will be on a regional basis. Please see the attached listing for regional descriptions as designated by the SHCC.

2. An applicant for an inpatient hospice facility must be an established and licensed hospice provider and has been operational for at least thirty-six (36) months.

3. An applicant for an inpatient hospice facility must demonstrate the ability to comply with Medicare/Medicaid regulations.

4. An applicant for an inpatient hospice facility must demonstrate that existing inpatient hospice beds in the region cannot meet the community demand for inpatient hospice services.

5. An applicant for an inpatient hospice facility must demonstrate that sharing arrangements with existing facilities have been studied and implemented when possible.

6. An applicant for an inpatient hospice facility may provide supplemental evidence in support of its application from other data reported by licensed hospices on an annual basis to the State of Alabama or the Federal Government.

7. Additional need may be shown in situations involving a sustained high occupancy rate either for a region or for a single facility. An applicant may apply for additional beds, and thus the establishment of need above and beyond the standard methodology, utilizing one of the following two policies. Once additional beds have been applied for under one of the policies, that applicant shall not qualify to apply for additional beds under either of these policies unless and until the established time limits listed below have passed. All CON Authorized Inpatient Hospice beds shall be included in consideration of occupancy rate and bed need.

(i). If the total combined occupancy rate for all CON Authorized Inpatient Hospice facilities in a region is above 90% as calculated by SHPDA using data reported on the most recent full year "Annual Report for Hospice Providers (Form HPCE-4)" published by or filed with SHPDA, an additional need of the greater of five percent (5%) of the current total CON Authorized bed capacity of that region or five (5) total beds may be approved for the expansion of an existing facility within that region. Once additional bed need has been shown under this policy, no new need shall be shown in that region based upon this rule for twenty-four (24) months following issuance of the initial CON to allow for the impact of those beds in that region to be analyzed. Should the initial applicant for beds in a region not apply for the total number of beds allowed to be created under this rule, the remaining beds would then be available to be applied for by other providers in the region, so long as said providers meet the conditions listed in this rule.

(ii). If the occupancy rate for a single facility within a region is greater than 90% as calculated by SHPDA using data reported on the most recent full year "Annual Report for Hospice Providers (Form HPCE-4)" published by or filed with SHPDA, irrespective of the total occupancy rate for all CON Authorized Inpatient Hospice facilities in that region, up to five (5) additional beds may be approved within that region for the expansion of that facility only. Once additional beds have been approved under this policy, no new beds shall be approved for that facility for twenty-four (24) months following issuance of the CON to allow for the impact of those beds at that facility to be analyzed.

8. No application for the establishment of a new, freestanding Inpatient Hospice facility shall be approved for fewer than then (10) beds to allow for the financial feasibility and viability of a project. Because of this, need may be modified by the Agency for any county currently showing a need of more than zero (0) but fewer than then (10) total beds to a total need of ten (10) new beds, but only in the consideration of an application for the construction of a new, freestanding facility in a region in which no freestanding Inpatient Hospice currently exists. Need shall not be adjusted in consideration of an application involving the expansion of a CON Authorized Inpatient Provider, nor shall need be adjusted according to this rule in any region wherein a CON Authorized freestanding Inpatient Hospice facility already exists.

(e) Adjustments. The need for inpatient hospice beds, as determined by the methodology, is subject to adjustments by the SHCC. SHCC may adjust the need for inpatient hospice beds in a region if an applicant documents the existence of at least one of the following conditions:

1. Absence of available inpatient beds for a hospice certified for Medicaid and Medicare in the proposed region, and evidence that the applicant will provide Medicaid and Medicare-certified hospice services in the region; or

2. Absence of services by a hospice in the proposed region that serves patients regardless of the patient's ability to pay, and evidence that the applicant will provide services for patients regardless of ability to pay.

3. A community need for additional inpatient hospice services greater than those supported by the numerical methodology.

(7) Inpatient Hospice Regions. The attached chart, listing "Inpatient Hospice Regional County Listing" is hereby adopted as an Appendix "A" to Section 410-2-4-.15.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed February 1, 2010; Effective March 8, 2010. Amended: Filed January 24, 2012; Effective: February 28, 2012. Amended: Filed November 2, 2012; Effective: December 7, 2012. Amended: Filed December 2, 2014; Effective January 6, 2015.

Appendix A

Inpatient Hospice Regional County Listings

Region 1	Region 2	Region 3	Region 4
Lauderdale	Limestone	Lawrence	Marshall
Colbert	Madison	Morgan	Blount
Franklin	Jackson	Winston	DeKalb
Marion		Cullman	Etowah
		Walker	

Region 5	Region 6	Region 7	Region 8
Jefferson	Cherokee	Lamar	Shelby
	St. Clair	Fayette	Chilton
	Calhoun	Pickens	Coosa
	Cleburne	Tuscaloosa	
		Greene	
		Hale	
		Bibb	

Region 9	Region 10	Region 11	Region 12
Talladega	Sumter	Autauga	Lee
Clay	Marengo	Elmore	Macon
Randolph	Perry	Lowndes	Russell
Tallapoosa	Choctaw	Montgomery	
Chambers	Dallas	Bullock	
	Wilcox	Butler	
		Crenshaw	
		Pike	

Region 13	Region 14	Region 15
Washington	Clarke	Barbour
Mobile	Monroe	Coffee
Baldwin	Conecuh	Dale
	Escambia	Henry
	Covington	Geneva
		Houston

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: New Rule: Filed January 24, 2012; Effective: February 28, 2012. Amended: Filed November 2, 2012; Effective: December 7, 2012. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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410-2-4-.16 Freestanding Emergency Departments (FEDs)

A "Freestanding Emergency Department" or "FED" is a new institutional health service requiring a Certificate of Need under Alabama law. In addition to other applicable criteria, all proposed FEDs must demonstrate, through substantial evidence, that their project will meet all the requirements for licensure under Ala. Admin. Code r. 420-5-9, which is incorporated herein by reference.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: §§ 22-21-260(13), (15), Code of Alabama, 1975.
History: Filed June 5, 2015; Effective July 10, 2015.
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ALABAMA
STATE HEALTH PLAN
2014-2017
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

Chapter 410-2-5
Alabama Health Statistics and Revision Procedures

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410-2-5-.01 **Introduction**. This chapter contains information that is pertinent to the *State Health Plan*, but of such detail that it is best included in this Appendix. Population is based on Center for Business and Economic Research (CBER) The University of Alabama.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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410-2-5-.02 **Population**

Alabama Population

COUNTY	Census 2000	Population Projection 2004	Population Projection 2005	Population Projection 2006	Population Projection 2007
AUTAUGA	43,671	47,624	48,615	49,577	50,557
BALDWIN	140,415	157,983	162,376	166,748	171,182
BARBOUR	20,826	30,203	30,494	30,763	31,043
BIBB	29,038	22,415	22,814	23,223	23,629
BLOUNT	51,024	56,083	57,348	58,610	59,898
BULLOCK	11,714	11,886	11,929	11,971	12,012
BUTLER	21,399	21,127	21,060	21,007	20,958
CALHOUN	112,249	112,121	112,087	112,084	112,132
CHAMBERS	36,583	36,444	36,404	36,391	36,387
CHEROKEE	23,988	25,738	26,176	26,600	27,031
CHILTON	39,593	42,699	43,472	44,249	45,042
CHOCTAW	15,922	15,880	15,871	15,858	15,850
CLARKE	27,867	28,098	28,153	28,208	28,269
CLAY	14,254	14,675	14,779	14,873	14,976
CLEBURNE	14,123	14,648	14,775	14,900	15,031
COFFEE	43,615	44,821	45,120	45,391	45,685
COLBERT	54,984	56,009	56,262	56,464	56,681
CONECUH	14,089	14,098	14,101	14,104	14,113
COOSA	12,202	12,603	12,702	12,783	12,872
COVINGTON	37,631	37,892	37,957	37,992	38,035
CRENSHAW	13,665	13,676	13,681	13,682	13,695
CULLMAN	77,483	81,394	82,369	83,275	84,215
DALE	49,129	49,701	49,837	49,972	50,128
DALLAS	46,365	45,769	45,623	45,514	45,418
DEKALB	64,452	68,791	69,877	70,969	72,095
ELMORE	65,874	72,308	73,923	75,516	77,138
ESCAMBIA	38,440	39,321	39,539	39,727	39,931
ETOWAH	103,459	104,532	104,805	105,009	105,245
FAYETTE	18,495	18,638	18,678	18,697	18,729
FRANKLIN	31,223	32,569	32,908	33,221	33,549
GENEVA	25,764	26,479	26,661	26,805	26,965
GREENE	9,974	9,844	9,811	9,786	9,766
HALE	17,185	17,878	18,055	18,217	18,390
HENRY	16,310	16,596	16,668	16,722	16,790
HOUSTON	88,787	91,138	91,720	92,202	92,721

Alabama Population

COUNTY	Census 2000	Population Projection 2004	Population Projection 2005	Population Projection 2006	Population Projection 2007
JACKSON	53,926	53,926	53,926	57,151	57,643
JEFFERSON	662,047	662,233	667,272	668,459	669,904
LAMAR	15,904	15,904	15,904	16,036	16,060
LAUDERDALE	87,966	87,966	87,966	92,319	92,997
LAWRENCE	34,803	35,911	36,188	36,419	36,669
LEE	115,092	125,515	128,124	130,739	133,400
LIMESTONE	65,676	70,145	71,264	72,324	73,419
LOWNDES	13,473	13,727	13,787	13,842	13,899
MACON	24,105	23,791	23,717	23,644	23,588
MADISON	276,700	290,453	293,895	296,986	300,198
MARENGO	22,539	22,237	22,159	22,085	22,018
MARION	31,214	31,702	31,821	31,912	32,010
MARSHALL	82,231	87,079	88,290	89,478	90,706
MOBILE	399,843	407,077	408,882	410,543	412,354
MONROE	24,324	24,364	24,373	24,380	24,395
MONTGOMERY	223,510	228,942	230,300	231,677	233,145
MORGAN	111,064	115,001	115,988	116,846	117,752
PERRY	11,861	11,589	11,519	11,473	11,426
PICKENS	20,949	21,070	21,098	21,128	21,166
PIKE	29,605	30,498	30,730	31,861	31,184
RANDOLPH	22,380	23,365	23,613	23,850	24,096
RUSSELL	49,756	50,704	50,945	51,159	51,395
SHELBY	143,293	162,326	167,085	171,935	176,854
ST. CLAIR	64,742	70,838	72,362	73,876	75,420
SUMTER	14,798	14,366	14,252	14,169	14,093
TALLADEGA	80,321	82,579	83,142	83,605	84,097
TALLAPOOSA	41,475	42,253	42,444	42,598	42,775
TUSCALOOSA	164,875	169,235	170,324	171,343	172,422
WALKER	70,713	71,726	71,980	72,151	72,347
WASHINGTON	18,097	18,552	18,662	18,746	18,853
WILCOX	13,183	13,056	13,028	13,019	13,009
WINSTON	24,843	25,962	26,246	26,504	26,771
STATE TOTAL	4,447,100	4,605,021	4,644,506	4,683,367	4,722,223

Sources: Center for Business and Economic Research (CBER), University of Alabama. Numbers have been modified by SHPDA staff due to the county totals not equaling state projected totals. .June 21, 2004

