July 2008 – Updated 2011, 2016

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INTRODUCTION: Flex Program Rural Health Plan Revision:

The basic purpose of the Flex Program Rural Health Plan revision is to strategically plan how Flex funding will be used in future years. Initially, funding was used to assist hospitals converting to Critical Access Hospital (CAH) status but since the elimination of the necessary provider rule in January 2006, there have been very few conversions. Most of Alabama's Flex funding is used for quality improvement, Emergency Medical Services (EMS) and evaluation activities. All Flex activities focus on three major objectives:

- Enhance access to quality medical care delivered by rural hospitals
- Provide a mechanism to integrate health service delivery
- Assist in stabilizing financially troubled rural hospitals

A strong collaboration was established between the Office of Primary Care and Rural Health (OPCRH) and the Alabama Hospital Association (AlaHA) in jointly implementing the Flex program. This joint approach grew out of the AlaHa ad hoc committee of the Rural Hospital Constituency Section that originally studied the appropriateness of the Flex program. Today, this collaboration continues with AlaHa and the OPCRH managing the Flex program and the revision of the Rural Health Plan.

In 2008, the Flex Grant Oversight Committee was revised to include nine members representing Alabama rural hospitals, the Alabama Quality Assurance Foundation, the Alabama Family Practice Rural Health Board and EMS. The OPCRH and AlaHa also serve on this committee. This grant oversight committee is involved with revising the rural health plan.

As part of the State Rural Health Plan revision process, three focus groups were organized to provide information for the plan revision. Focus group participants were identified from Flex hospitals and communities. The focus group topics included EMS, quality, and critical access hospitals.

In addition, health status indicator reports were developed for every county in Alabama. Five reports focusing on the leading causes of mortality in rural Alabama which include heart disease, accidents, cancer, diabetes and cerebrovascular disease were also used to identify the critical health factors affecting rural Alabama. The health status indicator information can be found in Appendices A, B and C.

The revised rural health plan is comprised of three sections. The first section provides a comprehensive report on the health status indicators of Alabama citizens on a statewide, regional and community level. Data on access and availability of affordable quality health care including demographics on the aging primary care workforce and the aging Alabama populations will demonstrate the need for immediate, intermediate and long-term Flex objectives in the areas of EMS, Quality and CAH's. These issues combined with limited public transportation will be shown to create a serious heath access challenge in rural and underserved areas of Alabama. The second section contains an

overview of Flex program achievements in Alabama and an overview of the Flex rural health plan revision process including a description of the focus group consultations and the future Flex plan objectives. The third section provides an evaluation plan to measure the effectiveness of the Flex activities and their anticipated impact on the health status indicators described in section one.

In addition, the Flex Program Rural Health Plan includes valuable information on Critical Access Hospital (CAH) conversion, a process that began under the Balanced Budget Act of 1997. This act authorized states to establish State Medicare Rural Hospital Flexibility Programs (Flex Program), under which certain facilities may qualify to become CAHs. In order to be designated as a CAH in Alabama, a hospital must meet the following criteria:

1. Be located in a rural area or be treated as rural under a special provision that allows qualified hospitals in urban areas to be treated as rural for purposes of becoming a CAH; and
2. Provide no more than 25 inpatient beds. If participating in the Medicare Swing Bed Program, no more than 10 of these 25 beds may be occupied at any one time by swing bed patients; and
3. Have an average annual length of stay of 96 hours or less; and
4. Be located either more than 35 miles from the nearest hospital or CAH, or more than 15 miles in areas with mountainous terrain or only secondary roads; and
5. Meet all general acute care hospital standards as set forth by the Alabama Department of Public Health licensure rules.

More information, including CMS clarifications on distance, rurality, and primary roads, is available in Appendix D.

1

Section 1:

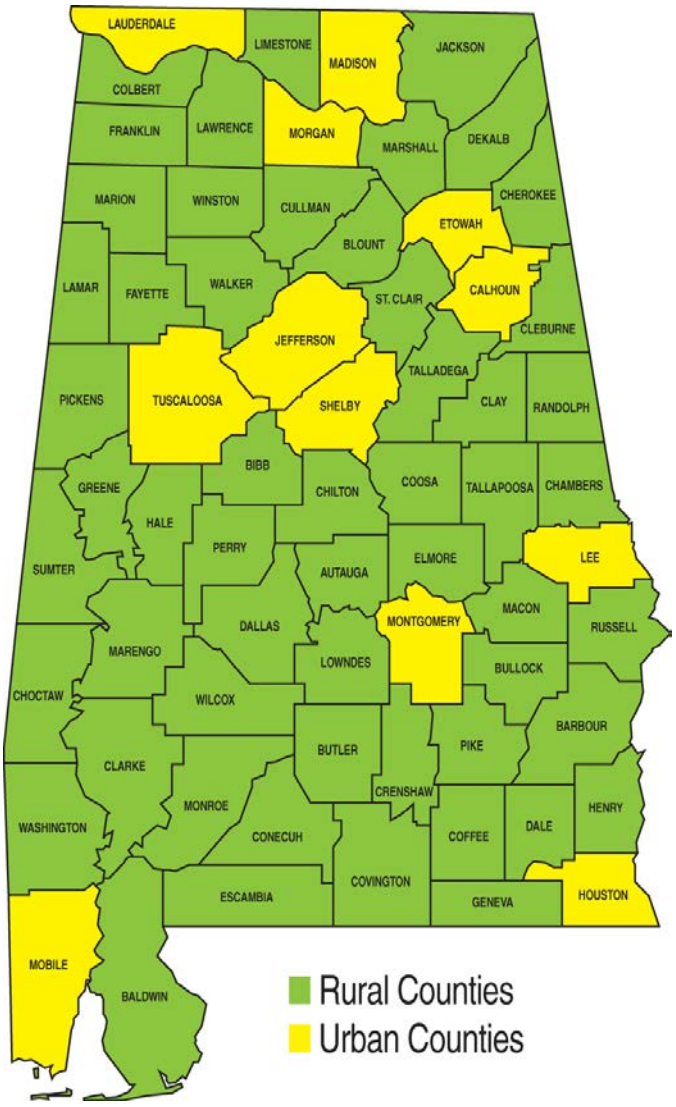
Health Status Indicators and Access/Availability Issues

In revising the Alabama Rural Health Plan, the Flex Grant Oversight Committee wanted to consider background information such as trends in rural demographics, restricted access to health care and health status of rural residents. In this section, we explore health status indicators and data on rural Alabama that impact the availability and accessibility of health care.

Health Status Indicators and Access/Availability Issues

Alabama's rural areas are of vital importance. Everyone benefits from the numerous resources, many of which must be classified as necessities, which are provided only from our rural areas and only by the residents who live and work in such areas. Knowing that our vital rural areas have adequate and quality healthcare locally available is an assurance that all Alabamians want. Our struggling small, rural hospitals must not only survive, but must become more stable financially.

Figure 1: Alabama's Rural and Urban Counties



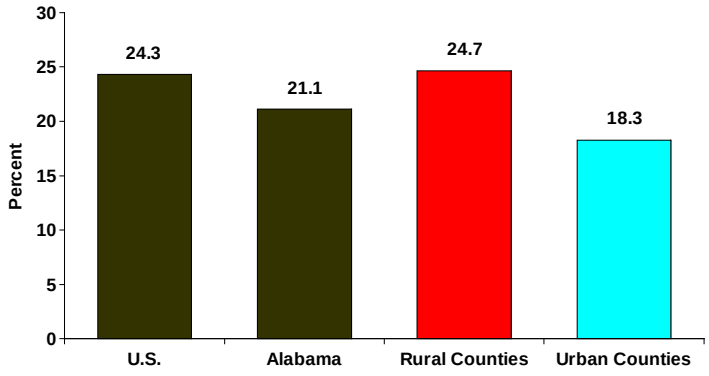
Rural hospitals are confronted with growing challenges that threaten financial stability and even survival. While there are major challenges such as the perception that larger medical centers provide a higher level of quality and inadequate or unstable emergency medical service that most rural hospitals must face, each hospital must also confront local issues. The Rural Hospital Flexibility Program emphasizes areas of service that are on target for positively intervening with most of these challenges. The limited funding that

is available through this program must be supported by other programs and initiatives to assure success. The following information attempts to shed more light on the current and future challenges that our rural hospitals must face.

Rural Areas are Experiencing Greater Population Growth

The Office of Primary Care and Rural Health in Alabama regards 55 of Alabama's 67 counties as being rural. These can be seen in Figure 1. Between 1910 and 2000, the rural counties experienced a meager 38 percent increase in population while the 12 urban counties increased by 246 percent. Twenty-six of the 55 rural counties actually lost population between 1910 and 2000 with five counties (Perry, Bullock, Wilcox, Lowndes, and Greene) losing nearly two-thirds of their population during that period. The two greatest reasons for this lack of population growth in Alabama's rural counties were the out migration of the African American population and the mechanization of agriculture.

Figure 2
Percent Population Change
Selected Areas, 2000-2025



SOURCE: Alabama State Data Center, The University of Alabama and the U.S. Census Bureau.

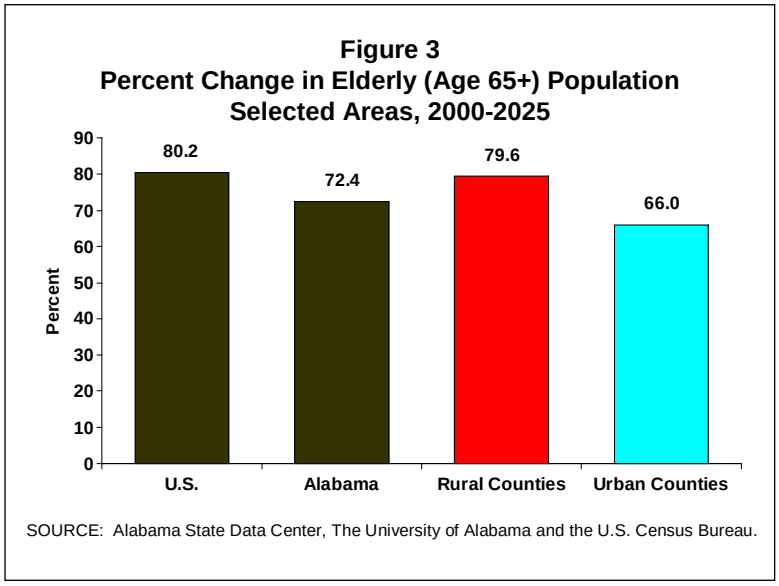
Starting around 1990 this trend has changed. Alabama's rural counties are now growing at a greater rate than the urban counties. This growth is greatest in the counties bordering major urban areas. Figure 2 presents projected population change between 2000 and 2025 showing the greater growth in rural counties. A second changing population trend is being seen within many counties where growth is greater in rural, unincorporated areas than is being seen within incorporated places.

These changing trends in Alabama's rural population are placing greater demands on many hospitals to serve a growing population and on an emergency medical system that may not be adequately staffed and/or trained. In many rural areas the first responder is almost certain to be volunteers.

Rural Areas Have an Older Population

According to the Alabama State Data Center's 2006 population estimates, the elderly (age 65 years or more) comprised 14.5 percent of Alabama's rural county population compared to only 12.5 percent in the urban counties. This difference is projected to become even greater. Between 2000 and 2025, the elderly population is projected to

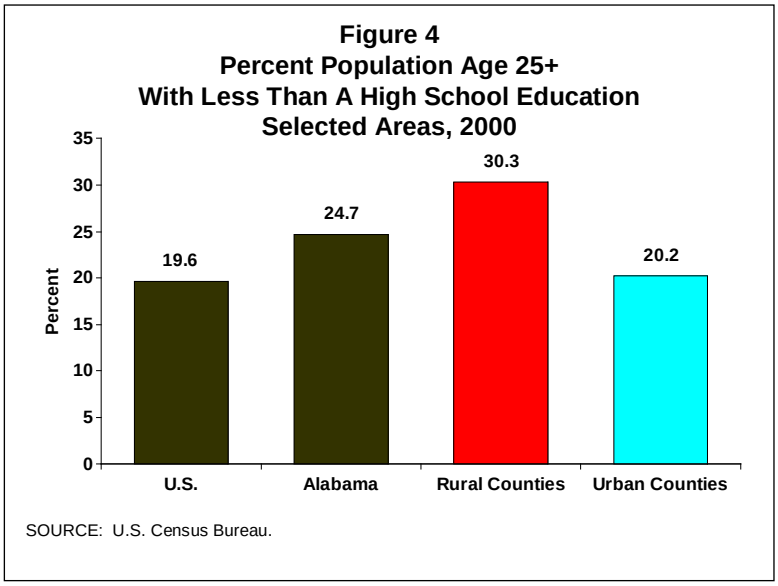
increase by 79.6 percent in Alabama's rural counties compared to a 66.0 percent increase in the urban counties. This can be seen in Figure 3.



This dramatic increase in the elderly population will seriously challenge Alabama's rural healthcare industry. It is estimated, using national data on visits to physician's offices from the National Ambulatory Medical Care Survey, that more than 904,000 additional annual office visits to primary care physicians will be needed in Alabama by 2025, primarily due to the aging population. This does not consider such trends as the obesity epidemic and the additional healthcare demands that this is certain to create.

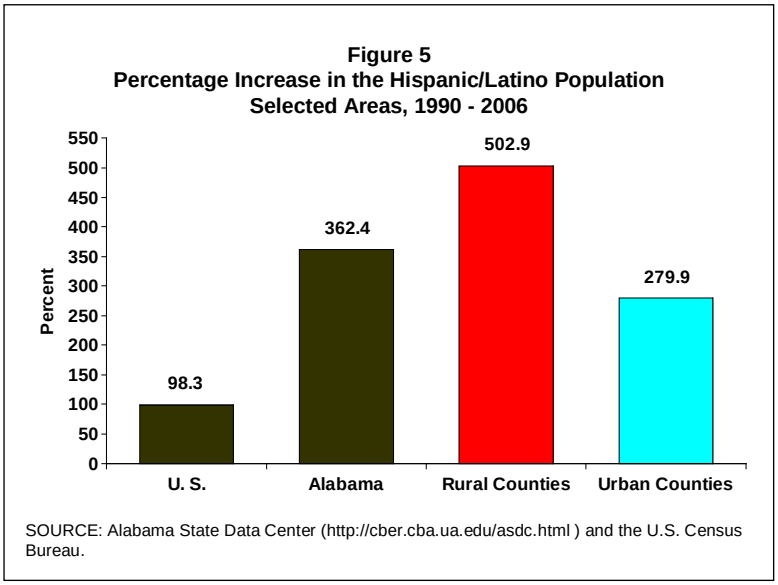
Alabama's Rural Population Has Less Formal Education

There is a strong relationship between educational attainment and health status. According to the 2000 Census of Population, nearly one-third (30.3%) of all rural Alabama residents aged 25 years or more had less than a high school education - far exceeding the 20.2 percent of urban residents in this age group with less than a high school education. This can be seen in Figure 4. A strong educational system producing well educated rural residents is vital to improving the long-term health status of Alabama's rural residents, reversing the economic struggles of rural Alabama, and to providing rural students with the educational opportunities that are needed for them to compete with their urban counterparts for opportunities such as admission to medical school.

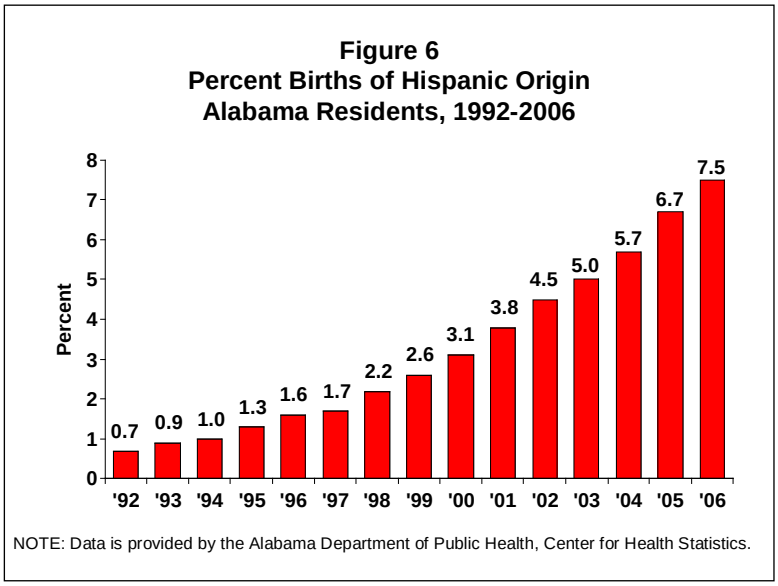


Alabama's Rural Population Reflects Greater Ethnic Diversity

Alabama's rural population has greater ethnic diversity primarily due to the relatively sudden increase in the Hispanic/Latino population. Alabama's Hispanic/Latino population increased by nearly 208 percent between the 1990 and 2000 Censuses, the seventh greatest increase among all 50 states. This tremendous growth is continuing.



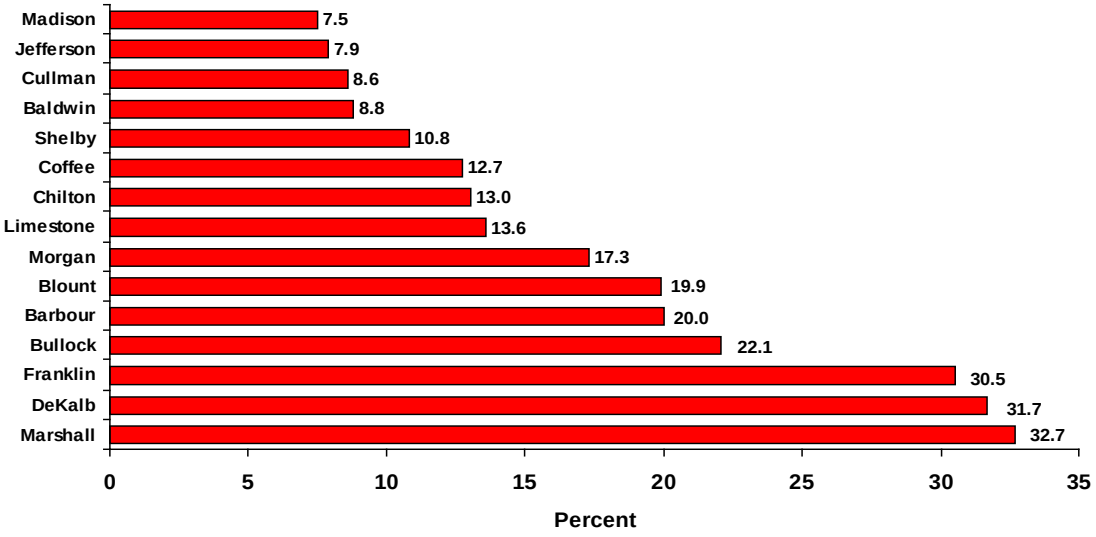
According to estimates developed by the Alabama State Data Center at the University of Alabama, rural Alabama's Hispanic/Latino population increased by 502.9 percent between 1990 and 2006, greatly exceeding the estimated 279.9 percent increase in urban counties and the 98.3 percent increase nationally. This can be seen in Figure 5. There is general agreement that estimates of the Hispanic/Latino population are likely to be understated.



This sudden increase in Alabama's Hispanic/Latino population has posed a challenge in counties where this growth has been the greatest. This is because of the presence of a language barrier in many instances which makes the services of an interpreter necessary. There is also a lack of knowledge about and experience with the cultural differences in providing healthcare to persons of Hispanic/Latino ethnicity. There have also been financial challenges in some areas where Alabama's new Hispanic/Latino population has a low rate of insurance. Rural Hospital Flexibility Program subcontract funding has been used to greatly assist in providing care for Hispanic/Latino Alabamians by securing training in medical Spanish for emergency department staff.

Another source which can be used to indicate the growth in Alabama's Hispanic/Latino population is data on births. This source is considered to be more complete since the benefits from reporting are much greater. All babies born within the United States are citizens of this country, regardless of the residence of the parents.

Figure 7
Percent Hispanic Births in Counties
Exceeding the State Percentage (7.5%), 2006



Source: Alabama Department of Public Health, Center for Health Statistics.

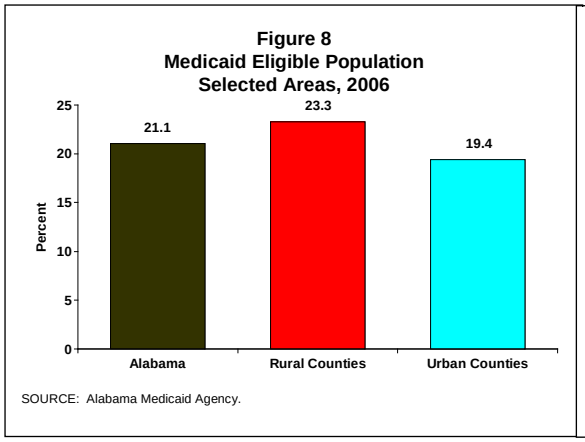
Figure 6 presents a graphical picture of the relatively sudden and tremendous growth of the Hispanic/Latino population in Alabama by looking at the percentage of all births to Alabama residents that is comprised by residents of Hispanic/Latino ethnicity. In 1992, only 0.7 percent of all births to Alabama residents were Hispanic/Latino. By 2006, this percentage steadily increased to 7.5 percent. Figure 7 presents these percentages by the mother's county of residence for 2006 births. Five Alabama counties had 20 percent or more of all births to county residents being of Hispanic/Latino ethnicity. All five of these counties are rural.

Alabama's Rural Population Is Not As Wealthy

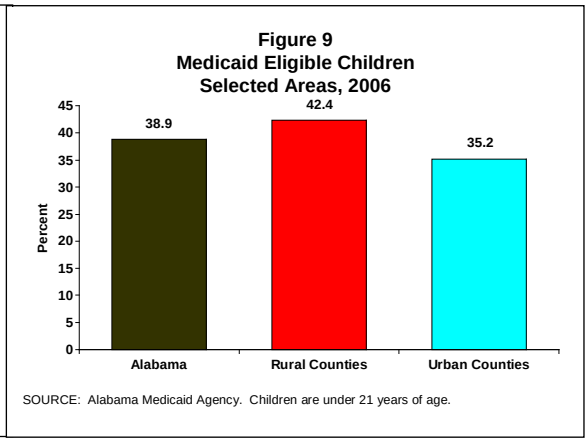
There is a strong relationship between personal wealth and health status. Medicaid has been referred to as "Rural Alabama's Health Insurance." There is a strong justification for this statement since 23.3 percent, or nearly one in every four rural residents, is eligible for Medicaid benefits. This compares to 19.4 percent for urban county residents. In addition, 42.4 percent of all rural children under age 21 are eligible for Medicaid benefits compared to 35.2 percent for urban children. Unfortunately, many rural Alabama

primary care physicians are electing not to provide service to Medicaid patients for various reasons. This greatly increases the importance of rural safety net providers. Figures 8 and 9 graphically describe rural Alabama's reliance on Medicaid for healthcare.

Per capita personal income is the income that is available to be spent for each person. According to 2007 per capita personal income figures recently released by the U. S. Bureau of Economic Analysis, the income per person for rural Alabama residents is $26,646 which is over 28 percent lower than the per capita income of $34,182 for urban

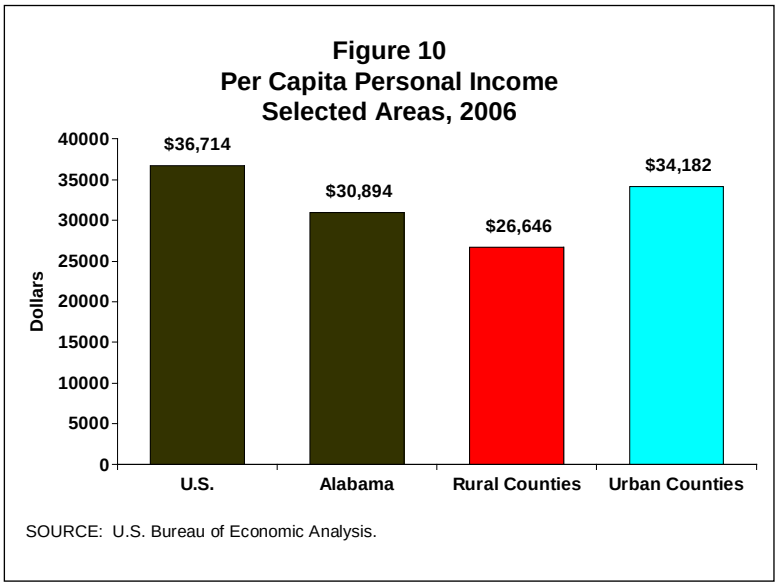


SOURCE: Alabama Medicaid Agency.



SOURCE: Alabama Medicaid Agency. Children are under 21 years of age.

residents and nearly 38 percent below the figure of $36,714 for the nation. The 31 Alabama counties with the lowest per capita income levels are all rural. Three rural Alabama counties (Wilcox, Bullock, and Macon) are among the 250 poorest counties in the nation. Figure 10 graphically describes the serious disparity in per capita personal income.



SOURCE: U.S. Bureau of Economic Analysis.

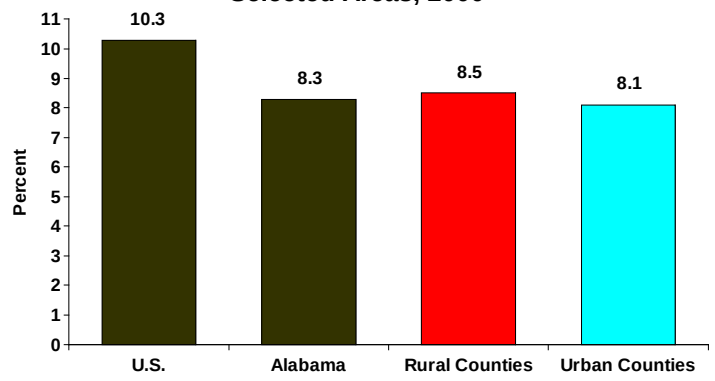
The great presence of poverty in Alabama's rural counties naturally results in more indigent care being provided by rural hospitals. This makes the attracting of patients with health insurance more important to these institutions. This can be accomplished only if these important potential patients are convinced that their local hospitals are providing quality care. Rural Hospital Flexibility Program subcontract funding is being used in many ways to enhance the visibility of rural hospitals and to convince and assure local residents that they do not need to bypass their local healthcare industry traveling to a larger urban medical center to receive high quality care.

The underlying issue that is adversely impacting on the wealth of rural residents is the lack of economic opportunity in many rural areas. This is further evidenced by the fact that unemployment is greater in rural areas (4.5 percent in rural counties versus 3.9 percent in urban counties in May 2008). Positive intervention aimed at enhancing economic opportunity in chronically depressed rural areas has been initiated by Governor' Bob Riley's Alabama Rural Action Commission and the Black Belt Action Commission and also by the Center for Rural Alabama in the Alabama Department of Agriculture. The goals of the Rural Hospital Flexibility Program are highly consistent with those of these important commissions and centers.

Alabama's Rural Population Has More Restricted Access to Health Care

A task force assembled by former Governor Jim Folsom, Jr. concluded that the greatest problem involving access to rural health care was transportation. The availability of public transportation varies greatly among Alabama's rural counties and even within counties. Transportation poses two different concerns for Alabama's rural Health care industry. First, there is a large portion of the rural population which does not have a reliable means for getting to health care providers. This is evidenced in Figure 11 where it can be seen that 8.5 percent of all households in Alabama's rural counties did not have a vehicle in 2000. An additional 30.3 percent of all rural households had only one vehicle which had to be used for going to work and other activities as well as being used for health care transportation.

Figure 11
Percentage Households With No Automobile
Selected Areas, 2000



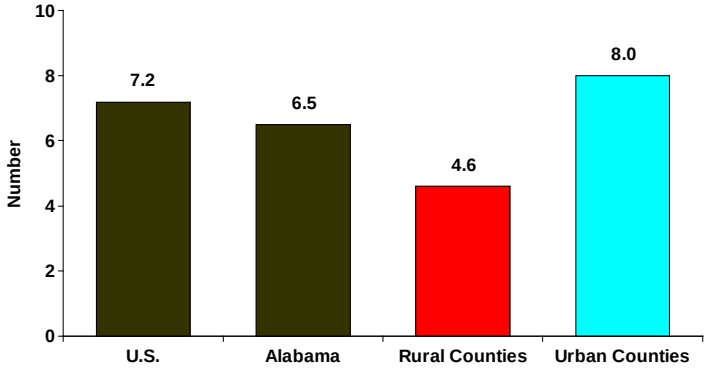
SOURCE: U.S. Bureau of the Census (www.census.gov).

Second, there is a portion of the rural population which has adequate transportation. This second group tends to include more persons with health insurance who are needed as paying consumers in the rural healthcare system. Unfortunately, many of these potential patients commute greater distances to seek health care from urban providers which they perceive as being of higher quality. Subcontract funding through the Rural Hospital Flexibility Program is being used in diverse ways to change this perception by improving the quality of care that is being received through rural hospitals and by enhancing the perception of the quality care that is locally available. Much remains to be done to establish a firm reputation of quality in smaller, rural hospitals and to dispel the long held thought that bigger is better.

While the lack of adequate transportation poses a serious concern for many rural residents, the lack of primary care practitioners and the aging of the current primary care physician workforce pose serious barriers to access for all rural residents. The Health Professional Shortage Area designation methodology developed by the U. S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) is the most widely recognized method for identifying primary care, dental, and mental health professional shortages. According to this methodology, 54 of Alabama's 55 rural counties are currently classified as having a shortage of primary care physicians providing service to either the entire population or the low-income population.

This methodology only measures what is considered to be the minimal level of service that is needed to serve a population rather than the level of service that is desirable. According to this methodology, Alabama currently needs an additional 132 strategically placed primary care physicians to eliminate all shortages. HRSA estimates that Alabama needs 474 strategically placed primary care physicians to provide a desirable level of service. Figure 12 presents a graphical picture of the lack of primary care physician service in rural counties. The 4.6 primary care physicians per 10,000 population in rural counties is just above one half of the 8.0 per 10,000 population in the urban counties.

Figure 12
Primary Care Physicians Per 10,000 Population
Selected Areas, 2006

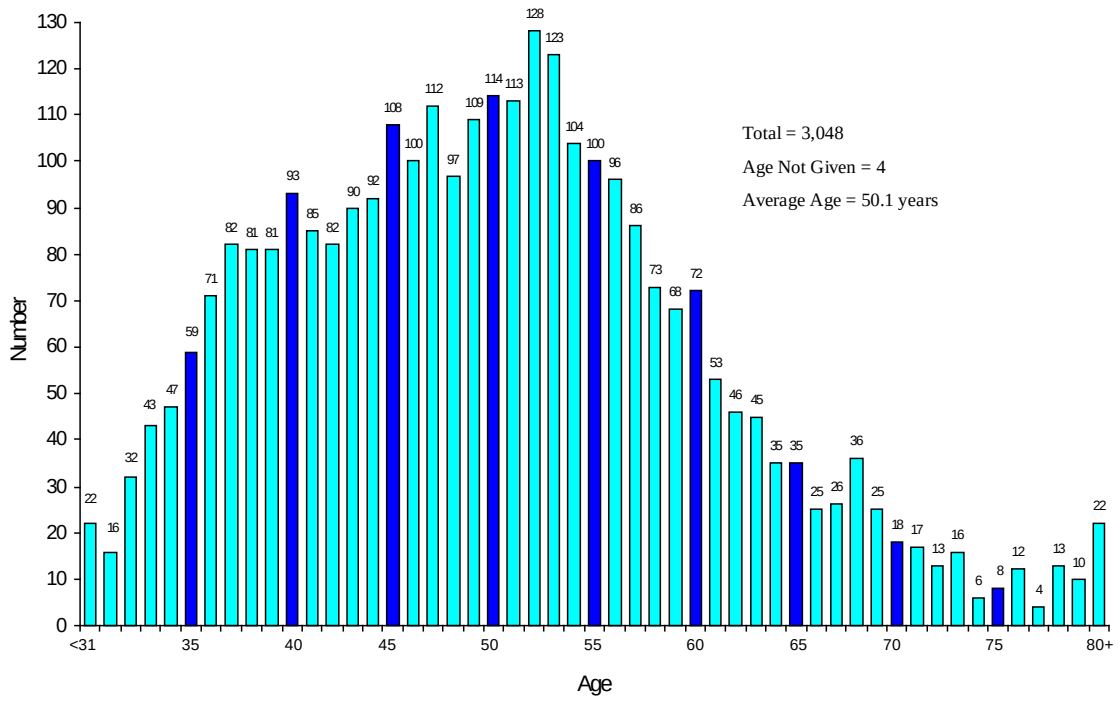


SOURCE: Medical Licensure Commission 2006 Licensed Physician Data Base and the U.S. Bureau of Labor Statistics.

As serious as these figures on the primary care physician shortage may appear, the shortage crisis is actually more serious. These figures do not include such concerns as the aging of the primary care physician workforce, the decreasing trend for medical students to elect rural primary care practice, the aging of Alabama's population and the increasing need for primary care that this will bring, and the dramatic increase in such population characteristics as obesity that is certain to create greater demands for primary care service.

Figure 13 presents an alarming graphical picture of Alabama's actively practicing primary care physician workforce of 3,048 in 2006. By 2011, more than one-half of these physicians will be over 55 years of age. Many current medical school graduates are indicating that they plan to retire at ages younger than 55. The smaller numbers of physicians in the younger age groups reflect the decrease in the number of medical school graduates who are electing primary care for their practice.

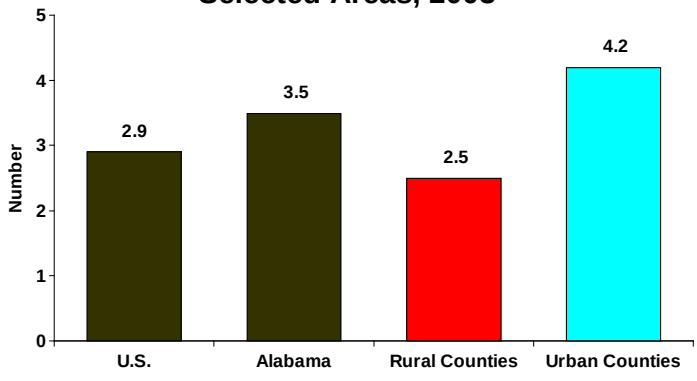
Figure 13
Primary Care Physicians Actively Practicing
In Alabama By Age, 2006



Source: Alabama Medical Licensure Commission Licensed Physician Data Base.

At the same time, Alabama's population is getting older and more vulnerable to chronic disease. As was pointed out earlier, it is estimated, using national data on visits to physician's offices from the National Ambulatory Medical Care Survey, that more than 904,000 additional office visits to primary care physicians will be needed in Alabama by 2025. According to the Centers for Disease Control and Prevention's 2007 Behavioral Risk Factor Surveillance System, 30.9 percent of all Alabamians are obese, not simply overweight. This is the second highest percentage among all 50 states and this percentage is increasing each year. This and other unhealthy characteristics are certain to require additional primary care physician services.

Figure 14
Dentists Per 10,000 Population
Selected Areas, 2003

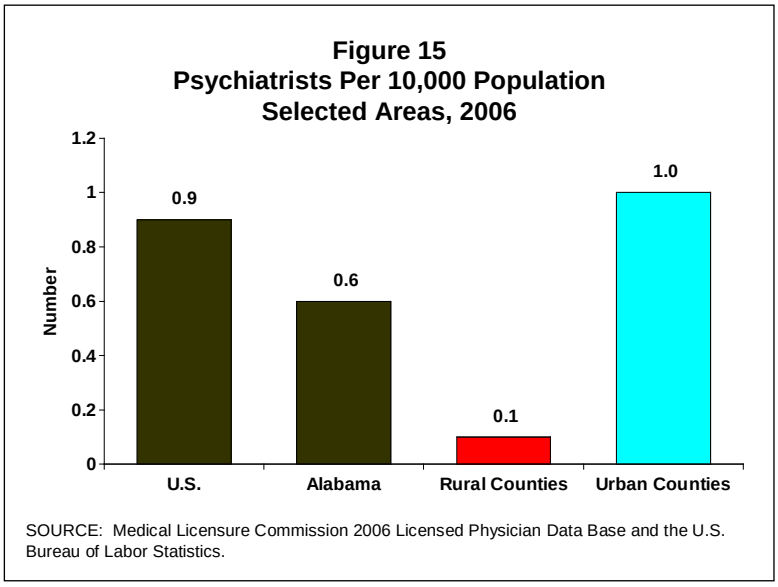


SOURCE: Board of Dental Examiners, 2003 Licensed Dentist Data Base and the U.S. Bureau of Labor Statistics.

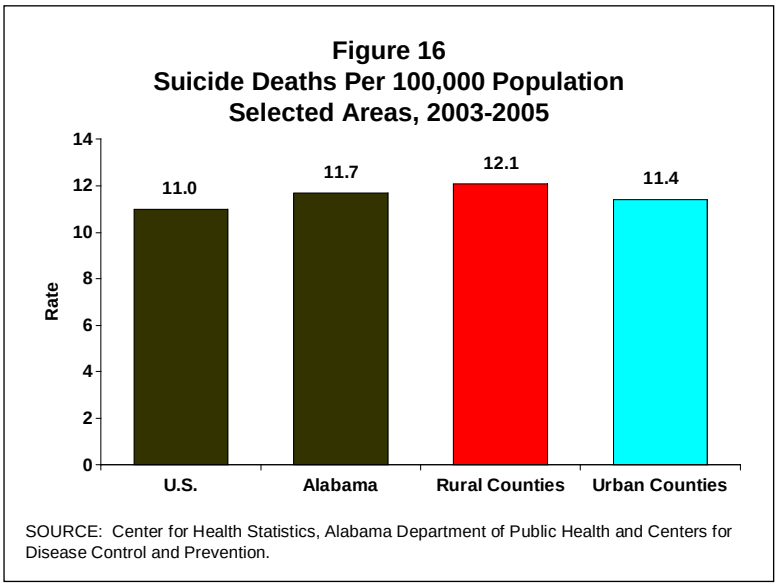
Alabama has several innovative programs for positively intervening in this shortage crisis. Programs such as the Rural Medical Scholars Program at the University of Alabama, the Rural Medicine Program at

Auburn University, rural medical programs at the University of South Alabama College of Medicine, and the Alabama Medical Education Consortium have created national interest.

The shortage of actively practicing dentists is even more critical in rural Alabama. HRSA estimates that Alabama currently needs an additional 294 strategically placed dentists to eliminate all shortages. Alabama's only dental school admits only 55 students each year. By 2011, with the aging of Alabama's dental workforce, it is expected that more than 55 dentists will be retiring from practice each year. Rural Alabama is in danger of having several counties with no dentist. Dental care for the low-income population is far from a certainty. Figure 14 presents rates for dentists per 10,000 population. This does not reflect the ages of Alabama's dental workforce, the amount of time each dentist works, or the service to Alabama's low-income population.



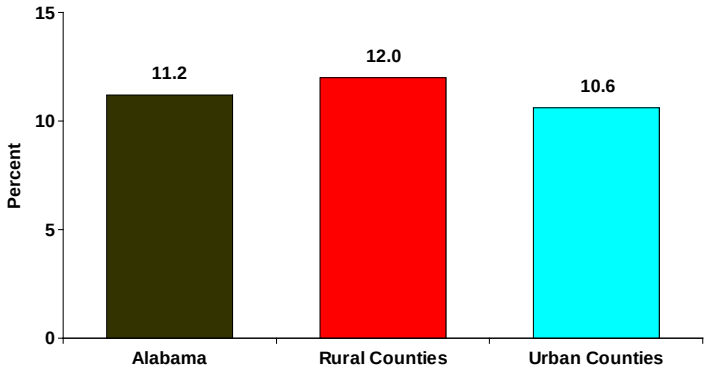
Perhaps no practitioner shortage is greater than that for mental health care professionals. Professional counselors and psychologists are not allowed to write prescriptions under Alabama law. Only psychiatrists have this privilege. Most rural Alabama counties only have the services of a visiting psychiatrist for a few hours per week at the local outpatient mental health center. Many rural hospital emergency rooms do not have staffing that is adequately trained in handling drug abuse cases or suicidal cases. Flex subcontract funds have been used in temporarily providing this highly specialized care and have been considered responsible for actually saving lives. Figure



15 presents a graphical description of the number of actively practicing psychiatrists per 10,000 population. Figure 16 presents a graphical picture of the higher suicide mortality rate among rural Alabamians. Suicide may be the most profound action indicating a vital need for expanded mental health service.

Having adequate and quality healthcare available does little good for those who are uninsured. In addition to the nearly one-quarter of all rural Alabamians who only have Medicaid coverage, it is estimated that 12.0 percent of all rural residents have no health insurance at all. This compares unfavorably to the estimate of 10.6 percent uninsured in Alabama's urban counties as can be seen in Figure 17. The lack of health insurance not only impacts on those without such coverage, but this greatly increased the amount of indigent care that Alabama's rural hospitals must serve.

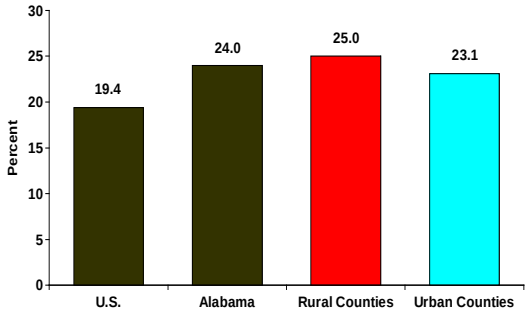
Figure 17
Percent Uninsured Population
Selected Areas, 2003



SOURCE: Alabama County Chartbook, State Health Access Data Assistance Center, University of Minnesota, July 2005.

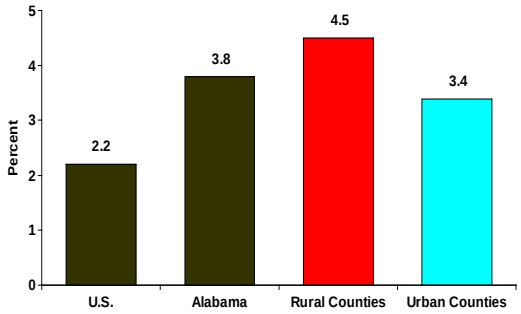
The greater prevalence of disability among rural residents creates another access to primary care barrier. According to 2000 Census data, 25.0 percent of all rural Alabamians aged 65 years or more had a disability that prevented them from going outside of their residence. This compares to 23.1 percent in Alabama's urban counties and 19.4 percent nationally. This can be seen in Figure 18. This greater presence of disability among rural residents is also supported by 2006 Medicare disability data indicating that 4.5 percent of all rural Alabama residents were receiving Medicare

Figure 18
Population Age 65 or More With A Home-Bound Disability
Selected Areas, 2000



SOURCE: U.S. Census Bureau.

Figure 19
Population Receiving Medicare Disability Benefits
Selected Areas, July 2006



SOURCE: Centers for Medicare and Medicaid Services.

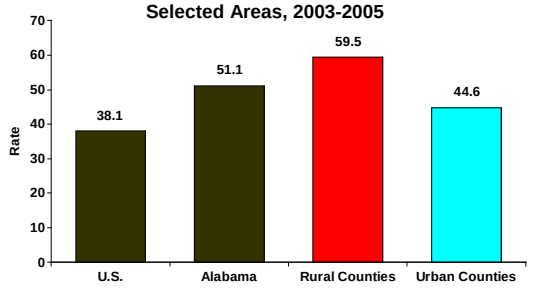
disability compared to 3.4 percent for urban residents and only 2.2 percent nationally. This can be seen in Figure 19.

Adequate Emergency Medical Services Are Not a Certainty in All Rural Areas

Some of Alabama's rural counties have well staffed, well trained, and adequately funded emergency medical services. Residents of many, if not most, rural counties are not so fortunate. This is not simply a local need. With so many people traveling distances for work or other reasons, the need for having adequate and quality health care, including emergency medical services, available in all counties is imperative. Even residents of the most urban counties may find themselves in need of such service while away from home. The presence of adequate and quality health care, including emergency medical services, is of extreme importance in attracting economic development.

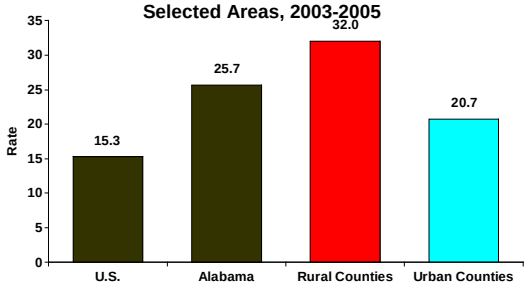
Unfortunately, Alabama does not currently have an ambulance run data base with mandatory reporting requirements. Thus, comparisons of such data between areas may not be accurate. However, to a great extent, accidental mortality data can be used in studying the adequacy of emergency medical services, especially mortality due to motor vehicle accidents. While there are several reasons for and contributors to accidental

Figure 20
Accidental Deaths
Per 100,000 Population
Selected Areas, 2003-2005



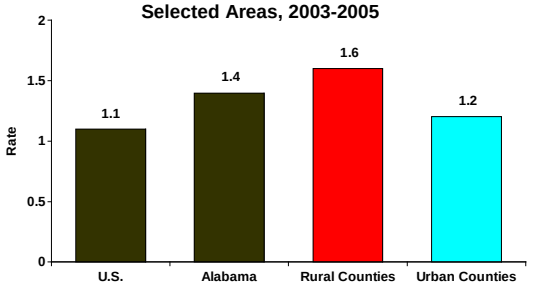
SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

Figure 21
Motor Vehicle Accident Deaths
Per 100,000 Population
Selected Areas, 2003-2005



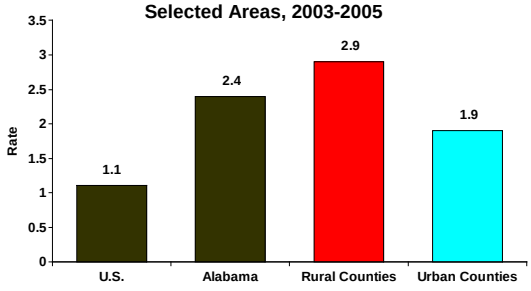
SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

Figure 22
Drowning and Submersion Deaths
Per 100,000 Population
Selected Areas, 2003-2005



SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

Figure 23
Deaths From Exposure to Smoke, Fire, and Flames
Per 100,000 Population
Selected Areas, 2003-2005



SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

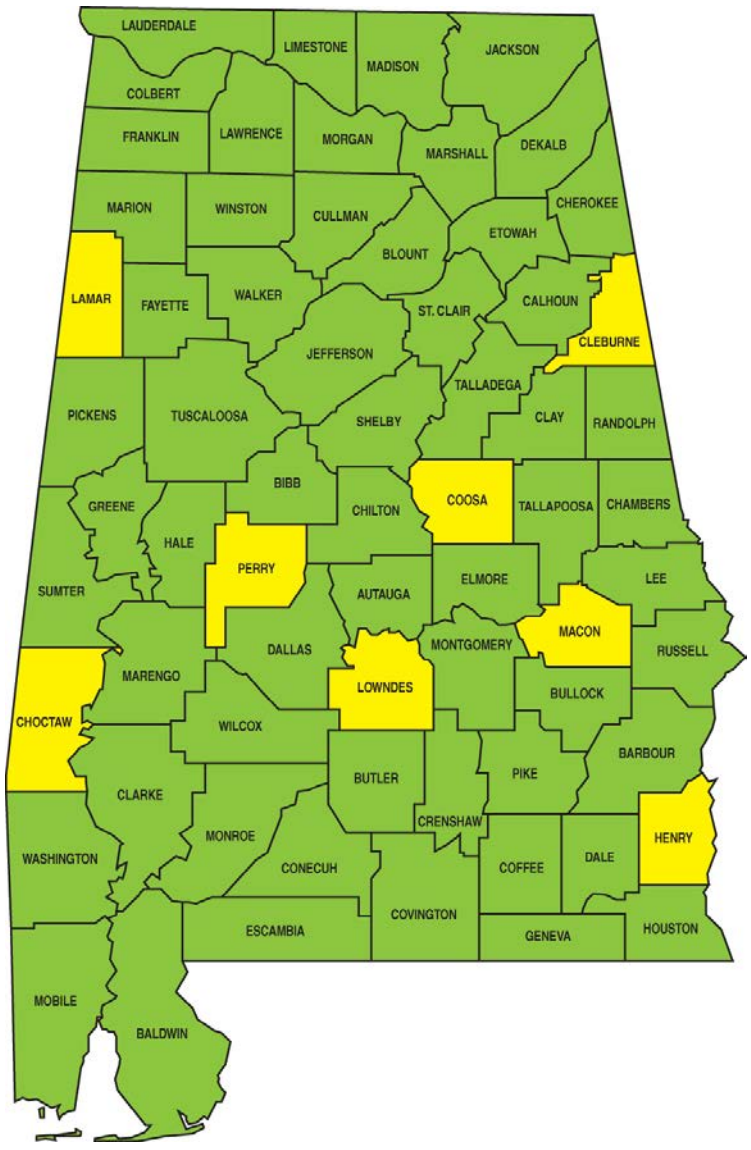
mortality, the ability of local emergency medical service to respond quickly in arriving at the accident scene, stabilizing conditions, and transporting the victim to qualified

emergency care is of critical importance. It has been long realized that the sooner within the "Golden Hour" following an accident that the victim can get to adequate emergency care, the greater the likelihood of survival.

Figures 20-23 present mortality rates from all accidents; motor vehicle accidents; drowning and submersion; and exposure to smoke, fire, and flames. The mortality rate from motor vehicle accidents for Alabama's rural residents of 32.0 deaths per 100,000 persons well exceeds the urban rate of 20.7 and is more than double the national rate of 15.3.

Disturbingly similar rates are seen for drowning and submersion deaths and mortality due to the exposure to smoke, fire, and flames. While well staffed, well trained, and adequately funded emergency medical service would certainly be expected to positively impact on death rates for these two types of accidents, better education and preparedness may provide a greater impact.

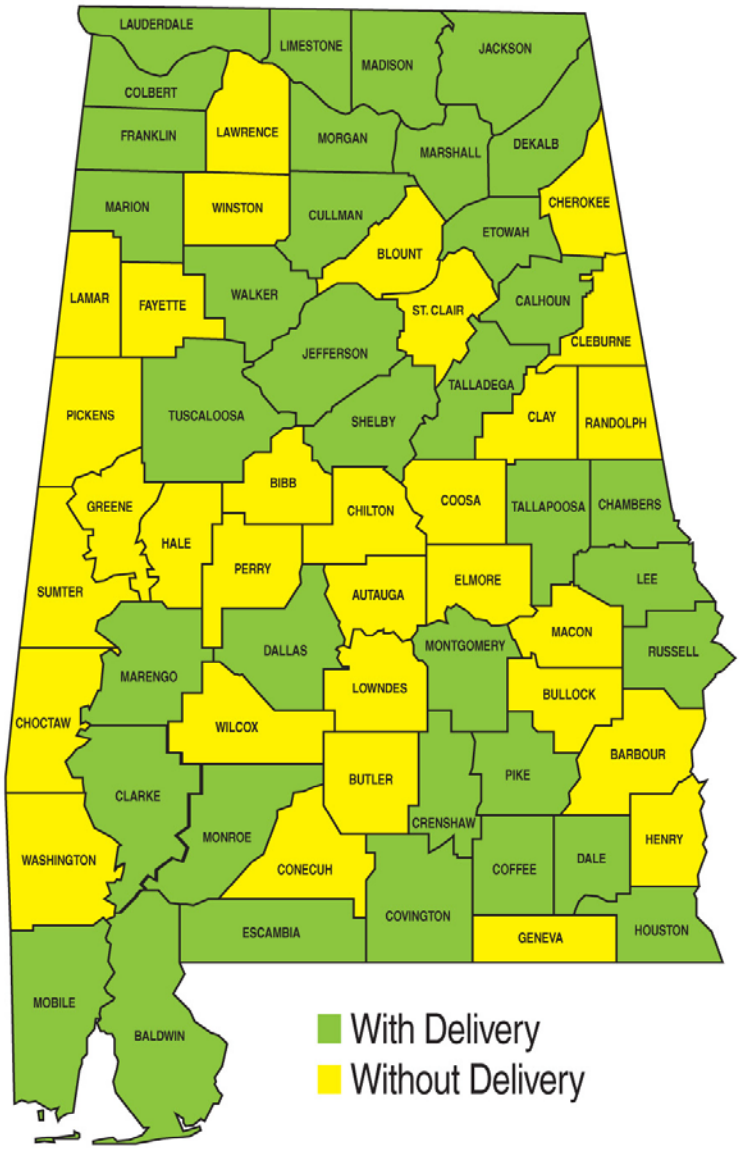
Figure 24: Alabama's Counties Without Hospitals (Yellow), July 2008



The final barrier to access that is noted in this particular report is the fact that eight of Alabama's 55 rural counties do not have hospitals. These are identified in Figure 24. This means that residents of these counties may have to travel farther distances for hospital or emergency service. Communities in counties without hospitals also tend to have greater difficulty in attracting primary care physicians to practice locally since physicians tend to locate closer to hospitals.

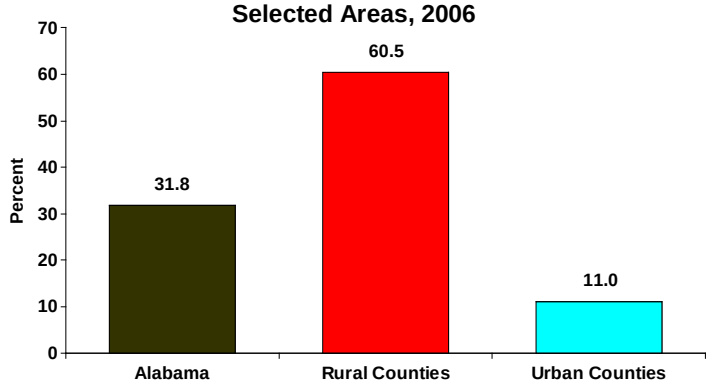
Pregnancies for Rural Women are of Higher Risk Than Those to Urban Women

Figure 25: Alabama's Counties With and Without Obstetrical Service, July 2008



The presence of obstetrical service must be considered a luxury in Alabama's rural counties. In 1980, 46 of Alabama's 55 rural counties had hospitals that delivered babies.

Figure 26
Percent of Births Occurring Outside Mother's County of Residence
Selected Areas, 2006



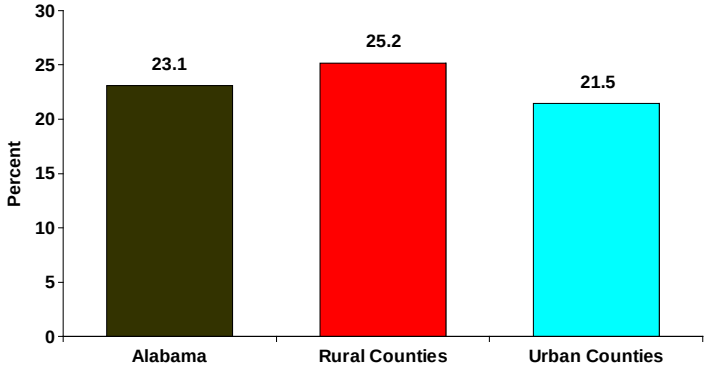
SOURCE: Center for Health Statistics, Alabama Department of Public Health.

This number has steadily declined to where only 24 of the 55 rural counties have hospitals that deliver babies today. These counties can be identified in Figure 25.

Because of the dramatic decrease in the availability of obstetrical service, 60.5 percent of all babies born to mothers who are rural county residents are born outside of the mother's county of residence. This compares to only 11.0 percent for mothers who are urban county residents. This is seen in Figure 26.

Unfortunately, the void of obstetrical service in so many of Alabama's rural counties contributes in creating a challenge for rural residents to receive adequate prenatal care during their pregnancies. There is a recognized relationship between the presence of a hospital providing obstetrical service and the receiving of adequate prenatal care by local women. This trend is evident in Figure 27 which graphically shows that over one quarter (25.2 percent) of all births to rural resident women in 2006 involved pregnancies where the mother received less than adequate prenatal care during her pregnancy. This compares to 21.5 percent for urban resident women.

Figure 27
Percent of Births With Less Than Adequate Prenatal Care
Selected Areas, 2006

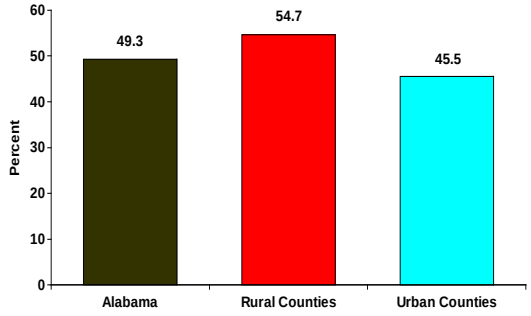


SOURCE: Center for Health Statistics, Alabama Department of Public Health.

The lower prevalence of adequate prenatal care and the difficulty in receiving obstetrical service are not the only birth related factors threatening the health status of rural Alabama's mothers and babies. Other selected demographic characteristics such as poverty and lower formal education and risk factors such as births to teenagers and tobacco use during pregnancy are threatening the short and long term health status of rural Alabama's mothers and babies.

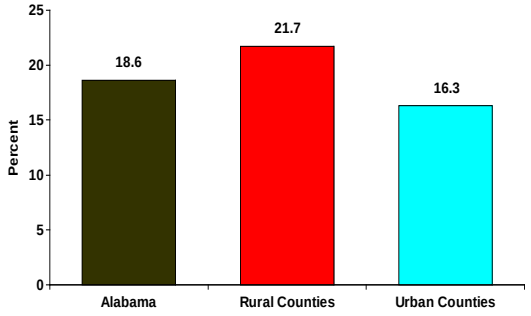
Figures 28-31 present graphical descriptions of this elevated risk. It was noted earlier that nearly one quarter of all rural Alabama residents are eligible for Medicaid coverage. This reliance upon Medicaid is even greater for births. As can be seen in Figure 28, 54.7 percent of all births to rural residents were paid for by Medicaid compared to 45.5 percent for urban residents. Nearly one in every five births to rural resident women (21.7 percent) involves a woman who is undereducated compared to 16.3 percent for urban resident women as is seen in Figure 29. Undereducated describes women who had more than two years of education less than would be normal for her age. Figure 30 reveals that 15.2 percent of all births to rural Alabama residents are to a teenage (under 20 years) woman compared to 12.8 percent for urban residents and only 10.3 percent nationally. Figure 31 reveals that 11.8 percent of all births to rural Alabama residents involved women who used tobacco during their pregnancy compared to only 9.6 percent for urban residents and 10.2 percent nationally.

Figure 28
Percent of Births Paid For by Medicaid
Selected Areas, 2006



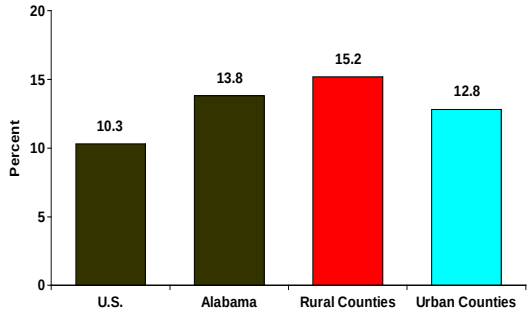
SOURCE: Center for Health Statistics, Alabama Department of Public Health.

Figure 29
Percent of Births to Undereducated Women
Selected Areas, 2006



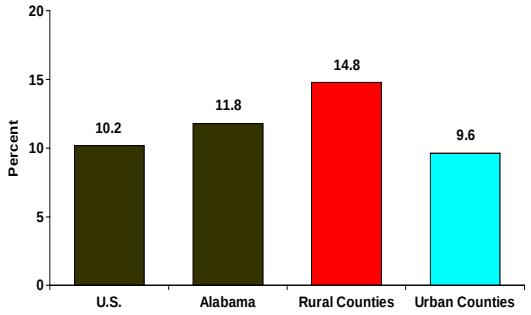
SOURCE: Center for Health Statistics, Alabama Department of Public Health.

Figure 30
Percent of Births to Teenagers (Under 20 Years)
Selected Areas, 2006



SOURCE: Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics.

Figure 31
Percent of Births Where Mother Used Tobacco
Selected Areas, 2006

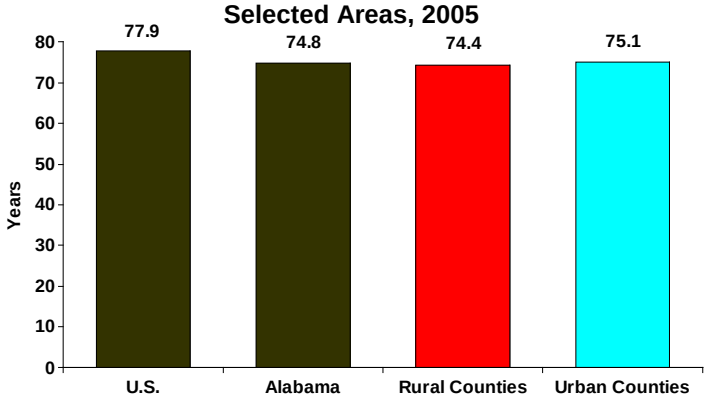


SOURCE: Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics.

General Health Status of Alabama's Rural Residents Compares Unfavorably to Urban Residents

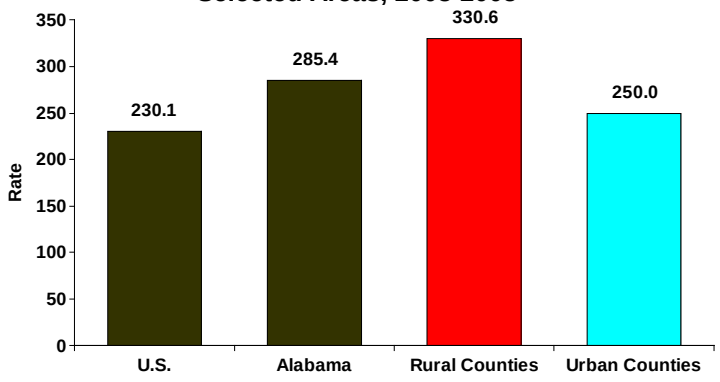
One of the most widely recognized indicators of health status, life expectancy, clearly shows the disparity between the overall health status of rural Alabamians compared to their urban counterparts. A rural resident born today is expected to have a lifetime that is more than one half of a year shorter than an urban resident born today – 74.4 years compared to 75.1 years. The disparity is even greater when compared to national life expectancy. Nationally, a person born today is expected to live 3.5 years longer than a rural Alabamian. These disparities can be seen in Figure 32.

Figure 32
Life Expectancy at Birth
Selected Areas, 2005



SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

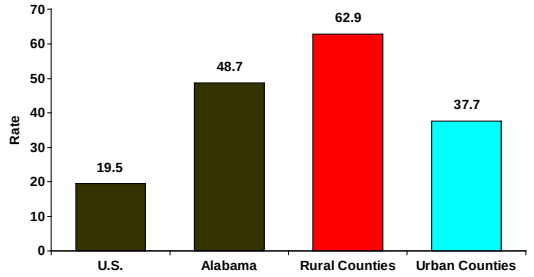
Figure 33
Heart Diseases Deaths Per 100,000 Population
Selected Areas, 2003-2005



SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

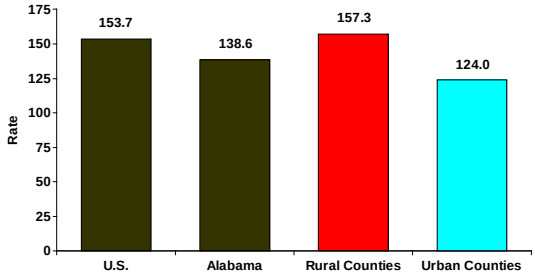
The reasons for life expectancy disparity between Alabama's rural and urban residents are quite diverse, including the factors already noted along with many other contributing factors. An analysis of the causes of death among rural Alabamians clearly reveals the diversity of environmental, behavioral, and other differences. Higher mortality rates from suicide and accidents (especially motor vehicle accidents, drowning, and fires) have already been described. In addition, mortality or death rates for heart diseases, Alabama's leading cause of death since 1924, are significantly higher among rural residents. During 2003-2005, Alabama's rural residents experienced a mortality rate of 330.6 deaths per 100,000 persons each year compared to only 250.0 for urban residents and 230.1 for the nation. The rural-urban disparity was greatest for heart failure and ischemic heart disease, two large components of heart diseases. These disparities can be seen in Figures 33-35.

Figure 34
Heart Failure Deaths Per 100,000 Population
Selected Areas, 2003-2005



SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

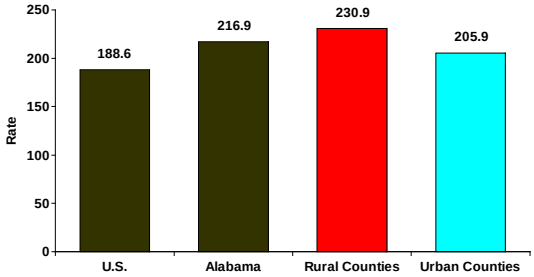
Figure 35
Ischemic Heart Disease Deaths Per 100,000 Population
Selected Areas, 2003-2005



SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

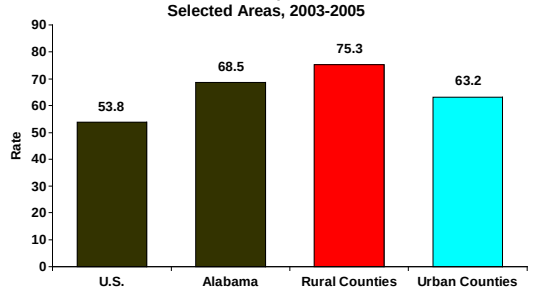
Cancer mortality is also greater among rural Alabamians. During 2003-2005, the mortality rate for deaths due to cancer was 230.9 deaths per 100,000 persons each year for Alabama's rural residents compared to 205.9 for urban county residents and 188.6 for the nation. This can be seen in Figure 36. This rural-urban disparity in mortality was also seen for cancer of the trachea, bronchus and lung where the rural mortality rate was 75.3 compared to 63.2 for urban residents and 53.8 for the nation. This can be seen in Figure 37. Other cancer sites with mortality rates higher among rural Alabama residents include the following: colon, rectum, and anus; breast; cervix uteri; ovary; prostate; and meninges, brain, and other parts of the central nervous system.

Figure 36
Cancer Deaths Per 100,000 Population
Selected Areas, 2003-2005



SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

Figure 37
Cancer of the Trachea, Bronchus, and Lung Deaths Per 100,000 Population
Selected Areas, 2003-2005



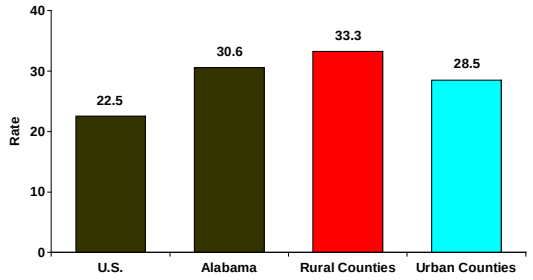
SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

Other major causes of death for which the rural-urban disparity is greater include Alzheimer's disease, cerebrovascular diseases (stroke), chronic lower respiratory diseases, diabetes, pneumonia, and septicemia (blood poisoning). Figures 38-43 graphically present descriptions of these disparities.

The risk factors for these conditions and others previously noted clearly indicate a greater need for health education, behavioral modification, and quality health care. Obesity is emerging as a major healthcare behavioral crisis in all of Alabama including rural areas. It was estimated in 2003 that 23.5 percent of all rural Alabama residents are obese – not simply overweight. According to the 2007 Behavioral Risk Factor Surveillance System,

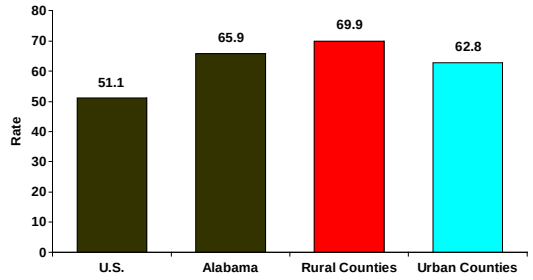
30.9 percent of all Alabamians were obese. This was the second highest percentage among all states.

Figure 38
Alzheimer's Disease Deaths Per 100,000 Population
Selected Areas, 2003-2005



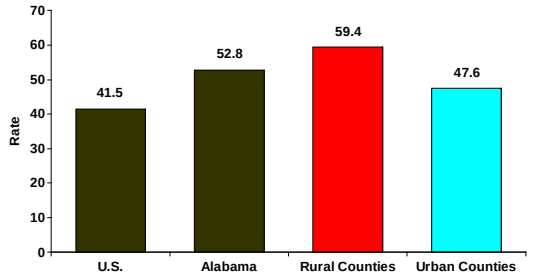
SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

Figure 39
Cerebrovascular Diseases (Stroke) Deaths Per 100,000 Population
Selected Areas, 2003-2005



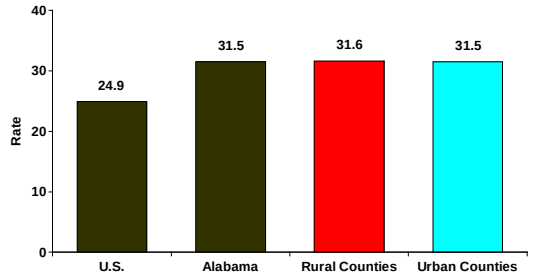
SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

Figure 40
Chronic Lower Respiratory Disease Deaths Per 100,000 Population
Selected Areas, 2003-2005



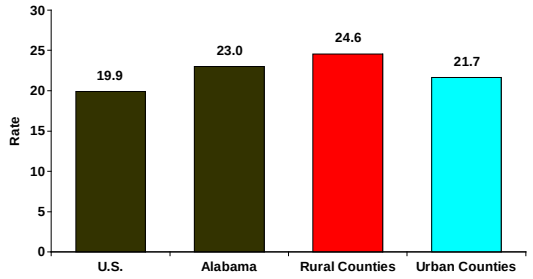
SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

Figure 41
Diabetes Mellitus Deaths Per 100,000 Population
Selected Areas, 2003-2005



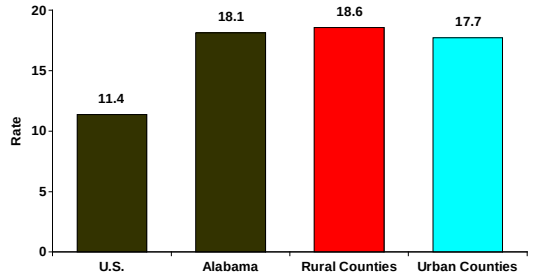
SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

Figure 42
Pneumonia Deaths Per 100,000 Population
Selected Areas, 2003-2005



SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

Figure 43
Septicemia (Blood Poisoning) Deaths Per 100,000 Population
Selected Areas, 2003-2005



SOURCE: Center for Health Statistics, Alabama Department of Public Health and Centers for Disease Control and Prevention.

This brief presentation of more prominent health status indicators and access/availability issues that are challenging Alabama's rural hospitals is far from being all-inclusive. At its very basis, the Rural Hospital Flexibility Program seeks to assure the survival of rural hospitals and improve the health status of rural residents. There is no quick and easy fix to this crisis. This will require a long and difficult struggle. It is a struggle for which

failure holds such destructive promises that failure cannot be considered as an option. FLEX funding, though small, has already been used to positively intervene, accomplishing many improvements and prompting innovations that rural hospitals would not have otherwise been financially able to consider. Alabama's rural healthcare system is stronger and providing additional and higher quality service because of participation in this program.

2

SECTION 2:

Flex Plans

Flex Plans

Section 2 of the Revised Rural Health Plan focuses on an overview of the Flex program achievements and discussion of the future Flex initiatives identified in the focus group consultations. Three focus groups were conducted concentrating on EMS Issues, Quality Initiatives and Critical Access Hospitals. The resulting needs identified from the focus groups were used by the Flex oversight committee to plan for Alabama's future Flex funding activities over the next three years. The future Flex objectives were prioritized in immediate (one year), intermediate (two years) and long-term (three years) time frames. Each future Flex objective also has a corresponding measure and outcome defined. The Flex oversight committee felt this format would enhance the development of the evaluation process described in Section 3 of the Revised Rural Health Plan. The future objectives, measures and outcomes for each time frame reflect activities for a total of 28 hospitals including three Alabama Critical Access Hospitals (CAHs) and twenty-five rural Alabama hospitals that meet the 2008 Medicare Rural Hospital Flexibility Program requirements. A fourth critical access hospital participated in the focus group but has converted back to general acute care hospital status due to greater financial returns under the PPS payment schedule.

In addition, the CAH hospital focus group identified immediate, intermediate and long-term objectives, measures and outcomes to strengthen their networking relationships. This objective applies to the critical access hospitals and their effort to develop a rural network designation with other full service hospitals. Although many of the network activities they identified are also applicable to non-CAH facilities as well.

Overview of Flex Program Achievements in Alabama During 2007-2008

During 2007-2008, the 29 Flex hospitals in Alabama allocated their Flex funds for training in the areas of EMS and quality improvement.

- The Alabama Quality Assurance Foundation (AQAF), the State Quality Improvement Organization, conducted a train-the-trainer program on root cause analysis for twenty-nine small rural hospitals.
- Twenty-five hospitals improved quality of clinical care delivery, operational performance of facilities, and health status of their communities by training their personnel on patient safety, management improvement, health promotion and accessing scarce health care services.
- Two Critical Access Hospitals (CAHs) have had personnel trained on and used the Rural Performance Measurement (RPM) web-based quality tracking and improvement system.
- Emergency Medical Services (EMS) training was provided to Emergency Department staff and first responders for 29 small, rural hospitals.

In addition to the training programs, other Flex program achievements include:

- One Flex hospital has been approved for a financial review to determine the feasibility of converting to CAH status.
- One of the Flex Grant Oversight Committee members provided rural representation to the State Trauma System regional and state advisory council.
- A consultant was engaged to evaluate the Flex program and the funding over the last three years.

Focus Groups

In an effort to update Alabama's Flex Program Rural Health Plan a series of focus groups were organized around the following Flex program goals:

1. Improvement and Integration of EMS services
2. Performance Improvement/Quality Improvement
3. Support and Networking of existing CAHs and designation of additional CAHs

The Alabama Hospital Association and the Office of Primary Care and Rural Health jointly sponsored these focus groups to help identify and plan the use of future Flex funding.

A list of focus group questions was developed by the AlaHA and the OPCRH. These questions were reviewed by the Flex oversight committee. The EMS, Quality Improvement and CAH focus groups included questions on best practices, networking, partnership opportunities and future Flex funding activities.

1. EMS Focus Groups

The EMS focus group included nine participants representing rural hospital directors of professional services, clinical and commercial services, and education; AlaHA; the regional director of West Alabama EMS; and the Deputy Director of EMS at the Alabama Department of Public Health.

The EMS focus group discussion focused on:

- Ways to integrate EMS with other services
- Opportunities to co-train EMS and hospital personnel
- Improve consistency in disaster training efforts across regions and state
- Educate EMS providers on behavioral health patient transport
- Communication issues between pre-hospital (EMS) and in-hospital (ER) under new trauma communication system
- Critical medication training for EMS personnel

EMS Needs and Initiatives Identified

1. Hospital and EMS personnel co-training opportunities focusing on Life Support Training and Certification including:

    Advanced Cardiac Life Support (ACLS)
    Pediatric Advanced Life Support (PALS)
    Basic Trauma Life Support (BTLS)
    Neonatal Advanced Life Support (NALS)

These trainings could be offered in the community to EMS and hospital personnel. Joint training opportunities at the community level would also enhance cooperation between hospital and EMS personnel.

2. Crisis consultations in Emergency Departments by behavioral health consultants. An in-depth discussion regarding interfacility transport of psychiatric and elderly/Alzheimer patients occurred during the focus group session. Both the EMS and hospital representatives agreed that educational sessions should be directed at increasing the comfort level of agitated patients during transport.

3. A recommendation was made that ER nurses and paramedics serving the Flex hospitals should be educated about the growing elderly population and patient handoff issues including medication concerns

4. Activities focused on disaster drill simulations involving hospital and EMS personnel including:

    Weather related
    Natural disaster
    Bio-terrorism response
    Chemical spills
    Volunteer EMS training

Discussion on communications equipment between EMS and the emergency department during a disaster ensued. In a recent tornado event in Enterprise, Alabama communication equipment failed. The only operational communication system in Alabama is the HEAR system. The focus group participants wanted more information on the status of the HEAR system.

5. Other EMS related training courses and programs that were discussed included:
    Emergency nurses pediatric course
    Trauma Nursing Core Course
    Cardio-Pulmonary Resuscitation(CPR) Training
    Automated External Defibrillator (AED) Training

Patient Transfer Training Course

6. Coordination of activities between the State Trauma System and the Flex Oversight Committee was mentioned during the EMS focus group session. State EMS representatives participating in the focus group session agreed that the Flex program can assist in preparing and integrating rural hospitals into the State Trauma System; however, leadership in developing this system is the responsibility of the State Trauma Program Coordinating Council.

2. Quality Initiative Focus Groups

The quality initiative activities focus group had nine participants representing the following rural hospital positions:

Director of Nursing
Director of Quality Improvement
Assistant Hospital Administrator
Director of Professional Services

In addition, representatives from the Alabama Hospital Association, the Alabama SORH as well as AQAF, the Alabama Medicare Quality Improvement Organization (QIO) were present at this focus group.

The Quality focus group discussion focused on:

- Best use of Flex funds for quality improvement activities
- Partnership opportunities for benchmarking
- New and Core measure monitoring
- Sharing of quality activities between hospitals

Quality Needs and Initiatives Identified

1. The best use of Flex funds would focus on:
    - The Continuous Service Readiness (CSR) Program and Joint Commission
    - The Alabama Quality Award Program
    - Patient safety and satisfaction surveys
    - Core measure monitoring and compliance

2. The sharing of quality activities between Flex hospitals. The discussion focused on sharing information that is educational such as comparing the use of beds before and after they are designated as swing beds.

3. Partnership opportunities for benchmarking were thought to be difficult because of the lack of uniformity between Flex hospital software/computer vendors. In addition, the rural Flex hospitals were at different levels of automation which would make data sharing difficult. However, plans were discussed during the

focus group that a Benchmark Indicator Program would be addressed. AlaHA mentioned that they were willing to work with the Flex hospitals to evaluate and implement the Rural Performance Management (RPM) Program.

4. Opportunities for educational activities addressing Core and New measures. The QIO and Quality Task Force of the Alabama Hospital Association offer educational activities including wound assessment training and infection control training.

5. Most rural hospitals in Alabama are unable to dedicate a full FTE for a quality improvement position. Most hospital personnel responsible for quality improvement have multiple responsibilities including patient care. Any quality improvement initiatives must take this into consideration.

6. The focus group participants felt that newly hired registered nurses were not familiar with quality measures even though this is now a big part of their job. RN education is not doing a good job of including quality measures in nursing education. The AlaHA Quality Task Force has initiated a work group with the deans of the schools of nursing and the Alabama Board of Nursing to develop curriculums addressing quality issues.

7. Creating group purchasing "GPO's" was discussed. However, due to the number of vendors used, the focus group decided this would not be feasible on the basis of proprietary issues and satisfaction with the current programs.

8. Many of the hospitals participate in both the SHIP and Flex grant programs. A discussion ensued about the possibility of combining awards at the hospital level from these two programs which would maximize the funding opportunities.