Alabama Population 65 Years and Older

COUNTY	Census 2000	Population Projection 2004	Population Projection 2005	Population Projection 2006	Population Projection 2007
AUTAUGA	4,451	5,193	5,381	5,622	5,865
BALDWIN	21,703	25,292	26,193	27,411	28,662
BARBOUR	2,413	3,946	3,964	4,034	4,109
BIBB	3,873	2,655	2,716	2,817	2,917
BLOUNT	6,558	7,393	7,600	7,881	8,167
BULLOCK	1,543	1,521	1,512	1,530	1,544
BUTLER	3,506	3,469	3,459	3,490	3,521
CALHOUN	15,872	16,269	16,367	16,539	16,730
CHAMBERS	5,928	5,857	5,840	5,901	5,967
CHEROKEE	3,818	4,363	4,501	4,677	4,858
CHILTON	5,097	5,548	5,662	5,840	6,022
CHOCTAW	2,332	2,486	2,528	2,593	2,660
CLARKE	3,764	3,999	4,056	4,143	4,231
CLAY	2,359	2,503	2,541	2,589	2,640
CLEBURNE	1,933	2,081	2,119	2,188	2,259
COFFEE	6,171	6,572	6,669	6,799	6,937
COLBERT	8,493	8,785	8,858	8,986	9,123
CONECUH	2,223	2,210	2,205	2,231	2,260
COOSA	1,761	1,843	1,864	1,897	1,934
COVINGTON	6,740	6,916	6,959	7,017	7,078
CRENSHAW	2,338	2,298	2,289	2,298	2,315
CULLMAN	11,342	12,116	12,307	12,563	12,830
DALE	5,807	6,413	6,563	6,733	6,912
DALLAS	6,428	6,450	6,456	6,476	6,498
DEKALB	8,882	9,358	9,477	9,668	9,871
ELMORE	7,071	7,862	8,062	8,319	8,579
ESCAMBIA	5,236	5,490	5,553	5,646	5,744
ETOWAH	16,560	16,545	16,542	16,620	16,714
FAYETTE	2,976	3,116	3,152	3,209	3,267
FRANKLIN	4,637	4,835	4,884	4,939	4,999
GENEVA	4,203	4,406	4,459	4,539	4,628
GREENE	1,470	1,463	1,462	1,469	1,479
HALE	2,316	2,329	2,332	2,356	2,384
HENRY	2,668	2,725	2,738	2,784	2,838
HOUSTON	12,162	12,787	12,944	13,210	13,491

Alabama Population 65 Years and Older

COUNTY	Census 2000	Population Projection 2004	Population Projection 2005	Population Projection 2006	Population Projection 2007
JACKSON	7,210	7,892	8,063	8,279	8,502
JEFFERSON	90,285	87,769	87,131	87,197	87,342
LAMAR	2,528	2,643	2,674	2,702	2,733
LAUDERDALE	13,241	13,968	14,149	14,401	14,664
LAWRENCE	4,195	4,517	4,596	4,735	4,876
LEE	9,337	10,267	10,501	10,862	11,229
LIMESTONE	7,271	7,938	8,105	8,334	8,575
LOWNDES	1,646	1,777	1,810	1,851	1,893
MACON	3,367	3,278	3,258	3,295	3,334
MADISON	30,015	33,568	34,462	35,374	36,323
MARENGO	3,287	3,329	3,339	3,365	3,393
MARION	4,934	5,252	5,329	5,438	5,548
MARSHALL	11,717	12,481	12,672	12,936	13,216
MOBILE	47,919	49,118	49,416	50,084	50,795
MONROE	3,363	3,476	3,502	3,559	3,622
MONTGOMERY	26,307	26,632	26,714	26,974	27,263
MORGAN	13,708	14,503	14,703	15,010	15,328
PERRY	1,762	1,760	1,760	1,761	1,765
PICKENS	3,293	3,326	3,332	3,343	3,355
PIKE	3,727	3,830	3,860	4,193	4,005
RANDOLPH	3,564	3,707	3,744	3,797	3,851
RUSSELL	6,541	6,695	6,736	6,794	6,858
SHELBY	12,179	14,794	15,451	16,461	17,490
ST. CLAIR	7,578	8,534	8,773	9,153	9,543
SUMTER	2,056	1,994	1,974	1,966	1,959
TALLADEGA	10,655	11,098	11,208	11,409	11,618
TALLAPOOSA	6,872	7,007	7,039	7,161	7,291
TUSCALOOSA	18,565	18,853	18,925	19,139	19,312
WALKER	10,453	10,955	11,078	11,251	11,431
WASHINGTON	2,246	2,385	2,416	2,474	2,540
WILCOX	1,810	1,784	1,780	1,787	1,792
WINSTON	3,533	3,813	3,884	3,990	4,099
STATE TOTAL	579,798	606,037	612,598	624,089	635,578

Sources: Center for Business and Economic Research (CBER), University of Alabama.. Numbers have been modified by SHPDA staff due to the county totals not equaling state projected totals. June 21, 2004

410-2-5-.03 **Vital Events** (Source: Alabama Department of Public Health)

TABLE 1
BIRTHS AND BIRTH RATES[1] BY RACE OF MOTHER[2]
ALABAMA AND UNITED STATES, 1945-2002

YEAR	TOTAL			WHITE			BLACK & OTHER		
	ALABAMA		U.S.	ALABAMA		U.S.	ALABAMA		U.S.
	NUMBER	RATE	RATE	NUMBER	RATE	RATE	NUMBER	RATE	RATE
1945	70,144	23.6	19.5	43,884	22.4	19.1	26,260	25.9	23.2
1946	78,966	26.3	23.3	50,978	25.8	23.0	27,988	27.4	25.3
1947	87,882	29.3	25.8	57,694	28.6	25.5	30,188	30.7	28.3
1948	85,461	28.3	24.2	53,742	26.4	23.5	31,719	32.2	29.8
1949	84,301	27.7	23.9	52,027	25.2	23.2	32,274	32.8	30.6
1950	82,566	26.9	23.6	49,640	23.8	22.7	32,926	33.4	31.1
1951	83,878	27.0	24.5	51,133	24.3	23.6	32,745	32.9	31.8
1952	82,876	26.7	24.7	51,055	24.0	23.9	31,821	32.4	31.8
1953	82,525	26.4	24.7	50,711	23.6	23.7	31,814	32.4	32.3
1954	82,518	26.2	24.9	50,842	23.5	23.9	31,676	32.2	33.2
1955	81,867	25.8	24.6	49,810	22.8	23.6	32,057	32.6	33.1
1956	84,026	26.3	24.9	51,399	23.3	23.8	32,627	33.2	33.9
1957	83,991	26.2	25.0	51,883	23.3	23.9	32,108	32.7	33.9
1958	82,228	25.4	24.3	51,416	22.9	23.2	30,812	31.3	33.0
1959	82,364	25.3	24.0	51,104	22.5	22.9	31,260	31.8	32.9
1960	80,955	24.7	23.7	50,849	22.2	22.7	30,106	30.6	32.1
1961	80,732	24.5	23.3	50,647	21.9	22.2	30,085	30.9	31.6
1962	78,639	23.8	22.4	49,360	21.1	21.4	29,279	30.3	30.5
1963	76,027	22.9	21.7	47,793	20.2	20.7	28,234	29.4	29.7
1964	76,480	22.9	21.1	48,402	20.3	20.0	28,078	29.5	29.2
1965	70,589	21.0	19.4	44,689	18.5	18.3	25,900	27.4	27.6
1966	66,455	19.7	18.4	42,900	17.6	17.4	23,555	25.1	26.1
1967	64,652	19.0	17.8	41,771	16.9	16.8	22,881	24.6	25.0
1968	63,583	18.6	17.6	42,091	16.9	16.6	21,492	22.3	24.2
1969	64,705	18.9	17.9	43,495	17.3	16.9	21,210	23.2	24.5
1970	67,570	19.6	18.4	45,479	17.9	17.4	22,091	24.3	25.1
1971	66,750	19.1	17.2	44,209	17.2	16.1	22,541	24.4	24.6
1972	61,765	17.4	15.6	40,134	15.4	14.5	21,631	23.1	22.8
1973	59,442	16.6	14.8	38,778	14.7	13.8	20,664	21.8	21.7
1974	59,342	16.2	14.8	38,642	14.4	13.9	20,700	21.6	21.2
1975	57,922	15.7	14.6	37,565	13.9	13.6	20,357	21.0	21.0
1976	57,895	15.6	14.6	37,415	13.6	13.6	20,480	20.9	20.8
1977	61,927	16.4	15.1	40,286	14.5	14.1	21,641	21.9	21.6
1978	60,108	15.8	15.0	38,646	13.7	14.0	21,462	21.4	21.6
1979	62,494	16.2	15.6	39,805	14.0	14.5	22,689	22.4	22.2
1980	63,405	16.3	15.9	40,624	14.1	14.9	22,781	22.3	22.5
1981	61,497	15.6	15.8	39,667	13.6	14.8	21,830	21.1	22.0
1982	60,296	15.1	15.9	38,895	13.2	14.9	21,401	20.5	21.9
1983	59,057	14.4	15.5	38,464	12.7	14.6	20,593	19.4	21.3
1984	59,104	14.3	15.5	38,255	12.5	14.5	20,849	19.5	21.2
1985	59,663	14.3	15.8	39,042	12.6	14.8	20,621	19.2	21.4
1986	59,441	14.5	15.6	38,632	12.8	14.5	20,809	19.3	21.4
1987	59,558	14.4	15.7	38,826	12.7	14.5	20,732	19.0	21.7
1988	60,718	14.5	15.9	39,155	12.7	14.7	21,563	19.5	22.5
1989	62,530	14.7	16.3	40,100	12.8	15.0	22,430	20.0	23.1
1990	63,420	15.7	16.7	41,072	13.8	15.8	22,348	21.0	21.7
1991	62,798	15.4	16.3	40,660	13.6	15.4	22,138	20.5	21.1
1992	62,226	15.3	15.9	40,144	13.4	15.0	22,082	20.6	20.5
1993	61,588	15.1	15.5	39,848	13.2	14.7	21,740	20.2	19.8
1994	60,836	14.8	15.2	39,579	13.1	14.4	21,257	19.7	19.0
1995	60,264	14.7	14.8	39,660	13.1	14.2	20,604	19.0	17.9
1996	60,460	14.6	14.7	40,142	13.2	14.1	20,318	18.6	17.5
1997	60,887	14.7	14.5	40,419	13.3	13.9	20,468	18.7	17.3
1998	62,025	14.9	14.6	41,486	13.6	14.0	20,539	18.6	17.4
1999	62,070	14.9	14.5	41,689	13.6	13.9	20,381	18.4	17.2
2000	63,166	14.2	14.7	41,946	13.3	14.1	21,220	16.5	17.6
2001	60,295	13.4	14.1	40,470	12.7	13.7	19,825	15.2	16.2
2002	58,867	13.0	13.9[3]	39,845	12.5	NA	19,022	14.3	NA

[1] Rate is per 1,000 population for specified group. See formula in Appendix B.
[2] Rates for 1945-1989 are by race of the child.
[3] Provisional Data.