3. CAH Focus Group

A focus group provided assistance in both describing the status of Alabama's four Critical Access Hospitals (CAHs) and defining future needs for each. The CEO from each of the four CAHs participated in the focus group's deliberations along with the Flex Co-Directors. The following hospitals were involved:

Washington County Hospital – CAH Conversion Date, November 2002
Atmore Community Hospital – CAH Conversion Date, July 2005
Red Bay Hospital – CAH Conversion Date, October 2005
Randolph Medical Center – CAH Conversion Date, January 2006

The CAH focus group discussed the progress, status, and potential benefits from their working relationship in addressing common needs of the four facilities. An individual interview with each CEO produced a final listing of needs and potential activities to address those needs with future Flex funding. This information is presented in the **CAH**

Status of Existing CAHs

All four facilities have benefited financially since converting to CAH status while expanding their line of services. One has made significant infrastructure improvements to its 54-year-old building including electrical system remediation and purchasing new beds and furniture. Another is exploring options to replace its facility using an architectural design more "hospitable" to both patients and their families. All four have enhanced staff training and increased participation in programs to monitor and address established quality of care standards and operational performance benchmarks.

One facility's revenue has doubled since its inception as a CAH. A recent assessment of this facility's cost-based revenue shows a $150,000 advantage compared to a *pro forma* projection of payments using the PPS schedule. The net revenue at another facility has increased 58% to $7,930,000; net loss has decreased 89% ($234,000) to $1,828,000. A new CEO manages the third CAH and its financial information is not readily available.

The status of the fourth facility provides a rare outcome for the CAH model. Initially, revenue increased approximately $700,000 the first full year following conversion. However, analysis that is more recent projects greater financial returns for the facility if it were under the PPS payment schedule. After considerable study, the Board and administration decided to relinquish its CAH designation and return to the general acute care hospital status. This process was completed recently.

An interview with the CEO identified several atypical situations for a CAH community in explaining these events. The community's economy is strong, but significant reductions in the physician workforce over the last several years produced a steadily declining hospital census. The lack of generalist physicians caused local residents to seek primary care outside their community, which resulted in hospital admissions taking place in those communities.

Aggressive recruitment during the last 2 years has successfully brought additional primary care and medical specialty physicians to the community. The added medical staff has produced a doubling of the facility's Average Daily Census since its CAH conversion – from eight to 17. The service of a general surgeon is contributing significantly to this growing inpatient volume.

Specific efforts to increase services to the Medicare eligible population, including establishing a Certified Rural Health Clinic, achieved some success during the facility's operation as a CAH. However, at the time of its reinstatement as a general acute care hospital the Medicare patient mix was only 50%. The CEO expressed the belief that remaining a CAH might be appropriate for his facility if Medicare accounted for at least 70% of admissions. However, the facility's recent surge in admissions may soon result in exceeding the 25-bed CAH limit.

Prospects for New CAHs

Last year the state Certificate of Need (CON) program approved an application for a new hospital in Choctaw County, Alabama. The application acknowledged plans to convert the proposed facility to CAH status following construction. Its location site meets the mileage criteria required between hospitals. No information is available on the anticipated completion date for the new facility. Another hospital that meets statutory requirements for CAH is undergoing a financial feasibility study.

An analysis of rural hospitals by geographic location will identify any additional hospitals eligible for CAH conversion. The analysis uses the 15-mile secondary road interpretation by CMS as a marker in identifying potential conversions to CAH status. Preliminary assessments suggest the locations of one or two additional hospitals may meet the 15-mile criteria. If corroborated by the analysis, consultation and guidance in considering CAH conversion will be made available.

CAH Networking

One of the CAHs has worked with the State Office of Primary Care and Rural Health in implementing a Health Information Technology (HIT) grant funded by HRSA. The grant is producing a HIT network to facilitate reduction of cardiovascular disease through electronic storage and transmission of medical records. One aspect of the network allows cardiovascular disease patients to benefit directly by receiving reminders of physician appointments and other personally tailored information on monitoring their health care needs.

The state's CAHs also have formalized a horizontal network. Although one facility is no longer a CAH, their common interests in operational issues have produced commitments by all four to continue a formal collaboration. The network was incorporated as the Rural Healthcare Consortium of Alabama (RHCA).

The Federal Office of Rural Health Policy awarded a one year Network Planning grant from an application submitted by the CAHs. Resources from this planning grant helped produce formation of the RHCA. The activities generated from the planning grant also included submitting a follow-up application for a Network Development grant. Approval was received recently for this three year Network Development Grant.

During the one year planning grant, the RHCA members identified numerous common needs along with potential strategies to address them. The following section lists these.

The Network Development grant included time-framed objectives to meet the needs identified. These objectives complement Flex Program goals and strengthen commitment of the four facilities to an extended engagement mutually beneficial to all. These objectives are listed later and described in the following time-lines of either immediate (1 year), intermediate (2 years), or long-term (3 years).

CAH Needs and Initiatives Identified

1. Improved access to quality EMS
   - Uniform protocols for ED patient transfers to other facilities
   - More training available in the community to EMS workers
   - Economic issues related to few patients or volume of services – economies of scale
   - EMS operations in some communities getting worse

2. Lack of access to capital – insufficient reimbursements for depreciation costs
   - Cost – based reimbursement from both Medicare and Blue Cross Blue Shield of Alabama – no revenue margin for capital improvements
   - Major infusion of funding to replace worn equipment and purchase new technologies
   - Major infusion of funding for extensive facility renovations (or total replacement) to focus on restoring the "hospitability" to hospitals on behalf of patients and their families

3. Community education and marketing activities
   - Market facility services to community residents – emphasize favorable patient satisfaction scores from HCAHPS in comparison to urban facilities
   - Healthy community education campaigns to stress increasing incidence of diabetes, hypertension, and other chronic disease conditions and the importance of lifestyle changes to combat this trend
   - Community health fairs including medical screening of residents to detect and refer those at need for more thorough medical evaluations and treatment
   - "Hometown Healthcare" meetings and receptions for residents and health care staff to meet and share thoughts on health service needs in the community

4. Electronic Networking and Communications
   - Purchase technology and establish electronic medical records arrangements for community health care providers to access patient information
   - Establish telemedicine network, including reimbursement arrangements, to access diagnostic and consultative medical specialty services not available in the community such as behavioral health, dermatology, and radiology
   - Develop electronic capabilities for intra and inter community communications among health care providers when usual links are not functional due to extensive use or disruption of service due to disasters
   - Establish and maintain health information systems for patients to facilitate control of their chronic diseases

5. Performance and management improvement
   - On-going access to performance improvement consultation from organizations such as Stroudwater Associates

- Management training available in the community for new hires and staff promoted to management positions
- Attendance of senior management at national meetings related to operating CAHS
- Monitor, report, and discuss with staff the results of performance core measures produced from Hospital Compare and other management tools; compare to facilities of similar size and patient volume

6. Enhance quality of clinical care delivery
   - Establish peer review consultation and education arrangements involving medical staff of the CAH facilities
   - Educational opportunities for clinical staff on diagnostic and treatment updates
   - Activities in establishing procedures that document compliance with the clinical protocols of Hospital Compare and other benchmark programs developed by CMS, Blue Cross Blue Shield of Alabama, or other organizations
   - Develop and provide staff training for timely and appropriate triage in the ED

7. Develop new service lines compatible with community needs identified through "Hometown Healthcare" meetings (see #3 above)
   - On-going training on maximizing use of the swing bed program
   - Establishing and financing services needed by aging rural populations such as physical therapy, rehabilitation services, and health promotion programs
   - Sustainability studies on establishing off-campus out-patient clinics such as Certified Rural Health Clinics

Plans for strengthening the network include exploring multiple areas of common interest among its four members. Intermediate (2 year) and Long Term (3 year) plans include adding additional horizontal organizations (hospitals) to the network without regard to whether or not they are CAHs. A network including both vertical and horizontal members moves closer to establishing a seamless and efficient system of health care in each community.

Future Flex Activities:
Immediate, Intermediate and Long Term Plans in the Areas of EMS, Quality and Networking

The needs and initiatives identified by the focus groups were used in developing the following Flex Program objectives for the next three years. However, they should be considered as tentative plans based on the availability of resources, concurrence with Flex Grant Oversight Committee guidelines, and the practicality of implementation.

Goal 1: Strengthen and Integrate EMS

(Some of these needs are addressed each year during all 3 years. Others will be completed in the coming year, and still others require at least 3 years to complete.)

Immediate (1 yr. Obj.)	Measures	Outcomes
	Objectives for All Flex Eligible Hospitals	
1A Encourage the providing of Life Support training/certification to hospital and community EMS staff members.	# training sessions by type of training; # staff trained by type of training	# staff certified and recertified by discipline and type of training
2A Encourage the offering of training courses in emergency and trauma care to staff already certified in Advanced Life Support.	# staff requesting training by course title; # of people approved for and completing training.	# staff by facility and discipline with EMS training beyond Life Support certification.
3A Encourage the providing of opportunities for hospital staff or local residents to become qualified to conduct certified training in Life Support.	# entering training; # completing required courses	# qualified trainers; # receiving training for certification in service area/community
	Objectives for Critical Access Hospitals	
4A Provide Life Support training/certification to hospital and community EMS staff members.	# training sessions by type of training; # staff trained by type of training	# staff certified and recertified by discipline and type of training
5A Offer training courses in emergency and trauma care to staff already certified in	# staff requesting training by course title; # of people approved for and completing	# staff by facility and discipline with EMS training beyond Life Support

Advanced Life Support.	training.	certification.
6A Provide opportunities for hospital staff or local residents to become qualified to conduct certified training in Life Support.	# entering training; # completing required courses	# qualified trainers; # receiving training for certification in service area/community
7A Engage a strategic planning exercise to identify EMS needs to be addressed.	# Needs prioritized and/or potential initiatives identified; # feasibility studies conducted	Plan produced with 1st, 2nd, and 3rd year objectives to improve EMS

Intermediate (2nd yr. Obj.)	Measures	Outcomes

Objectives for All Flex Eligible Hospitals

1A Encourage the providing of Life Support training/certification to hospital and community EMS staff members.	# training sessions by type of training; # staff trained by type of training	# staff certified and recertified by discipline and type of training
2A Encourage the offering of training courses in emergency and trauma care to staff already certified in Advanced Life Support.	# staff requesting training by course title; # of people approved for and completing training.	# staff by facility and discipline with EMS training beyond Life Support certification.
3A Encourage the providing of opportunities for hospital staff or local residents to become qualified to conduct certified training in Life Support.	# entering training; # completing required courses	# qualified trainers; # receiving training for certification in service area/community

Objectives for Critical Access Hospitals

4A Provide Life Support training/certification to hospital and community EMS staff members.	# training sessions by type of training; # staff trained by type of training	# staff certified and recertified by discipline and type of training
5A Offer training courses in emergency and trauma care to staff already certified in Advanced Life Support.	# staff requesting training by course title; # of people approved for and completing training.	# staff by facility and discipline with EMS training beyond Life Support certification.
6A Provide opportunities for hospital staff or local residents to become qualified to conduct certified training in Life	# entering training; # completing required courses	# qualified trainers; # receiving training for certification in service area

Support.		
7A Create focus groups to develop strategies for EMS needs including communication links and future needs. (It is possible that non-CAHs may be involved in this objective.)	Equal involvement of health and community representatives; strategies completed by established timelines	Entire community engaged in EMS system enhancement
8A Identify external services needed to improve Emergency Department operations such as behavioral health consultations. (It is possible that non-CAHs may be involved in this objective.)	# and types of services needed in each participating service area/community	Improved crisis care by networking with other health care providers
9A Investigate potential for other small, rural hospitals to participate in the RHDA Network to contract with Emergency Physician organization to provide 24/7 Emergency Department coverage.	Cost and arrangements for Emergency Department coverage	Confidence in Emergency Department services increased in service area/community; relief for local physicians
Long Term (3rd yr. Obj.)	Measures	Outcomes
Objectives for All Flex Eligible Hospitals		
1A Encourage the providing of Life Support training/certification to hospital and community EMS staff members.	# training sessions by type of training; # staff trained by type of training	# staff certified and recertified by discipline and type of training
2A Encourage the offering of training courses in emergency and trauma care to staff already certified in Advanced Life Support.	# staff requesting training by course title; # of people approved for and completing training.	# staff by facility and discipline with EMS training beyond Life Support certification.
3A Encourage the providing of opportunities for hospital staff or local residents to become qualified to conduct certified training in Life Support.	# entering training; # completing required courses	# qualified trainers; # receiving training for certification in service area

Objectives for Critical Access Hospitals

4A Provide Life Support training/certification to hospital and community EMS staff members.	# training sessions by type of training; # staff trained by type of training	# staff certified and recertified by discipline and type of training
5A Offer training courses in emergency and trauma care to staff already certified in Advanced Life Support.	# staff requesting training by course title; # of people approved for and completing training.	# staff by facility and discipline with EMS training beyond Life Support certification.
6A Provide of Life Support training/certification to hospital and community EMS staff members.	# training sessions by type of training; # staff trained by type of training	# staff certified and recertified by discipline and type of training
7A Organize and provide training for Emergency Department staff and community EMS workers on patient transfer procedures. (It is possible that non-CAHs may be involved in this objective.)	# staff/EMS workers trained; # training sessions	Integration of EMS in health system; Efficient use of health workers
8A Implement strategies developed previous year to meet service area/community specific needs in EMS. (It is possible that non-CAHs may be involved in this objective.)	# strategies implemented	Community involved in health care plans
9A Implement redundant methods for both intra-community and intra-state communications for EMS purposes. (It is possible that non-CAHs may be involved in this objective.)	# of systems by type needed; Delineate plan for use of each system; Cost per system	Consensus in each service area/community on EMS communications

Goal 2: Quality/Performance Improvement

Improve the Quality of Care Received in Rural Hospitals and the Public's Perception of This Quality

(Some of these needs are addressed each year during all 3 years. Others will be completed in the coming year, and still others require at least 3 years to complete.)

Immediate (1 yr. Obj.)	Measures	Outcomes
	Objectives for All Flex Eligible Hospitals	
1B Encourage the use of Flex funding for Continuous Service Readiness (CSR) program participation.	# Flex eligible hospitals using Flex funds for such participation.	Flex eligible hospitals improve performance on such surveys.
2B Encourage Flex eligible hospitals to use Flex funding to seek the Alabama Quality Award from the Alabama Productivity Center at the University of Alabama in Tuscaloosa or similar recognition.	# Flex eligible hospitals using Flex funds for such participation.	Flex eligible hospitals are recognized as facilities of higher production, service, and management quality.
3B Encourage Flex eligible hospitals to use Flex funding to conduct patient safety/satisfaction surveys.	# Flex eligible hospitals using Flex funds for such surveys.	Flex eligible hospitals learn more about their actual or perceived strengths and weaknesses and can react to improve their quality of care or perceived quality of care.
4B Encourage the use of Flex funding to increase hospital visibility and recognition as a major quality healthcare provider through such events as screenings, health fairs, etc.	# of Flex eligible hospitals participating in such events, # of such events being conducted by each hospital, # of screenings actually conducted, # different types of screenings conducted	Hospitals are seen by the local community as being quality providers of healthcare services. Erroneous quality opinions can be dispelled through such visibility.
5B Encourage the use of Flex funds to inform the local community about quality of healthcare activities, recognition, etc.	# of such public relations releases	Hospitals receive due credit for being quality facilities and increase utilization by potential consumers.
6B Encourage the use of Flex funds to address core	# of Flex eligible hospitals addressing such measures	Hospitals improve scores resulting in improved quality

measures.		of care
7B Encourage the use of Flex funds for Flex eligible hospitals to participate in benchmarking programs such as RPM.	# of Flex eligible hospitals participating in benchmarking programs such as RPM.	Increased efficiency, improved quality in Flex eligible hospitals
Objectives for Critical Access Hospitals		
8B Provide training to staff in selected new clinical procedures and/or protocols.	# clinical staff trained by discipline for specified courses; % total clinical staff trained during year.	Improved quality based on # staff completing training; # certified; other evidence of training successes.
9B Finalize Rural Performance Management (RPM) System implementation.	# Critical Access Hospitals (CAH) with fully operational systems.	Relevant operation data routinely reported to management.
10B Continue participating in Hospital Compare and finalize implementing RPM.	Process, outcome, and Hospital Consumer Assessment of Healthcare Providers (HCAHPS) measures of each CAH compared to national benchmarks.	Changes in procedures by management influenced by Hospital Compare reports.
11B Develop physician peer review/education program for medical staff of the CAHs.	# education forums held, # physicians participating, # favorable evaluations.	Improved outcomes of medical decisions from consultations.
12B Engage a strategic planning exercise to identify quality and performance needs to be addressed.	# needs prioritized and methods identified, # feasibility studies conducted.	Plan produced with 1st, 2nd, and 3rd year objectives to improve quality and performance.
Intermediate (2nd yr. Obj.)	Measures	Outcomes
Objectives for All Flex Eligible Hospitals		
1B Encourage continued participation in Continuous Service Readiness (CSR) program participation for hospitals already participating.	# qualified hospitals participating in CSR programs in year one that continue such participation.	# qualified hospitals improving performance on such surveys.
2B Continue encouragement of Flex eligible hospitals to use Flex funding to seek the Alabama Quality Award or	# additional Flex eligible hospitals using Flex funds for such participation.	Flex eligible hospitals are recognized as facilities of higher production, service, and management quality.

similar recognition.		
3B Encourage Flex eligible hospitals to use Flex funding or to secure more permanent and stable funding for continuing to conduct patient safety/satisfaction surveys or initiate such surveys if these are not already being conducted.	# Flex eligible hospitals using Flex funds for such surveys.	Flex eligible hospitals learn more about their actual or perceived strengths and weaknesses and can react to improve their quality of care or perceived quality of care.
4B Encourage Flex eligible hospitals to use Flex funding to conduct patient safety/satisfaction surveys.	# Flex eligible hospitals using Flex funds for such surveys.	Flex eligible hospitals learn more about their actual or perceived strengths and weaknesses and can react to improve their quality of care or perceived quality of care.
5B Encourage the expansion of hospital visibility and recognition as a major quality healthcare provider through such events as screenings, health fairs, etc.	# of hospitals participating in such events, # of such events being conducted by each hospital, # of screenings actually conducted, # different types of screenings conducted	Hospitals are seen by the local community as being quality providers of healthcare services. Erroneous quality opinions can be dispelled through such visibility.
6B Continue to encourage qualified hospitals to inform the local community about quality of healthcare activities, recognition, etc.	# of such public relations releases, daily census, hospital financial status.	Hospitals receive due credit for being quality facilities and increase utilization by potential consumers.
7B Encourage the use of Flex funds to address core measures.	# of Flex eligible hospitals addressing such measures	Hospitals improve scores resulting in improved quality of care
8B Encourage the use of Flex funds for Flex eligible hospitals to participate in benchmarking programs such as RPM.	# of Flex eligible hospitals participating in benchmarking programs such as RPM.	Increased efficiency, improved quality in Flex eligible hospitals
Objectives for Critical Access Hospitals		
9B Review, refine, finalize decisions on networking feasibility studies begun the previous year. (This is also Intermediate Strengthen Network Relationship Objective 3C)	Assess the following feasibility studies: tele-health arrangements, group purchasing of drugs and laboratory supplies, and staff recruiting services.	More efficient operation and increased local services.

10B Finalize implementation of the Healthcare Information Technology (HIT) system in all sites.	Completed implementation for each component by established dates.	Increased efficiency for data collection for financial, clinical and performance evaluation.
11B Engage Stroudwater Associates to assess Medicare Cost Reports and review RPM results with management.	Completeness in capturing all cost areas identified by RPM reports needing attention.	Maximize reimbursement and improve operations.
12B Initiate feasibility studies with business plans for joint expansion of service lines.	Studies completed on network owned home health/hospice services and physician/occupation/speech therapy services.	Improve quality/efficiency of services to residents.
Long Term (3rd yr. Obj.)	Measures	Outcomes
Objectives for All Flex Eligible Hospitals		
1B Identify hospitals recognizing the greatest benefits from Continuous Service Readiness (CSR) program participation, identify why and where this benefit was seen, and share this information with other hospitals.	# hospitals employing information learned through this analysis.	# hospitals improving performance after employing findings form this study.
2B Encourage hospitals using Flex funding for Continuous Service Readiness (CSR) program participation to secure more permanent and stable funding for continuing program participation.	# hospitals seeking and finding non-Flex funding to continue program participation.	Hospitals realize the value of such program participation to their financial status and are able to continue program participation without Flex funding.
3B Encourage Flex eligible hospitals to secure more permanent and stable funding for continuing Alabama Quality Award or similar recognition participation.	# hospitals seeking and finding non-Flex funding to continue program participation.	Hospitals realize the value of such program participation to their financial status and are able to continue program participation without Flex funding.
4B Encourage Flex eligible hospitals to use Flex funding to conduct patient safety/satisfaction surveys.	# Flex eligible hospitals using Flex funds for such surveys.	Flex eligible hospitals learn more about their actual or perceived strengths and weaknesses and can react to improve their quality of care or perceived quality of care.

5B Continue to encourage the expansion of hospital visibility and recognition as a major quality healthcare provider through such events as screenings, health fairs, etc.	# of hospitals participating in such events, # of such events being conducted by each hospital, # of screenings actually conducted, # different types of screenings conducted	Hospitals are seen by the local community as being quality providers of healthcare services. Erroneous quality opinions can be dispelled through such visibility.
6B Continue to encourage qualified hospitals to inform the local community about quality of healthcare activities, recognition, etc.	# of such public relations releases, daily census, hospital financial status.	Hospitals receive due credit for being quality facilities and increase utilization by potential consumers.
7B Encourage the use of Flex funds to address core measures.	# of Flex eligible hospitals addressing such measures	Hospitals improve scores resulting in improved quality of care
8B Encourage the use of Flex funds for Flex eligible hospitals to participate in benchmarking programs such as RPM.	# of Flex eligible hospitals participating in benchmarking programs such as RPM.	Increased efficiency, improved quality in Flex eligible hospitals

Objectives for Critical Access Hospitals

7B Review strategic plan and update as appropriate.	Changes prioritized.	Increased likelihood of network continuing.
8B Make decisions on feasibility studies to expand lines of service.	Consensus on services to be pursued.	Increased quality services, revenue enhanced.
9B Develop on-line staff education program.	Resources identified for instruction in swing bed management, community education on diabetes and hypertension, supervision, and other needed topics.	Improve clinical care and management.

Goal 3: Strengthen Networking Relationships

(Some of these needs are addressed each year during all 3 years. Others will be completed in the coming year, and still others require at least 3 years to complete.)

Immediate (1 yr. Obj.)	Measures	Outcomes
	Objectives for All Flex Eligible Hospitals	
1C Encourage the use of Flex funds for participating in an existing network or establishing new networks to enhance or improve EMS, quality, or otherwise strengthening rural hospitals.	Estimates of financial status with and without participation in the network(s).	More efficient operation
	Objectives for Critical Access Hospitals	
2C Conduct feasibility study on building a wellness center in each of the CAH communities.	Potential partners specify centers' contents and operations	Pro or Con decision in each community
3C Conduct feasibility studies on tele-health arrangements, group purchasing of drugs and laboratory supplies, and staff recruiting services.	Potential partners identify possible tele-health services; Potential savings per item and delivery options from group purchasing; Potential partners evaluate staff recruitment advantages and disadvantages	Pro or Con decision in each CAH
4C Identify other potential joint ventures for network members.	Assignments to lead feasibility studies with business plans	Shared services e.g. telehealth arrangements with USA Medical Center; staff recruitment
5C Develop a network web site.	Web site content; Projections of cost to develop/maintain	Staff interaction; Foundation to expand network
6C Develop marketing/public relations strategy including community education on chronic disease.	Engage focus groups to discuss methods; Identify knowledgeable subject matter experts	Awareness of locally available health services; improved health status
7C Finalize HIT system plans and start implementing system at each site.	Final decisions on system use and requirements; Completion of project by established due dates	Improved record system and data bases; Easy access to patient data

Intermediate (2nd yr. Obj.)	Measures	Outcomes
Objectives for All Flex Eligible Hospitals		
1C Encourage the use of Flex funds for participating in an existing network or establishing new networks to enhance or improve EMS, quality, or otherwise strengthening rural hospitals.	Estimates of financial status with and without participation in the network(s).	More efficient operation
Objectives for Critical Access Hospitals		
2C Develop network sustainability plan including financial needs and potential funding sources.	Determine financial need; Identify potential resources; Initiate plans to secure funds	Network continues
3C Expand Web site by adding links to resources, similar organizations, and the community at large.	Setting and meeting expansion time lines; Decide expansion links	Communication link with potential network partners
4C Review, refine, finalize decisions on networking feasibility studies begun the previous year. (This is also Intermediate Quality/Performance Improvement Objective 8B)	Assess the following feasibility studies: tele-health arrangements, group purchasing of drugs and laboratory supplies, and staff recruiting services.	More efficient operation and increased local services.
5C Pilot implementation of marketing/public relations plan including community education on chronic disease.	Decisions based on community feedback	Increased confidence for success of final marketing and education products
Long Term (3rd yr. Obj.)	Measures	Outcomes
Objectives for All Flex Eligible Hospitals		
1C Encourage the use of Flex funds for participating in an existing network or establishing new networks to enhance or improve EMS, quality, or otherwise strengthening rural hospitals.	Estimates of financial status with and without participation in the network(s).	More efficient operation

Objectives for Critical Access Hospitals

2C Continue expansion of Web site links and services.	Prioritized list of potential links and other information added.	Enhanced tool for recruiting additional network members
3C Formalize arrangements and add additional network members.	# and types of new network members	Network strengthened with new members; Network resources expanded
4C Continue pursuing resources to sustain the network.	Potential resources contacted; maximize allowable CAH cost reimbursement	Network sustained or partially sustained
5C Fully implement the marketing/public relations plan and community education program on chronic diseases.	# marketing encounters reaching public; # educational materials distributed	Use of local health services increased; Self management of chronic disease
6C Complete HIT system implementation in original and new network member sites.	# sites functional	Enhanced data collection and management; Improved patient health status

3

SECTION 3:

Evaluation Plans

Evaluation Plans

The peer reviews from Alabama's previous Medicare Rural Hospital Flexibility Grant Program (Flex) applications provide the foundation in developing evaluation strategies for the new cycle of Flex funding. These reviews emphasize the need for greater efforts in quantifying and measuring the results and impact from Alabama's Flex program. The guiding principle in evaluating all of Alabama's initiatives and activities will be to determine which work and which do not work. Those that do not work will be either discontinued or modified. If appropriate, resources will be re-directed to other Flex goals and objectives.

Evaluation of Alabama's Flex Program during the next 3 years will consider national needs, state needs, and community level needs. The Flex staff will continue participating in the National Flex Monitoring Program in satisfying national needs. The Flex Co-Directors will use guidance from the state level Grant Oversight Committee in identifying the information needed in evaluating the Program's impact at both state and community levels in Alabama.

The three CAHs and 25 other Flex eligible hospitals must first embrace proposed activities and strategies in order to achieve success. Including them in planning which initiatives are compatible with and accommodate their needs can accomplish this objective. Throughout the upcoming 3-year period, meetings and discussions will seek on-going feedback on the Flex program from all facilities. Formal arrangements to accomplish this include quarterly regional hospital council meetings and Flex staff conducting at least one on-site visit annually to each of the facilities.

Evaluating Subcontracts

From the beginning of the Flex Program, a significant portion of Alabama's grant has been subcontracted each year directly to Flex eligible hospitals. Sub-contract funding decisions are based on assessments of hospital applications made in response to RFPs. Community hospitals have used subcontract resources to provide initiatives in Quality/Performance Improvement, EMS Integration, and Networking activities. Many hospital staff and community EMS workers have participated in training programs funded by these Flex funds. Plans for the next 3 years include continuing this arrangement since surveys have found that many of these training opportunities would not be available without Flex support.

Flex staff will use technical assistance available from Grant Oversight Committee members in negotiating subcontract arrangements with vendors of computerized software packages, on-line training programs, and organizations such as the state QIO. Selections will consider the compatibility with existing programs, cost, and the needs of participating facilities.

Demonstrating the achievements and outcome in accomplishing Flex goals and objectives will become the concern of all participants in the Flex Program. Funding proposals for subcontracts will include suggested measures with quantified indicators of success. Subcontractors also will submit progress reports to Flex Program staff at negotiated time intervals. A year-end report from each subcontractor will include an assessment of the outcome and impact achieved based on the pre-established measures referenced above.

Flex approved projects and activities will be organized and tracked through a spreadsheet format. Quarterly progress assessments will enable Grant Oversight Committee members to remain current with program developments through phone communication and face-to-face meetings. Activities not progressing according to established timelines or that appear to be unworkable will be monitored more frequently. Discussions with the Grant Oversight Committee could result in decisions to redirect grant resources.

Use of Benchmarks

All Flex eligible hospitals participate in Hospital Compare. Implementation of additional benchmarking programs will allow comparisons of critical measures on operational performance and quality of care among the state's small rural hospitals. The Rural Performance Management (RPM) system was implemented in two CAHs in May, 2008. A similar benchmarking program for the Flex eligible facilities to establish networks for sharing information on operational performance issues, physician peer reviews, and educational programs tailored to common needs should be explored.

One outcome from the Flex program has been greater participation by rural hospitals in JCAHO's Continuous Survey Readiness Program. The information provided from this program is provided on a scheduled arrangement to enrolled hospitals. Analysis of reports from this program identifies educational needs of administrative and clinical staff members.

The Alabama Blue Cross and Blue Shield organization provides coverage to at least 2/3 of state residents with commercial insurance. The organization has established a Tier System of care that requires facilities to comply with specified standards of services for each respective Tier (level) of care. Surveillance reports from this program provide the information needed in developing management action plans to achieve a prescribed level of quality care.

The Flex Program staff will encourage participation by rural hospitals in the Alabama Quality Improvement Forum. The Alabama Hospital Association, Alabama Quality Assurance Foundation, and Blue Cross Blue Shield of Alabama sponsor the Forum jointly. Benefits of participating include learning issues and trends impacting hospitals both nationally and statewide along with a dual educational tract for rural and urban hospitals with shared best practices being distributed.

Collection of Information

The Alabama Flex Program is dedicated to fulfilling reporting needs as published November 14, 2007 in the Federal Register, Vol. 72, No. 219, pg. 64084. Attachment 1- **Subcontract Hospital Report Form** will provide a common format for all Flex eligible hospitals to capture and submit measurable indicators as outlined in the Federal Register citation.

This includes information such as:

- number people entering training
- number people completing training
- trainee assessments of courses
- number attending educational meetings
- number of hospitals funded
- number of people screened during health fair;
- number of people identified during high risk factors;
- referral outcomes
- number of behavioral health consultations provided in hospital Emergency Departments

The Flex Co-Directors will schedule site visits to each of the SHIP eligible hospitals. These visits will include discussion of the benchmarking activities described above and any technical assistance needed in addressing unresolved issues.

Examples of Best Practices will be gathered during these visits and both successful and unsuccessful experiences shared with the rural hospital constituency group. The Attachment 2 – **On -Site Surveillance Form** will provide the format and guidance for these visits.

All community visits and attendance at regional or state level meetings will emphasize the importance of measuring the Flex program's impact. The strategic planning conducted in producing this revised State Rural Health Plan has produced a continued commitment to identifying more in-depth evaluations and public announcements of Flex accomplishments. The ultimate intent of all evaluation efforts is to ensure the most productive and efficient use of funds in providing quality health care to rural residents, improving their health status, and stabilizing rural hospitals.

The purpose of the on-site visits is to assist Flex eligible hospitals to compile and report information in a quantified format on the activities provided from grant support. In addition, it provides a uniform format for data collection from all participating hospitals. Measurable indicators of activities are an important component in monitoring the annual progress of the Flex Program at both state and national levels. Examples include how many hospitals receive grant support, the total number of people trained, and the number of quality improvement systems implemented in CAHs and other Flex eligible hospitals.

To the extent possible, the information below should be collected as activities occur beginning with the effective date of the subcontract and ending with the conclusion of the grant year.

Attachment 1

Subcontract Hospital Report Form

Quality Improvement

Q1. Number of Flex funded conferences, meetings, seminars, or workshops attended _____ Number of staff members participating _____

Q2. Number of staff members participating in on-line training programs, ____; AQAF training sessions, ____; training sessions on clinical care issues such as wound care management or infection control _____

Q3. Quality Improvement software purchased or upgraded? ___Yes ___NO
If yes, please specify type and use_____

Q4. Other educational packages or videos purchased relating to (please check) reducing medications errors ___, improving patient safety ___, hospital safety compliance___, tracking/reporting core measures, ____, EMTALA training ___

Q5. Other training and education activities provided directed to improving delivery of clinical services and patient outcomes?
Please specify _____
Number of staff participating ____

Q6. Number of health fairs participated in ____, Number of other organizations participating ____, Number of community residents attending ____;
Number of abnormal screenings (or people at risk) detected ____

Comments on Quality Improvement activities?

Performance or Management Improvement

P1. Number of training programs provided for staff on leadership, supervision, management principles, or similar purposes _____
Number of staff members who participated _____

P2. Number of patients participating in Customer Satisfaction Surveys _____

P3. Check here if your Charge Master Account was up-dated ( )

Comments on Performance or Management Improvement activities?

EMS Improvement and Integration

E1. Life Support Training and Certification: (Hospital and EMS Workers)
Number trained/certified in Advanced Cardiac Life Support (ACLS) ____
Number trained/certified in Pediatric Advanced Life Support (PALS) ____
Number trained/certified in Basic Trauma Life Support (BTLS) ____
Number trained/certified in Neonatal Advanced Life Support (NALS) ____

E2. Number participating in other ED and EMS Training such as Emergency Nurses Pediatric Course, Trauma Nursing Core Course, CPR, AED use, etc. ____

E3. Number of training sessions for volunteer EMS workers ____
Number of people trained ____

E4. ED Quality Improvement initiatives implemented or supported?
Please specify: _____

Comments on EMS activities?

Networking Enhancements or Initiatives:

N1. Number of networking initiatives ongoing ____ and description:
_____

_____

N2. Actual or expected benefits derived from these networking initiatives:
_____

_____

Comments on Networking activities:

Other uses of Flex funds

Equipment purchased for training. Please specify _____

Number of educational videos purchased ____

Number of educational manuals purchased ____

Please note any other uses of your Flex funds:

Attachment 2

ON-SITE SURVEILLANCE FORM

1. Name of Hospital:

2. Ownership:

3. Date(s) of visit:

4. Check all that apply and provide information requested:

   CAH ____
   Date converted _____

   PPS Hospital: ____
   # Beds ____
   Average Daily Census _____

   Swing Bed Program ____
   Date started _____
   Occupancy rate _____
   Did staff attended Flex supported Swing Bed training? Yes ___ No ___
   Describe program status before and after training:

   Distinct Part Unit ____
   Gero-Psychiatric _____
   Extended Rehab _____

   Certified Rural Health Clinic ____
   Location proximity to Hospital _____

   Home Health Program ____

   Attached with Nursing Home ____
   # Beds ____
   Occupancy ____

Community EMS arrangements:

Patient transfer (handoff) arrangements:

5. Summary of Flex supported activities previous 2 years:

6. Progress in implementing this Year's Flex activities:

7. CAH Specific Information

   Revenue impact from most recent year:
   Improvements in facility since conversion:
   Improvements in services provided:
   Comments on staff recruitment since conversion:
   Networking activities with members of Mid-South CAH Consortium

8. Benchmarking Participation

   Hospital Compare ___ (Review Hospital reports at hospitalcompare.hhs.gov prior to visit)
   Results?

   RPM ____
   Results?

   JCAHO Continuous Survey Readiness ___
   Results?

   AQAF ___ Specify Program:
   Results?

   Blue Cross Blue Shield Tier System ___ Tier Level ____
   Results?

   Other?

9. Technical Assistance Needs:

10. Best Practices Identified:

11. Other Issues identified

4

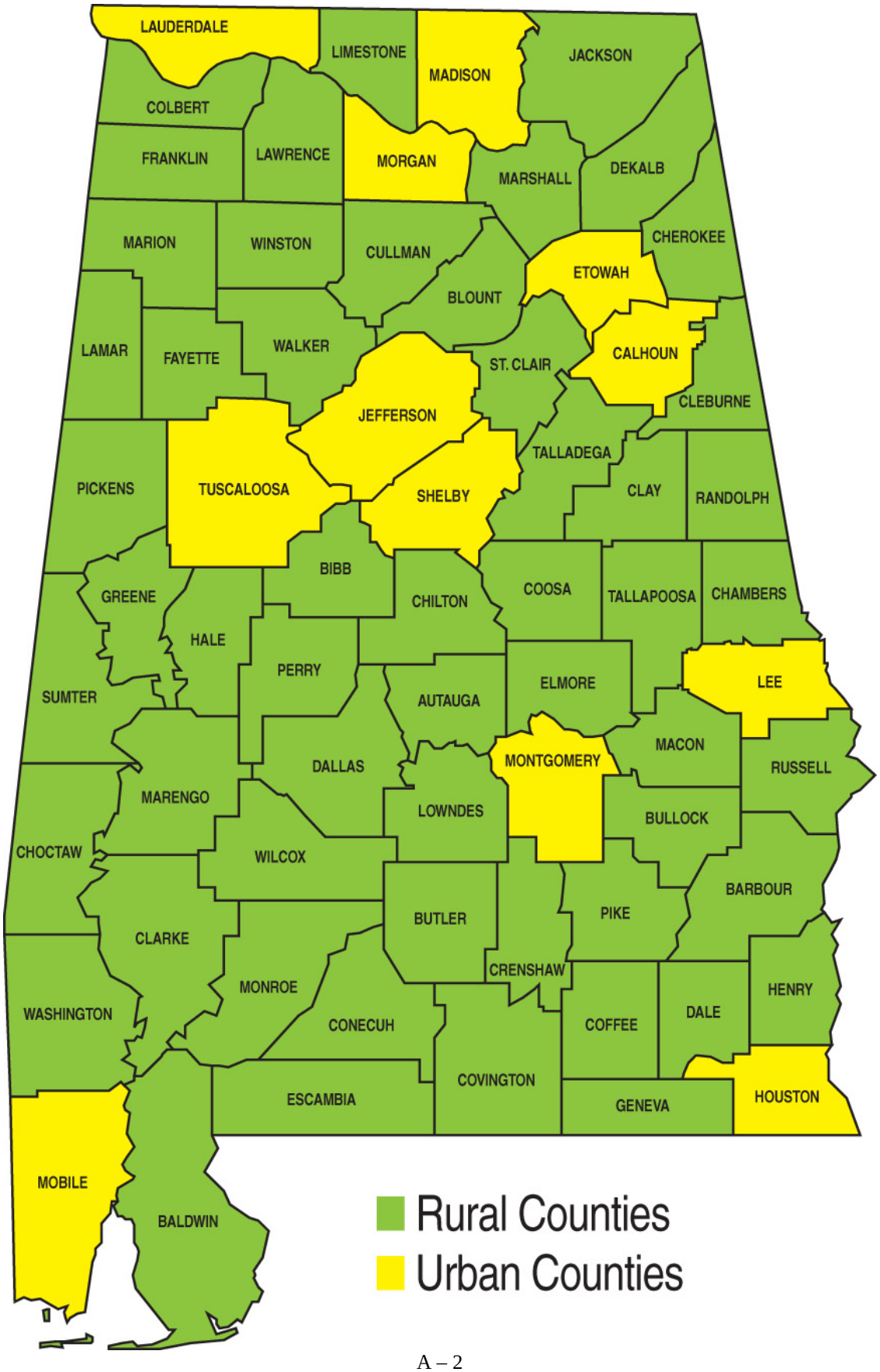
APPENDICES

The next section of the revised rural health plan includes three appendices addressing health status indicators. These health status indicators have been presented in several ways including urban and rural categories, by county specific categories, by regional classifications such as ARC and Delta Regions and by leading causes of death in Alabama. These classifications were made to accommodate the diverse needs of Flex hospitals.

APPENDIX A:

Selected Indicators of Health Status in Alabama, Alabama's Rural Counties, Alabama's Urban Counties, and the United States

October 2007


LAUDERDALE
LIMESTONE
MADISON
JACKSON
COLBERT
FRANKLIN
LAWRENCE
MORGAN
MARSHALL
DEKALB
MARION
WINSTON
CULLMAN
CHEROKEE
ETOWAH
BLOUNT
LAMAR
FAYETTE
WALKER
ST. CLAIR
CALHOUN
CLEBURNE
JEFFERSON
TALLADEGA
PICKENS
TUSCALOOSA
SHELBY
CLAY
RANDOLPH
BIBB
GREENE
CHILTON
COOSA
TALLAPOOSA
CHAMBERS
HALE
PERRY
ELMORE
LEE
SUMTER
AUTAUGA
MACON
MONTGOMERY
RUSSELL
DALLAS
MARENGO
LOWNDES
BULLOCK
CHOCTAW
WILCOX
BARBOUR
BUTLER
PIKE
CLARKE
CRENSHAW
MONROE
HENRY
WASHINGTON
CONECUH
COFFEE
DALE
COVINGTON
ESCAMBIA
GENEVA
HOUSTON
MOBILE
BALDWIN
Rural Counties
Urban Counties

SELECTED HEALTH STATUS INDICATORS
United States, Alabama, Rural Alabama Counties, and Urban Alabama Counties

Indicators	United States		Alabama		Rural Counties		Urban Counties	
2006 Population	**Number**	**Pct. of Total**	**Number**	**Pct. of Total**	**Number**	**Pct. of Total**	**Number**	**Pct. of Total**
Total	299,398,484	100.0	4,599,030	100.0	2.020,120	100.0	2,578,910	100.0
African American (alone)	38,342,549	12.8	1,211,583	26.3	427,128	21.1	784,455	30.4
White (alone)	239,746,254	80.1	3,276,561	71.2	1,552,622	76.9	1,723,939	66.8
American Indian (alone)	2,902,851	1.0	23,799	0.5	13,064	0.6	10,735	0.4
Asian (alone)	13,159,343	4.4	41,881	0.9	7,612	0.4	34,269	1.3
Hispanic	44,321,038	14.8	113,890	2.5	54,944	2.7	58,946	2.3
Age 19 Years or Less	82,079,106	27.4	1,240,643	27.0	532,043	26.3	708,600	27.5
Age 65 Years or More	37,260,352	12.4	615,597	13.4	292,694	14.5	322.903	12.5
Age 85 Years or More	5,296,817	1.8	79,530	1.7	37,909	1.9	41,621	1.6
Population Change	**Number**	**Pct. Change**	**Number**	**Pct. Change**	**Number**	**Pct. Change**	**Number**	**Pct. Change**
1910 – 2000	91,972,266 to 281,421,906	206.0	2,138,093 to 4,447,100	108.0	1,418,814 to 1,958,215	38.0	719,279 to 2,488,885	246.0
2000 – 2025 Projected	281,421,906 to 349,695,000	24.3	4,447,100 to 5,385,997	21.1	1,958,215 to 2,441,629	24.7	2,488,885 to 2,944,868	18.3
Age 65+: 2000 – 2025 Projected	34,991,753 to 63,042,500	80.2	579,907 to 999,769	72.4	273,757 to 491,636	79.6	306,150 to 508,133	66.0
Hispanic: 1990 – 2006 Estimated	22,354,059 to 44,321,038	98.3	24,629 to 113,890	362.4	9,113 to 54,944	502.9	15,516 to 58,946	279.9
Income Related Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**
Population Below Poverty Level – 2004	37,039,804	12.7%	727,308	16.1%	331,089	16.7%	397,803	15.7%
Children Under 18 Below Poverty Level - 2004	13,041,492	17.8%	245,017	22.6 %	110,845	23.5%	134,170	21.9%
Per Capita Personal Income – 2005	N.A.	$34,471	N.A.	$29,623	N.A.	$25,589	N.A.	$32,790
Medicaid Eligible Population – 2006	N.A.	N.A.	988,677	21.1%	484,384	23.3%	503,822	19.4%
Medicaid Eligible Children (Under 21) - 2006	N.A.	N.A.	520,256	38.9%	251,712	42.4%	268,078	35.2%
Medicaid Births - 2006	N.A.	N.A.	30,114	49.3%	13,690	54.7%	16,424	45.5%
Access to Health Care Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**
Primary Care Physicians – 2006 (Per 10,000 Pop.)	209,550	7.2	3,044	6.5	964	4.6	2,080	8.0
Dentists – 2003 (Per 10,000 Pop.)	86,110	2.9 (2006)	1,557	3.5	487	2.5	1,070	4.2
Psychiatrists – 2006 (Per 10,000 Pop.)	24,730	0.9	298	0.6	31	0.1	267	1.0
Hospital Beds (Per 10,000 Pop.)	N.A.	N.A.	16,917	36.1	5,061	24.3	11,856	45.6
Households With No Vehicle – 2000	10,861,067	10.3%	143,594	8.3%	64,550	8.5%	79,044	8.1%
Uninsured Population - 2003	39,803,527	14.2% (2001)	504,539	11.2%	237,946	12.0%	266,593	10.6%

SELECTED HEALTH STATUS INDICATORS
United States, Alabama, Rural Alabama Counties, and Urban Alabama Counties

Indicators	United States		Alabama		Rural Counties		Urban Counties	
Cause of Death 2003-2005	2004 Number	2004 Rate Per 100,000	Number	Rate Per 100,000	Number	Rate Per 100,000	Number	Rate Per 100,000
All Causes	**2,397,615**	**816.5**	**139,414**	**1,028.7**	**66,134**	**1,109.7**	**73,280**	**965.2**
Septicemia	**33,373**	**11.4**	**2,451**	**18.1**	**1,109**	**18.6**	**1,342**	**17.7**
Cancer	**553,888**	**188.6**	**29,389**	**216.9**	**13,759**	**230.9**	**15,630**	**205.9**
Colon, Rectum, and Anus	53,772	18.3	2,696	19.9	1,279	21.5	1,417	18.7
Trachea, Bronchus, and Lung	158,091	53.8	9,286	68.5	4,486	75.3	4,800	63.2
Breast (female)	40,954	27.5	2,072	29.4	920	30.0	1,152	29.0
Cervix Uteri (female)	3,850	2.6	241	3.4	119	3.9	122	3.1
Ovary (female)	14,716	9.9	786	11.2	369	12.0	417	10.5
Prostate (male)	29,004	20.1	1,609	24.3	736	25.0	873	23.7
Meninges, Brain, Other Central Nervous System	12,829	4.4	611	4.5	291	4.9	320	4.2
Alzheimer's Disease	**65,965**	**22.5**	**4,145**	**30.6**	**1,982**	**33.3**	**2,163**	**28.5**
Diabetes Mellitus	**73,138**	**24.9**	**4,273**	**31.5**	**1,881**	**31.6**	**2,392**	**31.5**
Heart Diseases	**675,562**	**230.1**	**38,683**	**285.4**	**19,704**	**330.6**	**18,979**	**250.0**
Ischemic Heart Diseases	451,326	153.7	18,789	138.6	9,374	157.3	9,415	124.0
Heart Failure	57,120	19.5	6,606	48.7	3,747	62.9	2,859	37.7
Cerebrovascular Diseases (Stroke)	**150,074**	**51.1**	**8,934**	**65.9**	**4,168**	**69.9**	**4,766**	**62.8**
Pneumonia	**58,564**	**19.9**	**3,111**	**23.0**	**1,466**	**24.6**	**1,645**	**21.7**
Chronic Lower Respiratory Dis.	**121,987**	**41.5**	**7,156**	**52.8**	**3,539**	**59.4**	**3,617**	**47.6**
Chronic Liver Disease and Cirrhosis	**27,013**	**9.2**	**1,378**	**10.2**	**611**	**10.3**	**767**	**10.1**
Nephritis, Nephrotic Syndrome, and Nephrosis	**42,480**	**14.5**	**3,132**	**23.1**	**1,463**	**24.5**	**1,669**	**22.0**
Accidents	**112,012**	**38.1**	**6,931**	**51.1**	**3,546**	**59.5**	**3,385**	**44.6**
Motor Vehicle Accidents	44,933	15.3	3,480	25.7	1,909	32.0	1,571	20.7
Drowning and Submersion	3,308	1.1	187	1.4	96	1.6	91	1.2
Smoke, Fire, and Flames	3,229	1.1	322	2.4	174	2.9	148	1.9
Poisoning and Exposure to Noxious Substances	20,950	7.1	646	4.8	262	4.4	348	5.1
Homicide	**17,357**	**5.9**	**1,233**	**9.1**	**422**	**7.1**	**811**	**10.7**
Suicide	**32,439**	**11.0**	**1,586**	**11.7**	**719**	**12.1**	**867**	**11.4**

SELECTED HEALTH STATUS INDICATORS
United States, Alabama, Rural Alabama Counties, and Urban Alabama Counties

Indicators	United States		Alabama		Rural Counties		Urban Counties	
Natality Related	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**
2004-2006 Infant Mortality Rate (per 1,000 Live Births)	28,534 (2005)	6.9	1,646	9.0	682	8.9	964	9.1
Low Weight Births - 2006 (Percent of All Births)	331,772 (2004)	8.1%	6,616	10.5 %	2,561	9.7 %	4,055	11.1 %
Births to Teens (10-19) - 2006 (Percent of All Births)	422,043 (2004)	10.3%	8,670	13.8 %	4,011	15.2 %	4,659	12.8 %
Births With Less Than Adequate Prenatal Care - 2006 (Percent of All Births)	Not Available	Not Available	14,390	23.1 %	6,607	25.2 %	7,783	21.5 %
Tobacco Use During Pregnancy - 2006 (Percent of All Births)	419,429	10.2%	7,394	11.8 %	3,902	14.8 %	3,492	9.6 %
Births Occurring Outside of the Mother's County of Residence - 2006 (Percent of All Births)	Not Available	Not Available	20,002	31.8 %	15,987	60.5 %	4,015	11.0 %
Births to Under-Educated Women - 2006 (Percent of All Births)	Not Available	Not Available	11,648	18.6 %	5,710	21.7 %	5,938	16.3 %
Other Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**
Age 65+ With "Go Outside" Disability - 2000	6,795,517	19.4 %	139,401	24.0%	68,529	25.0 %	70,872	23.1 %
Age 25+ With Less Than High School Education - 2000	35,715,625	19.6 %	714,081	24.7 %	391,305	30.3	322,776	20.2 %
Receiving Medicare Disability - 2003 (Percent of Total Population)	6,079,424	2.2 %	150,573	3.3 %	75,499	3.8 %	75,022	3.0 %
Obese - 2003 (Percent of Total Population)	Not Comparable	Not Comparable	1,073,329	23.9 %	465,494	23.5	607,835	24.1
Accidental Deaths Occurring Outside of a Health Care Facility: 2003-2005 (Percent of all Accidental Deaths)	Not Available	Not Available	3,621	52.2 %	1,974	55.7 %	1,647	48.7 %
Life Expectancy at Birth - 2005	--	77.9 years	--	74.8 years	--	74.4 years	--	75.1 years
Sexually Transmitted Disease Cases Reported in 2006 (Per 10,000 Population)	1,349,333	45.9	33,463	73.6	10,958	52.6	22,505	86.6
Cumulative HIV Cases as of December 31, 2006 (Per 10,000 Population)	Not Comparable	Not Comparable	14,737	32.4	3,755	18.0	10,949	42.1
Families Being Counseled for Drug Issues by the Alabama Department of Mental Health During FY 2004 (Percent of All Families)	Not Available	Not Available	20,881	1.7 %	7,750	1.4 %	13,131	2.0 %

Sources of Information and Special Notes

2006 Population: U.S. Census Bureau, County Population Estimates – characteristics; County Population by Age, Sex, Race, and Hispanic Origin: April 1, 2000 through July 1, 2006. http://www.census.gov/popest/counties/asrh/CC-EST2006-alldata.html

Population Change 1910-2000: U.S. Census Bureau, County Population Census Counts 1900-90, http://www.census.gov/population/cencounts/al190090.txt for 1910 data; U.S. Census Bureau, American FactFinder, Census 2000 Summary File 1 (SF 1) 100-Percent Data for 2000 data.

Population Change 2000-2025: U.S. Census Bureau, American FactFinder, Census 2000 Summary File 1 (SF 1) 100-Percent Data for 2000 data. Alabama State Data Center, Alabama County Population 2000 and Projections 2005-2025 for 2025. http://cber.cba.ua.edu/edata/est_prj.html

Age 65+ Population Change 2000-2025: Alabama State Data Center, Alabama County Population 65 and Over 2000 and Projections 2005-2025 for 2025. http://cber.cba.ua.edu/edata/est_prj.html

Hispanic Population Change 1990-2006: U.S. Census Bureau, American FactFinder, Census 1990 Summary File 1 (STF 1) 100-Percent Data for 1990 data. Alabama State Data Center, Estimates of the Hispanic Population by County, 2006. http://cber.cba.ua.edu/edata/est_prj.html

Population Below Poverty Level - 2004: U.S. Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/hhes/www/saipe/saipe.html

Children Under 18 Below Poverty Level - 2004: U.S. Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/hhes/www/saipe/saipe.html

2005 Per Capita Personal Income: U.S. Bureau of Economic Analysis, Interactive Tables: Local Area Personal Income, Table CA1-3. http://www.bea.gov/regional/reis/default.cfm?catable=CA1-3&section=2

Medicaid Eligible Population - 2006: Alabama Medicaid Agency, Alabama Medicaid Statistics by County – 2006. http://www.medicaid.alabama.gov/resources/stats_reports.aspx?tab=5

Medicaid Eligible Children (Under 21) - 2006: Alabama Medicaid Agency, Alabama Medicaid Statistics by County – 2006. http://www.medicaid.alabama.gov/resources/stats_reports.aspx?tab=5

Medicaid Births - 2006: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2006 Birth Statistics File.

Primary Care Physicians in 2006: Medical Licensure Commission, Licensed Physician Data Base – 2006. (In this publication, primary care physicians include family practitioners, internal medicine specialists, pediatricians, and obstetricians and gynecologists.)

Dentists in 2003: Board of Dental Examiners of Alabama, Licensed dentists data base - 2003.

Psychiatrists in 2006: Medical Licensure Commission, Licensed Physician Data Base – 2006.

Hospital Beds in 2007: Alabama Department of Public Health, Division of Provider Services, Healthcare Facilities Directory – Hospital Section. October 4, 2007. http://ph.state.al.us/facilitiesdirectory/(S(ikg10gmphl4ih5550hmu4t45))/Default.aspx

Households With No Vehicle in 2000: U.S. Census Bureau, American FactFinder, Census 2000 Summary File 3 (SF 3) Sample Data, Table H44 - Tenure by Vehicles Available.

Uninsured Persons - 2003: State Health Access Data Assistance Center, Alabama County Chartbook: County-Level Estimates of Uninsurance July 2005. (Prepared for the Alabama Department of Public Healthy, Children's Health Insurance Program)

Cause of Death Indicators: Alabama Department of Public Health, Center for Health Statistics, Special queries of the 2003, 2004, and 2005 Mortality Statistics Files for Alabama data. Centers for Disease Control and Prevention, CDC Wonder Interactive Program, Mortality – Underlying Cause of Death 2004 file. http://wonder.cdc.gov/ (Cause of death data included in this publication is not age-adjusted)

Infant Mortality Rate - 2004-2006; Alabama Department of Public Health, Center for Health Statistics, Special querries of the 2004, 2005, and 2006 Birth Statistics Files for birth data. Alabama Department of Public Health, Center for Health Statistics, Total Resident Infant Deaths and Infant Mortality Rates by County, Alabama, 2006, 2005, 2004, and Combined 2006-2004.
http://adph.org/healthstats/assets/06TotInfantDeaths.pdf

Low Weight Births - 2006: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2006 Birth Statistics File.
(Births weighing less than 2,500 grams or 5 pounds and 8 ounces are defined as being of low weight.)

Births to Teenagers (Age 10-19) - 2006: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2006 Birth Statistics File.

Births With Less Than Adequate Prenatal Care - 2006: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2006 Birth Statistics File.
(The Kotelchuck Index is used in determining adequacy of prenatal care. This index primarily considers the date when prenatal care was begun and the number of visits in determining adequacy.)

Births With Tobacco Use During Pregnancy - 2006: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2006 Birth Statistics File.

Births Occurring Outside Mother's County of Residence - 2006: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2006 Birth Statistics File.
(This indicator was included because of the serious decline in the number of rural hospitals where obstetrics are performed and the natural relationship between women receiving adequate prenatal care and the presence of obstetrical care in the county.)

Births to Undereducated Women - 2006: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2006 Birth Statistics File.
(Women are considered to be "undereducated" when their years of education is at least two years less than what would be expected for someone of their age.)

Age 65+ With "Home Bound" Disability - 2000: U.S. Census Bureau, American FactFinder, Census 2000 Summary File 3 (SF 3) Sample Data, Table P41 – Age by Types of Disability for the Civilian Noninstitutionalized Population 5 Years and Over With Disabilities.

Age 25+ With Less Than High School Education - 2000: U.S. Census Bureau, American FactFinder, Census 2000 Summary File 3 (SF 3) Sample Data, Table P37 – Sex by Educational Attainment for the Population 25 Years and Over.

Persons Receiving Medicare Disability - 2003: Centers for Medicare and Medicaid Services, Medicare County Enrollment, As of July 1, 2003. http://www.cms.hhs.gov/MedicareEnrpts/

Obesity - Percent of Population in 2003: Chronic Disease in Alabama: Past, Present, and Future Trends. Pp. 16-17. http://adph.org/ADMINISTRATION/chronicdisease.pdf

Accidental Deaths Occurring Outside of a Health Care Facility - (2003-2005): Alabama Department of Public Health, Center for Health Statistics, Special query of the 2003, 2004, and 2005 Mortality Statistics File.
(This indicator was used in the place of an "emergency medical services emergency ambulance runs" data base. While there is such a data base maintained within the Alabama Department of Public Health, reporting to this data base is not complete and could produce confusing findings. The provision of adequate emergency medical service continues to be a serious issue in most rural Alabama counties.)

Life Expectancy at Birth - 2005: Alabama Department of Public Health, Center for Health Statistics, County Health Profiles – 2005. http://www.adph.org/healthstats/Default.asp?id=1521

Sexually Transmitted Disease Cases - 2006: Alabama Department of Public Health, Division of STD Prevention and Control, Statistics, County Totals – 2006. http://www.adph.org/STD/Default.asp?id=1080

Cumulative HIV Cases as of 12/31/2006: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control, Statistics, Public Health Area (January – December 2006). http://www.adph.org/aids/Default.asp?id=984
(National data for the cumulative number of HIV cases as of December 31, 2006 is not comparable due to the fact that not all states report this information to the Centers for Disease Control and Prevention and those that are reporting initiated this reporting at varying times.)

Families Served by the Division of Substance Abuse Services in the Alabama Department of Mental Health - FY 2004: Alabama Department of Mental Health, Department's Annual Report, '03-'04. p35. http://www.mh.alabama.gov/downloads/AnnualReports/ADMH_AnnualReport_03_04Part3.pdf

For additional information please contact the Office of Primary Care and Rural Health Development at (334) 206-5396 or the Alabama Rural Health Association at (334) 281-3866.

APPENDIX B:

Selected Health Status Indicators - County Specific Data

October 2007

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Counties in Various Regions or Classifications of Alabama

North Alabama Action Commission includes Colbert, Cullman, DeKalb, Franklin, Jackson, Lauderdale, Lawrence, Limestone, Madison, Marion, Marshall, Morgan, and Winston.

West Alabama Action Commission includes Bibb, Fayette, Greene, Hale, Lamar, Pickens, and Tuscaloosa.

Central Alabama Action Commission includes Blount, Chilton, Jefferson, St. Clair, Shelby, and Walker.

East Alabama Action Commission includes Calhoun, Chambers, Cherokee, Clay, Cleburne, Coosa, Etowah, Randolph, Talladega, and Tallapoosa.

South Central Alabama Action Commission includes Autauga, Bullock, Butler, Crenshaw, Elmore, Lee, Lowndes, Macon, Montgomery, Pike, and Russell.

Tombigbee Action Commission includes Choctaw, Clarke, Conecuh, Dallas, Marengo, Monroe, Perry, Sumter, Washington, and Wilcox.

Wiregrass Action Commission includes Barbour, Coffee, Covington, Dale, Geneva, Henry, and Houston.

Southwest Alabama Action Commission includes Baldwin, Escambia, and Mobile.

Black Belt Action Commission includes Bullock, Choctaw, Dallas, Greene, Hale, Lowndes, Macon, Marengo, Perry, Pickens, Sumter, and Wilcox counties.

Rural Counties include Autauga, Baldwin, Barbour, Bibb, Blount, Bullock, Butler, Chambers, Cherokee, Chilton, Choctaw, Clarke, Clay, Cleburne, Coffee, Colbert, Conecuh, Coosa, Covington, Crenshaw, Cullman, Dale, Dallas, DeKalb, Elmore, Escambia, Fayette, Franklin, Geneva, Greene, Hale, Henry, Jackson, Lamar, Lawrence, Limestone, Lowndes, Macon, Marengo, Marion, Marshall, Monroe, Perry, Pickens, Pike, Randolph, Russell, St. Clair, Sumter, Talladega, Tallapoosa, Walker, Washington, Wilcox, and Winston.

Highly Rural Counties include Barbour, Bibb, Blount, Bullock, Butler, Cherokee, Choctaw, Clarke, Clay, Cleburne, Coffee, Conecuh, Coosa, Covington, Crenshaw, Cullman, Dallas, DeKalb, Escambia, Fayette, Franklin, Geneva, Greene, Hale, Henry, Jackson, Lamar, Lawrence, Lowndes, Macon, Marengo, Marion, Marshall, Monroe, Perry, Pickens, Pike, Randolph, Sumter, Washington, Wilcox, and Winston.

Moderately Rural Counties include Autauga, Baldwin, Chambers, Chilton, Colbert, Dale, Elmore, Limestone, Russell, St. Clair, Talladega, Tallapoosa and Walker.

Rural North Counties include Bibb, Blount, Chambers, Cherokee, Chilton, Clay, Cleburne, Colbert, Coosa, Cullman, DeKalb, Elmore, Fayette, Franklin, Hale, Jackson, Lamar, Lawrence, Limestone, Macon, Marion, Marshall, Pickens, Randolph, St. Clair, Talladega, Tallapoosa, Walker, and Winston.

Rural South Counties include Autauga, Baldwin, Barbour, Bullock, Butler, Choctaw, Clarke, Coffee, Conecuh, Covington, Crenshaw, Dale, Dallas, Escambia, Geneva, Greene, Henry, Lowndes, Marengo, Monroe, Perry, Pike, Russell, Sumter, Washington, and Wilcox.

Urban Counties include Calhoun, Etowah, Houston, Jefferson, Lauderdale, Lee, Madison, Mobile, Montgomery, Morgan, Shelby, and Tuscaloosa.

Appalachian Region includes Bibb, Blount, Calhoun, Chambers, Cherokee, Chilton, Clay, Cleburne, Colbert, Coosa, Cullman, DeKalb, Elmore, Etowah, Fayette, Franklin, Hale, Jackson, Jefferson, Lamar, Lauderdale, Lawrence, Limestone, Macon, Madison, Marion, Marshall, Morgan, Pickens, Randolph, St. Clair, Shelby, Talladega, Tallapoosa, Tuscaloosa, Walker, and Winston counties.

Delta Region includes Barbour, Bullock, Butler, Choctaw, Clarke, Conecuh, Dallas, Escambia, Greene, Hale, Lowndes, Macon, Marengo, Monroe, Perry, Pickens, Russell, Sumter, Washington, and Wilcox counties.

Data for Counties

County	2006 Total Population	2006 African Am. (alone) Pop.	2006 White (alone) Pop.	2006 Am. Indian (alone) Pop.
Alabama	4,599,030	1,211,583	3,276,561	23,799
Autauga	49,730	8,614	40,105	219
Baldwin	169,162	16,470	149,531	833
Barbour	28,171	13,125	14,632	127
Bibb	21,482	4,746	16,523	66
Blount	56,436	898	54,658	308
Bullock	10,906	7,700	3,071	44
Butler	20,520	8,577	11,731	47
Calhoun	112,903	22,314	88,182	469
Chambers	35,176	13,388	21,422	56
Cherokee	24,863	1,363	23,142	104
Chilton	41,953	4,452	36,961	122
Choctaw	14,656	6,474	8,075	27
Clarke	27,248	11,848	15,151	70
Clay	13,829	2,066	11,554	59
Cleburne	14,700	640	13,879	53
Coffee	46,027	8,618	35,670	417
Colbert	54,766	9,086	44,756	209
Conecuh	13,403	5,887	7,383	32
Coosa	11,044	3,480	7,449	40
Covington	37,234	4,763	31,882	224
Crenshaw	13,719	3,439	10,089	60
Cullman	80,187	979	77,912	374
Dale	48,392	10,322	36,096	277
Dallas	43,945	29,433	14,045	55
DeKalb	68,014	1,201	65,221	552
Elmore	75,688	15,803	58,270	325
Escambia	37,849	11,852	24,266	1,162
Etowah	103,362	14,994	86,557	364
Fayette	18,005	2,164	15,657	39
Franklin	30,847	1,326	29,031	127
Geneva	25,868	2,768	22,671	198
Greene	9,374	7,432	1,888	12
Hale	18,236	10,709	7,382	34
Henry	16,706	5,194	11,328	42
Houston	95,660	24,690	69,072	353
Jackson	53,745	2,003	49,604	939
Jefferson	656,700	271,121	370,406	1,872
Lamar	14,548	1,707	12,727	26
Lauderdale	87,891	8,650	77,860	249
Lawrence	34,312	4,041	27,328	1,734
Lee	125,781	29,423	92,674	327
Limestone	72,446	9,528	61,450	368
Lowndes	12,759	9,055	3,614	16
Macon	22,594	18,641	3,489	39
Madison	304,307	71,658	218,924	2,105
Marengo	21,842	11,360	10,268	24
Marion	30,165	1,201	28,546	111
Marshall	87,185	1,485	83,892	477
Mobile	404,157	139,533	251,026	2,623
Monroe	23,342	9,540	13,311	241
Montgomery	223,571	118,904	99,030	567
Morgan	115,237	13,829	98,525	822
Perry	11,186	7,700	3,392	10
Pickens	20,133	8,420	11,517	26
Pike	29,620	10,949	17,740	210
Randolph	22,673	4,916	17,475	53
Russell	50,085	20,946	28,036	203
St. Clair	75,232	6,343	67,663	280
Shelby	178,182	17,293	156,428	559
Sumter	13,606	10,051	3,452	18
Talladega	80,271	25,145	53,979	216
Tallapoosa	41,010	10,642	29,904	114
Tuscaloosa	171,159	52,046	115,255	425
Walker	70,034	4,583	64,532	231
Washington	17,651	4,620	11,572	1,267
Wilcox	12,911	9,276	3,579	17
Winston	24,634	159	24,121	130

Data for Counties

County	2006 Asian (alone) Pop.	2006 Hispanic Pop.	2006 Pop. Under Age 20	2006 Age 65+ *Pop.*
Alabama	41,881	113,890	1,240,643	615,597
Autauga	281	827	14,163	5,338
Baldwin	687	4,176	41,734	27,770
Barbour	88	953	7,355	3,662
Bibb	25	304	5,590	2,700
Blount	136	3,752	14,599	7,666
Bullock	23	752	2,890	1,296
Butler	83	171	5,536	3,248
Calhoun	828	2,399	29,323	16,432
Chambers	82	432	9,263	5,601
Cherokee	63	273	5,749	4,279
Chilton	149	1,608	11,086	5,311
Choctaw	13	122	3,814	2,394
Clarke	55	195	7,759	3,952
Clay	14	296	3,268	2,455
Cleburne	25	298	3,671	2,138
Coffee	535	1,568	11,995	6,666
Colbert	186	783	13,467	8,863
Conecuh	17	129	3,527	2,167
Coosa	7	163	2,674	1,793
Covington	107	366	9,227	6,772
Crenshaw	16	111	3,499	2,273
Cullman	230	2,748	20,320	12,094
Dale	590	1,580	14,393	6,270
Dallas	173	276	13,395	6,228
DeKalb	156	6,460	18,194	9,525
Elmore	390	1,240	20,101	8,368
Escambia	113	419	9,812	5,372
Etowah	524	2,674	26,259	16,303
Fayette	60	171	4,449	3,003
Franklin	92	3,527	8,111	4,745
Geneva	48	529	6,358	4,337
Greene	14	60	2,745	1,436
Hale	27	176	5,134	2,352
Henry	12	363	4,132	2,700
Houston	699	1,488	25,899	13,740
Jackson	147	866	13,421	8,050
Jefferson	7,853	17,337	177,329	88,032
Lamar	10	198	3,483	2,520
Lauderdale	420	1,135	21,388	14,274
Lawrence	74	512	8,907	4,480
Lee	2,210	2,238	35,780	10,900
Limestone	401	2,589	18,559	8,567
Lowndes	17	119	3,790	1,715
Macon	235	211	6,604	3,378
Madison	6,587	7,371	82,276	37,031
Marengo	50	387	6,412	3,147
Marion	71	475	7,107	5,212
Marshall	388	8,100	23,851	12,242
Mobile	6,883	6,067	118,035	49,502
Monroe	70	190	6,752	3,291
Montgomery	2,941	3,429	65,785	26,543
Morgan	750	5,842	30,312	15,474
Perry	7	111	3,750	1,681
Pickens	23	172	5,649	3,299
Pike	322	496	8,119	3,802
Randolph	68	354	6,045	3,709
Russell	345	1,067	14,079	6,917
St. Clair	220	1,054	19,152	9,121
Shelby	2,524	5,934	49,646	15,589
Sumter	17	162	4,051	2,052
Talladega	291	932	21,081	10,924
Tallapoosa	103	397	10,329	6,940
Tuscaloosa	2,050	3,032	46,568	19,083
Walker	185	934	17,637	10,893
Washington	21	172	5,043	2,479
Wilcox	16	107	4,175	1,775
Winston	34	511	6,037	3,726

Data for Counties

County	2006 Age 85+ Pop.	Pop. Change 1910-2000 - Pct.				Pop. Change 2000-2025 (Projected) - Pct.			
Alabama	79,530	2,138,093	**to**	4,447,100	108.0%	4,447,100	**to**	5,386,497	21.1%
Autauga	517	20,038	**to**	43,671	117.9%	43,671	**to**	68,368	56.6%
Baldwin	3,426	18,178	**to**	140,415	672.4%	140,415	**to**	248,436	76.9%
Barbour	543	32,728	**to**	29,038	-11.3%	29,038	**to**	35,246	21.4%
Bibb	331	22,791	**to**	20,826	-8.6%	20,826	**to**	30,749	47.6%
Blount	830	21,456	**to**	51,024	137.8%	51,024	**to**	81,713	60.1%
Bullock	263	30,196	**to**	11,714	-61.2%	11,714	**to**	12,578	7.4%
Butler	567	29,030	**to**	21,399	-26.3%	21,399	**to**	20,447	-4.4%
Calhoun	1,969	39,115	**to**	112,249	187.0%	112,249	**to**	112,472	0.2%
Chambers	924	36,056	**to**	36,583	1.5%	36,583	**to**	36,532	-0.1%
Cherokee	482	20,226	**to**	23,988	18.6%	23,988	**to**	34,220	42.7%
Chilton	519	23,187	**to**	39,593	70.8%	39,593	**to**	59,022	49.1%
Choctaw	329	18,483	**to**	15,922	-13.9%	15,922	**to**	15,568	-2.2%
Clarke	534	30,987	**to**	27,867	-10.1%	27,867	**to**	29,365	5.4%
Clay	414	21,006	**to**	14,254	-32.1%	14,254	**to**	16,553	16.1%
Cleburne	237	13,385	**to**	14,123	5.5%	14,123	**to**	16,920	19.8%
Coffee	881	26,119	**to**	43,615	67.0%	43,615	**to**	50,303	15.3%
Colbert	1,231	24,802	**to**	54,984	121.7%	54,984	**to**	59,484	8.2%
Conecuh	289	21,433	**to**	14,089	-34.3%	14,089	**to**	14,101	0.1%
Coosa	217	16,634	**to**	12,202	-26.6%	12,202	**to**	13,875	13.7%
Covington	1,066	32,124	**to**	37,631	17.1%	37,631	**to**	38,294	1.8%
Crenshaw	367	23,313	**to**	13,665	-41.4%	13,665	**to**	13,714	0.4%
Cullman	1,500	28,321	**to**	77,483	173.6%	77,483	**to**	98,897	27.6%
Dale	787	21,608	**to**	49,129	127.4%	49,129	**to**	52,820	7.5%
Dallas	788	53,401	**to**	46,365	-13.2%	46,365	**to**	44,648	-3.7%
DeKalb	1,278	28,261	**to**	64,452	128.1%	64,452	**to**	91,301	41.7%
Elmore	1,049	28,245	**to**	65,874	133.2%	65,874	**to**	105,245	59.8%
Escambia	712	18,889	**to**	38,440	103.5%	38,440	**to**	42,660	11.0%
Etowah	2,234	39,109	**to**	103,459	164.5%	103,459	**to**	108,578	4.9%
Fayette	456	16,248	**to**	18,495	13.8%	18,495	**to**	18,752	1.4%
Franklin	588	19,369	**to**	31,223	61.2%	31,223	**to**	38,469	23.2%
Geneva	592	26,230	**to**	25,764	-1.8%	25,764	**to**	28,836	11.9%
Greene	242	22,717	**to**	9,974	-56.1%	9,974	**to**	9,311	-6.6%
Hale	352	27,883	**to**	17,185	-38.4%	17,185	**to**	21,215	23.5%
Henry	410	20,943	**to**	16,310	-22.1%	16,310	**to**	17,428	6.9%
Houston	1,898	32,414	**to**	88,787	173.9%	88,787	**to**	99,832	12.4%
Jackson	944	32,918	**to**	53,926	63.8%	53,926	**to**	64,516	19.6%
Jefferson	13,116	226,476	**to**	662,047	192.3%	662,047	**to**	701,651	6.0%
Lamar	339	17,487	**to**	15,904	-9.1%	15,904	**to**	16,175	1.7%
Lauderdale	1,910	30,936	**to**	87,966	184.3%	87,966	**to**	103,176	17.3%
Lawrence	457	21,984	**to**	34,803	58.3%	34,803	**to**	39,664	14.0%
Lee	1,292	32,867	**to**	115,092	250.2%	115,092	**to**	179,495	56.0%
Limestone	948	26,880	**to**	65,676	144.3%	65,676	**to**	90,865	38.4%
Lowndes	204	31,894	**to**	13,473	-57.8%	13,473	**to**	14,708	9.2%
Macon	521	26,049	**to**	24,105	-7.5%	24,105	**to**	22,505	-6.6%
Madison	3,648	47,041	**to**	276,700	488.2%	276,700	**to**	349,713	26.4%
Marengo	459	39,923	**to**	22,539	-43.5%	22,539	**to**	20,848	-7.5%
Marion	779	17,495	**to**	31,214	78.4%	31,214	**to**	32,710	4.8%
Marshall	1,483	28,553	**to**	82,231	188.0%	82,231	**to**	111,385	35.5%
Mobile	6,275	80,854	**to**	399,843	394.5%	399,843	**to**	443,553	10.9%
Monroe	490	27,155	**to**	24,324	-10.4%	24,324	**to**	24,586	1.1%
Montgomery	3,810	82,178	**to**	223,510	172.0%	223,510	**to**	259,679	16.2%
Morgan	1,766	33,781	**to**	111,064	228.8%	111,064	**to**	131,112	18.1%
Perry	265	31,222	**to**	11,861	-62.0%	11,861	**to**	10,872	-8.3%
Pickens	470	25,055	**to**	20,949	-16.4%	20,949	**to**	21,740	3.8%
Pike	428	30,815	**to**	29,605	-3.9%	29,605	**to**	34,967	18.1%
Randolph	566	24,659	**to**	22,380	-9.2%	22,380	**to**	28,232	26.1%
Russell	832	25,937	**to**	49,756	91.8%	49,756	**to**	55,198	10.9%
St. Clair	935	20,715	**to**	64,724	212.4%	64,742	**to**	102,121	57.7%
Shelby	1,403	26,949	**to**	143,293	431.7%	143,293	**to**	265,083	85.0%
Sumter	422	28,699	**to**	14,798	-48.4%	14,798	**to**	13,051	-11.8%
Talladega	1,330	37,921	**to**	80,321	111.8%	80,321	**to**	90,021	12.1%
Tallapoosa	1,013	31,034	**to**	41,475	33.6%	41,475	**to**	44,567	7.5%
Tuscaloosa	2,300	47,559	**to**	164,875	246.7%	164,875	**to**	190,524	15.6%
Walker	1,299	37,013	**to**	70,713	91.0%	70,713	**to**	73,970	4.6%
Washington	276	14,454	**to**	18,097	25.2%	18,097	**to**	20,123	11.2%
Wilcox	298	33,810	**to**	13,183	-61.0%	13,183	**to**	13,021	-1.2%
Winston	430	12,855	**to**	24,843	93.3%	24,843	**to**	30,714	23.6%