TABLE 2
RESIDENT BIRTHS AND BIRTH RATES[1]
BY RACE OF MOTHER AND COUNTY OF RESIDENCE
ALABAMA, 2002

COUNTY	TOTAL		WHITE		BLACK & OTHER	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
TOTAL	58,867	13.0	39,845	12.5	19,022	14.3
Autauga	601	13.2	465	12.6	136	15.6
Baldwin	1,740	11.7	1,483	11.4	257	13.6
Barbour	361	12.2	176	11.8	185	12.6
Bibb	276	12.8	229	13.9	47	9.2
Blount	668	12.5	656	13.0	12	4.1
Bullock	141	12.0	38	13.0	103	11.6
Butler	249	11.7	101	8.2	148	16.6
Calhoun	1,456	13.0	1,096	12.4	360	15.0
Chambers	438	12.0	256	11.6	182	12.6
Cherokee	269	10.8	247	10.7	22	12.3
Chilton	528	12.8	469	13.2	59	10.6
Choctaw	199	12.5	103	11.7	96	13.5
Clarke	338	12.1	168	10.8	170	13.7
Clay	148	10.2	127	10.6	21	8.3
Cleburne	153	10.6	148	10.9	5	6.5*
Coffee	549	12.4	418	12.4	131	12.4
Colbert	629	11.3	510	11.3	119	11.5
Conecuh	174	12.3	81	10.4	93	14.7
Coosa	128	10.3	77	9.8	51	11.3
Covington	444	11.8	375	11.5	69	13.2
Crenshaw	182	13.3	141	14.0	41	11.5
Cullman	949	11.9	939	12.3	10	3.5
Dale	752	15.2	559	15.5	193	14.6
Dallas	706	15.3	158	10.0	548	18.1
DeKalb	886	13.3	847	13.9	39	6.9
Elmore	920	13.3	677	12.7	243	15.4
Escambia	510	13.1	325	13.1	185	13.1
Etowah	1,261	12.1	1,037	12.1	224	12.2
Fayette	194	10.5	167	10.4	27	11.0
Franklin	453	14.2	430	15.2	23	6.3
Geneva	303	11.6	271	11.9	32	9.5
Greene	147	14.8	11	5.8	136	17.0
Hale	227	12.9	71	10.2	156	14.8
Henry	227	13.8	148	13.6	79	14.1
Houston	1,242	13.8	820	12.6	422	17.1
Jackson	619	11.3	597	11.8	22	4.7
Jefferson	8,928	13.4	4,612	12.2	4,316	15.1
Lamar	173	10.8	154	11.1	19	8.9
Lauderdale	919	10.3	792	10.1	127	11.9
Lawrence	364	10.3	317	11.5	47	6.0
Lee	1,360	11.3	945	10.7	415	13.1
Limestone	833	12.3	750	13.2	83	7.4
Lowndes	200	14.7	34	9.6	166	16.5
Macon	238	9.9	38	11.3	200	9.7
Madison	3,519	12.4	2,519	12.5	1,000	12.2
Marengo	292	13.0	123	11.7	169	14.2
Marion	361	11.5	350	11.8	11	6.3
Marshall	1,299	15.3	1,254	16.1	45	6.9
Mobile	5,830	14.5	3,312	13.2	2,518	16.5
Monroe	306	12.6	154	11.0	152	14.6
Montgomery	3,338	14.8	1,329	12.4	2,009	16.9
Morgan	1,503	13.3	1,298	13.6	205	11.5
Perry	191	16.3	39	11.0	152	18.6
Pickens	252	12.0	141	12.1	111	11.9
Pike	388	12.9	204	11.3	184	15.3
Randolph	272	11.9	179	10.2	93	17.3
Russell	602	12.0	377	13.5	225	10.1
St. Clair	813	12.0	758	12.4	55	8.1
Shelby	2,375	15.5	2,132	15.6	243	15.1
Sumter	184	12.6	35	9.5	149	13.7
Talladega	1,028	12.6	662	12.2	366	13.5
Tallapoosa	472	11.3	315	10.2	157	14.1
Tuscaloosa	2,146	12.8	1,307	11.6	839	15.4
Walker	901	12.7	839	12.8	62	10.8
Washington	244	13.3	160	13.5	84	13.0
Wilcox	216	16.5	43	12.2	173	18.0
Winston	253	10.0	252	10.2	1	1.2*

[1] Rate is per 1,000 population. See formula in Appendix B. Caution should be exercised in using rates derived from small numbers. Rates which apply to populations of less than 1,000 are denoted by an "*".

TABLE 3
BIRTHS BY PLURALITY
ALABAMA, 1980-2002

YEAR	TOTAL	SINGLE BIRTHS	TWINS	TRIPLETS	QUADRUPLETS OR GREATER
1980	63,405	62,148	1,237	20	0
1981	61,497	60,089	1,385	23	0
1982	60,296	59,042	1,231	23	0
1983	59,057	57,766	1,268	14	9
1984	59,104	57,819	1,270	15	0
1985	59,663	58,434	1,184	41	4
1986	59,441	58,127	1,297	13	4
1987	59,558	58,235	1,287	36	0
1988	60,718	59,294	1,389	33	2
1989	62,530	61,153	1,341	36	0
1990	63,420	61,874	1,488	54	4
1991	62,798	61,273	1,479	46	0
1992	62,226	60,711	1,457	49	9
1993	61,588	60,042	1,507	37	2
1994	60,836	59,215	1,573	32	16
1995	60,264	58,780	1,408	68	8
1996	60,460	58,784	1,595	62	19
1997	60,887	59,117	1,661	97	12
1998	60,025	60,118	1,803	87	17
1999	62,070	60,208	1,762	91	9
2000	63,166	61,032	2,018	98	18
2001	60,295	58,241	1,923	115	16
2002	58,867	56,882	1,850	124	11

NOTE: This table gives the number of live born individuals who were part of a twin, triplet, quadruplet or greater pregnancy; however, this table does not refer to the number of deliveries.

TABLE 4
BIRTHS BY HOSPITAL OF OCCURRENCE
ALABAMA, 2002

COUNTY AND HOSPITAL	TOTAL	COUNTY AND HOSPITAL	TOTAL
ALABAMA	**57,864**	**CRENSHAW**	**114**
AUTAUGA	**1**	Crenshaw Community Hospital	114
Out of Hospital	1	**CULLMAN**	**996**
BALDWIN	**1,437**	Cullman Regional Medical Center	843
North Baldwin Infirmary	213	Woodland Medical Center	145
South Baldwin Regional Medical Center	413	Out of Hospital	8
Thomas Hospital	807	**DALE**	**246**
Out of Hospital	4	Dale Medical Center	244
BARBOUR	**2**	Out of Hospital	2
Lakeview Community Hospital	1	**DALLAS**	**1,018**
Out of Hospital	1	Vaughan Regional Medical Center Parkway	983
BIBB	**0**	Vaughan Regional Medical Center Dallas	32
BLOUNT	**1**	Out of Hospital	3
Out of Hospital	1	**DEKALB**	**810**
BULLOCK	**2**	Baptist Medical Center - DeKalb	805
Bullock County Hospital	2	Out of Hospital	5
BUTLER	**21**	**ELMORE**	**5**
L. V. Stabler Memorial Hospital	20	Community Hospital, Inc.	3
Out of Hospital	1	Out of Hospital	2
CALHOUN	**1,689**	**ESCAMBIA**	**375**
Northeast AL Regional Medical Center	1,475	Atmore Community Hospital	67
Jacksonville Medical Center	212	D. W. McMillan Memorial Hospital	308
Out of Hospital	2	**ETOWAH**	**1,470**
CHAMBERS	**395**	Gadsden Regional Medical Center	556
George H. Lanier Memorial Hospital	394	Riverview Regional Medical Center	911
Out of Hospital	1	Out of Hospital	3
CHEROKEE	**0**	**FAYETTE**	**0**
CHILTON	**0**	**FRANKLIN**	**301**
CHOCTAW	**0**	Russellville Hospital	301
CLARKE	**345**	**GENEVA**	**2**
Grove Hill Memorial Hospital	144	Wiregrass Medical Center	1
Jackson Medical Center	200	Out of Hospital	1
Out of Hospital	1	**GREENE**	**1**
CLAY	**1**	Greene County Hospital	1
Out of Hospital	1	**HALE**	**2**
CLEBURNE	**0**	Out of Hospital	2
COFFEE	**780**	**HENRY**	**0**
Medical Center Enterprise	780	**HOUSTON**	**2,347**
COLBERT	**747**	Flowers Hospital	1,143
Helen Keller Memorial Hospital	747	Southeast Alabama Medical Center	1,201
CONECUH	**1**	Out of Hospital	3
Out of Hospital	1	**JACKSON**	**340**
COOSA	**0**	Jackson County Hospital	340
COVINGTON	**463**	**JEFFERSON**	**13,968**
Mizell Memorial Hospital	87	Baptist Medical Center – Princeton	569
Andalusia Regional Hospital	375	Medical Center East	984
Out of Hospital	1	University of Alabama Hospital	2,717

TABLE 4 (Continued)
BIRTHS BY HOSPITAL OF OCCURRENCE
ALABAMA, 2002

COUNTY AND HOSPITAL	TOTAL	COUNTY AND HOSPITAL	TOTAL
St. Vincent's Hospital	3,364	Jackson Hospital	1,119
UAB Medical West	550	Baptist Medical Center South	2,361
Montclair Baptist Medical Center	943	Baptist Medical Center East	2,211
Cooper Green Hospital	962	Out of Hospital	13
Brookwood Medical Center	3,860	**MORGAN**	**1,870**
Out of Hospital	19	Parkway Medical Center	221
LAMAR	**0**	Hartselle Medical Center	1
LAUDERDALE	**1,066**	Decatur General Hospital	1,642
Eliza Coffee Memorial Hospital	1,066	Out of Hospital	6
LAWRENCE	**1**	**PERRY**	**0**
Out of Hospital	1	**PICKENS**	**38**
LEE	**1,390**	Pickens County Medical Center	38
East Alabama Medical Center	1,382	**PIKE**	**466**
Out of Hospital	8	Edge Regional Medical Center	463
LIMESTONE	**414**	Out of Hospital	3
Athens Limestone Hospital	413	**RANDOLPH**	**61**
Out of Hospital	1	Randolph Medical Center	60
LOWNDES	**1**	Out of Hospital	1
Out of Hospital	1	**RUSSELL**	**91**
MACON	**0**	Phenix Regional Hospital	88
MADISON	**4,378**	Out of Hospital	3
Huntsville Hospital, The	3,667	**ST. CLAIR**	**2**
Crestwood Medical Center	694	Out of Hospital	2
Out of Hospital	17	**SHELBY**	**866**
MARENGO	**351**	Shelby Baptist Medical Center	862
Bryan W. Whitfield Memorial Hospital	351	Out of Hospital	4
MARION	**473**	**SUMTER**	**0**
Marion Regional Medical Center	1	**TALLADEGA**	**831**
Northwest Medical Center	472	Citizens Baptist Medical Center	386
MARSHALL	**939**	Coosa Valley Baptist Medical Center	441
Marshall Medical Center South	543	Out of Hospital	4
Marshall Medical Center North	392	**TALLAPOOSA**	**442**
Out of Hospital	4	Russell Hospital	442
MOBILE	**6,826**	**TUSCALOOSA**	**2,915**
Mobile Infirmary	1,240	DCH Regional Medical Center	1,590
Providence Hospital	1,230	Northport Medical Center	1,319
U.S.A. Children's and Women's Hospital	2,894	Out of Hospital	6
Springhill Memorial Hospital	1,442	**WALKER**	**609**
U.S.A. Medical Center	1	Walker Baptist Medical Center	608
Out of Hospital	19	Out of Hospital	1
MONROE	**246**	**WASHINGTON**	**0**
Monroe County Hospital	245	**WILCOX**	**4**
Out of Hospital	1	Out of Hospital	4
MONTGOMERY	**5,704**	**WINSTON**	**0**

TABLE 5
BIRTHS AND PERCENT[1] OF BIRTHS TO UNMARRIED WOMEN BY RACE OF MOTHER[2] ALABAMA, 1960-2002[3]

YEAR	TOTAL		WHITE		BLACK AND OTHER	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
1960	9,271	11.6	859	1.7	8,412	28.2
1961	9,433	11.8	868	1.7	8,565	28.8
1962	9,295	11.9	941	1.9	8,354	28.8
1963	9,298	12.3	1,012	2.1	8,286	30.0
1964	9,690	12.7	1,055	2.2	8,635	31.1
1965	9,145	13.1	1,070	2.4	8,075	31.6
1966	8,746	13.3	1,195	2.8	7,551	32.5
1967	9,002	14.1	1,257	3.1	7,745	34.2
1968	8,861	14.0	1,245	3.0	7,616	35.8
1969	8,927	13.9	1,400	3.3	7,527	35.8
1970	9,794	14.6	1,546	3.4	8,248	37.6
1971	10,498	15.7	1,492	3.4	9,006	40.0
1972	10,735	17.4	1,547	3.9	9,188	42.5
1973	10,725	18.0	1,570	4.1	9,155	44.3
1974	10,826	18.2	1,569	4.1	9,257	44.7
1975	11,476	19.8	1,811	4.8	9,665	47.5
1976	11,170	19.3	1,627	4.4	9,543	46.6
1977	12,212	19.7	1,882	4.7	10,330	47.7
1978	12,867	21.4	2,036	5.3	10,831	50.5
1979	13,674	21.9	2,196	5.5	11,478	50.6
1980	14,033	22.1	2,401	5.9	11,632	51.1
1981	13,848	22.5	2,555	6.4	11,293	51.7
1982	13,929	23.1	2,553	6.6	11,376	53.2
1983	14,026	23.8	2,716	7.1	11,314	54.9
1984	14,469	24.5	2,776	7.3	11,693	56.1
1985	14,876	24.9	3,133	8.0	11,743	57.0
1986	15,381	25.9	3,340	8.7	12,041	57.9
1987	15,946	26.8	3,655	9.4	12,291	59.3
1988	16,930	27.9	4,146	10.6	12,784	59.3
1989	18,632	29.8	4,652	11.6	13,980	62.3
1990	19,099	30.1	4,902	11.9	14,197	63.5
1991	20,008	31.9	5,202	12.8	14,806	66.9
1992	20,263	32.6	5,518	13.8	14,745	66.8
1993	20,649	33.5	5,933	14.9	14,716	67.7
1994	20,989	34.5	6,218	15.7	14,771	69.5
1995	20,782	34.5	6,598	16.6	14,184	68.9
1996	20,358	33.7	6,570	16.4	13,788	67.9
1997	20,614	33.9	6,825	16.9	13,789	67.4
1998	21,120	34.1	7,141	17.2	13,979	68.1
1999	20,658	33.3	7,166	17.2	13,492	66.2
2000	21,663	34.3	7,556	18.0	14,107	66.5
2001	20,739	34.4	7,615	18.8	13,124	66.2
2002	20,503	34.8	7,862	19.7	12,641	66.5

[1] Denominator includes only births where marital status is known.
[2] Data for 1960-1989 are by race of the child.
[3] Data for the years 1960-1970 are by occurrence. Data for 1971-2002 are by residence.