Data for Counties

County	Age 65+ Pop. Change 2000-2025 (Projected) - Pct.				Hispanic Pop. Change 1990-2006 - Pct.			
Alabama	579,907	**to**	999,769	72.4	24,629	**to**	113,890	362.4%
Autauga	4,451	**to**	11,983	169.2	230	**to**	827	259.6%
Baldwin	21,703	**to**	60,687	179.6	1,022	**to**	4,176	308.6%
Barbour	3,873	**to**	6,865	77.3	124	**to**	953	668.5%
Bibb	2,413	**to**	5,384	123.1	39	**to**	304	679.5%
Blount	6,558	**to**	14,311	118.2	286	**to**	3,752	1,211.9%
Bullock	1,543	**to**	2,485	61.0	65	**to**	752	1,056.9%
Butler	3,506	**to**	5,122	46.1	65	**to**	171	163.1%
Calhoun	15,872	**to**	22,520	41.9	1,282	**to**	2,399	87.1%
Chambers	5,928	**to**	8,398	41.7	127	**to**	432	240.2%
Cherokee	3,818	**to**	8,736	128.8	57	**to**	273	378.9%
Chilton	5,097	**to**	10,785	111.6	116	**to**	1,608	1,286.2%
Choctaw	2,332	**to**	3,987	71.0	53	**to**	122	130.2%
Clarke	3,764	**to**	6,244	65.9	103	**to**	195	89.3%
Clay	2,359	**to**	3,857	63.5	27	**to**	296	996.3%
Cleburne	1,933	**to**	3,745	93.7	38	**to**	298	684.2%
Coffee	6,171	**to**	10,379	68.2	471	**to**	1,568	232.9%
Colbert	8,493	**to**	12,468	46.8	187	**to**	783	318.7%
Conecuh	2,332	**to**	3,987	71.0	82	**to**	129	57.3%
Coosa	1,761	**to**	3,071	74.4	18	**to**	163	805.6%
Covington	6,740	**to**	9,099	35.0	130	**to**	366	181.5%
Crenshaw	2,338	**to**	3,068	31.2	30	**to**	111	270.0%
Cullman	11,342	**to**	19,369	70.8	272	**to**	2,748	910.3%
Dale	5,807	**to**	10,796	85.9	1,,215	**to**	1,580	30.0%
Dallas	6,428	**to**	8,664	34.8	131	**to**	276	110.7%
DeKalb	8,882	**to**	15,267	71.9	215	**to**	6,460	2,904.7%
Elmore	7,071	**to**	17,435	146.6	270	**to**	1,240	359.3%
Escambia	5,236	**to**	8,408	60.6	169	**to**	419	147.9%
Etowah	16,560	**to**	21,582	30.3	331	**to**	2,674	707.9%
Fayette	2,976	**to**	4,413	48.3	78	**to**	171	119.2%
Franklin	4,637	**to**	6,523	40.7	101	**to**	3,527	3,392.1%
Geneva	4,203	**to**	6,611	57.3	121	**to**	529	337.2%
Greene	1,470	**to**	2,233	51.9	24	**to**	60	150.0%
Hale	2,316	**to**	3,867	67.0	57	**to**	176	208.8%
Henry	2,668	**to**	4,286	60.6	92	**to**	363	294.6%
Houston	12,162	**to**	20,321	67.1	464	**to**	1,488	220.7%
Jackson	7,210	**to**	12,932	79.4	208	**to**	866	316.3%
Jefferson	90,285	**to**	118,741	31.5	2,745	**to**	17,337	531.6%
Lamar	2,528	**to**	3,438	36.0	71	**to**	198	178.9%
Lauderdale	13,241	**to**	21,219	60.3	313	**to**	1,135	262.6%
Lawrence	4,195	**to**	7,840	86.9	102	**to**	512	402.0%
Lee	9,337	**to**	22,418	140.1	552	**to**	2,238	305.4%
Limestone	7,271	**to**	15,306	110.5	261	**to**	2,589	892.0%
Lowndes	1,646	**to**	3,247	97.3	60	**to**	119	98.3%
Macon	3,367	**to**	4,754	41.2	103	**to**	211	104.9%
Madison	30,015	**to**	62,701	108.9	2,984	**to**	7,371	147.0%
Marengo	3,287	**to**	4,421	34.5	75	**to**	387	416.0%
Marion	4,934	**to**	7,431	50.6	65	**to**	475	630.8%
Marshall	11,717	**to**	19,044	62.5	289	**to**	8,100	2,702.8%
Mobile	47,919	**to**	74,927	56.4	3,164	**to**	6,067	91.8%
Monroe	3,363	**to**	5,207	54.8	94	**to**	190	102.1%
Montgomery	26,307	**to**	40,171	52.7	1,624	**to**	3,429	111.1%
Morgan	13,708	**to**	23,716	73.0	584	**to**	5,842	900.3%
Perry	1,762	**to**	2,031	15.3	36	**to**	111	208.3%
Pickens	3,293	**to**	4,372	32.8	50	**to**	172	244.0%
Pike	3,727	**to**	6,186	66.0	108	**to**	496	359.3%
Randolph	3,564	**to**	5,714	60.3	53	**to**	354	567.9%
Russell	6,541	**to**	9,135	39.7	301	**to**	1,067	254.5%
St. Clair	7,578	**to**	18,994	150.6	209	**to**	1,054	404.3%
Shelby	12,179	**to**	49,316	304.9	525	**to**	5,934	1,030.3%
Sumter	2,056	**to**	2,634	28.1	78	**to**	162	107.7%
Talladega	10,655	**to**	17,908	68.1	490	**to**	932	90.2%
Tallapoosa	6,872	**to**	10,416	51.6	71	**to**	397	459.2%
Tuscaloosa	18,565	**to**	30,501	64.3	948	**to**	3,032	219.8%
Walker	10,453	**to**	15,703	50.2	224	**to**	934	317.0%
Washington	2,246	**to**	3,932	75.1	51	**to**	172	237.3%
Wilcox	1,810	**to**	2,460	35.9	40	**to**	107	167.5%
Winston	3,533	**to**	5,998	69.8	59	**to**	511	766.1%

Data for Counties

	Pop. Below Poverty - 2004		Children (<18) Below Poverty - 2004		2005 Per Capita
County	Number	Pct.	Number	Pct.	**Personal Income**
Alabama	727,308	16.1	245,017	22.6	$29,623
Autauga	5,496	11.6	2,041	16.3	$27,567
Baldwin	15,690	10.0	5,415	14.9	$30,899
Barbour	6,798	23.9	2,024	31.1	$23,343
Bibb	3,634	17.1	1,211	23.8	$21,732
Blount	6,812	12.4	2,207	16.9	$23,492
Bullock	3,382	30.3	910	35.0	$19,262
Butler	4,331	21.0	1,502	29.8	$24,749
Calhoun	18,907	16.9	6,171	24.6	$28,156
Chambers	6,102	17.2	2,011	24.0	$23,562
Cherokee	3,937	16.1	1,229	23.8	$23,507
Chilton	6,113	14.8	2,232	22.4	$23,754
Choctaw	3,046	20.2	975	27.9	$24,388
Clarke	5,698	20.9	2,050	28.8	$24,006
Clay	1,951	13.9	597	20.0	$24,860
Cleburne	2,129	14.7	670	20.9	$23,997
Coffee	6,386	14.2	2,237	21.2	$30,655
Colbert	8,031	14.7	2,471	20.8	$25,368
Conecuh	3,086	23.1	1,060	33.4	$23,481
Coosa	1,580	14.0	513	20.9	$23,094
Covington	6,876	18.7	2,209	26.9	$25,419
Crenshaw	2,534	18.6	840	26.6	$28,377
Cullman	10,911	13.8	3,485	19.4	$26,125
Dale	8,169	16.7	3,008	23.5	$25,421
Dallas	12,198	27.4	4,566	37.5	$24,085
DeKalb	10,572	15.8	3,601	22.4	$25,102
Elmore	8,965	12.5	3,008	17.1	$27,119
Escambia	7,673	20.1	2,290	26.3	$22,515
Etowah	16,571	16.1	5,590	24.0	$26,658
Fayette	3,159	17.4	986	24.6	$23,973
Franklin	5,456	17.8	1,825	25.3	$24,160
Geneva	4,626	18.1	1,533	27.4	$25,232
Greene	2,564	26.5	897	34.7	$22,551
Hale	3,984	22.0	1,329	28.7	$20,373
Henry	2,822	17.1	938	25.1	$24,394
Houston	14,644	15.8	5,456	23.5	$30,418
Jackson	8,212	15.3	2,721	22.6	$24,812
Jefferson	101,221	15.4	32,300	20.7	$38,861
Lamar	2,519	16.8	760	23.8	$22,085
Lauderdale	14,152	16.2	4,303	23.2	$26,462
Lawrence	5,055	14.7	1,619	20.0	$24,891
Lee	19,252	16.0	4,747	18.2	$24,804
Limestone	8,783	12.7	2,887	17.8	$26,698
Lowndes	3,336	25.5	1,233	34.5	$21,875
Macon	6,518	28.3	1,834	35.8	$19,823
Madison	34,327	11.7	11,657	16.4	$34,987
Marengo	4,675	21.3	1,676	28.9	$27,140
Marion	5,390	17.9	1,614	25.2	$24,303
Marshall	13,393	15.8	4,682	22.3	$27,365
Mobile	79,789	20.0	30,321	29.0	$25,602
Monroe	4,371	18.5	1,542	25.0	$24,319
Montgomery	42,876	19.4	15,468	27.7	$35,130
Morgan	15,800	14.0	5,478	20.2	$30,814
Perry	3,484	30.4	1,296	40.1	$20,352
Pickens	4,218	20.8	1,431	28.3	$23,628
Pike	6,278	21.4	2,036	29.7	$28,842
Randolph	3,624	16.1	1,250	23.3	$22,189
Russell	9,521	19.4	3,461	28.1	$24,291
St. Clair	9,193	13.1	3,112	18.6	$26,872
Shelby	11,577	7.0	3,941	9.2	$39,590
Sumter	3,971	28.3	1,346	36.9	$20,509
Talladega	14,230	17.8	4,698	25.2	$27,793
Tallapoosa	6,957	17.1	2,276	24.8	$25,519
Tuscaloosa	28,687	17.2	8,738	23.2	$30,951
Walker	11,308	16.2	3,523	22.5	$26,155
Washington	3,216	18.1	1,140	25.0	$21,494
Wilcox	3,916	30.4	1,493	39.4	$18,820
Winston	4,210	17.2	1,345	25.2	$23,630

Data for Counties

	Medicaid Eligible Pop. - 2006		Medicaid Elig. Children (<21) - 2006		Medicaid Births - 2006	
County	Number	Percent	Number	Percent	Number	Percent
Alabama	988,677	21.1	520,256	38.9	30,114	49.3
Autauga	8,495	17.1	4,631	29.5	270	42.2
Baldwin	24,195	14.5	13,286	29.7	1,015	46.6
Barbour	7,975	25.9	4,310	51.4	196	64.7
Bibb	4,932	21.2	2,514	37.7	132	51.4
Blount	9,480	16.2	5,228	30.6	274	39.5
Bullock	4,207	35.1	2,294	69.0	151	77.8
Butler	6,887	32.8	3,596	58.4	189	62.6
Calhoun	28,431	25.4	14,429	47.7	859	56.9
Chambers	8,912	24.5	4,585	45.0	261	70.7
Cherokee	5,881	22.1	3,018	45.0	129	57.1
Chilton	9,111	20.6	4,849	37.5	285	51.5
Choctaw	4,260	26.9	1,998	43.8	17	70.8
Clarke	7,818	27.7	3,851	43.2	191	59.1
Clay	3,264	21.9	1,586	39.3	93	54.1
Cleburne	3,503	23.5	1,839	45.3	96	64.0
Coffee	9,277	20.4	4,796	37.9	285	45.9
Colbert	12,237	21.7	6,133	40.0	320	52.2
Conecuh	4,447	31.5	2,344	58.1	120	72.7
Coosa	2,480	19.4	1,142	34.6	57	57.6
Covington	10,017	26.4	4,972	49.2	291	64.8
Crenshaw	3,940	28.8	1,896	49.9	98	59.4
Cullman	16,468	19.8	8,327	36.3	420	42.1
Dale	11,394	22.8	6,236	42.6	312	41.1
Dallas	18,705	41.1	9,501	65.1	480	72.6
DeKalb	18,287	25.8	10,327	50.5	565	59.1
Elmore	12,205	16.2	6,649	30.7	425	42.5
Escambia	10,098	25.4	5,631	51.8	345	77.2
Etowah	23,529	22.4	11,714	40.5	698	53.9
Fayette	4,095	21.9	1,934	38.6	99	55.0
Franklin	8,547	25.7	4,550	48.8	284	59.7
Geneva	6,773	25.3	3,355	47.0	167	50.9
Greene	4,046	41.3	2,154	68.8	103	74.1
Hale	5,771	31.7	3,010	49.5	105	56.8
Henry	4,157	24.9	2,061	45.9	99	53.2
Houston	22,709	24.6	12,525	47.1	702	51.1
Jackson	11,548	20.2	5,893	37.8	326	58.7
Jefferson	128,327	19.2	66,153	34.8	4,016	41.7
Lamar	3,984	24.8	1,811	42.0	105	68.2
Lauderdale	17,694	19.2	8,472	31.6	472	46.3
Lawrence	6,991	19.2	3,410	32.9	198	48.5
Lee	20,282	15.5	10,886	26.4	587	45.7
Limestone	12,023	16.6	6,214	30.5	389	41.3
Lowndes	4,446	32.1	2,341	52.4	142	70.6
Macon	7,243	30.6	3,752	50.3	164	67.5
Madison	42,023	14.2	22,702	26.1	1,525	37.9
Marengo	6,583	29.8	3,275	46.9	157	60.6
Marion	7,606	23.8	3,715	45.4	225	64.3
Marshall	21,924	24.5	12,531	48.8	928	60.9
Mobile	94,188	22.9	52,401	40.9	3,460	56.9
Monroe	6,051	24.8	3,172	41.3	164	62.6
Montgomery	57,036	24.6	31,973	46.1	1,895	54.6
Morgan	21,317	18.2	11,652	34.9	663	45.7
Perry	4,851	42.3	2,482	61.0	116	72.0
Pickens	6,025	28.5	2,851	44.1	138	60.3
Pike	9,006	29.1	4,568	49.4	261	62.6
Randolph	5,428	22.8	2,875	41.5	158	69.0
Russell	14,336	28.0	7,902	51.3	76	81.7
St. Clair	12,953	17.5	7,132	34.1	385	36.5
Shelby	14,119	8.2	7,533	15.3	559	21.5
Sumter	5,564	39.3	2,778	59.1	57	74.0
Talladega	22,051	26.4	11,010	47.3	615	61.0
Tallapoosa	10,415	24.5	5,385	46.3	316	61.6
Tuscaloosa	34,167	19.9	17,638	34.9	988	42.2
Walker	17,033	23.6	8,132	41.7	491	55.7
Washington	4,257	22.7	2,040	34.1	91	50.8
Wilcox	5,835	44.8	2,860	63.7	136	76.0
Winston	6,367	24.0	2,980	41.6	178	62.0

Data for Counties

	Primary Care Physicians in 2006		Dentists in 2003		Psychiatrists in 2006	
County	Number	Rate per 10,000[1]	Number	Rate per 10,000[1]	Number	Rate per 10,000[1]
Alabama	3,044	6.5	1,557	3.5	298	0.6
Autauga	17	3.4	12	2.6	0	0.0
Baldwin	98	5.9	52	3.4	12	0.7
Barbour	13	4.2	7	2.4	0	0.0
Bibb	5	2.2	5	2.4	0	0.0
Blount	13	2.2	6	1.1	0	0.0
Bullock	6	5.0	2	1.8	0	0.0
Butler	10	4.8	5	2.4	1	0.5
Calhoun	80	7.1	38	3.4	7	0.6
Chambers	23	6.3	8	2.2	0	0.0
Cherokee	8	3.0	5	2.1	0	0.0
Chilton	11	2.5	9	2.2	0	0.0
Choctaw	6	3.8	6	3.9	0	0.0
Clarke	18	6.4	7	2.6	0	0.0
Clay	6	4.0	2	1.4	0	0.0
Cleburne	2	1.3	0	0.0	0	0.0
Coffee	23	5.1	18	4.1	0	0.0
Colbert	43	7.6	15	2.8	0	0.0
Conecuh	7	5.0	2	1.5	0	0.0
Coosa	1	0.8	1	0.9	0	0.0
Covington	23	6.1	9	2.4	1	0.3
Crenshaw	3	2.2	3	2.2	1	0.7
Cullman	42	5.0	20	2.6	4	0.5
Dale	16	3.2	15	3.0	0	0.0
Dallas	31	6.8	12	2.7	3	0.7
DeKalb	26	3.7	19	2.9	0	0.0
Elmore	22	2.9	11	1.6	0	0.0
Escambia	22	5.5	10	2.6	0	0.0
Etowah	72	6.9	31	3.0	5	0.5
Fayette	9	4.8	3	1.6	0	0.0
Franklin	12	3.6	8	2.6	0	0.0
Geneva	9	3.4	4	1.6	0	0.0
Greene	4	4.1	0	0.0	0	0.0
Hale	5	2.7	1	0.5	0	0.0
Henry	3	1.8	5	3.0	0	0.0
Houston	87	9.4	37	4.0	7	0.8
Jackson	30	5.2	13	2.4	0	0.0
Jefferson	726	10.9	408	6.2	108	1.6
Lamar	3	1.9	3	2.0	0	0.0
Lauderdale	61	6.6	43	4.9	9	1.0
Lawrence	12	3.3	3	0.9	0	0.0
Lee	70	5.4	30	2.5	4	0.3
Limestone	29	4.0	15	2.2	0	0.0
Lowndes	3	2.2	0	0.0	0	0.0
Macon	11	4.7	4	1.7	2	0.8
Madison	235	7.9	136	4.7	32	1.1
Marengo	9	4.1	5	2.3	0	0.0
Marion	16	5.0	7	2.3	1	0.3
Marshall	55	6.1	30	3.6	3	0.3
Mobile	291	7.1	138	3.5	28	0.7
Monroe	12	4.9	5	2.1	0	0.0
Montgomery	219	9.5	93	4.2	13	0.6
Morgan	75	6.4	37	3.3	15	1.3
Perry	5	4.4	1	0.9	0	0.0
Pickens	11	5.2	2	1.0	1	0.5
Pike	16	5.2	6	2.1	0	0.0
Randolph	11	4.6	4	1.8	0	0.0
Russell	13	2.5	7	1.4	0	0.0
St. Clair	78	10.6	14	2.0	0	0.0
Shelby	21	1.2	39	2.4	5	0.3
Sumter	7	4.9	3	2.1	0	0.0
Talladega	35	4.2	14	1.8	0	0.0
Tallapoosa	22	5.2	10	2.5	0	0.0
Tuscaloosa	143	8.3	65	3.9	34	2.0
Walker	31	4.3	25	3.6	2	0.3
Washington	5	2.7	2	1.1	0	0.0
Wilcox	4	3.1	2	1.5	0	0.0
Winston	9	3.4	5	2.0	0	0.0

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Hospital Beds in 2007		Households With No Vehicle in 2000		Uninsured Persons - 2003	
County	Number	Rate per 10,000[1]	Number	Percent	Number	Percent
Alabama	16,917	36.1	143,594	8.3	504,539	11.2
Autauga	47	9.5	832	5.2	3,746	8.1
Baldwin	300	18.0	2,340	4.2	16,233	10.7
Barbour	74	24.1	1,303	12.5	2,901	10.1
Bibb	28	12.1	721	9.7	1,925	9.1
Blount	40	6.8	1,045	5.4	4,492	8.3
Bullock	41	34.3	702	17.6	1,580	14.0
Butler	94	44.8	1,013	12.1	2,008	9.7
Calhoun	526	46.9	3,566	7.9	11,854	10.6
Chambers	115	31.6	1,477	10.2	4,358	12.2
Cherokee	60	22.6	580	6.0	3,803	15.6
Chilton	30	6.8	1,076	7.0	5,198	12.7
Choctaw	0	0.0	697	11.0	1,545	10.1
Clarke	114	40.4	1,192	11.3	3,230	11.8
Clay	45	30.3	485	8.4	1,729	12.2
Cleburne	0	0.0	343	6.1	1,984	13.6
Coffee	151	33.3	1,308	7.5	4,976	11.2
Colbert	314	55.6	1,441	6.4	7,797	14.3
Conecuh	58	41.1	670	11.6	1,298	9.6
Coosa	0	0.0	378	8.1	1,245	10.8
Covington	235	61.9	1,372	8.8	3,503	9.5
Crenshaw	49	35.8	640	11.5	1,594	11.7
Cullman	215	25.8	1,944	6.3	11,054	14.1
Dale	89	17.8	1,198	6.3	5,365	10.9
Dallas	163	35.8	2,884	16.2	5,523	12.3
DeKalb	134	18.9	1,533	6.1	7,628	11.5
Elmore	138	18.3	940	4.1	7,043	10.0
Escambia	116	29.2	1,314	9.2	3,897	10.2
Etowah	560	53.3	3,144	7.6	10,494	10.2
Fayette	61	32.6	610	8.1	2,283	12.5
Franklin	125	37.6	1,021	8.3	5,420	17.6
Geneva	83	31.0	827	7.9	3,774	14.8
Greene	20	20.4	641	16.3	1,032	10.5
Hale	39	21.4	1,003	15.6	2,551	14.0
Henry	0	0.0	597	9.1	1,805	11.0
Houston	605	65.6	2,958	8.3	10,143	11.1
Jackson	170	29.7	1,554	7.2	7,107	13.2
Jefferson	4377	65.5	26,148	9.9	59,897	9.1
Lamar	0	0.0	528	8.2	1,698	11.2
Lauderdale	328	35.5	2,164	6.0	12,527	14.4
Lawrence	98	26.9	1,045	7.7	4,588	13.3
Lee	276	21.1	3,104	6.8	13,076	11.0
Limestone	101	14.0	1,627	6.6	10,758	15.8
Lowndes	0	0.0	743	15.1	1,733	13.0
Macon	0	0.0	1,684	18.8	3,346	14.3
Madison	1001	33.7	6,133	5.6	24,045	8.3
Marengo	99	44.8	1,259	14.4	2,766	12.5
Marion	128	40.1	1,129	8.9	3,139	10.4
Marshall	240	26.8	2,257	6.9	13,869	16.5
Mobile	1811	44.1	13,410	8.9	55,047	13.8
Monroe	94	38.6	989	10.5	3,322	14.0
Montgomery	841	36.3	8,426	9.8	20,617	9.3
Morgan	552	47.2	2,726	6.3	16,681	14.8
Perry	0	0.0	720	16.6	2,128	18.3
Pickens	48	22.7	958	11.8	2,681	13.1
Pike	97	31.3	1,362	11.4	2,791	9.6
Randolph	50	21.0	679	7.9	1,742	7.8
Russell	108	21.1	2,489	12.6	8,206	16.8
St. Clair	82	11.1	1,169	4.8	5,134	7.5
Shelby	192	11.2	1,860	3.4	11,158	7.0
Sumter	33	23.3	1,105	19.4	2,518	17.8
Talladega	270	32.3	3,141	10.2	8,066	10.1
Tallapoosa	101	23.7	1,559	9.4	6,030	14.8
Tuscaloosa	787	45.9	5,405	8.4	21,054	12.7
Walker	267	37.0	2,135	7.5	8,052	11.5
Washington	15	8.0	550	8.2	1,966	11.0
Wilcox	32	24.6	959	20.1	1,231	9.5
Winston	50	18.9	782	7.7	2,555	10.4

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Mortality – All Causes (2003-2005)		Septicemia Mortality (2003-2005)		Cancer Mortality – All Sites (2003-2005)	
County	Number	Rate per 100,000	Number	Rate per 100,000[1]	Number	Rate per 100,000
Alabama	139,414	1,028.7	2,451	18.1	29,389	216.9
Autauga	1,196	841.5	16	11.3	245	172.4
Baldwin	4,647	987.2	48	10.2	1,094	232.4
Barbour	888	1,040.6	14	16.4	180	210.9
Bibb	682	1,069.6	13	20.4	143	224.3
Blount	1,617	981.1	23	14.0	319	193.5
Bullock	390	1,164.6	6	17.9	77	229.9
Butler	892	1,441.6	10	16.2	167	269.9
Calhoun	3,961	1,180.2	106	31.6	815	242.8
Chambers	1,390	1,306.0	18	16.9	279	262.1
Cherokee	849	1,157.4	11	15.0	196	267.2
Chilton	1,379	1,113.0	8	6.5	276	222.8
Choctaw	509	1,125.1	6	13.3	100	221.0
Clarke	845	1,033.1	12	14.7	173	211.5
Clay	544	1,292.1	9	21.4	113	268.4
Cleburne	508	1,168.9	15	34.5	110	253.1
Coffee	1,414	1,048.0	9	6.7	323	239.4
Colbert	1,851	1,129.3	26	15.9	402	245.3
Conecuh	537	1,339.7	8	20.0	116	289.4
Coosa	420	1,240.5	4	11.8	83	245.1
Covington	1,547	1,402.4	32	29.0	324	293.7
Crenshaw	516	1,262.7	8	19.6	81	198.2
Cullman	2,676	1,128.1	37	15.6	549	231.4
Dale	1,348	918.6	18	12.3	321	218.8
Dallas	1,672	1,252.0	53	39.7	301	225.4
DeKalb	2,095	1,043.7	35	17.4	404	201.3
Elmore	1,878	872.9	24	11.2	391	181.7
Escambia	1,351	1,179.7	19	16.6	265	231.4
Etowah	4,024	1,303.2	95	30.8	801	259.4
Fayette	673	1,235.6	12	22.0	127	233.2
Franklin	1,132	1,231.0	25	27.2	223	242.5
Geneva	1,002	1,306.8	12	15.7	207	270.0
Greene	339	1,167.8	6	20.7	54	186.0
Hale	607	1,117.3	10	18.4	138	254.0
Henry	636	1,284.5	8	16.2	129	260.5
Houston	2,680	963.8	31	11.1	620	223.0
Jackson	1,779	1,104.9	30	18.6	382	237.2
Jefferson	21,639	1,097.4	380	19.3	4,365	221.4
Lamar	542	1,204.8	12	26.7	119	264.5
Lauderdale	2,805	1,070.3	32	12.2	591	225.5
Lawrence	1,052	1,019.6	14	13.6	219	212.3
Lee	2,386	661.0	48	13.3	534	147.9
Limestone	1,822	878.1	36	17.4	406	195.7
Lowndes	453	1,154.3	12	30.6	95	242.1
Macon	794	1,149.2	16	23.2	163	235.9
Madison	6,951	789.7	122	13.9	1,604	182.2
Marengo	772	1,172.4	13	19.7	156	236.9
Marion	1,158	1,281.8	16	17.7	254	281.2
Marshall	2,916	1,146.7	45	17.7	583	229.3
Mobile	11,858	990.8	194	16.2	2,634	220.1
Monroe	787	1,110.4	18	25.4	147	207.4
Montgomery	6,101	920.2	100	15.1	1,322	199.4
Morgan	3,239	956.7	53	15.7	687	202.9
Perry	424	1,233.1	14	40.7	91	264.6
Pickens	769	1,264.1	19	31.2	184	302.5
Pike	939	1,066.9	26	29.5	178	202.2
Randolph	823	1,218.6	33	48.9	156	231.0
Russell	1,606	1,090.8	36	24.5	329	223.5
St. Clair	2,159	1,025.5	38	18.1	496	235.6
Shelby	3,134	631.6	57	11.5	720	145.1
Sumter	432	1,026.3	9	21.4	75	178.2
Talladega	2,628	1,095.7	41	17.1	550	229.3
Tallapoosa	1,573	1,288.7	29	23.8	339	277.7
Tuscaloosa	4,502	899.8	124	24.8	937	187.3
Walker	2,917	1,393.0	66	31.5	552	263.6
Washington	506	949.3	8	15.0	114	213.9
Wilcox	427	1,105.1	11	28.5	89	230.3
Winston	826	1,124.8	12	16.3	172	234.2

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Colon, Rectum, Anus Cancer Mortality (2003-2005)		Trachea, Bronchus, Lung Cancer Mortality (2003-2005)		Breast Cancer Mortality (Females 2003-2005)	
County	Number	Rate per 100,000[1]	Number	Rate per 100,000[1]	Number	Rate per 100,000[1]
Alabama	2,696	19.9	9,286	68.5	2,072	29.4
Autauga	25	17.6	82	57.7	19	25.4
Baldwin	105	22.3	351	74.6	57	23.0
Barbour	17	19.9	58	68.0	12	29.6
Bibb	19	29.8	41	64.3	10	32.0
Blount	24	14.6	110	66.7	23	27.5
Bullock	12	35.8	19	56.7	11	71.2
Butler	16	25.9	44	71.1	10	30.5
Calhoun	73	21.8	312	93.0	51	29.2
Chambers	20	18.8	79	74.2	16	28.8
Cherokee	16	21.8	70	95.4	11	29.2
Chilton	25	20.2	101	81.5	18	28.4
Choctaw	11	24.3	32	70.7	7	29.8
Clarke	16	19.6	51	62.4	24	55.8
Clay	13	30.9	40	95.0	6	28.3
Cleburne	13	29.9	37	85.1	10	46.2
Coffee	32	23.7	104	77.1	11	15.8
Colbert	35	21.4	125	76.3	36	42.2
Conecuh	9	22.5	44	109.8	5	23.8
Coosa	6	17.7	28	82.7	4	23.9
Covington	27	24.5	113	102.4	25	43.4
Crenshaw	10	24.5	26	63.6	5	23.2
Cullman	38	16.0	185	78.0	38	31.4
Dale	23	15.7	106	72.2	19	25.8
Dallas	46	34.4	84	62.9	17	23.5
DeKalb	30	14.9	131	65.3	27	26.4
Elmore	38	17.7	127	59.0	32	29.3
Escambia	25	21.8	87	76.0	23	41.0
Etowah	61	19.8	279	90.4	46	28.6
Fayette	17	31.2	41	75.3	8	28.5
Franklin	17	18.5	79	85.9	14	30.2
Geneva	11	14.3	76	99.1	17	43.0
Greene	8	27.6	14	48.2	4	25.9
Hale	13	23.9	27	49.7	16	58.8
Henry	13	26.3	42	84.8	10	38.7
Houston	44	15.8	186	66.9	42	28.5
Jackson	37	23.0	139	86.3	28	34.0
Jefferson	411	20.8	1,245	63.1	361	34.8
Lamar	13	28.9	44	97.8	5	21.7
Lauderdale	54	20.6	190	72.5	37	27.0
Lawrence	21	20.4	71	68.8	13	24.5
Lee	40	11.1	154	42.7	43	22.9
Limestone	38	18.3	137	66.0	23	22.1
Lowndes	13	33.1	23	58.6	4	19.1
Macon	17	24.6	47	68.0	11	29.9
Madison	153	17.4	488	55.4	111	24.3
Marengo	17	25.8	49	74.4	6	17.5
Marion	20	22.1	102	112.9	13	28.6
Marshall	49	19.3	227	89.3	37	28.2
Mobile	236	19.7	781	65.3	193	30.8
Monroe	17	24.0	45	63.5	7	19.0
Montgomery	123	18.6	362	54.6	104	30.0
Morgan	61	18.0	247	73.0	49	28.3
Perry	9	26.2	25	72.7	4	21.8
Pickens	12	19.7	52	85.5	14	43.7
Pike	17	19.3	48	54.5	16	34.7
Randolph	18	26.7	35	51.8	8	22.8
Russell	39	26.5	99	67.2	21	27.1
St. Clair	44	20.9	181	86.0	28	26.0
Shelby	65	13.1	238	48.0	53	20.4
Sumter	4	9.5	20	47.5	5	22.2
Talladega	59	24.6	156	65.0	43	35.0
Tallapoosa	29	23.8	111	90.9	32	50.4
Tuscaloosa	96	19.2	318	63.6	62	23.7
Walker	49	23.4	207	98.9	32	29.4
Washington	4	7.5	42	78.8	8	29.5
Wilcox	10	25.9	14	36.2	5	23.8
Winston	13	17.7	58	79.0	12	32.2

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Cervix Uteri Cancer Mortality (Females 2003-2005)		Ovarian Cancer Mortality (Females 2003-2005)		Prostate Cancer Mortality (Males 2003-2005)	
County	Number	Rate per 100,000[1]	Number	Rate per 100,000[1]	Number	Rate per 100,000[1]
Alabama	241	3.4	786	11.2	1,609	24.3
Autauga	3	4.0	7	9.4	10	14.1
Baldwin	7	2.8	37	14.9	76	31.7
Barbour	3	7.4	5	12.3	16	35.8
Bibb	5	16.0	3	9.6	4	12.0
Blount	3	3.6	11	13.1	12	14.4
Bullock	1	6.5	1	6.5	8	45.1
Butler	2	6.1	2	6.1	14	47.5
Calhoun	6	3.4	16	9.1	43	26.6
Chambers	2	3.6	9	16.2	19	37.5
Cherokee	2	5.3	4	10.6	11	30.6
Chilton	1	1.6	9	14.2	13	21.0
Choctaw	1	4.3	0	0.0	10	47.7
Clarke	3	7.0	5	11.6	15	38.6
Clay	2	9.4	3	14.1	6	29.0
Cleburne	1	4.6	1	4.6	7	32.2
Coffee	2	2.9	11	15.8	20	29.8
Colbert	1	1.2	6	7.0	9	11.4
Conecuh	2	9.5	6	28.6	8	42.7
Coosa	0	0.0	3	17.9	5	29.8
Covington	5	8.7	11	19.1	14	26.2
Crenshaw	1	4.6	4	18.6	5	25.5
Cullman	3	2.5	13	10.7	31	26.1
Dale	4	5.4	10	13.6	15	20.7
Dallas	4	5.5	6	8.3	25	41.1
DeKalb	2	2.0	12	11.7	12	12.1
Elmore	1	0.9	13	11.9	22	19.5
Escambia	3	5.3	3	5.3	12	20.6
Etowah	3	1.9	29	18.1	41	27.5
Fayette	0	0.0	2	7.1	8	30.0
Franklin	0	0.0	5	10.8	10	21.8
Geneva	0	0.0	4	10.1	10	26.6
Greene	0	0.0	5	32.4	4	29.6
Hale	3	11.0	3	11.0	10	36.0
Henry	1	3.9	4	15.5	7	29.1
Houston	2	1.4	19	12.9	40	29.6
Jackson	3	3.6	8	9.7	17	21.6
Jefferson	32	3.1	114	11.0	276	29.5
Lamar	1	4.3	3	13.0	3	13.7
Lauderdale	6	4.4	10	7.3	31	24.6
Lawrence	0	0.0	3	5.7	7	13.8
Lee	1	0.5	16	8.5	40	22.0
Limestone	3	2.9	6	5.8	12	11.2
Lowndes	0	0.0	1	4.8	4	21.8
Macon	2	5.4	3	8.2	14	44.2
Madison	16	3.5	42	9.2	75	17.1
Marengo	0	0.0	1	2.9	17	54.4
Marion	3	6.6	7	15.4	13	28.9
Marshall	6	4.6	18	13.7	20	15.9
Mobile	21	3.3	65	10.4	138	23.9
Monroe	1	2.7	6	16.3	4	11.7
Montgomery	17	4.9	50	14.4	86	27.1
Morgan	7	4.0	17	9.8	37	22.0
Perry	0	0.0	4	21.8	9	57.2
Pickens	3	9.4	4	12.5	13	45.6
Pike	0	0.0	4	8.7	6	14.0
Randolph	1	2.8	8	22.8	7	21.2
Russell	6	7.7	9	11.6	27	38.3
St. Clair	4	3.7	22	20.4	13	11.9
Shelby	5	1.9	17	6.5	20	7.9
Sumter	1	4.4	2	8.9	13	68.8
Talladega	4	3.3	4	3.3	27	22.8
Tallapoosa	3	4.7	11	17.3	17	29.0
Tuscaloosa	6	2.3	22	8.4	46	18.7
Walker	5	4.6	15	13.8	23	22.6
Washington	4	14.7	2	7.4	9	34.4
Wilcox	1	4.8	2	9.5	9	50.5
Winston	0	0.0	8	21.5	4	11.0

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Meninges, Brain, Other Cen. Nervous System Cancer Mortality (2003-2005)		Alzheimer's Disease Mortality (2003-2005)		Diabetes Mellitus Mortality (2003-2005)	
County	Number	Rate per 100,000[1]	Number	Rate per 100,000[1]	Number	Rate per 100,000[1]
Alabama	611	4.5	4,145	30.6	4,273	31.5
Autauga	8	5.6	46	32.4	51	35.9
Baldwin	26	5.5	164	34.8	124	26.3
Barbour	4	4.7	34	39.8	17	19.9
Bibb	2	3.1	7	11.0	20	31.4
Blount	6	3.6	53	32.2	29	17.6
Bullock	0	0.0	27	80.6	13	38.8
Butler	4	6.5	14	22.6	29	46.9
Calhoun	24	7.2	78	23.2	64	19.1
Chambers	6	5.6	58	54.5	44	41.3
Cherokee	4	5.5	29	39.5	16	21.8
Chilton	2	1.6	36	29.1	22	17.8
Choctaw	0	0.0	14	30.9	7	15.5
Clarke	1	1.2	40	48.9	29	35.5
Clay	2	4.8	10	23.8	16	38.0
Cleburne	4	9.2	17	39.1	12	27.6
Coffee	8	5.9	49	36.3	33	24.5
Colbert	12	7.3	50	30.5	60	36.6
Conecuh	1	2.5	13	32.4	19	47.4
Coosa	2	5.9	7	20.7	15	44.3
Covington	3	2.7	54	49.0	30	27.2
Crenshaw	1	2.4	15	36.7	17	41.6
Cullman	12	5.1	107	45.1	75	31.6
Dale	4	2.7	47	32.0	50	34.1
Dallas	3	2.2	59	44.2	59	44.2
DeKalb	15	7.5	53	26.4	41	20.4
Elmore	9	4.2	48	22.3	71	33.0
Escambia	9	7.9	71	62.0	68	59.4
Etowah	19	6.2	152	49.2	99	32.1
Fayette	1	1.8	22	40.4	16	29.4
Franklin	5	5.4	18	19.6	65	70.7
Geneva	4	5.2	48	62.6	37	48.3
Greene	1	3.4	3	10.3	9	31.0
Hale	2	3.7	12	22.1	23	42.3
Henry	1	2.0	26	52.5	16	32.3
Houston	13	4.7	121	43.5	51	18.3
Jackson	7	4.3	37	23.0	62	38.5
Jefferson	75	3.8	626	31.7	736	37.3
Lamar	2	4.4	19	42.2	11	24.5
Lauderdale	20	7.6	130	49.6	62	23.7
Lawrence	5	4.8	30	29.1	42	40.7
Lee	12	3.3	71	19.7	66	18.3
Limestone	11	5.3	33	15.9	43	20.7
Lowndes	1	2.5	6	15.3	20	51.0
Macon	2	2.9	30	43.4	30	43.4
Madison	35	4.0	197	22.4	286	32.5
Marengo	3	4.6	8	12.1	31	47.1
Marion	5	5.5	29	32.1	22	24.4
Marshall	16	6.3	84	33.0	32	12.6
Mobile	53	4.4	332	27.7	325	27.2
Monroe	2	2.8	17	24.0	25	35.3
Montgomery	20	3.0	188	28.4	344	51.9
Morgan	16	4.7	74	21.9	126	37.2
Perry	3	8.7	11	32.0	14	40.7
Pickens	2	3.3	17	27.9	15	24.7
Pike	4	4.5	16	18.2	44	50.0
Randolph	5	7.4	24	35.5	24	35.5
Russell	11	7.5	37	25.1	34	23.1
St. Clair	8	3.8	60	28.5	43	20.4
Shelby	18	3.6	93	18.7	99	20.0
Sumter	1	2.4	10	23.8	13	30.9
Talladega	14	5.8	90	37.5	57	23.8
Tallapoosa	5	4.1	49	40.1	61	50.0
Tuscaloosa	15	3.0	101	20.2	134	26.8
Walker	12	5.7	59	28.2	67	32.0
Washington	2	3.8	21	39.4	17	31.9
Wilcox	0	0.0	15	38.8	16	41.4
Winston	8	10.9	29	39.5	25	34.0

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Heart Diseases Mortality (2003-2005)		Ischemic Heart Diseases Mortality (2003-2005)		Heart Failure Mortality (2003-2005)	
County	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000[1]
Alabama	38,683	285.4	18,789	138.6	6,606	48.7
Autauga	348	244.8	122	85.8	120	84.4
Baldwin	1,300	276.2	700	148.7	170	36.1
Barbour	252	295.3	63	73.8	34	39.8
Bibb	151	236.8	89	139.6	26	40.8
Blount	468	284.0	210	127.4	96	58.2
Bullock	108	322.5	58	173.2	12	35.8
Butler	299	483.2	109	176.2	87	140.6
Calhoun	1,294	385.5	714	212.7	176	52.4
Chambers	420	394.6	161	151.3	62	58.3
Cherokee	224	305.4	131	178.6	43	58.6
Chilton	426	343.8	244	196.9	74	59.7
Choctaw	150	331.6	75	165.8	27	59.7
Clarke	220	269.0	142	173.6	34	41.6
Clay	182	432.3	134	318.3	24	57.0
Cleburne	128	294.5	57	131.2	30	69.0
Coffee	435	322.4	217	160.8	133	98.6
Colbert	606	369.7	378	230.6	45	27.5
Conecuh	169	421.6	73	182.1	12	29.9
Coosa	123	363.3	57	168.4	28	82.7
Covington	462	418.8	209	189.5	85	77.1
Crenshaw	161	394.0	70	171.3	33	80.8
Cullman	803	338.5	425	179.2	154	64.9
Dale	375	255.6	216	147.2	70	47.7
Dallas	488	365.4	231	173.0	79	59.2
DeKalb	769	383.1	311	154.9	243	121.1
Elmore	544	252.8	239	111.1	77	35.8
Escambia	344	300.4	208	181.6	29	25.3
Etowah	1,202	389.3	718	232.5	234	75.8
Fayette	184	337.8	67	123.0	34	62.4
Franklin	343	373.0	172	187.0	28	30.4
Geneva	292	380.8	154	200.9	67	87.4
Greene	135	465.1	23	79.2	20	68.9
Hale	189	347.9	90	165.7	28	51.5
Henry	166	335.3	83	167.6	32	64.6
Houston	671	241.3	321	115.4	124	44.6
Jackson	588	365.2	285	177.0	115	71.4
Jefferson	5,222	264.8	2,662	135.0	776	39.4
Lamar	161	357.9	83	184.5	42	93.4
Lauderdale	638	243.4	306	116.8	109	41.6
Lawrence	289	280.1	162	157.0	46	44.6
Lee	643	178.1	337	93.4	173	47.9
Limestone	547	263.6	255	122.9	58	28.0
Lowndes	157	400.0	44	112.1	84	214.0
Macon	258	373.4	71	102.8	148	214.2
Madison	1,779	202.1	586	66.6	307	34.9
Marengo	260	394.9	170	258.2	38	57.7
Marion	364	402.9	197	218.1	103	114.0
Marshall	971	381.8	422	165.9	154	60.6
Mobile	3,237	270.5	1,858	155.2	312	26.1
Monroe	237	334.4	87	122.8	28	39.5
Montgomery	1,507	227.3	795	119.9	211	31.8
Morgan	945	279.1	298	88.0	144	42.5
Perry	107	311.2	44	128.0	27	78.5
Pickens	217	356.7	91	149.6	76	124.9
Pike	312	354.5	82	93.2	27	30.7
Randolph	238	352.4	147	217.7	42	62.2
Russell	274	186.1	152	103.2	54	36.7
St. Clair	576	273.6	291	138.2	128	60.8
Shelby	722	145.5	314	63.3	103	20.8
Sumter	144	342.1	54	128.3	16	38.0
Talladega	773	322.3	313	130.5	171	71.3
Tallapoosa	442	362.1	258	211.4	87	71.3
Tuscaloosa	1,119	223.6	506	101.1	190	38.0
Walker	980	468.0	443	211.6	140	66.9
Washington	146	273.9	61	114.4	26	48.8
Wilcox	138	357.1	40	103.5	17	44.0
Winston	261	355.4	104	141.6	84	114.4

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Cerebrovascular Diseases (Stroke) Mortality (2003-2005)		Pneumonia Mortality (2003-2005)		Chronic Lower Respiratory Diseases Mortality (2003-2005)	
County	Number	Rate per 100,000	Number	Rate per 100,000[1]	Number	Rate per 100,000[1]
Alabama	8,934	65.9	3,111	23.0	7,156	52.8
Autauga	65	45.7	22	15.5	67	47.1
Baldwin	278	59.1	69	14.7	195	41.4
Barbour	64	75.0	21	24.6	57	66.8
Bibb	89	139.6	15	23.5	35	54.9
Blount	87	52.8	70	42.5	94	57.0
Bullock	25	74.7	8	23.9	17	50.8
Butler	61	98.6	30	48.5	49	79.2
Calhoun	228	67.9	100	29.8	206	61.4
Chambers	127	119.3	24	22.6	74	69.5
Cherokee	51	69.5	25	34.1	56	76.3
Chilton	86	69.4	39	31.5	74	59.7
Choctaw	49	108.3	7	15.5	28	61.9
Clarke	80	97.8	9	11.0	38	46.5
Clay	31	73.6	12	28.5	26	61.8
Cleburne	29	66.7	9	20.7	33	75.9
Coffee	86	63.7	37	27.4	88	65.2
Colbert	106	64.7	38	23.2	99	60.4
Conecuh	40	99.8	18	44.9	22	54.9
Coosa	30	88.6	8	23.6	17	50.2
Covington	101	91.6	62	56.2	74	67.1
Crenshaw	41	100.3	19	46.5	50	122.4
Cullman	169	71.2	43	18.1	166	70.0
Dale	65	44.3	18	12.3	108	73.6
Dallas	111	83.1	31	23.2	55	41.2
DeKalb	102	50.8	40	19.9	138	68.7
Elmore	93	43.2	27	12.5	108	50.2
Escambia	86	75.1	22	19.2	51	44.5
Etowah	254	82.3	120	38.9	255	82.6
Fayette	59	108.3	16	29.4	37	67.9
Franklin	77	83.7	30	32.6	70	76.1
Geneva	64	83.5	12	15.7	60	78.3
Greene	22	75.8	12	41.3	8	27.6
Hale	34	62.6	14	25.8	15	27.6
Henry	68	137.3	7	14.1	31	62.6
Houston	149	53.6	27	9.7	137	49.3
Jackson	104	64.6	42	26.1	92	57.1
Jefferson	1,566	79.4	504	25.6	972	49.3
Lamar	39	86.7	14	31.1	32	71.1
Lauderdale	193	73.6	71	27.1	139	53.0
Lawrence	62	60.1	23	22.3	57	55.2
Lee	161	44.6	39	10.8	129	35.7
Limestone	135	65.1	46	22.2	81	39.0
Lowndes	25	63.7	6	15.3	13	33.1
Macon	44	63.7	14	20.3	23	33.3
Madison	428	48.6	155	17.6	326	37.0
Marengo	55	83.5	17	25.8	32	48.6
Marion	59	65.3	27	29.9	65	72.0
Marshall	186	73.1	85	33.4	210	82.6
Mobile	734	61.3	221	18.5	535	44.7
Monroe	52	73.4	25	35.3	40	56.4
Montgomery	382	57.6	115	17.3	330	49.8
Morgan	156	46.1	90	26.6	171	50.5
Perry	33	96.0	5	14.5	9	26.2
Pickens	49	80.5	24	39.5	30	49.3
Pike	47	53.4	18	20.5	27	30.7
Randolph	53	78.5	13	19.2	39	57.7
Russell	80	54.3	34	23.1	70	47.5
St. Clair	123	58.4	57	27.1	155	73.6
Shelby	198	39.9	55	11.1	170	34.3
Sumter	39	92.7	7	16.6	19	45.1
Talladega	187	78.0	46	19.2	160	66.7
Tallapoosa	80	65.5	40	32.8	97	79.5
Tuscaloosa	317	63.4	148	29.6	247	49.4
Walker	142	67.8	74	35.3	174	83.1
Washington	30	56.3	8	15.0	21	39.4
Wilcox	31	80.2	9	23.3	6	15.5
Winston	37	50.4	18	24.5	47	64.0

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Chronic Liver Disease and Cirrhosis Mortality (2003-2005)		Nephritis, Nephrotic Syndrome, and Nephrosis Mortality (2003-2005)		Accident (All Types) Mortality (2003-2005)	
County	Number	Rate per 100,000[1]	Number	Rate per 100,000[1]	Number	Rate per 100,000[1]
Alabama	1,378	10.2	3,132	23.1	6,931	51.1
Autauga	11	7.7	20	14.1	74	52.1
Baldwin	75	15.9	64	13.6	277	58.8
Barbour	6	7.0	17	19.9	43	50.4
Bibb	10	15.7	8	12.5	55	86.3
Blount	12	7.3	46	27.9	91	55.2
Bullock	6	17.9	16	47.8	16	47.8
Butler	6	9.7	24	38.8	47	76.0
Calhoun	32	9.5	90	26.8	199	59.3
Chambers	8	7.5	28	26.3	61	57.3
Cherokee	11	15.0	20	27.3	40	54.5
Chilton	10	8.1	26	21.0	97	78.3
Choctaw	5	11.1	11	24.3	36	79.6
Clarke	1	1.2	19	23.2	58	70.9
Clay	8	19.0	13	30.9	24	57.0
Cleburne	1	2.3	11	25.3	30	69.0
Coffee	13	9.6	31	23.0	50	37.1
Colbert	10	6.1	33	20.1	80	48.8
Conecuh	6	15.0	13	32.4	29	72.3
Coosa	3	8.9	8	23.6	27	79.7
Covington	13	11.8	44	39.9	70	63.5
Crenshaw	3	7.3	16	39.2	29	71.0
Cullman	18	7.6	70	29.5	144	60.7
Dale	18	12.3	23	15.7	66	45.0
Dallas	10	7.5	41	30.7	79	59.2
DeKalb	18	9.0	46	22.9	129	64.3
Elmore	18	8.4	28	13.0	105	48.8
Escambia	19	16.6	11	9.6	87	76.0
Etowah	51	16.5	94	30.4	169	54.7
Fayette	5	9.2	12	22.0	42	77.1
Franklin	8	8.7	23	25.0	67	72.9
Geneva	12	15.7	16	20.9	57	74.3
Greene	0	0.0	20	68.9	15	51.7
Hale	3	5.5	22	40.5	33	60.7
Henry	7	14.1	16	32.3	31	62.6
Houston	24	8.6	39	14.0	104	37.4
Jackson	28	17.4	27	16.8	104	64.6
Jefferson	210	10.7	562	28.5	952	48.3
Lamar	4	8.9	13	28.9	23	51.1
Lauderdale	27	10.3	68	25.9	128	48.8
Lawrence	10	9.7	33	32.0	78	75.6
Lee	21	5.8	44	12.2	112	31.0
Limestone	12	5.8	43	20.7	111	53.5
Lowndes	1	2.5	9	22.9	37	94.3
Macon	1	1.4	23	33.3	43	62.2
Madison	76	8.6	171	19.4	329	37.4
Marengo	6	9.1	20	30.4	42	63.8
Marion	11	12.2	35	38.7	70	77.5
Marshall	39	15.3	67	26.3	128	50.3
Mobile	143	11.9	211	17.6	592	49.5
Monroe	4	5.6	21	29.6	45	63.5
Montgomery	72	10.9	132	19.9	256	38.6
Morgan	28	8.3	79	23.3	165	48.7
Perry	2	5.8	16	46.5	33	96.0
Pickens	5	8.2	23	37.8	44	72.3
Pike	5	5.7	28	31.8	59	67.0
Randolph	4	5.9	26	38.5	51	75.5
Russell	18	12.2	34	23.1	64	43.5
St. Clair	26	12.4	50	23.8	91	43.2
Shelby	39	7.9	69	13.9	180	36.3
Sumter	4	9.5	14	33.3	22	52.3
Talladega	28	11.7	49	20.4	110	45.9
Tallapoosa	12	9.8	30	24.6	54	44.2
Tuscaloosa	44	8.8	110	22.0	199	39.8
Walker	31	14.8	67	32.0	149	71.2
Washington	3	5.6	11	20.6	25	46.9
Wilcox	2	5.2	10	25.9	27	69.9
Winston	1	1.4	18	24.5	47	64.0

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Motor Vehicle Accident Mortality (2003-2005)		Accidental Drowning and Submersion Mortality (2003-2005)		Accidental Smoke, Fire, Flames Mortality (2003-2005)	
County	Number	Rate per 100,000[1]	Number	Rate per 100,000[1]	Number	Rate per 100,000[1]
Alabama	3,480	25.7	187	1.4	322	2.4
Autauga	40	28.1	2	1.4	4	2.8
Baldwin	111	23.6	9	1.9	9	1.9
Barbour	28	32.8	0	0.0	2	2.3
Bibb	31	48.6	0	0.0	3	4.7
Blount	50	30.3	5	3.0	6	3.6
Bullock	10	29.9	0	0.0	1	3.0
Butler	27	43.6	2	3.2	2	3.2
Calhoun	108	32.2	2	0.6	11	3.3
Chambers	27	25.4	1	0.9	3	2.8
Cherokee	24	32.7	0	0.0	0	0.0
Chilton	51	41.2	4	3.2	4	3.2
Choctaw	22	48.6	2	4.4	2	4.4
Clarke	35	42.8	3	3.7	1	1.2
Clay	7	16.6	1	2.4	1	2.4
Cleburne	17	39.1	0	0.0	0	0.0
Coffee	30	22.2	0	0.0	1	0.7
Colbert	38	23.2	1	0.6	2	1.2
Conecuh	18	44.9	1	2.5	0	0.0
Coosa	16	47.3	2	5.9	3	8.9
Covington	41	37.2	2	1.8	3	2.7
Crenshaw	15	36.7	0	0.0	3	7.3
Cullman	94	39.6	2	0.8	10	4.2
Dale	34	23.2	1	0.7	2	1.4
Dallas	41	30.7	1	0.7	10	7.5
DeKalb	66	32.9	2	1.0	5	2.5
Elmore	61	28.4	4	1.9	3	1.4
Escambia	47	41.0	4	3.5	5	4.4
Etowah	77	24.9	4	1.3	9	2.9
Fayette	18	33.0	0	0.0	1	1.8
Franklin	34	37.0	4	4.3	4	4.3
Geneva	35	45.6	2	2.6	2	2.6
Greene	11	37.9	2	6.9	0	0.0
Hale	23	42.3	1	1.8	3	5.5
Henry	21	42.4	1	2.0	0	0.0
Houston	50	18.0	5	1.8	3	1.1
Jackson	55	34.2	6	3.7	6	3.7
Jefferson	382	19.4	25	1.3	55	2.8
Lamar	13	28.9	0	0.0	1	2.2
Lauderdale	68	25.9	5	1.9	3	1.1
Lawrence	48	46.5	0	0.0	7	6.8
Lee	60	16.6	2	0.6	5	1.4
Limestone	71	34.2	2	1.0	2	1.0
Lowndes	23	58.6	1	2.5	6	15.3
Macon	24	34.7	3	4.3	1	1.4
Madison	151	17.2	11	1.2	9	1.0
Marengo	24	36.4	0	0.0	4	6.1
Marion	33	36.5	2	2.2	1	1.1
Marshall	66	26.0	4	1.6	4	1.6
Mobile	283	23.6	22	1.8	19	1.6
Monroe	30	42.3	1	1.4	1	1.4
Montgomery	131	19.8	5	0.8	12	1.8
Morgan	72	21.3	3	0.9	6	1.8
Perry	21	61.1	0	0.0	7	20.4
Pickens	24	39.5	0	0.0	3	4.9
Pike	32	36.4	0	0.0	4	4.5
Randolph	27	40.0	1	1.5	2	3.0
Russell	32	21.7	3	2.0	3	2.0
St. Clair	35	16.6	0	0.0	7	3.3
Shelby	89	17.9	3	0.6	8	1.6
Sumter	15	35.6	1	2.4	0	0.0
Talladega	60	25.0	4	1.7	3	1.3
Tallapoosa	29	23.8	3	2.5	1	0.8
Tuscaloosa	100	20.0	4	0.8	8	1.6
Walker	68	32.5	4	1.9	11	5.3
Washington	16	30.0	1	1.9	2	3.8
Wilcox	18	46.6	1	2.6	1	2.6
Winston	22	30.0	0	0.0	2	2.7

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Accidental Poisoning and Exposure to Noxious Subst. Mortality (2003-2005)		Homicide Mortality (2003-2005)		Suicide Mortality (2003-2005)	
County	Number	Rate per 100,000[1]	Number	Rate per 100,000[1]	Number	Rate per 100,000[1]
Alabama	646	4.8	1,233	9.1	1,586	11.7
Autauga	4	2.8	5	3.5	14	9.9
Baldwin	40	8.5	18	3.8	54	11.5
Barbour	4	4.7	10	11.7	5	5.9
Bibb	1	1.6	3	4.7	12	18.8
Blount	5	3.0	13	7.9	23	14.0
Bullock	1	3.0	3	9.0	2	6.0
Butler	1	1.6	13	21.0	8	12.9
Calhoun	18	5.4	33	9.8	48	14.3
Chambers	7	6.6	5	4.7	7	6.6
Cherokee	4	5.5	4	5.5	15	20.4
Chilton	13	10.5	3	2.4	21	16.9
Choctaw	1	2.2	3	6.6	5	11.1
Clarke	3	3.7	6	7.3	5	6.1
Clay	0	0.0	1	2.4	5	11.9
Cleburne	3	6.9	8	18.4	11	25.3
Coffee	3	2.2	5	3.7	9	6.7
Colbert	11	6.7	11	6.7	27	16.5
Conecuh	5	12.5	8	20.0	5	12.5
Coosa	1	3.0	3	8.9	6	17.7
Covington	2	1.8	4	3.6	15	13.6
Crenshaw	1	2.4	3	7.3	6	14.7
Cullman	4	1.7	6	2.5	29	12.2
Dale	10	6.8	5	3.4	17	11.6
Dallas	6	4.5	31	23.2	17	12.7
DeKalb	3	1.5	5	2.5	18	9.0
Elmore	2	0.9	10	4.6	19	8.8
Escambia	10	8.7	10	8.7	12	10.5
Etowah	23	7.4	25	8.1	49	15.9
Fayette	3	5.5	4	7.3	10	18.4
Franklin	5	5.4	4	4.3	12	13.0
Geneva	4	5.2	2	2.6	15	19.6
Greene	0	0.0	6	20.7	3	10.3
Hale	0	0.0	9	16.6	5	9.2
Henry	2	4.0	6	12.1	4	8.1
Houston	4	1.4	22	7.9	30	10.8
Jackson	8	5.0	10	6.2	24	14.9
Jefferson	126	6.4	343	17.4	228	11.6
Lamar	1	2.2	0	0.0	8	17.8
Lauderdale	7	2.7	12	4.6	38	14.5
Lawrence	4	3.9	8	7.8	13	12.6
Lee	6	1.7	30	8.3	35	9.7
Limestone	6	2.9	12	5.8	28	13.5
Lowndes	0	0.0	12	30.6	3	7.6
Macon	2	2.9	16	23.2	6	8.7
Madison	30	3.4	46	5.2	96	10.9
Marengo	0	0.0	8	12.1	2	3.0
Marion	3	3.3	9	10.0	10	11.1
Marshall	11	4.3	5	2.0	28	11.0
Mobile	78	6.5	136	11.4	116	9.7
Monroe	0	0.0	5	7.1	7	9.9
Montgomery	21	3.2	86	13.0	70	10.6
Morgan	29	8.6	22	6.5	54	15.9
Perry	0	0.0	4	11.6	3	8.7
Pickens	2	3.3	3	4.9	7	11.5
Pike	2	2.3	6	6.8	11	12.5
Randolph	5	7.4	8	11.8	11	16.3
Russell	5	3.4	22	14.9	22	14.9
St. Clair	12	5.7	11	5.2	27	12.8
Shelby	18	3.6	20	4.0	46	9.3
Sumter	1	2.4	4	9.5	0	0.0
Talladega	9	3.8	16	6.7	34	14.2
Tallapoosa	5	4.1	9	7.4	18	14.7
Tuscaloosa	24	4.8	36	7.2	57	11.4
Walker	22	10.5	13	6.2	29	13.8
Washington	0	0.0	2	3.8	4	7.5
Wilcox	1	2.6	9	23.3	0	0.0
Winston	4	5.4	3	4.1	8	10.9

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Infant Mortality Rate – 2004-2006 (Per 1,000 births)		Low Weight Births - 2006		Births to Teenagers (age 10-19) - 2006	
County	Number	Rate[1]	Number	Percent[1]	Number	Percent
Alabama	1,646	9.0	6,616	10.5	8,670	13.8
Autauga	19	9.8	61	9.5	83	12.9
Baldwin	42	6.8	210	9.5	282	12.7
Barbour	12	10.6	44	10.6	80	19.3
Bibb	13	16.6	35	13.6	52	20.2
Blount	16	7.8	46	6.7	92	13.3
Bullock	5	9.1	27	13.4	36	17.9
Butler	9	10.8	31	10.2	58	19.1
Calhoun	31	6.8	123	8.1	219	14.5
Chambers	7	5.7	42	10.7	60	15.2
Cherokee	6	7.6	20	7.8	35	13.7
Chilton	16	9.8	55	9.9	81	14.6
Choctaw	2	4.1	22	13.8	22	13.9
Clarke	13	13.2	42	12.9	39	12.0
Clay	4	8.7	19	11.0	29	16.9
Cleburne	1	2.1	14	8.8	18	11.3
Coffee	16	9.0	48	7.7	82	13.1
Colbert	20	10.8	78	12.7	80	13.0
Conecuh	3	6.3	22	13.0	30	17.6
Coosa	5	16.3	7	7.1	17	17.2
Covington	8	5.8	38	8.2	83	18.0
Crenshaw	2	4.1	17	10.2	28	16.9
Cullman	15	5.1	87	8.7	132	13.1
Dale	14	6.1	63	8.3	91	11.9
Dallas	13	6.5	79	11.9	144	21.7
DeKalb	28	9.5	74	7.4	152	15.3
Elmore	19	6.4	88	8.8	126	12.6
Escambia	16	11.5	61	12.3	90	18.2
Etowah	29	7.7	126	9.7	212	16.4
Fayette	5	9.5	16	8.7	29	15.8
Franklin	15	11.0	32	6.7	77	16.1
Geneva	6	6.6	25	7.6	36	10.9
Greene	4	10.5	16	11.5	23	16.5
Hale	10	16.2	25	13.5	30	16.2
Henry	2	3.5	22	11.6	30	15.9
Houston	32	8.2	105	7.6	187	13.5
Jackson	16	8.7	49	8.0	89	14.5
Jefferson	312	11.2	1,191	12.4	1,196	12.4
Lamar	5	9.7	18	10.1	39	21.9
Lauderdale	20	7.0	100	9.8	149	14.5
Lawrence	15	12.4	41	10.0	68	16.6
Lee	41	9.5	136	8.8	163	10.6
Limestone	15	5.6	67	7.1	124	13.1
Lowndes	7	12.9	29	14.4	47	23.4
Macon	10	13.6	27	10.9	48	19.4
Madison	93	8.0	434	10.7	401	9.9
Marengo	7	8.5	34	12.7	34	12.7
Marion	9	8.6	38	10.3	69	18.6
Marshall	40	9.2	122	8.0	257	16.8
Mobile	151	8.5	725	11.8	996	16.3
Monroe	7	8.2	31	11.7	38	14.3
Montgomery	94	9.3	431	12.4	507	14.6
Morgan	38	8.4	150	10.3	193	13.2
Perry	6	12.7	26	16.1	29	18.0
Pickens	10	14.0	27	11.3	28	11.7
Pike	16	13.7	34	8.1	63	15.0
Randolph	8	10.3	17	6.2	62	22.7
Russell	24	12.1	76	11.1	130	19.0
St. Clair	25	8.8	84	7.9	107	10.1
Shelby	53	6.8	247	9.5	151	5.8
Sumter	5	10.6	29	17.3	20	11.9
Talladega	33	11.1	134	13.3	173	17.1
Tallapoosa	12	8.2	57	11.1	92	17.9
Tuscaloosa	70	10.3	287	12.2	285	12.1
Walker	25	9.6	84	9.5	128	14.5
Washington	8	13.6	21	10.7	34	17.4
Wilcox	6	10.7	22	12.2	31	17.1
Winston	7	8.2	28	9.7	54	18.7

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Births With Less Than Adequate Prenatal Care - 2006		Births With Tobacco Usage During Pregnancy - 2006		Births Occurring Outside Mother's County of Residence - 2006	
County	Number	Percent[1]	Number	Percent[1]	Number	Percent
Alabama	14,390	23.1	7,394	11.8	20,002	31.8
Autauga	122	19.1	84	13.1	638	99.2
Baldwin	500	22.6	329	14.9	446	20.1
Barbour	178	43.3	29	7.0	411	99.0
Bibb	66	26.6	41	16.0	256	99.6
Blount	90	13.4	87	12.6	691	99.7
Bullock	77	38.7	6	3.0	199	99.0
Butler	70	23.2	37	12.2	303	100.0
Calhoun	379	25.2	204	13.5	143	9.5
Chambers	92	23.5	55	14.0	168	42.6
Cherokee	73	28.6	49	19.1	256	100.0
Chilton	154	28.4	101	18.3	549	99.3
Choctaw	40	25.3	8	5.0	159	100.0
Clarke	92	28.2	27	8.3	134	41.1
Clay	28	16.3	34	19.8	169	98.3
Cleburne	44	28.4	39	24.5	158	99.4
Coffee	183	29.5	89	14.3	200	32.0
Colbert	86	14.0	121	19.7	217	35.3
Conecuh	60	35.3	16	9.4	169	99.4
Coosa	11	11.1	17	17.2	98	99.0
Covington	87	19.0	90	19.5	75	16.3
Crenshaw	49	29.5	29	17.5	129	77.7
Cullman	112	11.2	174	17.3	285	28.4
Dale	164	21.8	81	10.7	642	84.3
Dallas	236	35.8	74	11.2	58	8.7
DeKalb	435	44.1	137	13.8	257	25.8
Elmore	221	22.2	141	14.1	1,000	99.7
Escambia	169	34.3	74	15.0	317	64.2
Etowah	261	20.2	239	18.5	378	29.2
Fayette	25	13.7	39	21.3	183	100.0
Franklin	160	33.4	84	17.5	226	47.2
Geneva	79	24.0	51	15.4	331	100.0
Greene	61	44.5	9	6.5	137	98.6
Hale	59	33.0	7	3.8	185	100.0
Henry	35	18.5	12	6.3	189	100.0
Houston	352	25.6	82	5.9	44	3.2
Jackson	130	21.4	131	21.4	278	45.4
Jefferson	1,856	19.4	714	7.4	131	1.4
Lamar	23	13.1	45	25.4	177	99.4
Lauderdale	171	16.7	192	18.7	257	25.0
Lawrence	106	25.9	75	18.3	410	100.0
Lee	327	21.3	104	6.8	359	23.3
Limestone	228	24.2	142	15.0	503	52.9
Lowndes	53	26.4	13	6.5	199	99.0
Macon	88	35.5	15	6.0	244	98.0
Madison	785	19.4	374	9.2	118	2.9
Marengo	101	38.4	15	5.6	86	32.1
Marion	62	16.8	97	26.2	134	36.2
Marshall	539	35.5	252	16.5	486	31.8
Mobile	1,236	20.3	716	11.7	85	1.4
Monroe	52	19.8	18	6.8	76	28.7
Montgomery	861	24.8	219	6.3	47	1.4
Morgan	470	32.4	225	15.4	232	15.9
Perry	49	31.0	11	6.9	161	100.0
Pickens	60	25.2	34	14.3	234	97.9
Pike	117	28.3	38	9.1	132	31.5
Randolph	70	26.0	43	15.8	269	98.5
Russell	329	49.3	27	3.9	630	92.1
St. Clair	169	16.2	160	15.1	1,059	99.8
Shelby	453	17.6	169	6.5	2,057	78.9
Sumter	45	27.4	7	4.2	167	99.4
Talladega	160	16.0	175	17.3	346	34.2
Tallapoosa	75	14.7	79	15.5	176	34.3
Tuscaloosa	632	27.4	254	10.8	164	7.0
Walker	114	13.0	226	25.6	323	36.5
Washington	73	37.4	40	20.5	195	99.5
Wilcox	65	36.1	7	3.9	178	98.3
Winston	41	14.2	81	28.1	289	100.0

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Births to Undereducated Women - 2006		Age 65+ With "Home Bound" Disability - 2000		Age 25+ With Less Than High School Education - 2000	
County	Number	Percent[1]	Number	Percent	Number	Percent
Alabama	11,648	18.6	139,401	24.0	714,081	24.7
Autauga	79	12.3	1,115	25.1	5,872	21.3
Baldwin	370	16.7	3,913	18.0	17,258	18.0
Barbour	144	34.9	1,106	28.6	6,679	35.3
Bibb	57	22.2	680	28.2	4,984	36.8
Blount	183	26.4	1,616	24.6	9,960	29.6
Bullock	60	30.3	450	29.2	2,992	39.5
Butler	37	12.2	1,029	29.3	4,439	32.2
Calhoun	315	20.8	3,758	23.7	19,318	26.1
Chambers	67	17.0	1,348	22.7	8,778	35.8
Cherokee	58	22.7	843	22.1	6,138	36.5
Chilton	115	20.8	1,455	28.5	8,757	33.8
Choctaw	31	19.7	661	28.3	3,704	35.0
Clarke	42	12.9	1,005	26.7	5,165	29.2
Clay	46	26.7	556	23.6	3,322	34.0
Cleburne	50	31.4	445	23.0	3,536	37.1
Coffee	122	20.0	1,556	25.2	7,755	26.8
Colbert	119	19.4	1,894	22.3	9,972	26.7
Conecuh	23	13.6	610	26.2	2,984	32.3
Coosa	17	17.2	518	29.4	2,831	34.3
Covington	80	17.5	1,793	26.6	8,115	31.6
Crenshaw	30	18.1	741	31.7	3,700	39.9
Cullman	222	22.1	2,996	26.4	15,322	29.6
Dale	107	14.1	1,263	21.7	6,976	22.2
Dallas	130	19.6	1,843	28.7	8,524	29.7
DeKalb	374	37.6	2,273	25.6	15,469	36.2
Elmore	154	15.4	1,550	21.9	9,679	22.4
Escambia	97	19.6	1,328	25.4	8,030	31.5
Etowah	281	21.7	4,078	24.6	18,115	25.9
Fayette	37	20.2	904	30.4	4,265	33.9
Franklin	186	39.0	1,190	25.7	7,904	37.9
Geneva	64	19.4	1,025	24.4	6,046	34.4
Greene	14	10.2	454	30.9	2,182	35.2
Hale	19	10.4	672	29.0	3,683	34.8
Henry	34	18.0	714	26.8	3,654	33.3
Houston	236	17.1	2,787	22.9	13,771	23.5
Jackson	118	19.3	2,025	28.1	12,006	33.0
Jefferson	1,429	14.8	21,079	23.3	82,950	19.1
Lamar	41	23.0	591	23.4	3,759	34.9
Lauderdale	164	16.0	2,953	22.3	13,915	23.6
Lawrence	80	19.5	1,099	26.2	7,872	34.4
Lee	185	12.0	1,967	21.1	11,557	18.6
Limestone	227	23.9	1,889	26.0	11,081	25.5
Lowndes	25	12.4	463	28.1	2,925	35.7
Macon	43	17.4	925	27.5	4,188	30.0
Madison	527	13.0	6,141	20.5	26,308	14.6
Marengo	31	11.7	766	23.3	4,020	28.1
Marion	95	25.7	1,329	26.9	7,962	36.8
Marshall	663	43.9	2,572	22.0	16,845	30.6
Mobile	1,122	18.3	11,669	24.4	58,223	23.3
Monroe	42	15.8	877	26.1	4,939	32.1
Montgomery	651	18.8	6,156	23.4	27,905	19.7
Morgan	405	27.8	3,434	25.1	17,347	23.7
Perry	36	22.4	469	26.6	2,625	37.6
Pickens	33	13.9	782	23.7	4,108	30.3
Pike	88	21.0	955	25.6	5,472	30.9
Randolph	63	23.4	739	20.7	5,618	38.1
Russell	117	17.2	1,844	28.2	10,749	33.5
St. Clair	181	17.1	1,677	22.1	12,353	28.7
Shelby	277	10.6	2,398	19.7	12,386	13.2
Sumter	21	12.7	621	30.2	3,077	35.2
Talladega	205	20.4	2,891	27.1	16,102	30.3
Tallapoosa	127	24.8	1,702	24.8	8,489	29.9
Tuscaloosa	346	14.9	4,452	24.0	20,981	21.2
Walker	179	20.2	2,913	27.9	15,713	32.8
Washington	23	11.8	508	22.6	3,112	27.7
Wilcox	32	17.7	405	22.4	3,228	40.5
Winston	72	24.9	941	26.6	6,387	37.4

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Persons Receiving Medicare Disability - 2003		Obesity – Percent of Population in 2003		Accidental Deaths Occurring Outside of a Health Care Facility (2003-2005)	
County	Number	Percent	Number	Percent	Number	Percent[1]
Alabama	150,573	3.3	1,073,329	23.9	3,621	52.2
Autauga	1,209	2.6	10,776	23.3	39	52.7
Baldwin	3,839	2.5	34,287	22.6	133	48.0
Barbour	1,092	3.8	7,296	25.4	20	46.5
Bibb	974	4.6	4,971	23.5	32	58.2
Blount	1,300	2.4	12,178	22.5	57	62.6
Bullock	504	4.5	3,092	27.4	8	50.0
Butler	952	4.6	5,155	24.9	26	55.3
Calhoun	5,301	4.7	26,055	23.3	115	57.8
Chambers	1,497	4.2	8,823	24.7	28	45.9
Cherokee	854	3.5	5,437	22.3	23	57.5
Chilton	1,307	3.2	9,291	22.7	65	67.0
Choctaw	800	5.2	3,870	25.3	28	77.8
Clarke	1,150	4.2	6,926	25.3	38	65.5
Clay	610	4.3	3,245	22.9	9	37.5
Cleburne	646	4.4	3,181	21.8	18	60.0
Coffee	1,366	3.1	10,440	23.5	25	50.0
Colbert	2,302	4.2	12,595	23.1	35	43.8
Conecuh	725	5.4	3,422	25.3	18	62.1
Coosa	621	5.4	2,824	24.5	22	81.5
Covington	1,583	4.3	8,334	22.6	41	57.7
Crenshaw	568	4.2	3,228	23.7	11	37.9
Cullman	2,400	3.1	17,169	21.9	97	67.4
Dale	2,314	4.7	11,616	23.6	35	53.0
Dallas	2,302	5.1	12,079	26.9	35	44.3
DeKalb	2,351	3.5	14,725	22.2	64	49.6
Elmore	2,167	3.1	16,481	23.4	54	51.4
Escambia	1,476	3.9	9,321	24.4	55	63.2
Etowah	4,508	4.4	23,559	22.9	66	39.1
Fayette	731	4.0	4,145	22.7	26	61.9
Franklin	1,320	4.3	6,867	22.3	33	49.3
Geneva	1,118	4.4	5,763	22.6	31	54.4
Greene	461	4.7	2,782	28.3	14	93.3
Hale	825	4.5	4,810	26.4	23	69.7
Henry	631	3.8	4,003	24.4	19	61.3
Houston	2,416	2.6	21,658	23.7	37	35.6
Jackson	1,978	3.7	12,060	22.4	53	51.0
Jefferson	21,625	3.3	163,895	24.9	460	48.3
Lamar	702	4.6	3,425	22.6	15	65.2
Lauderdale	3,134	3.6	19,574	22.5	51	39.8
Lawrence	1,074	3.1	8,071	23.4	44	56.4
Lee	2,465	2.1	27,816	23.4	64	57.1
Limestone	1,778	2.6	15,661	23.0	58	52.3
Lowndes	507	3.8	3,679	27.6	21	56.8
Macon	781	3.3	6,716	28.7	24	55.8
Madison	5,431	1.9	69,239	23.9	150	45.6
Marengo	862	3.9	5,731	25.9	20	47.6
Marion	1,284	4.3	6,671	22.1	34	48.6
Marshall	3,083	3.7	18,492	22.0	57	44.5
Mobile	12,197	3.1	97,728	24.5	310	52.4
Monroe	889	3.7	5,671	23.9	28	62.2
Montgomery	6,378	2.9	56,530	25.5	126	49.2
Morgan	3,367	3.0	25,811	22.9	66	40.0
Perry	487	4.2	3,140	27.0	28	84.8
Pickens	929	4.5	5,137	25.1	25	56.8
Pike	1,180	4.1	7,151	24.6	33	55.9
Randolph	869	3.9	5,226	23.4	25	49.0
Russell	1,851	3.8	12,260	25.1	46	71.9
St. Clair	2,029	3.0	15,469	22.6	49	53.8
Shelby	2,661	1.7	36,182	22.7	101	56.1
Sumter	595	4.2	3,890	27.5	16	72.7
Talladega	4,300	5.4	19,326	24.2	65	59.1
Tallapoosa	1,749	4.3	9,656	23.7	23	42.6
Tuscaloosa	5,539	3.3	39,788	24.0	101	50.8
Walker	3,880	5.5	15,614	22.3	82	55.0
Washington	764	4.3	4,362	24.4	18	72.0
Wilcox	781	6.0	3,550	27.4	18	66.7
Winston	1,152	4.7	5,404	22.0	30	63.8

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

County	Life Expectancy at Birth- 2005 (years)	Sexually Transmitted Diseases Cases - 2006		Cumulative HIV Cases – as of 12/31/2006	
		Cases	Rate per 10,000	Cases	Rate per 10,000[1]
Alabama	74.8	33,463	73.6	14,737	32.4
Autauga	75.0	248	51.2	102	21.1
Baldwin	77.1	560	34.4	356	21.9
Barbour	72.9	273	96.5	119	42.1
Bibb	71.7	106	49.4	20	9.3
Blount	75.7	75	13.5	40	7.2
Bullock	71.4	123	111.7	51	46.3
Butler	71.5	240	116.3	46	22.3
Calhoun	72.5	821	73.1	270	24.1
Chambers	74.0	302	85.4	121	34.2
Cherokee	74.2	63	25.6	15	6.1
Chilton	73.9	152	36.5	41	9.8
Choctaw	75.0	72	48.9	29	19.7
Clarke	75.3	299	110.4	41	15.1
Clay	75.7	90	64.7	17	12.2
Cleburne	74.6	37	25.5	19	13.1
Coffee	75.6	321	70.6	78	17.2
Colbert	75.1	430	78.8	63	11.5
Conecuh	71.7	78	59.0	47	35.5
Coosa	72.3	60	53.9	16	14.4
Covington	73.1	138	37.3	58	15.7
Crenshaw	75.9	59	43.4	35	25.7
Cullman	74.6	109	13.7	63	7.9
Dale	75.8	353	72.8	121	25.0
Dallas	71.6	652	147.6	177	40.1
DeKalb	74.5	171	25.4	55	8.2
Elmore	76.0	395	53.6	167	22.6
Escambia	72.8	238	62.8	92	24.3
Etowah	73.3	700	68.0	182	17.7
Fayette	76.3	52	28.6	13	7.1
Franklin	74.0	102	33.2	18	5.9
Geneva	73.9	85	33.2	42	16.4
Greene	73.7	121	125.2	35	36.2
Hale	73.2	316	173.6	28	15.4
Henry	73.6	105	63.4	38	22.9
Houston	76.4	742	79.0	364	38.7
Jackson	74.1	103	19.3	33	6.2
Jefferson	74.3	6,851	104.4	4,263	65.0
Lamar	77.2	36	24.2	11	7.4
Lauderdale	76.1	520	59.5	86	9.8
Lawrence	72.8	96	27.8	19	5.5
Lee	76.4	676	54.9	228	18.5
Limestone	75.1	252	35.8	167	23.7
Lowndes	71.5	163	125.8	60	46.3
Macon	70.7	251	110.7	127	56.0
Madison	77.1	1,730	58.0	688	23.1
Marengo	73.1	217	99.4	31	14.2
Marion	74.9	70	23.3	30	10.0
Marshall	74.1	164	19.1	99	11.5
Mobile	74.0	4,629	115.8	2,381	59.5
Monroe	73.6	161	68.4	48	20.4
Montgomery	75.3	3,599	163.0	1,746	79.1
Morgan	75.1	477	41.9	175	15.4
Perry	71.8	115	101.7	31	27.4
Pickens	74.3	155	77.0	38	18.9
Pike	71.4	367	124.4	125	42.4
Randolph	75.9	92	40.8	35	15.5
Russell	74.6	314	63.6	185	37.5
St. Clair	74.8	236	32.7	75	10.4
Shelby	77.6	314	18.3	155	9.0
Sumter	77.4	213	154.8	40	29.1
Talladega	74.4	665	83.0	187	23.3
Tallapoosa	74.0	264	64.8	78	19.2
Tuscaloosa	75.3	1,446	85.9	411	24.4
Walker	71.6	297	42.4	104	14.9
Washington	76.5	93	52.5	28	15.8
Wilcox	74.7	170	131.7	25	19.4
Winston	74.1	39	15.9	16	6.5

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Data for Counties

	Families Served by the Division of Substance Abuse Services in the Ala. Department of Mental Health - FY 2004	
County	Number	Percent[1]
Alabama	20,881	1.7
Autauga	207	1.7
Baldwin	625	1.5
Barbour	98	1.3
Bibb	102	1.8
Blount	120	0.8
Bullock	19	0.7
Butler	59	1.0
Calhoun	476	1.5
Chambers	75	0.7
Cherokee	152	2.1
Chilton	111	1.0
Choctaw	18	0.4
Clarke	32	0.4
Clay	29	0.7
Cleburne	30	0.7
Coffee	191	1.5
Colbert	230	1.4
Conecuh	21	0.5
Coosa	243	7.0
Covington	175	1.6
Crenshaw	41	1.0
Cullman	404	1.8
Dale	123	0.9
Dallas	231	1.8
DeKalb	343	1.8
Elmore	327	1.9
Escambia	167	1.7
Etowah	293	1.0
Fayette	144	2.7
Franklin	209	2.3
Geneva	80	1.1
Greene	41	1.5
Hale	50	1.1
Henry	77	1.6
Houston	403	1.6
Jackson	295	1.9
Jefferson	5,887	3.3
Lamar	108	2.3
Lauderdale	359	1.4
Lawrence	85	0.8
Lee	456	1.7
Limestone	98	0.5
Lowndes	35	1.0
Macon	22	0.4
Madison	719	0.9
Marengo	65	1.0
Marion	176	1.9
Marshall	442	1.8
Mobile	1,401	1.3
Monroe	61	0.9
Montgomery	1,063	1.9
Morgan	643	2.0
Perry	30	1.0
Pickens	116	2.0
Pike	135	1.8
Randolph	63	1.0
Russell	179	1.3
St. Clair	198	1.1
Shelby	505	1.2
Sumter	29	0.8
Talladega	282	1.3
Tallapoosa	87	0.7
Tuscaloosa	926	2.2
Walker	306	1.5
Washington	14	0.3
Wilcox	46	1.4
Winston	104	1.4

[1] Caution should be used in using rates, percentages, etc. based upon fewer than 16 events. Statistical stability may be missing.