TABLE 6
BIRTHS AND PERCENT[1] OF BIRTHS TO UNMARRIED WOMEN BY COUNTY OF RESIDENCE AND RACE OF MOTHER
ALABAMA, 2002

COUNTY	TOTAL		WHITE		BLACK AND OTHER	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL	20,503	34.8	7,862	19.7	12,641	66.5
Autauga	168	28.0	78	16.8	90	66.2
Baldwin	449	25.8	276	18.6	173	67.3
Barbour	184	51.0	34	19.3	150	81.1
Bibb	68	24.6	36	15.7	32	68.1
Blount	130	19.5	124	18.9	6	50.0
Bullock	99	70.2	9	23.7	90	87.4
Butler	139	55.8	24	23.8	115	77.7
Calhoun	370	25.4	197	18.0	173	48.1
Chambers	207	47.3	66	25.8	141	77.5
Cherokee	79	29.4	66	26.7	13	59.1
Chilton	131	24.8	93	19.8	38	64.4
Choctaw	97	48.7	25	24.3	72	75.0
Clarke	141	41.7	30	17.9	111	65.3
Clay	46	31.1	28	22.0	18	85.7
Cleburne	20	13.1	17	11.5	3	60.0
Coffee	156	28.4	85	20.3	71	54.2
Colbert	183	29.1	105	20.6	78	65.5
Conecuh	90	51.7	17	21.0	73	78.5
Coosa	71	55.5	28	36.4	43	84.3
Covington	126	28.4	80	21.3	46	66.7
Crenshaw	66	36.3	32	22.7	34	82.9
Cullman	227	23.9	224	23.9	3	30.0
Dale	208	27.7	100	17.9	108	56.0
Dallas	478	67.7	44	27.8	434	79.2
DeKalb	246	27.8	225	26.6	21	53.8
Elmore	299	32.5	141	20.8	158	65.0
Escambia	211	41.4	90	27.7	121	65.4
Etowah	367	29.1	231	22.3	136	60.7
Fayette	35	18.0	23	13.8	12	44.4
Franklin	110	24.3	99	23.0	11	47.8
Geneva	96	31.7	72	26.6	24	75.0
Greene	105	71.4	1	9.1	104	76.5
Hale	115	50.7	9	12.7	106	67.9
Henry	90	39.6	30	20.3	60	75.9
Houston	480	38.6	193	23.5	287	68.0
Jackson	157	25.4	145	24.3	12	54.5
Jefferson	3,634	40.7	783	17.0	2,851	66.1
Lamar	28	16.2	19	12.3	9	47.4
Lauderdale	232	25.2	152	19.2	80	63.0
Lawrence	100	27.5	71	22.4	29	61.7
Lee	318	23.4	128	13.5	190	45.8
Limestone	246	29.5	191	25.5	55	66.3
Lowndes	127	63.5	4	11.8	123	74.1
Macon	119	50.0	7	18.4	112	56.0
Madison	1,002	28.5	453	18.0	549	54.9
Marengo	142	48.6	21	17.1	121	71.6
Marion	66	18.3	59	16.9	7	63.6
Marshall	349	26.9	332	26.5	17	37.8
Mobile	2,403	41.2	705	21.3	1,698	67.4
Monroe	141	46.1	30	19.5	111	73.0
Montgomery	1,649	49.4	247	18.6	1,402	69.8
Morgan	442	29.4	306	23.6	136	66.3
Perry	127	66.5	5	12.8	122	80.3
Pickens	103	40.9	18	12.8	85	76.6
Pike	202	52.1	51	25.0	151	82.1
Randolph	97	35.7	39	21.8	58	62.4
Russell	283	47.0	123	32.6	160	71.1
St. Clair	199	24.5	166	21.9	33	60.0
Shelby	307	12.9	200	9.4	107	44.0
Sumter	119	64.7	4	11.4	115	77.2
Talladega	442	43.0	167	25.2	275	75.1
Tallapoosa	190	40.3	76	24.1	114	72.6
Tuscaloosa	731	34.1	188	14.4	543	64.7
Walker	178	19.8	142	16.9	36	58.1
Washington	78	32.0	32	20.0	46	54.8
Wilcox	149	69.0	11	25.6	138	79.8
Winston	56	22.1	55	21.8	1	100.0

[1] Denominator includes only births where the marital status was known.

TABLE 7
TOTAL BIRTHS, BIRTHS TO UNMARRIED WOMEN AND PERCENT[1] OF BIRTHS TO UNMARRIED WOMEN BY RACE AND AGE OF MOTHER
ALABAMA, 2002

AGE OF MOTHER	TOTAL BIRTHS			BIRTHS TO UNMARRIED WOMEN			PERCENT OF BIRTHS TO UNMARRIED WOMEN		
	TOTAL	WHITE	BLACK & OTHER	TOTAL	WHITE	BLACK & OTHER	TOTAL	WHITE	BLACK & OTHER
TOTAL	58,867	39,845	19,022	20,503	7,862	12,641	34.8	19.7	66.5
UNDER 15	169	47	122	164	44	120	97.0	93.6	98.4
15-17	2,899	1,478	1,421	2,428	1,045	1,383	83.8	70.7	97.3
18-19	5,521	3,244	2,277	3,676	1,574	2,102	66.6	48.5	92.3
20-24	18,610	11,508	7,102	8,660	3,153	5,507	46.5	27.4	77.5
25-29	15,544	11,194	4,350	3,405	1,133	2,272	21.9	10.1	52.2
30-34	11,071	8,650	2,421	1,422	600	822	12.8	6.9	34.0
35-39	4,195	3,101	1,094	603	252	351	14.4	8.1	32.1
40-44	807	581	226	135	54	81	16.7	9.3	35.8
45+	42	35	7	5	3	2	--	--	--
NOT STATED	9	7	2	5	4	1	--	--	--

[1] Percentages were not calculated in instances where there were fewer than 50 births in specified population.

TABLE 8
PERCENT[1] OF BIRTHS TO UNMARRIED WOMEN BY RACE AND AGE OF MOTHER
ALABAMA, 1993-2002

RACE AND AGE OF MOTHER	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
TOTAL	33.5	34.5	34.5	33.7	33.9	34.1	33.3	34.3	34.4	34.8
UNDER 15	95.8	97.1	96.6	94.9	96.3	98.7	96.4	97.0	95.1	97.0
15-17	78.0	79.2	79.2	80.8	81.7	81.2	80.4	80.9	83.3	83.8
18-19	61.2	61.9	63.5	62.5	64.0	65.2	64.8	65.2	65.8	66.6
20-24	39.8	41.4	42.1	41.9	42.9	43.3	42.8	44.8	45.4	46.5
25-29	19.3	19.4	19.1	18.3	18.4	19.2	19.2	20.9	21.5	21.9
30-34	14.1	14.6	13.6	13.1	13.2	12.5	12.5	12.2	12.3	12.8
35-39	15.4	15.0	15.6	13.9	14.4	14.9	13.1	13.3	14.1	14.4
40-44	18.8	16.3	18.3	16.5	17.4	16.3	15.8	17.4	16.5	16.7
45+	--	--	--	--	-	--	--	--	--	--
WHITE	14.9	15.7	16.6	16.4	16.9	17.2	17.2	18.0	18.8	19.7
UNDER 15	83.2	83.3	85.7	82.4	82.5	94.7	90.9	91.8	84.7	93.6
15-17	54.1	56.1	58.1	60.9	63.6	63.0	63.6	64.7	68.5	70.7
18-19	34.6	35.4	39.6	38.0	42.0	42.8	43.8	44.8	48.0	48.5
20-24	18.6	19.4	20.8	20.9	21.5	22.2	22.5	23.8	25.4	27.4
25-29	7.3	8.1	8.2	8.0	8.1	8.7	8.5	9.7	10.2	10.1
30-34	5.1	5.6	5.4	5.5	5.9	5.4	5.7	5.8	5.7	6.9
35-39	5.9	5.6	6.2	6.2	6.2	7.5	6.4	6.2	7.5	8.1
40-44	9.2	6.8	6.9	8.1	9.4	6.0	8.1	9.3	7.5	9.3
45+	--	--	--	--	--	--	--	--	--	--
BLACK & OTHER	67.7	69.5	68.9	67.0	67.4	68.1	66.2	66.5	66.2	66.5
UNDER 15	100.0	100.0	10.0	99.6	100.0	100.0	98.7	99.3	100.0	98.4
15-17	97.5	98.3	97.7	98.0	98.0	98.6	97.5	97.4	98.1	97.3
18-19	92.1	92.4	92.6	92.1	91.9	92.4	91.2	91.7	90.3	92.3
20-24	74.7	76.2	76.7	75.7	75.8	76.5	74.7	76.1	76.6	77.5
25-29	50.8	50.2	49.4	48.1	48.0	49.5	49.0	49.4	50.5	52.2
30-34	38.5	41.2	39.1	37.5	36.6	36.4	36.1	34.2	35.5	34.0
35-39	36.2	38.2	38.3	34.4	36.8	35.7	32.9	34.7	33.3	32.1
40-44	34.5	33.9	36.8	34.4	33.5	38.0	34.1	36.8	35.3	35.8
45+	--	--	--	--	--	--	--	--	--	--

[1] Percentages were not calculated in instances where there were fewer than 50 births in specified population.

FETAL DEATHS AND FETAL DEATH RATIOS[1] BY RACE OF MOTHER[2]
ALABAMA AND UNITED STATES, 1945-2002

YEAR	TOTAL			WHITE		BLACK AND OTHER	
	ALABAMA		U.S.	ALABAMA		ALABAMA	
	NUMBER	RATIO	RATIO	NUMBER	RATIO	NUMBER	RATIO
1945	2,032	29.0	23.9	958	21.8	1,074	40.9
1946	2,295	29.1	22.8	1,142	22.4	1,153	41.2
1947	2,454	27.9	21.1	1,197	20.7	1,257	41.6
1948	2,310	27.0	20.6	1,085	20.2	1,225	38.6
1949	2,296	27.2	19.8	1,053	20.2	1,243	38.5
1950	2,153	26.1	19.2	943	19.0	1,210	36.7
1951	2,182	26.0	18.8	980	19.2	1,202	36.7
1952	2,118	25.6	18.3	918	18.0	1,200	37.7
1953	1,887	22.9	17.8	864	17.0	1,023	32.2
1954	1,863	22.6	17.5	819	16.1	1,044	33.0
1955	1,788	21.8	17.1	803	16.1	985	30.7
1956	1,777	21.1	16.5	760	14.8	1,017	31.2
1957	1,748	20.8	16.3	802	15.5	946	29.5
1958	1,740	21.2	16.5	758	14.7	982	31.9
1959	1,810	22.0	16.2	784	15.3	1,026	32.8
1960	1,793	22.1	16.1	780	15.3	1,013	33.6
1961	1,716	21.3	16.1	754	14.9	962	32.0
1962	1,596	20.3	15.9	694	14.1	902	30.8
1963	1,560	20.5	15.8	707	14.8	853	30.2
1964	1,581	20.7	16.4	718	14.8	863	30.7
1965	1,480	21.0	16.2	607	13.6	873	33.7
1966	1,357	20.4	15.7	597	13.9	760	32.3
1967	1,304	20.2	15.6	585	14.0	719	31.4
1968	1,286	20.2	15.8	584	13.9	702	32.7
1969	1,122	17.3	14.1	561	12.9	561	26.4
1970	1,091	16.1	14.2	559	12.3	532	24.1
1971	1,073	16.1	13.4	551	12.5	522	23.2
1972	1,042	16.9	12.7	523	13.0	519	24.0
1973	938	15.8	12.2	463	11.9	475	23.0
1974	886	14.9	11.5	441	11.4	445	21.5
1975	798	13.8	10.7	393	10.5	405	19.9
1976	723	12.5	10.5	345	9.2	378	18.5
1977	780	12.6	9.9	390	9.7	390	18.0
1978	775	12.9	9.7	382	9.9	393	18.3
1979	659	10.5	9.4	339	8.5	320	14.1
1980	723	11.4	9.2	368	9.1	355	15.6
1981	754	12.3	9.0	366	9.2	388	17.8
1982	675	11.2	8.9	352	9.1	323	15.1
1983	658	11.1	8.5	338	8.8	320	15.5
1984	608	10.3	8.2	316	8.3	292	14.0
1985	660	11.1	7.9	317	8.1	343	16.6
1986	690	11.6	7.7	347	9.0	343	16.5
1987	600	10.1	7.7	306	7.9	294	14.2
1988	656	10.8	7.5	330	8.4	326	15.1
1989	628	10.0	7.5	294	7.3	334	14.9
1990	680	10.7	7.5	333	8.1	347	15.5
1991	584	9.3	7.3	282	6.9	302	13.6
1992	639	10.3	7.4	294	7.3	345	15.6
1993	605	9.8	7.2	300	7.5	305	14.0
1994	585	9.6	7.0	268	6.8	317	14.9
1995	572	9.5	7.0	264	6.7	308	14.9
1996	563	9.3	6.9	266	6.6	297	14.6
1997	524	8.6	6.8	266	6.6	258	12.6
1998	591	9.5	6.7	284	6.8	307	14.9
1999	602	9.7	—[3]	290	7.0	312	15.3
2000	609	9.6	—[3]	266	6.3	343	16.2
2001	574	9.5	—[3]	274	6.8	300	15.1
2002	548	9.3	—[3]	245	6.1	303	15.9

[1] Ratio is per 1,000 live births in specified group.
[2] Fetal deaths are by race of the fetus and live births are by race of the child before 1990. Fetal deaths and live births are by the race of the mother since 1990. See formula in Appendix B.
[3] Not available.

FETAL DEATHS AND FETAL DEATH RATIOS[1]
BY RACE OF MOTHER AND COUNTY OF RESIDENCE
ALABAMA, 2002

COUNTY	TOTAL		WHITE		BLACK AND OTHER	
	NUMBER	RATIO	NUMBER	RATIO	NUMBER	RATIO
TOTAL	548	9.3	245	6.1	303	15.9
Autauga	3	5.0	2	4.3	1	7.4
Baldwin	15	8.6	13	8.8	2	7.8
Barbour	8	22.2	1	5.7	7	37.8
Bibb	3	10.9	1	4.4	2	42.6*
Blount	7	10.5	6	9.1	1	83.3*
Bullock	0	0.0	0	0.0	0	0.0
Butler	2	8.0	1	9.9	1	6.8
Calhoun	13	8.9	7	6.4	6	16.7
Chambers	11	25.1	2	7.8	9	49.5
Cherokee	0	0.0	0	0.0	0	0.0
Chilton	7	13.3	5	10.7	2	33.9
Choctaw	2	10.1	2	19.4	0	0.0
Clarke	3	8.9	2	11.9	1	5.9
Clay	3	20.3	3	23.6	0	0.0
Cleburne	1	6.5	1	6.8	0	0.0
Coffee	6	10.9	6	14.4	0	0.0
Colbert	6	9.5	4	7.8	2	16.8
Conecuh	2	11.5	1	12.3	1	10.8
Coosa	1	7.8	0	0.0	1	19.6
Covington	4	9.0	1	2.7	3	43.5
Crenshaw	1	5.5	1	7.1	0	0.0
Cullman	7	7.4	7	7.5	0	0.0
Dale	3	4.0	1	1.8	2	10.4
Dallas	10	14.2	1	6.3	9	16.4
DeKalb	5	5.6	5	5.9	0	0.0
Elmore	12	13.0	6	8.9	6	24.7
Escambia	7	13.7	3	9.2	4	21.6
Etowah	14	11.1	10	9.6	4	17.9
Fayette	2	10.3	2	12.0	0	0.0
Franklin	5	11.0	5	11.6	0	0.0
Geneva	1	3.3	1	3.7	0	0.0
Greene	1	6.8	0	0.0	1	7.4
Hale	3	13.2	0	0.0	3	19.2
Henry	1	4.4	0	0.0	1	12.7
Houston	7	5.6	5	6.1	2	4.7
Jackson	3	4.8	2	3.4	1	45.5*
Jefferson	94	10.5	25	5.4	69	16.0
Lamar	1	5.8	1	6.5	0	0.0
Lauderdale	15	16.3	8	10.1	7	55.1
Lawrence	3	8.2	3	9.5	0	0.0
Lee	21	15.4	4	4.2	17	41.0
Limestone	4	4.8	2	2.7	2	24.1
Lowndes	2	10.0	0	0.0	2	12.0
Macon	12	50.4	2	52.6*	10	50.0
Madison	25	7.1	12	4.8	13	13.0
Marengo	2	6.8	1	8.1	1	5.9
Marion	0	0.0	0	0.0	0	0.0
Marshall	4	3.1	4	3.2	0	0.0
Mobile	44	7.5	17	5.1	27	10.7
Monroe	1	3.3	0	0.0	1	6.6
Montgomery	38	11.4	8	6.0	30	14.9
Morgan	15	10.0	8	6.2	7	34.1
Perry	3	15.7	0	0.0	3	19.7
Pickens	5	19.8	2	14.2	3	27.0
Pike	1	2.6	1	4.9	0	0.0
Randolph	7	25.7	3	16.8	4	43.0
Russell	3	5.0	2	5.3	1	4.4
St. Clair	3	3.7	2	2.6	1	18.2
Shelby	17	7.2	14	6.6	3	12.3
Sumter	2	10.9	0	0.0	2	13.4
Talladega	14	13.6	6	9.1	8	21.9
Tallapoosa	3	6.4	1	3.2	2	12.7
Tuscaloosa	20	9.3	7	5.4	13	15.5
Walker	6	6.7	5	6.0	1	16.1
Washington	0	0.0	0	0.0	0	0.0
Wilcox	4	18.5	0	0.0	4	23.1
Winston	0	0.0	0	0.0	0	0.0

[1] Ratio is per 1,000 live births in specified group. See formula in Appendix B. Caution should be exercised in using ratios derived from small figures. Caution should also be exercised in using ratios which are based on small live birth totals. Ratios which apply to populations with fewer than 50 live births are denoted by an "*".

DEATHS AND DEATH RATES[1] BY RACE
ALABAMA AND UNITED SATES, 1945-2002

YEAR	TOTAL			WHITE			BLACK AND OTHER		
	ALABAMA		U.S.	ALABAMA		U.S.	ALABAMA		U.S.
	NUMBER	RATE	RATE	NUMBER	RATE	RATE	NUMBER	RATE	RATE
1945	25,368	8.5	10.6	14,548	7.4	10.4	10,820	10.7	11.9
1946	24,491	8.2	10.0	14,148	7.1	9.8	10,343	10.1	11.1
1947	26,074	8.7	10.1	15,127	7.5	9.9	10,947	11.1	11.4
1948	26,464	8.8	9.9	15,398	7.6	9.7	11,066	11.2	11.4
1949	26,609	8.7	9.7	15,240	7.4	9.5	11,369	11.6	11.2
1950	26,753	8.7	9.6	15,515	7.4	9.5	11,238	11.4	11.2
1951	27,336	8.8	9.7	15,926	7.6	9.5	11,410	11.5	11.1
1952	27,210	8.8	9.6	15,927	7.5	9.4	11,283	11.5	11.0
1953	27,051	8.6	9.6	15,957	7.4	9.4	11,094	11.3	10.8
1954	26,157	8.3	9.2	15,710	7.3	9.1	10,447	10.6	10.1
1955	26,419	8.3	9.3	16,082	7.4	9.2	10,337	10.5	10.0
1956	27,200	8.5	9.4	16,816	7.6	9.3	10,384	10.6	10.1
1957	28,396	8.8	9.6	17,569	7.9	9.5	10,827	11.0	10.5
1958	29,513	9.1	9.5	18,105	8.0	9.4	11,408	11.6	10.3
1959	28,692	8.8	9.4	17,846	7.9	9.3	10,846	11.0	9.9
1960	30,304	9.3	9.5	18,988	8.3	9.5	11,316	11.5	10.1
1961	29,738	9.0	9.3	18,897	8.2	9.3	10,841	11.1	9.6
1962	30,813	9.3	9.5	19,667	8.4	9.4	11,146	11.5	9.8
1963	32,016	9.6	9.6	20,481	8.7	9.5	11,535	12.0	10.1
1964	31,739	9.5	9.4	20,701	8.7	9.4	11,038	11.6	9.7
1965	32,520	9.7	9.4	21,260	8.8	9.4	11,260	11.9	9.7
1966	33,008	9.8	9.5	21,795	8.9	9.5	11,213	12.0	9.7
1967	31,915	9.4	9.4	21,467	8.7	9.4	10,448	11.2	9.4
1968	33,532	9.8	9.7	22,588	9.1	9.6	10,944	11.9	9.9
1969	33,830	9.9	9.5	22,916	9.1	9.5	10,914	11.9	9.6
1970	33,693	9.8	9.5	23,071	9.1	9.5	10,622	11.7	9.4
1971	33,807	9.6	9.3	23,455	9.1	9.3	10,352	11.3	9.2
1972	34,577	9.7	9.4	24,038	9.3	9.4	10,539	11.5	9.2
1973	35,342	9.8	9.3	24,570	9.2	9.4	10,772	11.3	9.0
1974	34,712	9.5	9.1	24,466	9.1	9.1	10,246	10.7	8.6
1975	33,629	9.1	8.8	23,745	8.7	8.9	9,884	10.2	8.2
1976	34,220	9.1	8.8	23,973	8.7	8.9	10,247	10.4	8.1
1977	34,772	9.2	8.6	24,531	8.8	8.7	10,241	10.3	8.0
1978	34,489	9.0	8.7	24,465	8.7	8.8	10,024	10.0	7.9
1979	33,502	8.6	8.5	23,746	8.3	8.7	9,756	9.6	7.7
1980	35,305	9.0	8.8	24,942	8.6	8.9	10,363	10.1	7.9
1981	35,348	8.8	8.6	25,498	8.6	8.8	9,850	9.4	7.5
1982	34,957	8.6	8.5	25,362	8.5	8.7	9,595	9.1	7.3
1983	35,471	8.7	8.6	25,594	8.4	8.8	9,877	9.3	7.4
1984	36,431	8.8	8.6	26,418	8.6	8.9	10,013	9.4	7.3
1985	37,531	9.0	8.7	27,198	8.8	9.0	10,333	9.6	7.4
1986	37,690	9.2	8.7	27,538	9.1	9.0	10,152	9.4	7.5
1987	37,681	9.1	8.7	27,631	9.0	9.0	10,050	9.2	7.5
1988	39,077	9.3	8.8	28,505	9.2	9.1	10,572	9.6	7.6
1989	38,924	9.2	8.7	28,464	9.1	8.9	10,460	9.3	7.6
1990	39,335	9.7	8.6	28,685	9.6	8.9	10,650	10.0	7.4
1991	40,024	9.8	8.6	29,350	9.8	8.9	10,674	9.9	7.3
1992	39,199	9.6	8.5	28,697	9.6	8.8	10,502	9.8	7.2
1993	41,232	10.1	8.8	30,397	10.1	9.1	10,835	10.1	7.4
1994	41,631	10.2	8.8	30,794	10.2	9.1	10,837	10.0	7.3
1995	42,321	10.3	8.8	31,317	10.3	9.1	11,004	10.1	7.3
1996	42,806	10.4	8.7	31,918	10.5	9.1	10,888	10.0	7.1
1997	43,208	10.4	8.6	32,370	10.6	9.0	10,838	9.9	6.9
1998	43,905	10.6	8.6	32,987	10.8	9.0	10,918	9.9	6.8
1999	44,720	10.7	8.8	33,588	11.0	9.2	11,132	10.0	6.9
2000	44,967	10.1	8.7	33,998	10.7	9.2	10,969	8.5	6.8
2001	45,196	10.1	8.5	34,034	10.7	9.0	11,162	8.5	6.4
2002	46,017	10.2	8.4[2]	34,690	10.9	N/A	11,327	8.5	N/A

[1] Rate is per 1,000 population for specified group. See formula in Appendix B.
[2] Provisional Data.