Sources of Information and Special Notes

2006 Population (pages 1-3): U.S. Census Bureau, County Population Estimates – characteristics; County Population by Age, Sex, Race, and Hispanic Origin: April 1, 2000 through July 1, 2006. http://www.census.gov/popest/counties/asrh/CC-EST2006-alldata.html

Population Change 1910-2000 (page 3): U.S. Census Bureau, County Population Census Counts 1900-90, http://www.census.gov/population/cencounts/al190090.txt for 1910 data; U.S. Census Bureau, American FactFinder, Census 2000 Summary File 1 (SF 1) 100-Percent Data for 2000 data.

Population Change 2000-2025 (page 3): U.S. Census Bureau, American FactFinder, Census 2000 Summary File 1 (SF 1) 100-Percent Data for 2000 data. Alabama State Data Center, Alabama County Population 2000 and Projections 2005-2025 for 2025. http://cber.cba.ua.edu/edata/est_prj.html

Age 65+ Population Change 2000-2025 (page 4): Alabama State Data Center, Alabama County Population 65 and Over 2000 and Projections 2005-2025 for 2025. http://cber.cba.ua.edu/edata/est_prj.html

Hispanic Population Change 1990-2006 (page 4): U.S. Census Bureau, American FactFinder, Census 1990 Summary File 1 (STF 1) 100-Percent Data for 1990 data. Alabama State Data Center, Estimates of the Hispanic Population by County, 2006. http://cber.cba.ua.edu/edata/est_prj.html

Population Below Poverty - 2004 (page 5): U.S. Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/hhes/www/saipe/saipe.html

Children (<18) Below Poverty - 2004 (page 5): U.S. Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/hhes/www/saipe/saipe.html

2005 Per Capita Personal Income (page 5): U.S. Bureau of Economic Analysis, Interactive Tables: Local Area Personal Income, Table CA1-3. http://www.bea.gov/regional/reis/default.cfm?catable=CA1-3&section=2

Medicaid Eligible Population - 2006 (page 6): Alabama Medicaid Agency, Alabama Medicaid Statistics by County – 2006. http://www.medicaid.alabama.gov/resources/stats_reports.aspx?tab=5

Medicaid Eligible Children (<21) - 2006 (page 6): Alabama Medicaid Agency, Alabama Medicaid Statistics by County – 2006. http://www.medicaid.alabama.gov/resources/stats_reports.aspx?tab=5

Medicaid Births - 2006 (page 6): Alabama Department of Public Health, Center for Health Statistics, Special query of the 2006 Birth Statistics File.

Primary Care Physicians in 2006 (page 7): Medical Licensure Commission, Licensed Physician Data Base – 2006.
(In this publication, primary care physicians include family practitioners, internal medicine specialists, pediatricians, and obstetricians and gynecologists.)

Dentists in 2003 (page 7): Board of Dental Examiners of Alabama, Licensed dentists data base - 2003.

Psychiatrists in 2006 (page 7): Medical Licensure Commission, Licensed Physician Data Base – 2006.

Hospital Beds in 2007 (page 8): Alabama Department of Public Health, Division of Provider Services, Healthcare Facilities Directory – Hospital Section. October 4, 2007. http://ph.state.al.us/facilitiesdirectory/(S(ikg10gmphl4ih5550hmu4t45))/Default.aspx

Households With No Vehicle in 2000 (page 8): U.S. Census Bureau, American FactFinder, Census 2000 Summary File 3 (SF 3) Sample Data, Table H44 - Tenure by Vehicles Available.

Uninsured Persons - 2003 (page 8): State Health Access Data Assistance Center, Alabama County Chartbook: County-Level Estimates of Uninsured July 2005. (Prepared for the Alabama Department of Public Healthy, Children's Health Insurance Program)

Cause of Death Indicators (pages 9-17): Alabama Department of Public Health, Center for Health Statistics, Special queries of the 2003, 2004, and 2005 Mortality Statistics Files for Alabama data. Centers for Disease Control and Prevention, CDC Wonder Interactive Program, Mortality – Underlying Cause of Death 2004 file. http://wonder.cdc.gov/ (Cause of death data included in this publication is not age-adjusted)

Infant Mortality Rate - 2004-2006 (page 18); Alabama Department of Public Health, Center for Health Statistics, Special queries of the 2004, 2005, and 2006 Birth Statistics Files for birth data. Alabama Department of Public Health, Center for Health Statistics, Total Resident Infant Deaths and Infant Mortality Rates by County, Alabama, 2006, 2005, 2004, and Combined 2006-2004. http://adph.org/healthstats/assets/06TotInfantDeaths.pdf

Low Weight Births - 2006 (page 18): Alabama Department of Public Health, Center for Health Statistics, Special query of the 2006 Birth Statistics File.
(Births weighing less than 2,500 grams or 5 pounds and 8 ounces are defined as being of low weight.)

Births to Teenagers (Age 10-19) - 2006 (page 18): Alabama Department of Public Health, Center for Health Statistics, Special query of the 2006 Birth Statistics File.

Births With Less Than Adequate Prenatal Care - 2006 (page 19): Alabama Department of Public Health, Center for Health Statistics, Special query of the 2006 Birth Statistics File.
(The Kotelchuck Index is used in determining adequacy of prenatal care. This index primarily considers the date when prenatal care was begun and the number of visits in determining adequacy.)

Births With Tobacco Use During Pregnancy - 2006 (page 19): Alabama Department of Public Health, Center for Health Statistics, Special query of the 2006 Birth Statistics File.

Births Occurring Outside Mother's County of Residence - 2006 (page 19): Alabama Department of Public Health, Center for Health Statistics, Special query of the 2006 Birth Statistics File.
(This indicator was included because of the serious decline in the number of rural hospitals where obstetrics are performed and the natural relationship between women receiving adequate prenatal care and the presence of obstetrical care in the county.)

Births to Undereducated Women - 2006 (page 20): Alabama Department of Public Health, Center for Health Statistics, Special query of the 2006 Birth Statistics File.
(Women are considered to be "undereducated" when their years of education is at least two years less than what would be expected for someone of their age.)

Age 65+ With "Home Bound" Disability - 2000 (page 20): U.S. Census Bureau, American FactFinder, Census 2000 Summary File 3 (SF 3) Sample Data, Table P41 – Age by Types of Disability for the Civilian Non-institutionalized Population 5 Years and Over With Disabilities.

Age 25+ With Less Than High School Education - 2000 (page 20): U.S. Census Bureau, American FactFinder, Census 2000 Summary File 3 (SF 3) Sample Data, Table P37 – Sex by Educational Attainment for the Population 25 Years and Over.

Persons Receiving Medicare Disability - 2003 (page 21): Centers for Medicare and Medicaid Services, Medicare County Enrollment, As of July 1, 2003. http://www.cms.hhs.gov/MedicareEnrpts/

Obesity - Percent of Population in 2003 (page 21): Chronic Disease in Alabama: Past, Present, and Future Trends. Pp. 16-17. http://adph.org/ADMINISTRATION/chronicdisease.pdf

Accidental Deaths Occurring Outside of a Health Care Facility - (2003-2005) (page 21): Alabama Department of Public Health, Center for Health Statistics, Special query of the 2003, 2004, and 2005 Mortality Statistics File.
(This indicator was used in the place of an "emergency medical services emergency ambulance runs" data base. While there is such a data base maintained within the Alabama Department of Public Health, reporting to this data base is not complete and could produce confusing findings. The provision of adequate emergency medical service continues to be a serious issue in most rural Alabama counties.)

Life Expectancy at Birth - 2005 (page 22): Alabama Department of Public Health, Center for Health Statistics, County Health Profiles – 2005. http://www.adph.org/healthstats/Default.asp?id=1521

Sexually Transmitted Disease Cases - 2006 (page 22): Alabama Department of Public Health, Division of STD Prevention and Control, Statistics, County Totals – 2006. http://www.adph.org/STD/Default.asp?id=1080

Cumulative HIV Cases as of 12/31/2006 (page 22): Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control, Statistics, Public Health Area (January – December 2006). http://www.adph.org/aids/Default.asp?id=984
(National data for the cumulative number of HIV cases as of December 31, 2006 is not comparable due to the fact that not all states report this information to the Centers for Disease Control and Prevention and those that are reporting initiated this reporting at varying times.)

Families Served by the Division of Substance Abuse Services in the Alabama Department of Mental Health - FY 2004 (page 23): Alabama Department of Mental Health, Department's Annual Report, '03-'04. p35.
http://www.mh.alabama.gov/downloads/AnnualReports/ADMH_AnnualReport_03_04Part3.pdf

PERMISSION IS GRANTED TO DUPLICATE OR OTHERWISE USE ALL OR ANY PORTION OF THIS REPORT

For additional information please contact the Office of Primary Care and Rural Health Development at (334) 206-5396 or the Alabama Rural Health Association at (334) 281-3866.

APPENDIX C:

Selected Indicators of Health Status in Alabama

Detailed information of five of Alabama's leading causes of death:

Heart Diseases
Cancer
Cerebrovascular Diseases (Stroke)
Accidents
Diabetes

October 2007

What Is Considered to be Rural In This Publication?

There are several differing definitions for "rural" with most definitions being specific to programs or initiatives. "Rural" is not a concrete term. Opinions on what is considered as rural tend to change between geographical areas and over time. For additional information on what areas are considered as being "rural" for the various federal programs, visit the Rural Assistance Center at http://maps.rupri.org/circ/racrural/amirural.asp where an address can be entered to determine rural status for each program.

This publication considers entire counties as being "rural" or "urban" since most data of interest for studies is available at the county level, but not at sub-county levels. Counties are assigned a score using four major indicators of rurality in this definition. These are population per square mile, the size and number of cities in a county, percentage of total employment comprised by employment in public education, and per capita agricultural sales. For additional information on the determination of which counties are considered "rural," please visit the "What Is Rural?" section at the Alabama Rural Health Association's Web site, www.arhaonline.org.

This publication also presents information on the eight regions established through the Alabama Rural Action Commission, the Black Belt Action Commission, Alabama's Appalachian Region counties, Alabama's Delta Region counties, Alabama's "rural" counties, and Alabama's "urban" counties. In addition, "rural" counties are further classified and presented as being "highly" or "moderately" rural according to their score. "Rural" counties are also classified and presented as being in "rural south" or "rural north" Alabama because of great demographic and health status variation in these portions of the state.

For additional information or assistance contact:

Alabama Department of Public Health
Office of Primary Care and Rural Health
The RSA Tower/Suite 1040
201 Monroe Street
P.O. Box 303017
Montgomery, AL 36130
Telephone: (334) 206-5396
dquinney@adph.state.al.us

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Pike Road, AL 36064
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Email: arhaquinney@mindspring.com

Table of Contents

Indicators of Health Status in Alabama:
HEART DISEASES MORTALITY

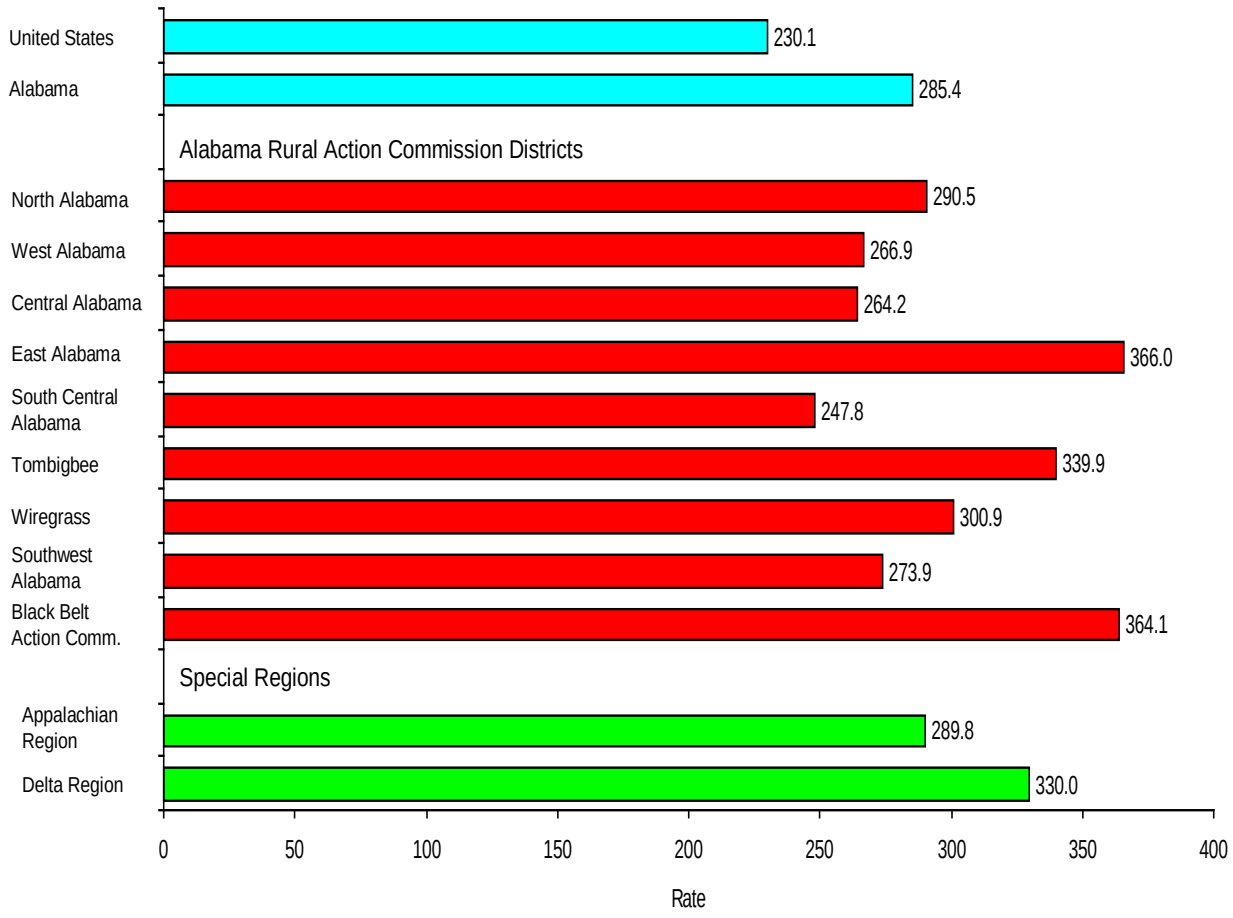
Heart disease usually occurs in individuals who:

- have high blood pressure.
- have high blood cholesterol.
- are physically inactive.
- smoke or are exposed to environmental tobacco smoke.
- are obese.
- have high low density (LDL) cholesterol.
- have low high density (HDL) cholesterol.
- have a family history of early heart disease (before age 55).

To prevent or delay the complications of heart disease, persons with heart disease should:

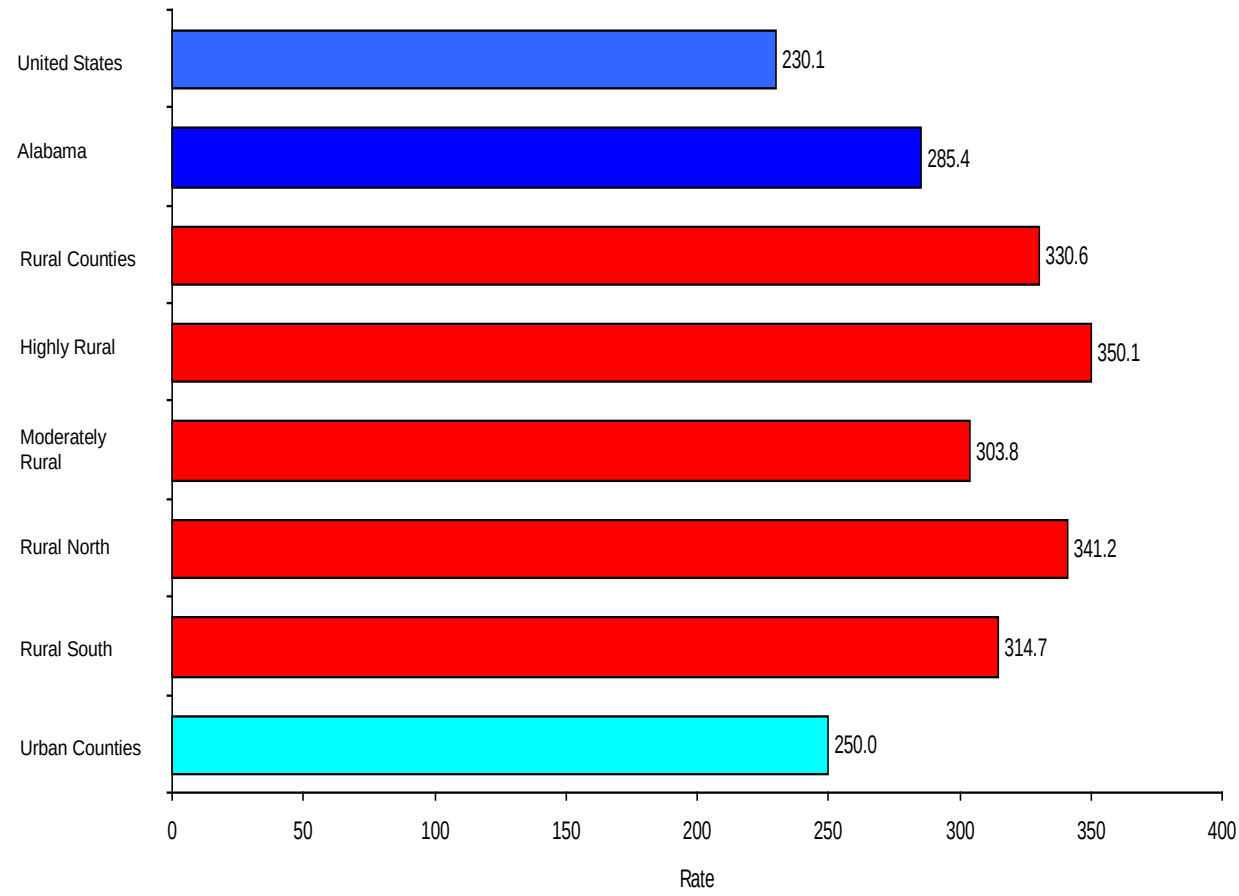
- control high blood pressure.
- reduce dietary fat, saturated fat, trans fat, and cholesterol to lower blood levels of cholesterol.
- participate in moderate physical activity four to five times a week.
- avoid or eliminate cigarette smoking, including environmental tobacco smoke.
- maintain blood sugar levels within normal ranges.
- eat five or more servings of fruits and vegetables daily.
- eat 6 to 11 servings daily of breads, cereals, rice, pastas, and other grain products.
- manage diet and physical activity to maintain a healthy weight.
- lose excess weight, be physically active, and avoid smoking to increase blood HDL levels.
- lose excess weight and reduce dietary fat to reduce blood LDL levels.
- visit physician regularly and take medication as directed.

Heart Diseases Mortality Rates for 2003-2005
U.S., Alabama, Alabama Rural Action Commission Districts, and Special Regions In Alabama



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

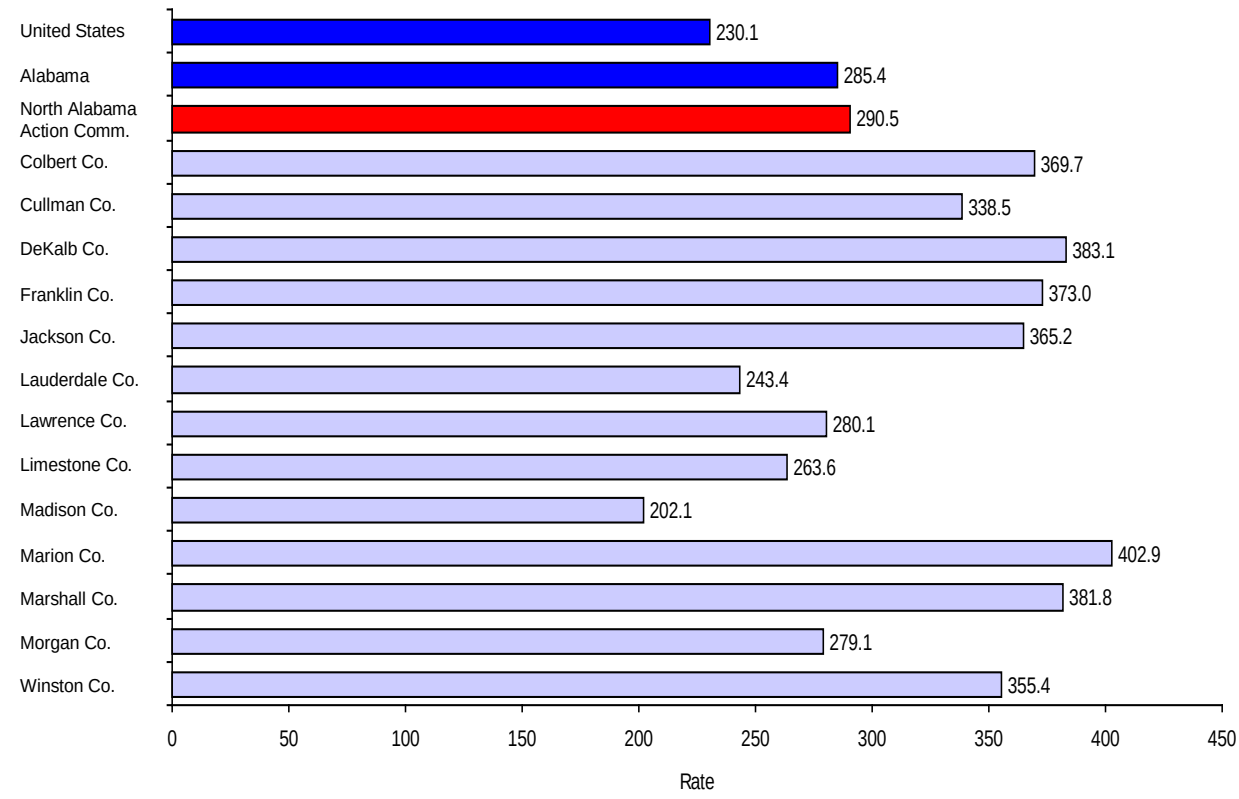
- Heart Diseases have been the leading cause of death in Alabama since 1926.
- Alabama currently has the 5th highest heart disease mortality rate among all 50 states. Alabamians aged 35-54 years have the 2nd highest heart disease mortality rate among all 50 states.
- Alabama lost 38,683 residents to heart diseases during 2003-2005.
- 47 of the 50 Alabama counties with the highest heart disease mortality rates are rural counties.



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Heart Disease Mortality and Mortality Rates
U.S. and Selected Alabama Areas, 2003 – 2005

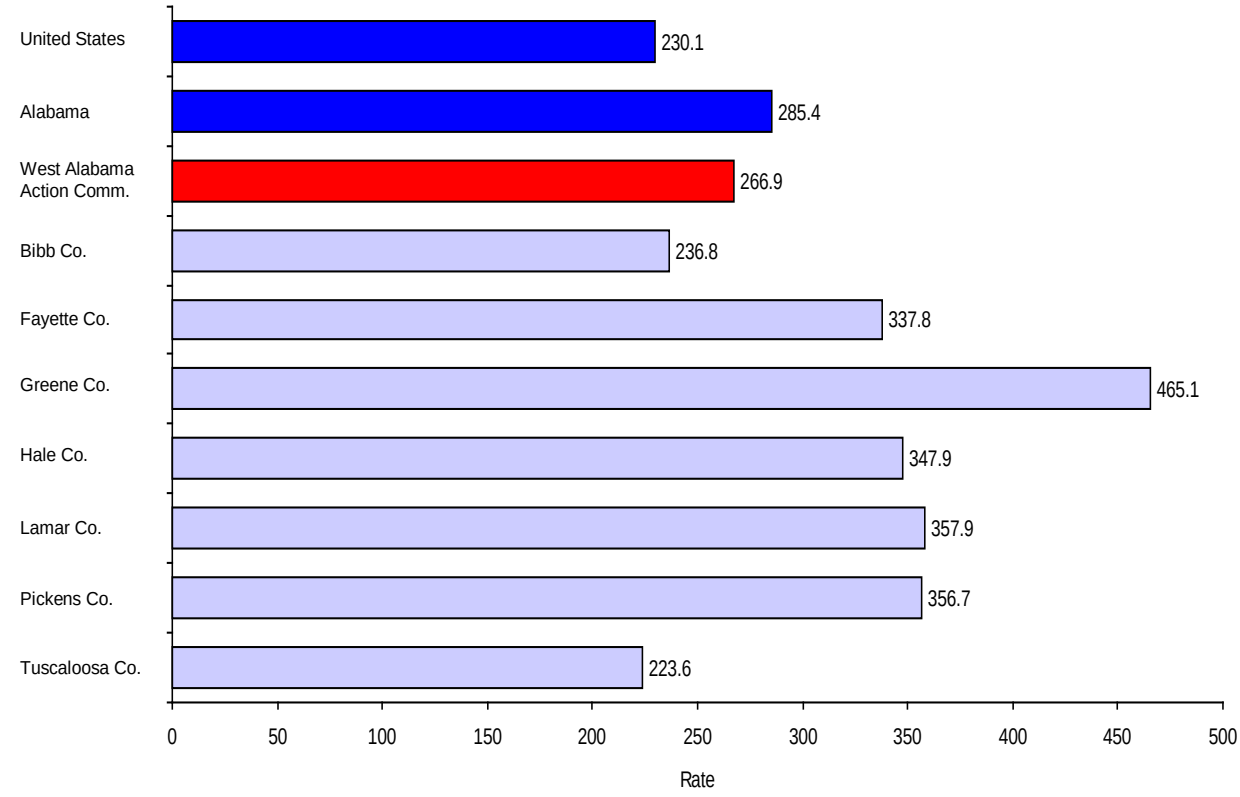
Area	Is County Rural?	Deaths	Rate Per 100,000
United States	**Not Applicable**	**675,562**	**230.1**
Alabama	**Not Applicable**	**38,683**	**285.4**
Rural Alabama Counties	**Not Applicable**	**19,704**	**330.6**
Highly Rural Alabama Counties	**Not Applicable**	**12,093**	**350.1**
Moderately Rural Alabama Counties	**Not Applicable**	**7,611**	**303.8**
Rural North Alabama Counties	**Not Applicable**	**12,225**	**341.2**
Rural South Alabama Counties	**Not Applicable**	**7,479**	**314.7**
Urban Alabama Counties	**Not Applicable**	**18,979**	**250.0**



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Heart Disease Mortality and Mortality Rates
North Alabama Action Commission Counties, 2003 – 2005

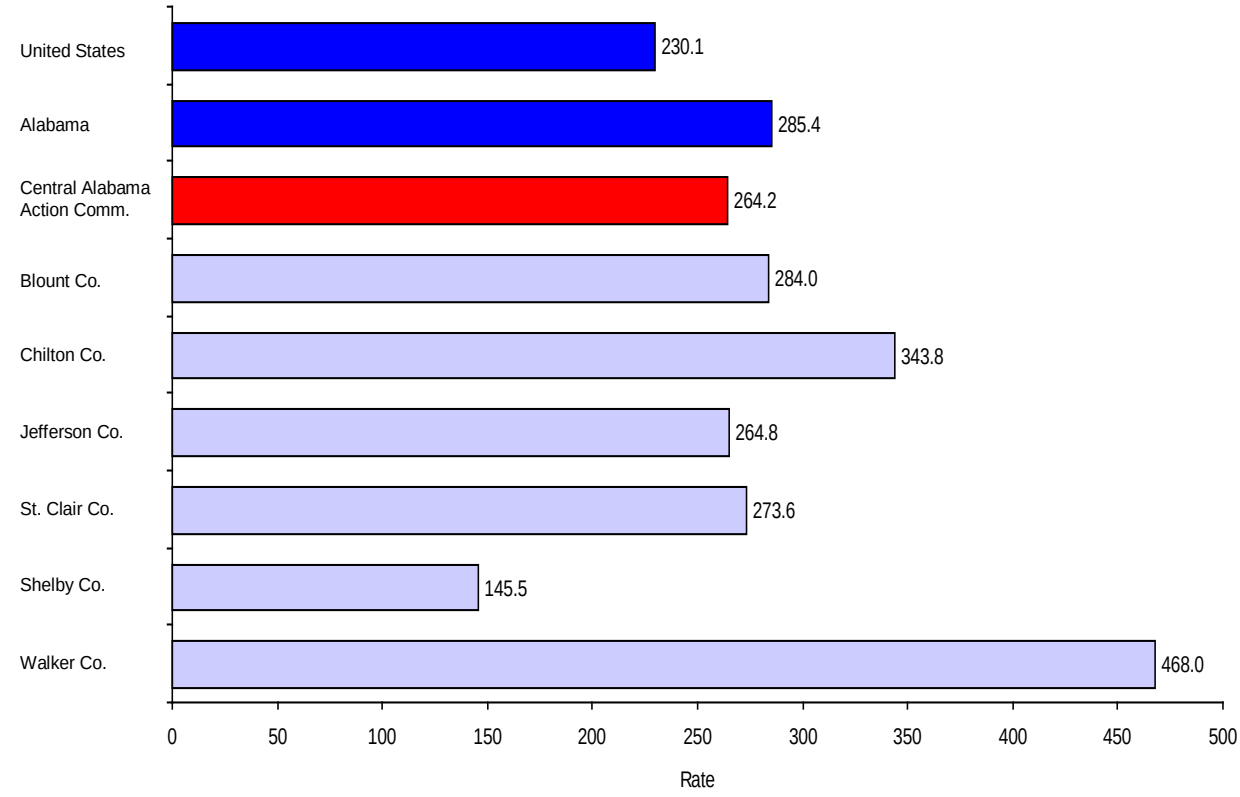
Area	Is County Rural?	Deaths	Rate Per 100,000
North Alabama Action Commission	**Not Applicable**	**8,903**	**290.5**
District's Rural Counties Combined	Not Applicable	5,541	349.9
District's Urban Counties Combined	Not Applicable	3,362	227.0
Colbert County	Yes	606	369.7
Cullman County	Yes	803	338.5
DeKalb County	Yes	769	383.1
Franklin County	Yes	343	373.0
Jackson County	Yes	588	365.2
Lauderdale County	No	638	243.4
Lawrence County	Yes	289	280.1
Limestone County	Yes	547	263.6
Madison County	No	1,779	202.1
Marion County	Yes	364	402.9
Marshall County	Yes	971	381.8
Morgan County	No	945	279.1
Winston County	Yes	261	355.4



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Heart Disease Mortality and Mortality Rates
West Alabama Action Commission Counties, 2003 – 2005

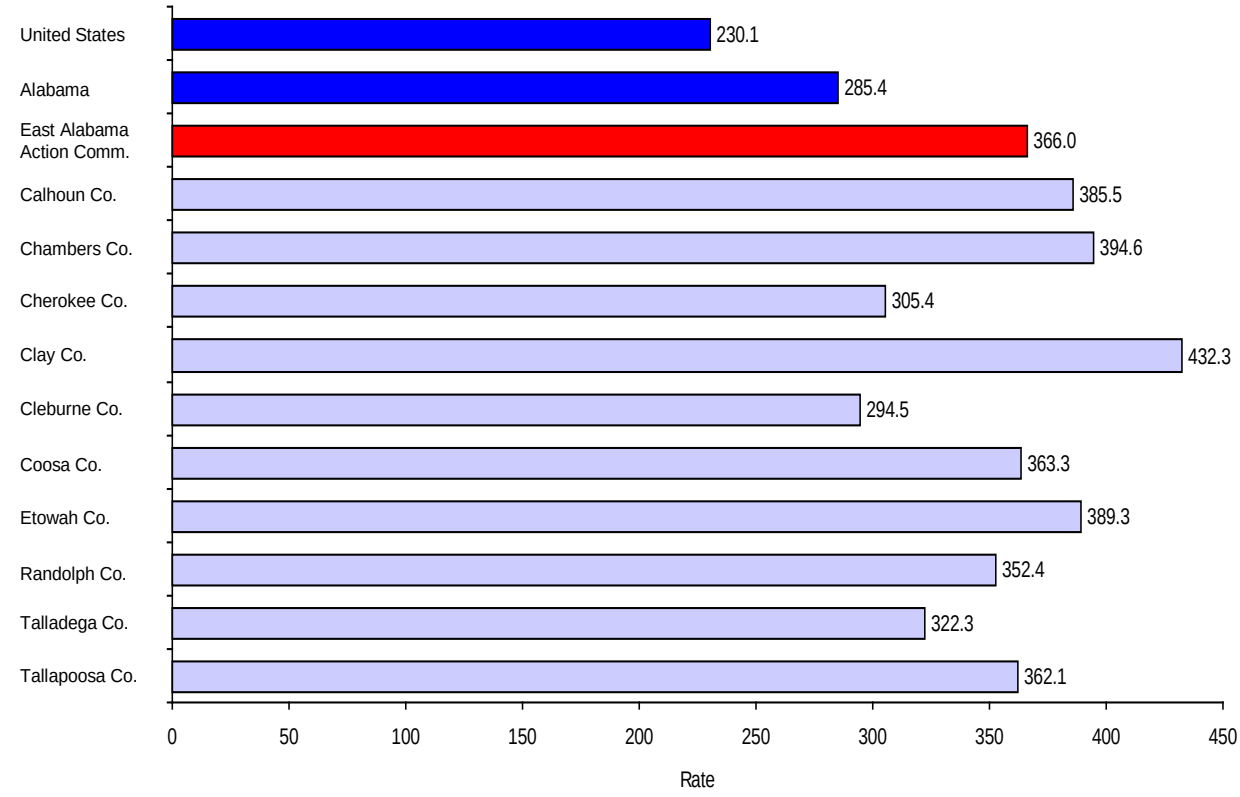
Area	Is County Rural?	Deaths	Rate Per 100,000
West Alabama Action Commission	**Not Applicable**	**2,156**	**266.9**
District's Rural Counties Combined	Not Applicable	1,037	337.3
District's Urban Counties Combined	Not Applicable	1,119	223.6
Bibb County	Yes	151	236.8
Fayette County	Yes	184	337.8
Greene County	Yes	135	465.1
Hale County	Yes	189	347.9
Lamar County	Yes	161	357.9
Pickens County	Yes	217	356.7
Tuscaloosa County	No	1,119	223.6



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Heart Disease Mortality and Mortality Rates
Central Alabama Action Commission Counties, 2003 – 2005

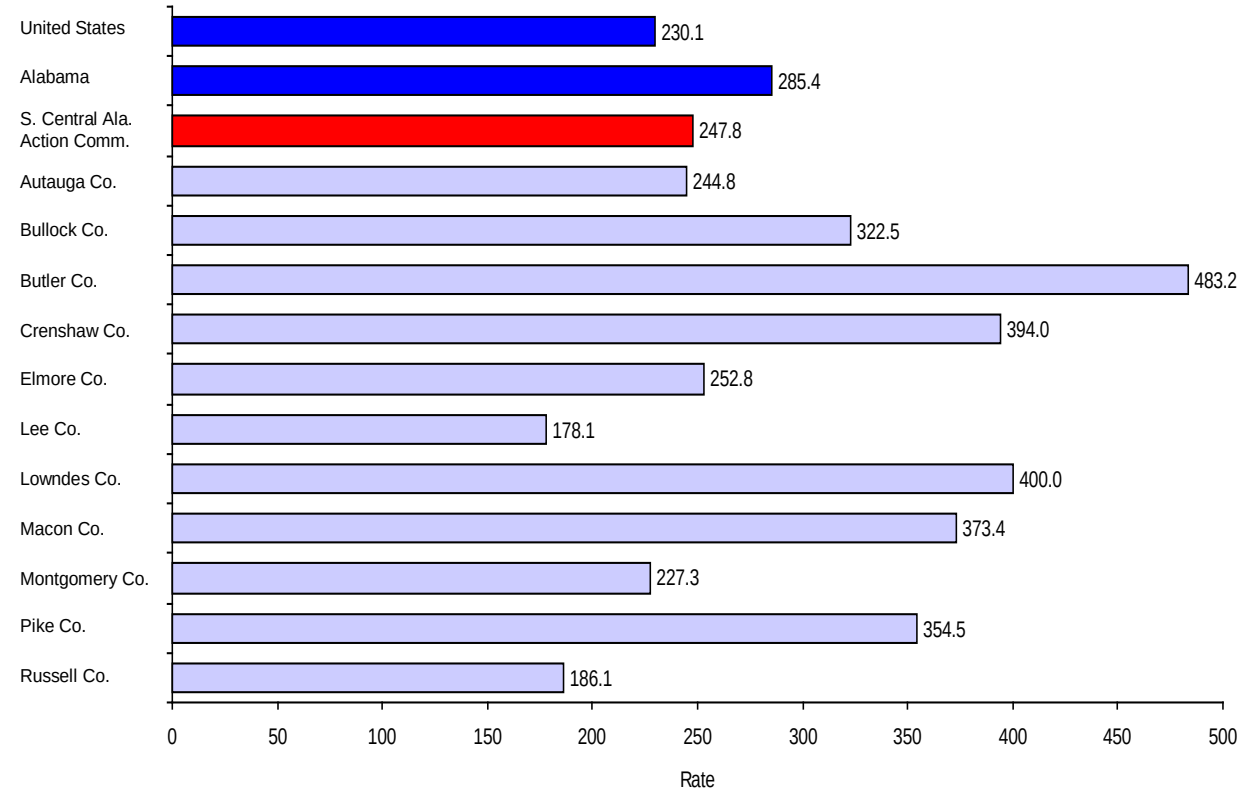
Area	Is County Rural?	Deaths	Rate Per 100,000
Central Alabama Action Commission	**Not Applicable**	**8,394**	**264.2**
District's Rural Counties Combined	Not Applicable	2,450	345.7
District's Urban Counties Combined	Not Applicable	5,944	240.8
Blount County	Yes	468	284.0
Chilton County	Yes	426	343.8
Jefferson County	No	5,222	264.8
St. Clair County	Yes	576	273.6
Shelby County	No	722	145.5
Walker County	Yes	980	468.0



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Heart Disease Mortality and Mortality Rates
East Alabama Action Commission Counties, 2003 – 2005