LEADING CAUSES OF DEATH, CRUDE DEATH RATES[1] BY RACE AND SEX ALABAMA, 2002

RANK	CAUSE OF DEATH	NUMBER	CRUDE RATE
RANK	TOTAL ALL RACE AND SEX	46,017	10.2
1	Diseases of the Heart	13,183	291.3
2	Malignant Neoplasms	9,685	214.0
3	Cerebrovascular Diseases	3,203	70.8
4	Chronic Lower Respiratory Disease	2,328	51.4
5	Accidents	2,212	48.9
6	Diabetes Milletus	1,485	32.8
7	Influenza and Pneumonia	1,217	26.9
8	Alzheimer's	1,189	26.3
9	Nephritis, Nephrotic Syn. & Nephrosis	1,031	22.8
10	Septicemia	763	16.9
11	Suicide	515	11.4
12	Chronic Liver Disease and Cirrhosis	425	9.4
13	Homicide	416	9.2
14	Essential (Primary) Hypertension	337	7.4
15	Pneumonitis Due to Solids and Liquids	322	7.1
	All Other Causes	7,706	--
RANK	TOTAL WHITE	34,690	10.9
1	Diseases of the Heart	10,132	317.2
2	Malignant Neoplasms	7,427	232.5
3	Cerebrovascular Diseases	2,339	73.2
4	Chronic Lower Respiratory Disease	2,061	64.5
5	Accidents	1,732	54.2
6	Alzheimer's	1,031	32.3
7	Influenza and Pneumonia	979	30.7
8	Diabetes Milletus	901	28.2
9	Nephritis, Nephrotic Syn. & Nephrosis	667	20.9
10	Septicemia	542	17.0
11	Suicide	450	14.1
12	Chronic Liver Disease and Cirrhosis	327	10.2
13	Pneumonitis Due to Solids and Liquids	250	7.8
14	Parkinson's Disease	215	6.7
15	Essential (Primary) Hypertension	200	6.3
	All Other Causes	5,437	-
RANK	TOTAL WHITE MALE	16,987	10.9
1	Diseases of the Heart	4,902	314.1
2	Malignant Neoplasms	4,047	259.3
3	Accidents	1,118	71.6
4	Chronic Lower Respiratory Disease	1,076	68.9
5	Cerebrovascular Diseases	872	55.9
6	Diabetes Milletus	420	26.9
7	Influenza and Pneumonia	412	26.4
8	Suicide	354	22.7
9	Nephritis, Nephrotic Syn. & Nephrosis	326	20.9
10	Alzheimer's	290	18.6
11	Septicemia	227	14.5
12	Chronic Liver Disease and Cirrhosis	207	13.3
13	Homicide	114	7.3
14	Pneumonitis Due to Solids and Liquids	114	7.3
15	Aortic Aneurysm	112	7.2
	All Other Causes	2,396	-
RANK	TOTAL WHITE FEMALE	17,703	10.8
1	Diseases of the Heart	5,230	320.2
2	Malignant Neoplasms	3,380	207.0
3	Cerebrovascular Diseases	1,467	89.8
4	Chronic Lower Respiratory Disease	985	60.3
5	Alzheimer's	741	45.4
6	Accidents	614	37.6
7	Influenza and Pneumonia	567	34.7
8	Diabetes Milletus	481	29.5
9	Nephritis, Nephrotic Syn. & Nephrosis	341	20.9
10	Septicemia	315	19.3
11	Pneumonitis Due to Solids and Liquids	136	8.3
12	Essential (Primary) Hypertension	122	7.5
13	Chronic Liver Disease and Cirrhosis	120	7.3
14	Parkinson's Disease	104	6.4
14	Suicide	96	5.9
--	All Other Causes	3,004	--
RANK	TOTAL BLACK AND OTHER	11,327	8.5
1	Diseases of the Heart	3,051	229.0
2	Malignant Neoplasms	2,258	169.5
3	Cerebrovascular Diseases	864	64.9
4	Diabetes Milletus	584	43.8
5	Accidents	480	36.0
6	Nephritis, Nephrotic Syn. & Nephrosis	364	27.3
7	Chronic Lower Respiratory Disease	267	20.0
8	Homicide	263	19.7
9	Influenza and Pneumonia	238	17.9
10	Septicemia	221	16.6
11	Alzheimer's	158	11.9
12	Certain Cond. Orig. in the Peri. Period	153	11.5
13	HIV	140	10.5
14	Essential (Primary) Hypertension	137	10.3
15	Chronic Liver Disease and Cirrhosis	98	7.4
--	All Other Causes	2,051	--
RANK	TOTAL BLACK AND OTHER MALE	5,630	9.0
1	Diseases of the Heart	1,400	223.5
2	Malignant Neoplasms	1,238	197.7
3	Cerebrovascular Diseases	369	58.9
4	Accidents	321	51.3
5	Diabetes Milletus	215	34.3
6	Homicide	210	33.5
7	Chronic Lower Respiratory Disease	171	27.3
8	Nephritis, Nephrotic Syn. & Nephrosis	165	26.3
9	Influenza and Pneumonia	107	17.1
10	Septicemia	101	16.1
11	HIV	100	16.0
12	Certain Cond. Orig. in the Peri. Period	80	12.8
13	Chronic Liver Disease and Cirrhosis	62	9.9
14	Essential (Primary) Hypertension	61	9.7
15	Suicide	60	9.6
--	All Other Causes	970	--
RANK	TOTAL BLACK AND OTHER FEMALE	5,697	8.1
1	Diseases of the Heart	1,651	233.9
2	Malignant Neoplasms	1,020	144.5
3	Cerebrovascular Diseases	495	70.1
4	Diabetes Milletus	369	52.3
5	Nephritis, Nephrotic Syn. & Nephrosis	199	28.2
6	Accidents	159	22.5
7	Influenza and Pneumonia	131	18.6
8	Septicemia	120	17.0
9	Alzheimer's	115	16.3
10	Chronic Lower Respiratory Disease	96	13.6
11	Essential (Primary) Hypertension	76	10.8
12	Certain Cond. Orig. in the Peri. Period	73	10.3
13	Homicide	53	7.5
14	HIV	40	5.7
15	Chronic Liver Disease and Cirrhosis	36	5.1
--	All Other Causes	1,064	--

[1] Total rates are per 1,000 population. Cause-specific rates are per 100,000 population. See formulas in Appendix B.

LEADING CAUSES OF DEATH AND DEATH RATES[1]
BY RACE AND AGE GROUP
ALABAMA, 2002

CAUSE OF DEATH	TOTAL		WHITE		BLACK AND OTHER	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
UNDER 1 YEAR	538	9.0	278	7.3	260	12.0
Congenital Malformations, Deformations, and Abnormalities	95	158.3	61	159.4	34	156.4
Disorders Related to Short Gestation and Low Birth Weight	91	151.6	30	78.4	61	280.6
Respiratory Distress of Newborn	42	70.0	23	60.1	19	87.4
Sudden Infant Death Syndrome	34	56.7	22	57.5	12	55.2
Newborn Affected by Maternal Complications of Pregnancy	23	38.3	12	31.4	11	50.6
1-4 YEARS	102	0.4	60	0.4	42	0.5
Accidents	46	19.2	30	19.6	16	18.4
Homicide	9	3.7	5	3.3	4	4.6
Malignant Neoplasms	6	2.5	5	3.3	1	1.1
Diseases of the Heart	5	2.1	1	0.7	4	4.6
Congenital Anomalies	4	1.7	3	2.0	1	1.1
5-14 YEARS	149	0.2	86	0.2	63	0.3
Accidents	67	10.6	37	9.2	30	13.1
Malignant Neoplasms	14	2.2	10	2.5	4	1.7
Congenital Anomalies	11	1.7	6	1.5	5	2.2
Diseases of the Heart	8	1.3	2	0.5	6	2.6
Suicide	8	1.3	4	1.0	4	1.7
15-19 YEARS	315	1.0	220	1.0	95	0.8
Accidents	182	55.4	152	72.4	30	25.3
Homicide	33	10.0	7	3.3	26	21.9
Suicide	23	7.0	17	8.1	6	5.1
Malignant Neoplasms	12	3.7	7	3.3	5	4.2
Diseases of the Heart	10	3.0	2	1.0	8	6.7
20-24 YEARS	406	1.3	251	1.2	155	1.4
Accidents	193	61.2	144	70.7	49	43.8
Homicide	66	20.9	15	7.4	51	45.6
Suicide	37	11.7	27	13.3	10	8.9
Malignant Neoplasms	13	4.1	8	3.9	5	4.5
Diseases of the Heart	12	3.8	8	3.9	4	3.6
25-34 YEARS	907	1.5	559	1.4	348	1.9
Accidents	284	47.3	211	51.1	73	38.9
Diseases of the Heart	104	17.3	54	13.1	50	26.6
Homicide	98	16.3	27	6.5	71	37.8
Suicide	77	12.8	64	15.5	13	6.9
Malignant Neoplasms	64	10.7	42	10.2	22	11.7

[1] Age-specific rate is per 1,000 population. Cause-specific rate is per 100,000 population. See formulas in Appendix B. Caution should be exercised in using rates derived from small numbers.

LEADING CAUSES OF DEATH AND DEATH RATES[1]
BY RACE AND AGE GROUP
ALABAMA, 2002

CAUSE OF DEATH	TOTAL		WHITE		BLACK AND OTHER	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
35-44 YEARS	1,803	2.7	1,169	2.4	634	3.3
Diseases of the Heart	392	58.1	257	53.4	135	69.8
Accidents	314	46.5	248	51.5	66	34.1
Malignant Neoplasms	265	39.3	173	35.9	92	47.5
Suicide	116	17.2	106	22.0	10	5.2
Homicide	85	12.6	34	7.1	51	26.4
45-54 YEARS	3,565	5.7	2,253	4.9	1,312	7.8
Malignant Neoplasms	919	146.1	607	131.8	312	185.4
Diseases of the Heart	911	144.9	571	124.0	340	202.0
Accidents	252	40.1	191	41.5	61	36.2
Cerebrovascular Diseases	166	26.4	74	16.1	92	54.7
Chronic Liver Disease and Cirrhosis	135	21.5	89	19.3	46	27.3
55-64 YEARS	5,290	11.7	3,818	10.7	1,472	15.3
Malignant Neoplasms	1,774	393.0	1,367	384.6	407	424.2
Diseases of the Heart	1,417	313.9	1,021	287.2	396	412.7
Chronic Lower Respiratory Diseases	265	58.7	223	62.7	42	43.8
Cerebrovascular Diseases	255	56.5	151	42.5	104	108.4
Diabetes Mellitus	227	50.3	138	38.8	89	92.8
65-74 YEARS	8,580	26.7	6,538	25.4	2,042	31.9
Malignant Neoplasms	2,661	827.8	2,090	812.0	571	891.4
Diseases of the Heart	2,318	721.1	1,747	678.7	571	891.4
Chronic Lower Respiratory Diseases	601	187.0	544	211.3	57	89.0
Cerebrovascular Diseases	498	154.9	341	132.5	157	245.1
Diabetes Mellitus	346	107.6	199	77.3	147	229.5
75-84 YEARS	12,842	63.9	10,323	63.5	2,519	65.6
Diseases of the Heart	3,826	1905.1	3,081	1896.6	745	1941.2
Malignant Neoplasms	2,722	1355.4	2,189	1347.5	533	1388.8
Cerebrovascular Diseases	1,039	517.4	807	496.8	232	604.5
Chronic Lower Respiratory Diseases	939	467.6	845	520.2	94	244.9
Diabetes Mellitus	441	219.6	270	166.2	171	445.6
85+ YEARS	11,517	163.1	9,132	166.3	2,385	151.6
Diseases of the Heart	4,163	5893.8	3,378	6153.2	785	4988.9
Malignant Neoplasms	1,234	1747.1	929	1692.2	305	1938.4
Cerebrovascular Diseases	1,158	1639.5	921	1677.7	237	1506.2
Alzheimer's Disease	656	928.7	558	1016.4	98	622.8
Pneumonia and Influenza	538	761.7	438	797.8	100	635.5

[1] Age-specific rate is per 1,000 population. Cause-specific rate is per 100,000 population. See formulas in Appendix B. Caution should be exercised in using rates derived from small numbers.

HEART DISEASE DEATHS AND DEATH RATES[1] BY RACE AND TOTAL UNITED STATES RATES
ALABAMA, 1960-2002

YEAR	U.S. RATE	ALABAMA					
		TOTAL		WHITE		BLACK AND OTHER	
		NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
1960	369.0	9,948	304.1	6,740	294.4	3,208	326.3
1961	362.4	9,995	301.5	6,812	292.9	3,183	321.7
1962	370.1	10,412	310.2	7,215	305.6	3,197	321.1
1963	375.2	10,600	312.0	7,312	305.1	3,228	328.4
1964	365.7	10,496	305.2	7,529	309.7	2,967	294.5
1965	367.4	10,563	314.4	7,575	314.0	2,988	315.4
1966	371.2	11,153	330.2	8,028	329.4	3,125	332.2
1967	364.5	10,693	314.9	7,823	317.8	2,870	307.3
1968	373.5	11,126	325.9	8,188	329.4	2,938	316.9
1969	367.1	11,183	325.9	8,242	328.3	2,941	319.6
1970	362.0	11,311	328.0	8,404	331.5	2,907	318.2
1971	360.5	11,412	329.2	8,562	333.8	2,850	316.2
1972	363.0	11,346	325.7	8,581	331.3	2,765	309.3
1973	360.8	11,605	331.4	8,696	332.5	2,909	328.1
1974	349.2	11,612	329.9	8,792	333.0	2,820	320.7
1975	336.2	10,967	310.0	8,457	317.3	2,510	287.8
1976	337.2	11,158	313.9	8,498	315.9	2,660	307.6
1977	332.3	11,210	313.8	8,607	317.0	2,603	303.5
1978	334.3	11,326	302.7	8,574	306.6	2,752	291.1
1979	326.5	11,470	302.9	8,668	306.4	2,802	292.6
1980	336.0	11,807	302.6	8,960	311.3	2,847	278.3
1981	328.7	12,010	304.4	9,275	318.5	2,735	264.5
1982	326.0	12,091	302.7	9,220	312.7	2,871	274.4
1983	329.2	12,385	302.5	9,357	308.5	3,028	285.4
1984	323.5	12,695	307.2	9,558	311.9	3,137	293.8
1985	323.0	13,048	312.9	9,774	315.7	3,274	304.9
1986	317.5	12,887	314.2	9,678	320.2	3,209	297.3
1987	312.4	13,093	315.6	9,855	322.4	3,238	296.2
1988	311.3	13,211	314.9	10,017	324.2	3,194	288.8
1989	295.6	13,118	309.3	9,900	317.0	3,218	287.5
1990	289.5	12,893	319.1	9,778	328.6	3,115	292.5
1991	285.9	13,186	323.4	9,931	331.7	3,255	300.7
1992	282.5	12,806	314.6	9,682	322.6	3,124	292.1
1993	288.4	13,549	331.7	10,324	342.9	3,225	300.1
1994	281.3	13,107	319.7	10,104	334.6	3,003	278.1
1995	280.7	13,341	324.3	10,159	335.5	3,182	293.3
1996	276.4	13,466	326.2	10,415	342.9	3,051	279.7
1997	271.6	13,522	326.5	10,493	344.6	3,029	276.3
1998	268.2	13,449	323.7	10,361	339.4	3,088	280.2
1999	265.8	13,381	321.0	10,340	337.9	3,041	274.4
2000	258.2	13,354	300.3	10,358	327.5	2,996	233.3
2001	247.8	13,177	293.7	10,141	319.1	3,036	232.1
2002	N/A	13,183	291.3	10,132	317.2	3,051	229.0

[1] Rate is per 100,000 population in specified group. See formula in Appendix B.

HEART DISEASE DEATHS AND DEATH RATES[1] BY AGE GROUP, RACE AND SEX ALABAMA, 2002

AGE GROUP	TOTAL		WHITE				BLACK AND OTHER			
			MALE		FEMALE		MALE		FEMALE	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
TOTAL	13,183	291.3	4,902	314.1	5,230	320.2	1,400	223.5	1,651	233.9
UNDER 1	17	28.3	6	30.5	4	21.5	6	54.6	1	9.3
1-4	5	2.1	1	1.3	0	0.0	1	2.3	3	7.0
5-9	3	1.0	0	0.0	1	1.0	1	1.8	1	1.8
10-14	5	1.5	1	0.9	0	0.0	2	3.4	2	3.5
15-19	10	3.0	1	0.9	1	1.0	4	6.7	4	6.8
20-24	12	3.8	6	5.9	2	2.0	1	1.8	3	5.2
25-29	39	13.0	10	9.8	8	8.0	14	30.6	7	13.6
30-34	65	21.6	24	22.6	12	11.5	14	33.2	15	31.0
35-39	151	46.0	62	52.7	33	28.3	33	76.2	23	45.1
40-44	241	69.5	118	95.1	44	35.7	49	108.0	30	55.8
45-49	394	119.5	166	140.7	67	56.1	97	228.4	64	127.9
50-54	517	172.9	251	227.7	87	77.0	124	354.4	55	134.7
55-59	666	267.2	313	330.5	148	148.2	127	508.0	78	263.0
60-64	751	371.5	370	482.2	190	225.8	112	611.8	79	343.7
65-69	1,003	581.5	481	750.6	264	358.6	143	978.7	115	570.6
70-74	1,315	882.6	599	1131.1	403	603.9	159	1394.7	154	860.7
75-79	1,779	1486.9	735	1876.3	681	1182.7	162	1967.7	201	1370.7
80-84	2,047	2521.6	752	3203.4	913	2162.3	156	3020.9	226	2190.6
85+	4,163	5893.8	1,006	6802.8	2,372	5913.7	195	4533.8	590	5160.0
NOT STATED	0	-	0	-	0	-	0	-	0	-

[1] Rate is per 100,000 population in specified group. Caution should be exercised in using rates derived from small numbers. See formula in Appendix B.

ACCIDENTAL DEATHS AND DEATH RATES[1] BY RACE AND TOTAL UNITED STATES RATES
ALABAMA, 1960-2002

YEAR	U.S. RATE	ALABAMA					
		TOTAL		WHITE		BLACK AND OTHER	
		NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
1960	52.3	2,029	62.0	1,317	57.5	712	72.4
1961	50.4	2,028	61.2	1,362	58.6	666	67.3
1962	52.3	2,097	62.5	1,372	58.1	725	72.8
1963	53.4	2,204	64.9	1,480	61.8	724	72.3
1964	54.3	2,203	64.1	1,534	63.1	669	66.4
1965	55.7	2,425	72.2	1,699	70.4	726	76.6
1966	58.0	2,437	72.2	1,654	67.9	783	83.2
1967	57.2	2,424	71.4	1,731	70.3	693	74.2
1968	57.5	2,489	72.9	1,778	71.5	711	76.7
1969	57.6	2,524	73.6	1,758	70.0	766	83.2
1970	56.4	2,457	71.2	1,702	67.1	755	82.6
1971	55.0	2,603	74.9	1,817	71.0	786	86.0
1972	55.4	2,528	72.0	1,800	69.5	728	79.3
1973	55.2	2,577	72.7	1,817	69.3	760	82.4
1974	49.5	2,347	65.6	1,677	63.2	670	72.3
1975	48.4	2,204	61.0	1,562	58.2	642	69.0
1976	46.9	2,305	63.1	1,617	59.5	688	73.5
1977	47.7	2,459	66.6	1,746	63.5	713	75.9
1978	48.4	2,480	66.3	1,793	64.1	687	72.7
1979	46.9	2,161	57.1	1,551	54.8	610	63.7
1980	46.7	2,295	58.8	1,596	55.5	699	68.3
1981	43.9	2,160	54.7	1,551	53.3	609	58.9
1982	40.6	1,907	47.7	1,439	48.8	468	44.7
1983	39.5	2,037	49.8	1,473	48.6	564	53.2
1984	39.3	1,958	47.4	1,461	47.7	497	46.6
1985	39.1	1,985	47.6	1,400	45.2	585	54.5
1986	39.5	2,204	53.7	1,623	53.7	581	53.8
1987	39.0	2,169	52.3	1,564	51.2	605	55.4
1988	39.5	2,165	51.6	1,537	49.7	628	56.8
1989	38.3	2,186	52.1	1,581	51.2	605	54.7
1990	37.0	2,299	56.9	1,697	57.0	602	56.5
1991	35.4	2,201	54.0	1,605	53.6	596	55.1
1992	34.0	2,049	50.3	1,508	50.3	541	50.6
1993	35.1	2,143	52.5	1,546	51.4	597	55.6
1994	35.1	2,148	52.4	1,565	51.8	583	54.0
1995	35.5	2,232	54.3	1,620	53.5	612	56.4
1996	35.8	2,237	54.2	1,675	55.2	562	51.5
1997	35.7	2,313	55.9	1,749	57.4	564	51.4
1998	34.5	2,209	53.2	1,680	55.0	529	48.0
1999	35.7	2,284	54.8	1,667	54.5	617	55.7
2000	35.6	2,097	47.2	1,567	49.5	530	41.3
2001	35.7	2,187	48.7	1,648	51.9	539	41.2
2002	N/A	2,212	48.9	1,732	54.2	480	36.0

[1] Rate is per 100,000 population in specified group. See formula in Appendix B.

ACCIDENTAL DEATHS AND DEATH RATES[1]
BY AGE GROUP AND RACE
ALABAMA, 2002

AGE GROUP	TOTAL		WHITE		BLACK AND OTHER	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
TOTAL	2,212	48.9	1,732	54.2	480	36.0
UNDER 1	16	26.7	10	26.1	6	27.6
1-4	46	19.2	30	19.6	16	18.4
5-9	32	10.4	18	9.1	14	12.5
10-14	35	10.8	19	9.2	16	13.7
15-19	182	55.4	152	72.4	30	25.3
20-24	193	61.2	144	70.7	49	43.8
25-29	143	47.7	100	49.4	43	44.3
30-34	141	46.9	111	52.8	30	33.2
35-39	167	50.8	131	55.9	36	38.2
40-44	147	42.4	117	47.3	30	30.3
45-49	135	40.9	97	40.9	38	41.1
50-54	117	39.1	94	42.1	23	30.3
55-59	90	36.1	66	33.9	24	43.9
60-64	100	49.5	79	49.1	21	50.9
65-69	95	55.1	74	53.7	21	60.4
70-74	97	65.1	86	71.9	11	37.6
75-79	119	99.5	93	96.1	26	113.6
80-84	139	171.2	130	197.9	9	58.1
85+	216	305.8	179	326.1	37	235.1
NOT STATED	2	-	2	-	0	-

[1] Rate is per 100,000 population in specified group. Caution should be exercised in using rates derived from small numbers. See formula in Appendix B.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.

410-2-5-.04 **Plan Revision Procedures**

(1) Introduction. The Statewide Health Coordinating Council (SHCC) is responsible for the development of the State Health Plan (SHP) with final approval resting with the Governor. The SHCC desires (a) a process that will maintain a viable and current SHP; (b) a coordinated system of revising the SHP; and (c) an application form to be used by individuals, groups, or other entities that request a specific revision to the SHP commonly called an adjustment.

(2) There are three types of plan revisions:

(a) Plan Adjustment – In addition to such other criteria that may be set out in the SHP, a requested modification or exception, to the SHP, of limited duration, to permit additional facilities, beds, services, or equipment to address circumstances and meet the identified needs of a specific county, or part thereof, or another specific planning region that is less than statewide and identified in the State Health Plan. A Plan Adjustment is not of general applicability and is thus not subject to the AAPA's rulemaking requirements. Unless otherwise provided by the SHCC, a Plan Adjustment shall be valid for only one (1) year from the date the Plan Adjustment becomes effective, subject to the exceptions provided in this paragraph 2(a). If an Application is not filed with SHPDA seeking a Certificate of Need for all or part of the additional facilities, beds, services or equipment identified in the Plan Adjustment within one (1) year of the Plan Adjustment, the Plan Adjustment shall expire and be null and void. If an Application(s) seeking a Certificate of Need for all or part of the additional facilities, beds, services or equipment identified in the Plan Adjustment is filed prior to the expiration of the one (1) year period, the Plan Adjustment shall remain effective for purposes of such pending Certificate of Need Application(s). Such one (1) year period shall be further extended for the duration of any deadline provided by SHPDA for the filing of applications as part of a batching schedule established in response to a letter of intent filed within nine (9) months of the effective date of the adjustment. Upon the expiration of such deadlines, no Certificate of Need Applications shall be accepted by SHPDA which are based, in whole or in part, upon the expired Plan Adjustment.

(b) Statistical Update – An update of a specific section of the SHP to reflect more current population, utilization, or other statistical data.

(c) Plan Amendment – The alteration or adoption of rules, policies, methodologies, or any other plan revision that does not meet the plan adjustment or statistical update definition. An amendment is of "general applicability" and subject to the AAPA's rulemaking requirements.

(3) Application Procedures.

(a) Application Procedure for Plan Adjustment – Any person may propose an adjustment to the SHP, which will be considered in accordance with the provisions of SHPDA Rule 410-2-5-.04(4). The proposal will state with specificity the proposed language of the adjustment on such forms as may be prescribed by SHPDA from time to time and shall meet the electronic filing requirements of SHPDA Rule 410-1-3-.09 (Electronic Filing).

b) Procedure for Statistical Update – SHPDA staff shall make statistical updates to the SHP as needed. The SHCC shall be informed at its next regularly scheduled meeting of such updates.

(c) Application Procedure for Plan Amendment – Any person may propose an amendment to the SHP by submitting a detailed description of the proposal to the SHPDA, on such forms as may be prescribed by SHPDA from time to time, in accordance with the electronic filing requirements of SHPDA Rule 410-1-3-.09 (Electronic Filing). Such amendment shall be considered in accordance with the provisions of Rule 410-2-5-.04(4). The proposal will state with specificity the proposed language of the amendment. If it is to amend a methodology, the exact formula will be included, as well as the results of the application of the formula. The SHCC may also consider Plan Amendments on its own motion.

(4) Review Cycle

(a) Within fifteen (15) days from the date of receipt of an application for an amendment or adjustment, the SHPDA staff shall determine if the applicant has furnished all required information for SHCC review and may thus be accepted as complete. The SHCC Chairman and the applicant will be notified when the application is accepted as complete.

(b) Within forty-five (45) days after the application is deemed complete, the application will be added to the SHCC calendar for review. SHPDA shall provide notice of the application for an amendment or adjustment when the application is deemed complete to: (1) all certificated health care facilities known to provide similar services in the county where the adjustment is requested; (2) all certificated health care facilities known to provide similar services in adjacent counties; and (3) such health care associations, state agencies and other entities that have requested to be placed on SHPDA's general notice list for such county. Once an application is deemed complete, persons other than the applicant will have thirty (30) days from the date of completion to electronically file statements in opposition to or in support of the application, as well as any other documentation they wish to be considered by the SHCC. All such documentation shall be filed with SHPDA in accordance with the provisions of Rule 410-1-3-.09 (Electronic Filing), together with a certification that it has been served on the applicant and/or any other persons that have filed notices of support or opposition to the application. No documentation may be submitted beyond the deadlines in this subsection and subsection (3) unless authorized by written order issued by the Chairperson. All persons shall adhere to SHPDA's rules governing electronic filing.

(c) Procedure for Consideration of Plan Adjustments. Proposed Plan Adjustments deemed complete will be placed on the SHCC agenda (individually or collectively) for a public hearing without further action by the SHCC. Unless otherwise provided herein, all written documentation to be considered by the SHCC at the public hearing shall be filed with the State Agency and served on the applicant and any intervenors and opponents of record not less than fourteen (14) days prior to the public hearing. Interested parties may address the proposed Plan Adjustments at the SHCC meeting, subject to such time limits and notice requirements as may be imposed by the SHCC Chairman. If the SHCC approves the Plan Adjustment in whole or in part, the adjustment, along with the SHCC's favorable recommendation, will be sent to the Governor for his consideration and approval/disapproval. A Plan Adjustment shall be deemed disapproved by the Governor if not acted upon within fifteen (15) days.

(d) Procedure for Consideration of Plan Amendments. A proposed Plan Amendment deemed complete will be placed on the SHCC agenda (individually or along with other proposed amendments) for an initial determination if the proposed amendment should be published in accordance with the AAPA and set for public hearing. At the Chairman's discretion, interested parties may be allowed to address the SHCC regarding the proposed amendments prior to such initial consideration. If the SHCC accepts the amendment for publication and hearing in accordance with the AAPA, SHPDA shall cause such publication and notice to be issued in accordance with the AAPA and the provisions of Rule 410-1-3-.10. Interested parties may address the proposed Plan Amendment at the SHCC meeting, subject to such time limits and notice requirements as may be imposed by the SHCC Chairman.

(e) If approved by the SHCC, a Plan Amendment, along with the SHCC's favorable recommendation, will be sent to the Governor for his approval or disapproval. A Plan Amendment shall be deemed disapproved by the Governor if not acted upon within fifteen (15) days. Upon approval by the Governor, a Plan Amendment shall be filed with the Legislative Reference Service for further review in accordance with the AAPA. No party shall have any rights of administrative review, reconsideration or appeal of the approval or denial of a Plan Amendment except as may be specifically provided in the AAPA.

(f) MEDIATION. At the discretion of the Chairman of the SHCC, non-binding mediation may be used to resolve differences between interested parties in regard to any pending matter before the SHCC. Said mediation will be conducted by the Chairman of the SHCC or his or her designee. Any modification or compromise relating to a pending proposal resulting from the mediation shall be sent to all interested parties as defined in paragraph (4)(b). No statement, representation or comment by any party to the Mediation shall be used, cited to, referenced or otherwise introduced at the SHCC's hearing on the proposal in question. Any proposed compromise or other agreement between the parties shall not be binding upon the SHCC.

(5) Filing Fees. Any person proposing a Plan Adjustment shall be required to pay an administrative fee equal to the minimum fee set by SHPDA for the filing of a Certificate of Need Application. Such fees shall be non-refundable and shall be used to defray costs associated with the processing and consideration of Plan Adjustment requests. All required filing fees must be submitted to the State Agency via overnight mail or other delivery method and marked in such a way as to clearly identify the fee with the electronic submission; or the fee may be submitted electronically via the payment portal available through the State Agency's website.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: §§ 22-21-260 (13), (15), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended: Filed February 1, 2013; Effective: March 8, 2013. Amended: Filed September 8, 2014; effective October 13, 2014. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015. Amended: Filed December 22, 2016; Effective: February 5, 2017. Amended: Filed: February 6, 2018; effective: March 23, 2018.
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410-2-5-.05 **Application for State Health Plan Adjustment**

1. Requirements

(1) Applicant Identification. An application for a Plan Adjustment must be filed in accordance with SHPDA Rule 410-1-3-.09, and accompanied by the administrative fee specified in Rule 410-2-5-.04(c)(5). The application must include the name of the applicant, physical address, telephone number, the contact person and their mailing address, telephone number, and e-mail address.

(2) Project Description. Provide a narrative statement explaining the nature of the request, with details of the plan adjustment desired. (If the request is for additional beds, indicate the number and type, i.e., Psychiatric, Rehabilitation, Pediatric, Nursing Home, etc.) The narrative should address availability, accessibility, cost, quality of the health care in question, and state with specificity the proposed language of the adjustment.

(3) Service Area. Describe the geographical area to be served. (Provide a 8½" x 11" map of the service area. The map should indicate the location of other similar health care facilities in the area.)

(4) Population Projections. Provide population projections for the service area. In the case of beds for a specific age group, such as pediatric beds or nursing home beds, be sure to document the existence of the affected population. An example for nursing home beds would be the number of persons 65 and older. The applicant must include the source of all information provided.

(5) Need for the Adjustment. Address the current need methodology. If the application is to increase beds or services in a planning area, give evidence that those beds or services have not been available and/or accessible to the population of the area.

(6) Current and Projected Utilization. Provide current and projected utilization of similar facilities or services within the proposed service area.

(7) If additional staffing will be required to support the additional need, indicate the availability of such staffing.

(8) Effect on Existing Facilities or Services. Address the impact this plan adjustment will have on other facilities in the area both in occupancy and manpower.

(9) Community Reaction. Give evidence of project support demonstrated by local community, civic and other organizations. (Testimony and/or comments regarding plan adjustment provided by community leaders, health care professionals, and other interested citizens.)

(10) Provide any other information or data available in justification of the plan adjustment request.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed October 18, 2004; Effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015. Amended: Filed February 6, 2018; Effective: March 23, 2018.
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410-2-5-.06 Open Meetings Act.

All meetings of the Statewide Health Coordinating Council (SHCC) shall be held in compliance with the provisions of the "Alabama Open Meetings Act" ("Act") ALA. CODE §§ 36-25A-1 through -11 (1975 as amended), which requires public notice of any gathering, whether or not prearranged, of a quorum of a governmental body, committee or subcommittee during which the members deliberate specific matters expected to come before the body, committee or subcommittee at a later date. To ensure compliance with the letter and spirit of the Act, entities seeking to sponsor inspection or educational sessions for multiple SHCC members relating, directly or indirectly, to a pending or contemplated plan adjustment or amendment must first file a written request for approval from the Chairman, with a copy of all other entities that have filed comments or pleadings relating to the matter. Such requests will only be granted in extraordinary circumstances, and will be publicized and conducted in accordance with the provisions of the Act relating to meetings involving a quorum of the SHCC.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(13), (15), Code of Alabama, 1975.
History: Filed September 9, 2010; Effective: October 14, 2010. Amended (SHP Year Only): Filed 2, 2014; Effective January 6, 2015.
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410-2-5-.07 Electronic Notice

SHPDA may provide any written notice required under these rules in electronic PDF format, which shall be considered delivered upon the date of transmission. All health care providers holding a certificate of need from SHPDA, as well as any other interested parties seeking to be included in SHPDA's general distribution list, shall maintain with the agency a current e-mail address for purposes of this rule.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed February 1, 2013; Effective March 8, 2013. Amended (SHP Year Only): Filed December 2, 2014; Effective January 6, 2015.
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