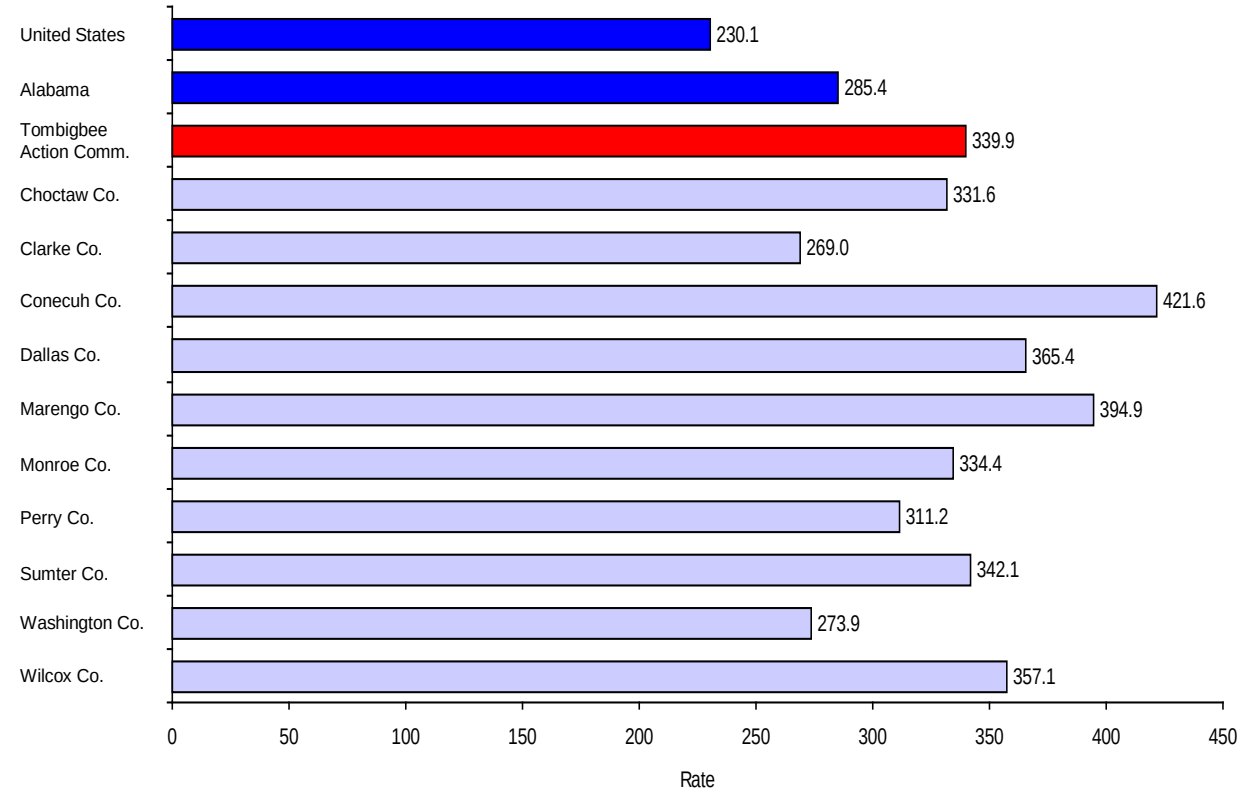
Area	Is County Rural?	Deaths	Rate Per 100,000
East Alabama Action Commission	**Not Applicable**	**5,026**	**366.0**
District's Rural Counties Combined	Not Applicable	2,530	347.2
District's Urban Counties Combined	Not Applicable	2,496	387.3
Calhoun County	No	1,294	385.5
Chambers County	Yes	420	394.6
Cherokee County	Yes	224	305.4
Clay County	Yes	182	432.3
Cleburne County	Yes	128	294.5
Coosa County	Yes	123	363.3
Etowah County	No	1,202	389.3
Randolph County	Yes	238	352.4
Talladega County	Yes	773	322.3
Tallapoosa County	Yes	442	362.1



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Heart Disease Mortality and Mortality Rates
South Central Alabama Action Commission Counties, 2003 – 2005

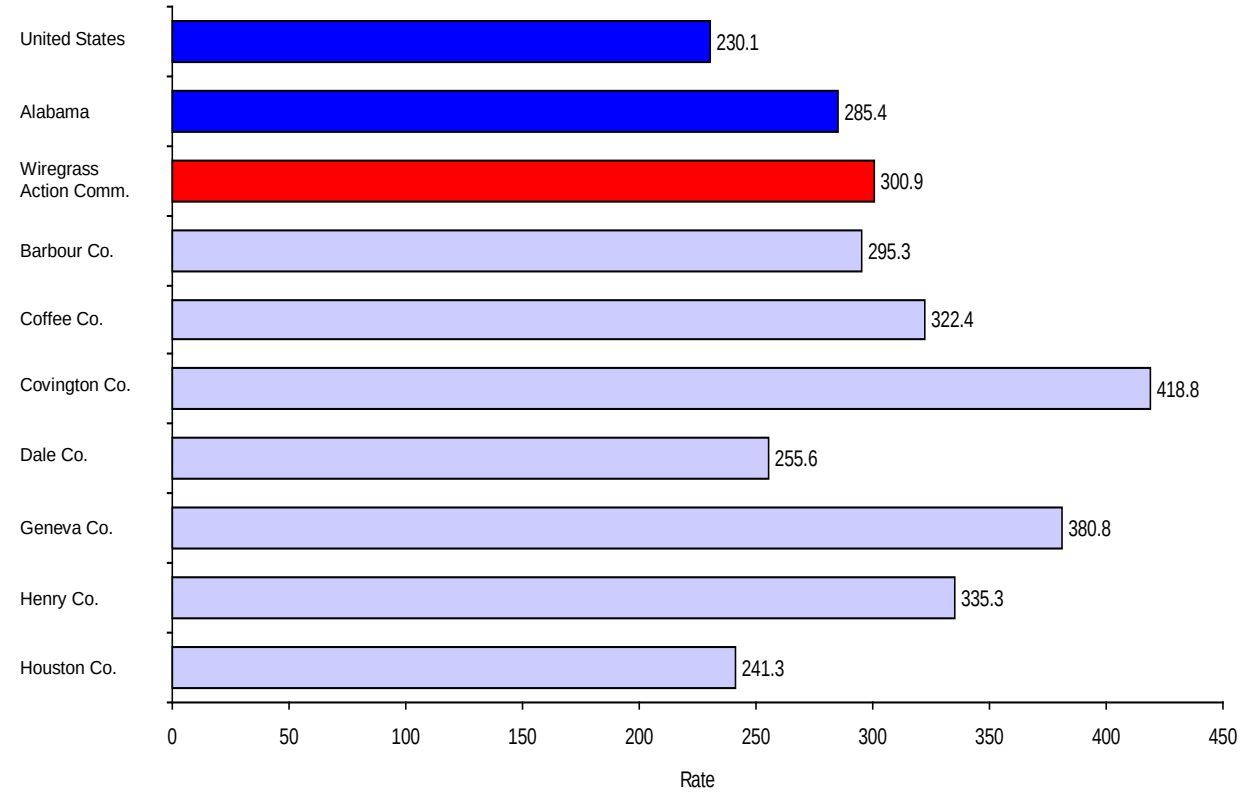
Area	Is County Rural?	Deaths	Rate Per 100,000
South Central Alabama Action Commission	**Not Applicable**	**4,611**	**247.8**
District's Rural Counties Combined	Not Applicable	2,461	294.0
District's Urban Counties Combined	Not Applicable	2,150	210.0
Autauga County	Yes	348	244.8
Bullock County	Yes	108	322.5
Butler County	Yes	299	483.2
Crenshaw County	Yes	161	394.0
Elmore County	Yes	544	252.8
Lee County	No	643	178.1
Lowndes County	Yes	157	400.0
Macon County	Yes	258	373.4
Montgomery County	No	1,507	227.3
Pike County	Yes	312	354.5
Russell County	Yes	274	186.1



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Heart Disease Mortality and Mortality Rates
Tombigbee Action Commission Counties, 2003 – 2005

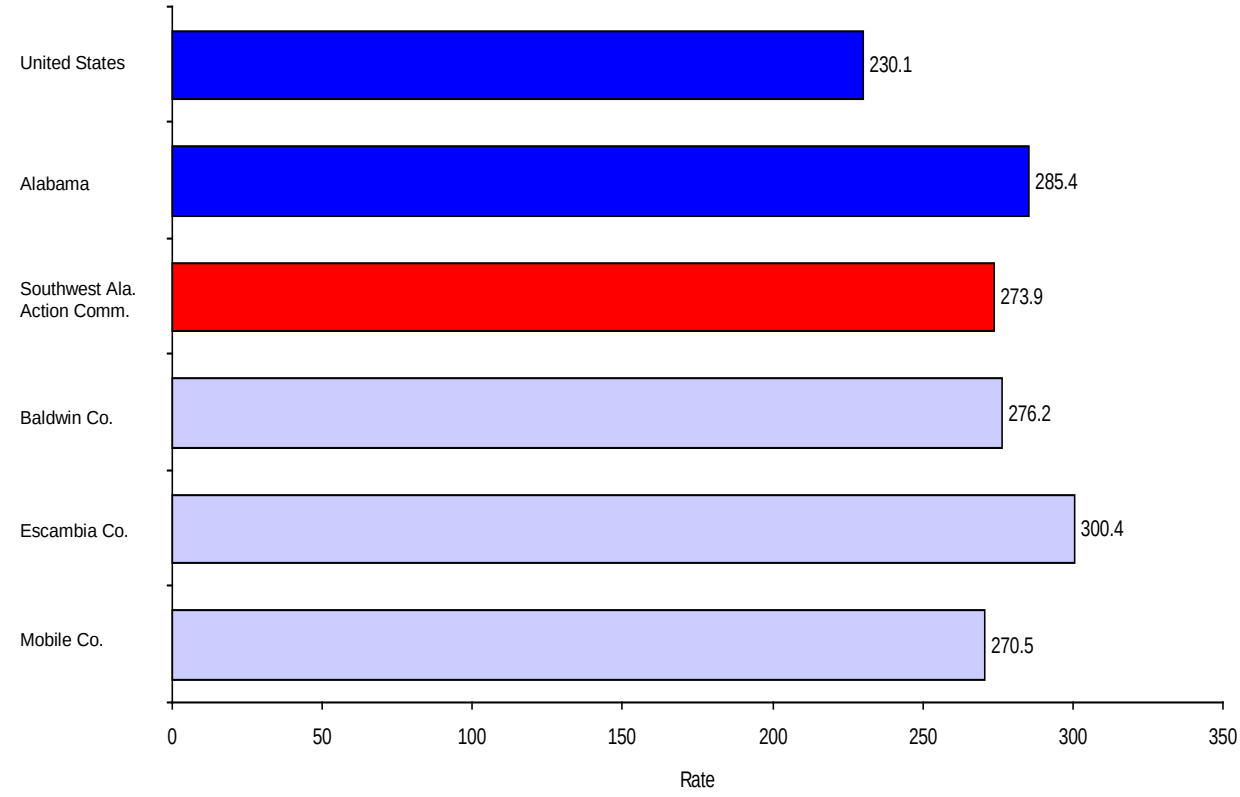
Area	Is County Rural?	Deaths	Rate Per 100,000
Tombigbee Action Commission	**Not Applicable**	**2,059**	**339.9**
District's Rural Counties Combined	Not Applicable	2,059	339.9
District's Urban Counties Combined	Not Applicable	No Urban Counties in District	
Choctaw County	Yes	150	331.6
Clarke County	Yes	220	269.0
Conecuh County	Yes	169	421.6
Dallas County	Yes	488	365.4
Marengo County	Yes	260	394.9
Monroe County	Yes	237	334.4
Perry County	Yes	107	311.2
Sumter County	Yes	144	342.1
Washington County	Yes	146	273.9
Wilcox County	Yes	138	357.1



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Heart Disease Mortality and Mortality Rates
Wiregrass Action Commission Counties, 2003 – 2005

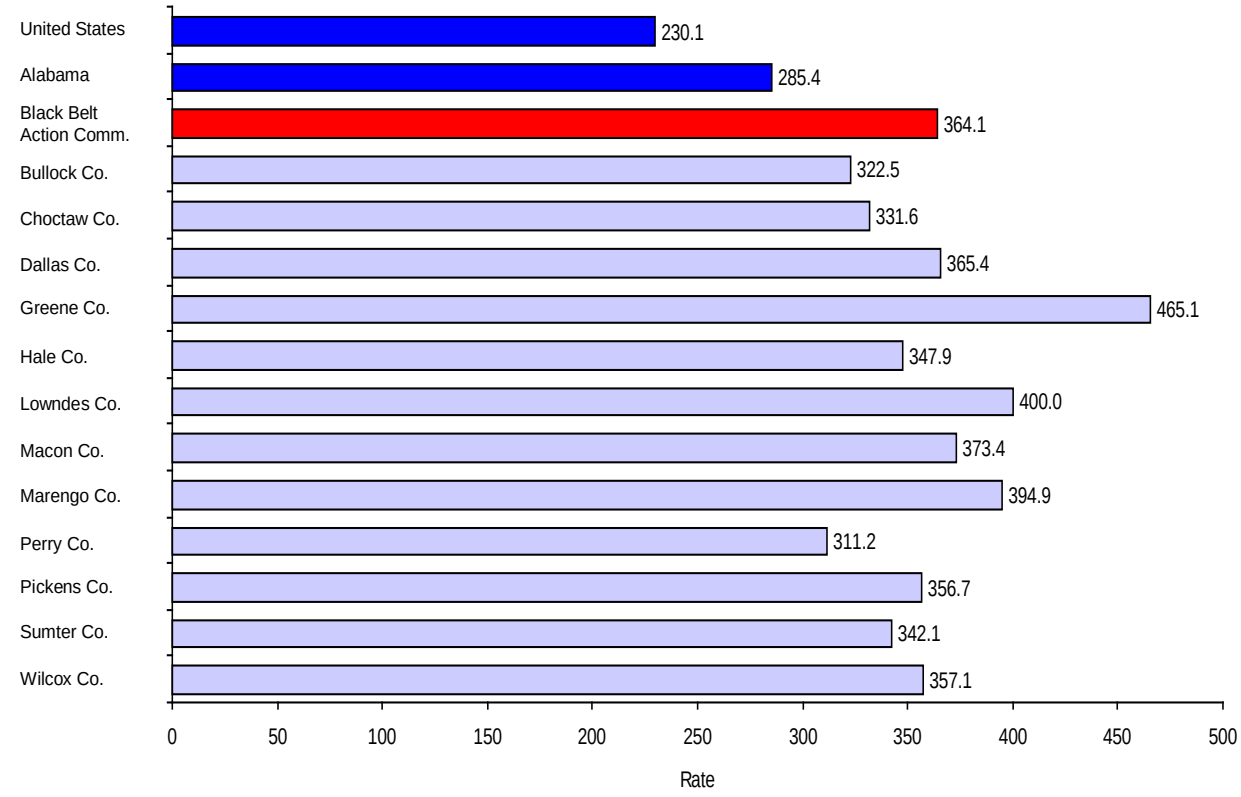
Area	Is County Rural?	Deaths	Rate Per 100,000
Wiregrass Action Commission	**Not Applicable**	**2,653**	**300.9**
District's Rural Counties Combined	Not Applicable	1,982	328.4
District's Urban Counties Combined	Not Applicable	671	241.3
Barbour County	Yes	252	295.3
Coffee County	Yes	435	322.4
Covington County	Yes	462	418.8
Dale County	Yes	375	255.6
Geneva County	Yes	292	380.8
Henry County	Yes	166	335.3
Houston County	No	671	241.3



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Heart Disease Mortality and Mortality Rates
Southwest Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Southwest Alabama Action Commission	**Not Applicable**	**4,881**	**273.9**
District's Rural Counties Combined	Not Applicable	1,644	280.9
District's Urban Counties Combined	Not Applicable	3,237	270.5
Baldwin County	Yes	1,300	276.2
Escambia County	Yes	344	300.4
Mobile County	No	3,237	270.5



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Heart Disease Mortality and Mortality Rates
Black Belt Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Black Belt Action Commission	**Not Applicable**	**2.351**	**364.1**
District's Rural Counties Combined	Not Applicable	2,351	364.1
District's Urban Counties Combined	Not Applicable	No Urban Counties in District	
Bullock County	Yes	108	322.5
Choctaw County	Yes	150	331.6
Dallas County	Yes	488	365.4
Greene County	Yes	135	465.1
Hale County	Yes	189	347.9
Lowndes County	Yes	157	400.0
Macon County	Yes	258	373.4
Marengo County	Yes	260	394.9
Perry County	Yes	107	311.2
Pickens County	Yes	217	356.7
Sumter County	Yes	144	342.1
Wilcox County	Yes	138	357.1

Heart Disease Mortality and Mortality Rates
Alabama's Appalachian Region Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Alabama's Appalachian Region	**Not Applicable**	**25,146**	**289.8**
Region's Rural Counties Combined	Not Applicable	12,225	341.2
Region's Urban Counties Combined	Not Applicable	12,921	353.7
Bibb County	Yes	151	236.8
Blount County	Yes	468	284.0
Calhoun County	No	1,294	385.5
Chambers County	Yes	420	394.6
Cherokee County	Yes	224	305.4
Chilton County	Yes	426	343.8
Clay County	Yes	182	432.3
Cleburne County	Yes	128	294.5
Colbert County	Yes	606	369.7
Coosa County	Yes	123	363.3
Cullman County	Yes	803	338.5
DeKalb County	Yes	769	383.1
Elmore County	Yes	544	252.8
Etowah County	No	1,202	389.3
Fayette County	Yes	184	337.8
Franklin County	Yes	343	373.0
Hale County	Yes	189	347.9
Jackson County	Yes	588	365.2
Jefferson County	No	5,222	264.8
Lamar County	Yes	161	357.9
Lauderdale County	No	638	243.4
Lawrence County	Yes	289	280.1
Limestone County	Yes	547	263.6
Macon County	Yes	258	373.4
Madison County	No	1,779	202.1
Marion County	Yes	364	402.9
Marshall County	Yes	971	381.8
Morgan County	No	945	279.1
Pickens County	Yes	217	356.7
Randolph County	Yes	238	352.4
St. Clair County	Yes	576	273.6
Shelby County	No	722	145.5
Talladega County	Yes	773	322.3
Tallapoosa County	Yes	442	362.1
Tuscaloosa County	No	1,119	223.6
Walker County	Yes	980	468.0
Winston County	Yes	261	355.4

For additional information on the Appalachian Region, visit the Appalachian Regional Commission's Web site at http://www.arc.gov/index.jsp; the Appalachian Regional Commission – Alabama Programs Office Web site at http://www.adeca.alabama.gov/default.aspx; or contact Bonnie Durham, Alabama Program Manager at (256) 845-3472.

Heart Disease Mortality and Mortality Rates
Alabama's Delta Region Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Alabama's Delta Region	**Not Applicable**	**4,292**	**330.3**
Region's Rural Counties Combined	Not Applicable	**4,292**	**330.3**
Region's Urban Counties Combined	Not Applicable	No Urban Counties in Region	
Barbour County	Yes	252	295.3
Bullock County	Yes	108	322.5
Butler County	Yes	299	483.2
Choctaw County	Yes	150	331.6
Clarke County	Yes	220	269.0
Conecuh County	Yes	169	421.6
Dallas County	Yes	488	365.4
Escambia County	Yes	344	300.4
Greene County	Yes	135	465.1
Hale County	Yes	189	347.9
Lowndes County	Yes	157	400.0
Macon County	Yes	258	373.4
Marengo County	Yes	260	394.9
Monroe County	Yes	237	334.4
Perry County	Yes	107	311.2
Pickens County	Yes	217	356.7
Russell County	Yes	274	186.1
Sumter County	Yes	144	342.1
Washington County	Yes	146	273.9
Wilcox County	Yes	138	357.1

For additional information on the Delta Region, visit the Delta Regional Authority's Web site at http://www.dra.gov/ or contact one of the Delta Regional Authority – Local Development District Offices as follows:

Alabama – Tombigbee Regional Commission, (334) 682-4234 (Choctaw, Clarke, Conecuh, Dallas, Marengo, Monroe, Perry, Sumter, Washington, and Wilcox counties)

Lee – Russell Council of Governments, (334) 749-5264 (Russell County)

South Alabama Regional Planning Commission, (251) 433-6541 (Escambia County)

South Central Alabama Development Commission (334) 244-6903 (Bullock, Butler, Lowndes, and Macon counties)

Southeast Alabama Regional Planning and Development Commission, (334) 794-4093 (Barbour County)

West Alabama Planning and Development Council, (205) 333-2990 (Greene, Hale, and Pickens counties)

Indicators of Health Status in Alabama:
CANCER MORTALITY

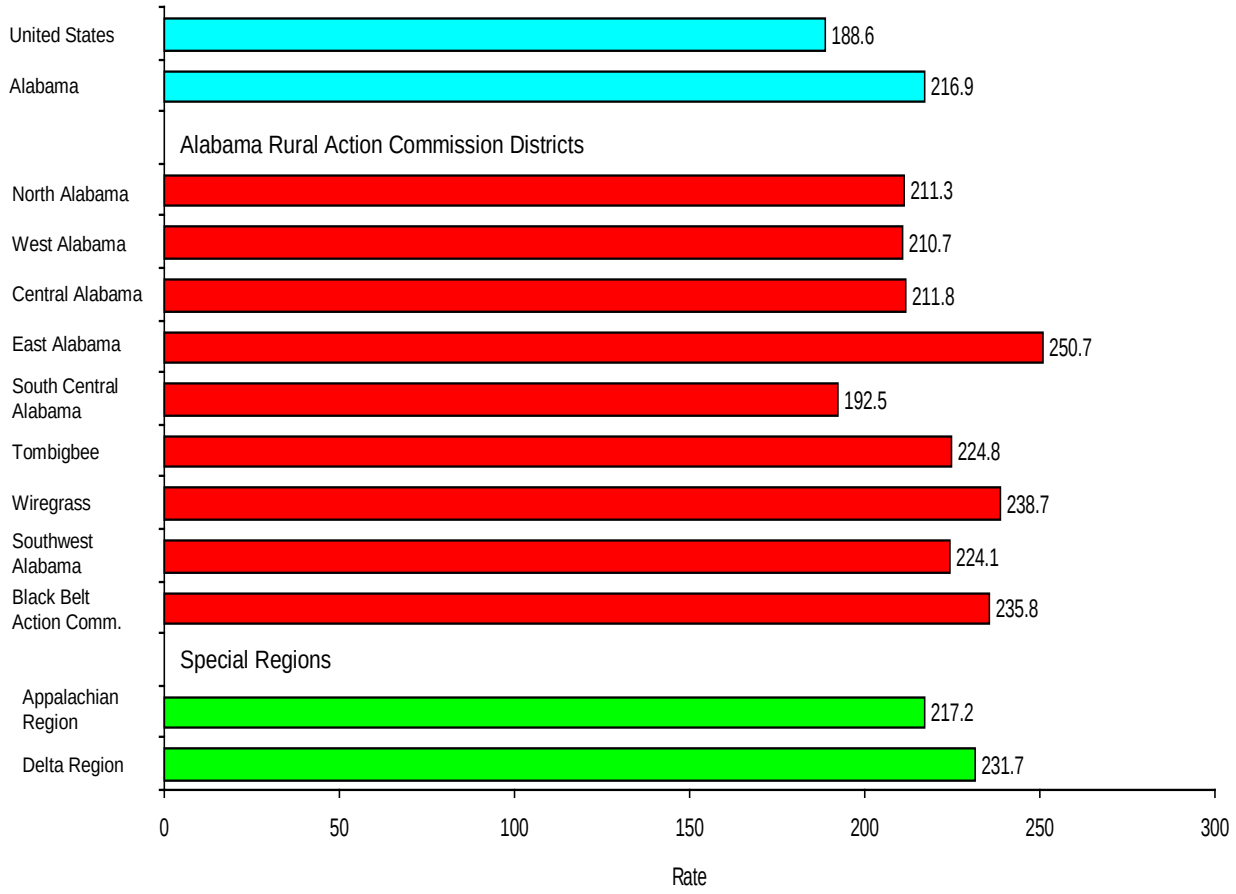
Cancer occurs in individuals who usually:

- smoke, use tobacco products, or are exposed to environmental smoke.
- have low consumption of fruits, vegetables, and whole grain foods.
- have excessive consumption of high fat foods, particularly from animal sources.
- are physically inactive.
- are obese.
- have excessive alcohol consumption.
- have excessive sun exposure.

To prevent or detect cancer early, individuals at risk should:

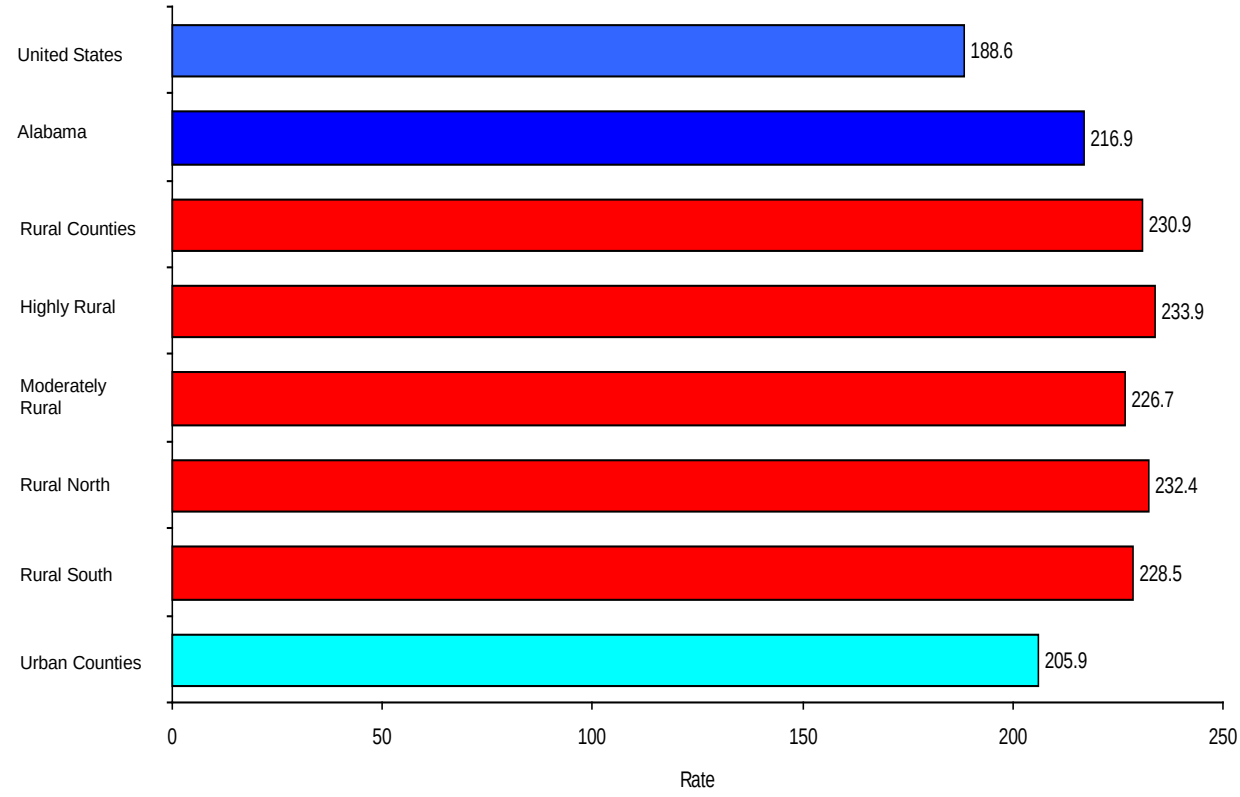
- avoid or eliminate exposure to cigarette smoke, tobacco products, or environmental tobacco smoke.
- eat 5 or more servings of fruits and vegetables daily and 6 to 11 servings daily of breads, cereals, rice, pastas, and other grain products.
- use more non-meat main dishes such as dried peas and beans, and tofu.
- balance food and physical activity to maintain a healthy weight.
- if alcohol is consumed, for men drink no more than two drinks a day, and for women, drink no more than one drink a day.
- protect against excessive sun exposure with protective clothing and sun-screens with at least a sun protective factor (SPF) of 15 or higher.
- have recommended screening tests as appropriate – for women, screening mammograms, Pap smears, tests for colorectal cancer, skin examinations; for men, testicular examinations, tests for colorectal cancer, and skin examinations.

Cancer Mortality Rates for 2003-2005
U.S., Alabama, Alabama Rural Action Commission Districts, and Special Regions In Alabama



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

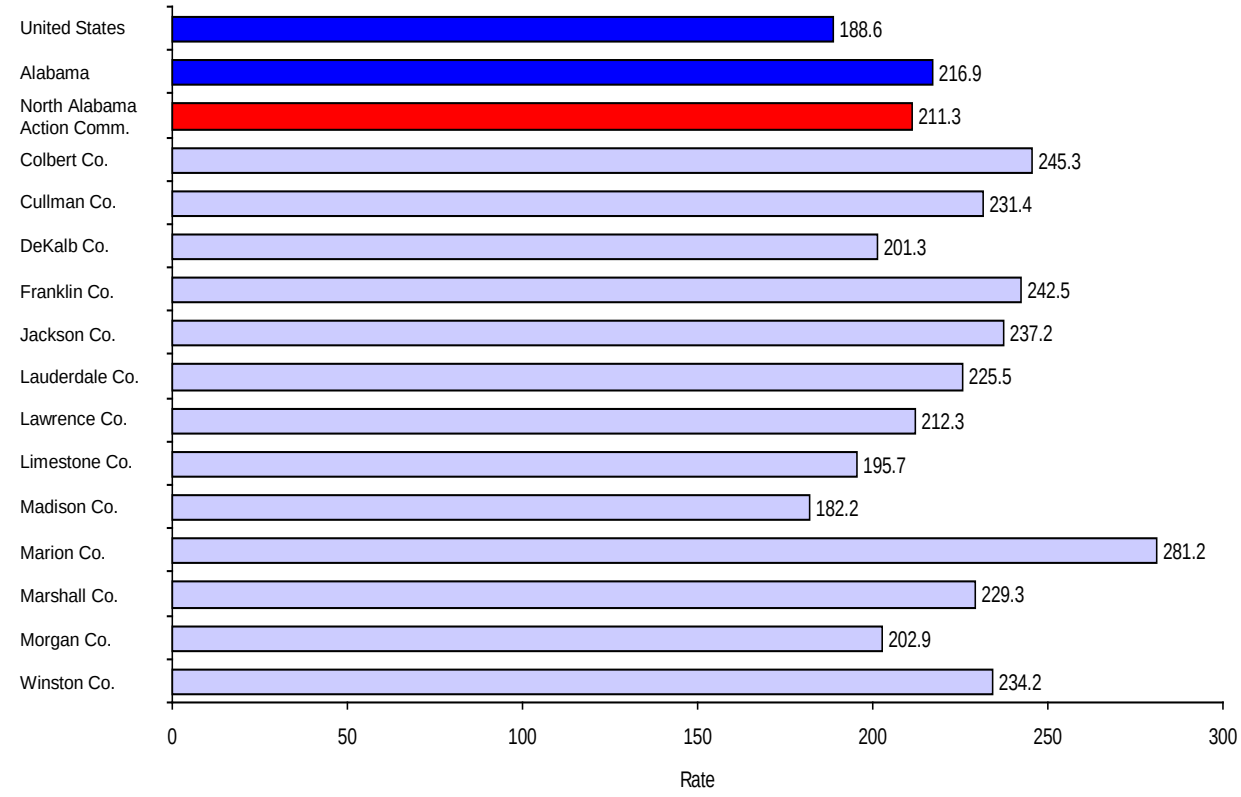
- Cancer has been the second leading cause of death in Alabama since 1966.
- Alabama currently has the 11th highest cancer mortality rate among all 50 states. Alabamians aged 35-64 years have the 5th highest cancer mortality rate among all 50 states.
- Alabama lost 29,389 residents to cancer during 2003-2005.
- 37 of the 40 Alabama counties with the highest cancer mortality rates are rural counties.



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Cancer Mortality and Mortality Rates
U.S. and Selected Alabama Areas, 2003 – 2005

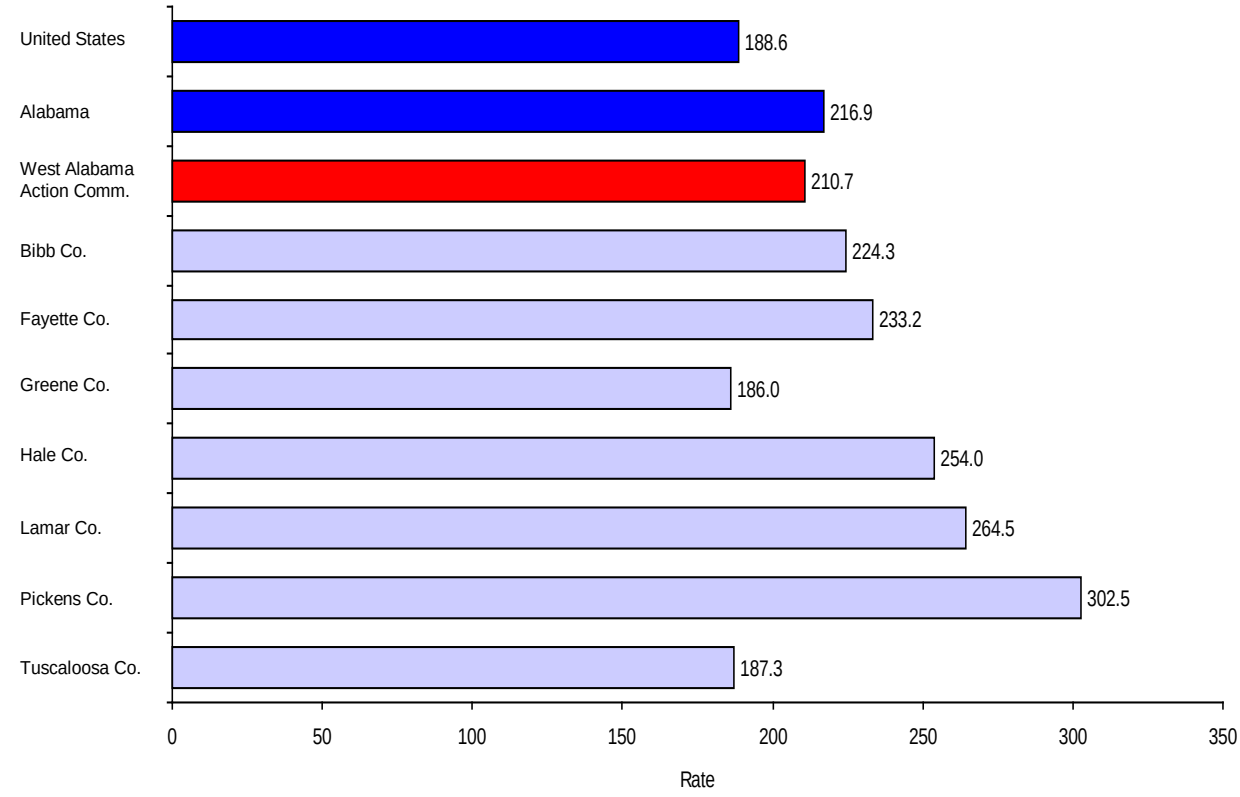
Area	Is County Rural?	Deaths	Rate Per 100,000
United States	**Not Applicable**	**553,888**	**188.6**
Alabama	**Not Applicable**	**29,389**	**216.9**
Rural Alabama Counties	**Not Applicable**	**13,759**	**230.9**
Highly Rural Alabama Counties	**Not Applicable**	**8,079**	**233.9**
Moderately Rural Alabama Counties	**Not Applicable**	**5,680**	**226.7**
Rural North Alabama Counties	**Not Applicable**	**8,328**	**232.4**
Rural South Alabama Counties	**Not Applicable**	**5,431**	**228.5**
Urban Alabama Counties	**Not Applicable**	**15,630**	**205.9**



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Cancer Mortality and Mortality Rates
North Alabama Action Commission Counties, 2003 – 2005

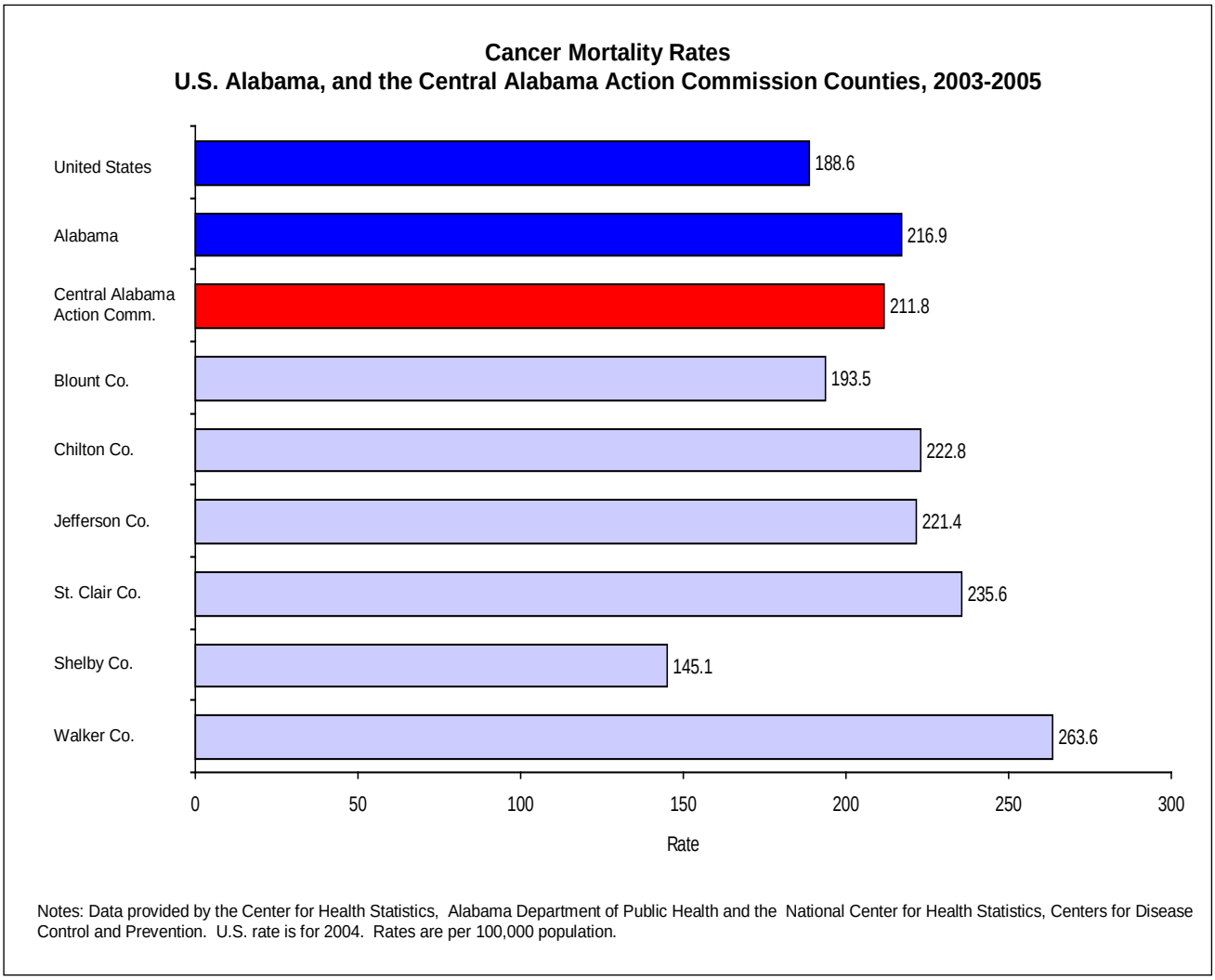
Area	Is County Rural?	Deaths	Rate Per 100,000
North Alabama Action Commission	**Not Applicable**	**6,476**	**211.3**
District's Rural Counties Combined	Not Applicable	3,594	227.0
District's Urban Counties Combined	Not Applicable	2,882	194.6
Colbert County	Yes	402	245.3
Cullman County	Yes	549	231.4
DeKalb County	Yes	404	201.3
Franklin County	Yes	223	242.5
Jackson County	Yes	382	237.2
Lauderdale County	No	591	225.5
Lawrence County	Yes	219	212.3
Limestone County	Yes	406	195.7
Madison County	No	1,604	182.2
Marion County	Yes	254	281.2
Marshall County	Yes	583	229.3
Morgan County	No	687	202.9
Winston County	Yes	172	234.2



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Cancer Mortality and Mortality Rates
West Alabama Action Commission Counties, 2003 – 2005

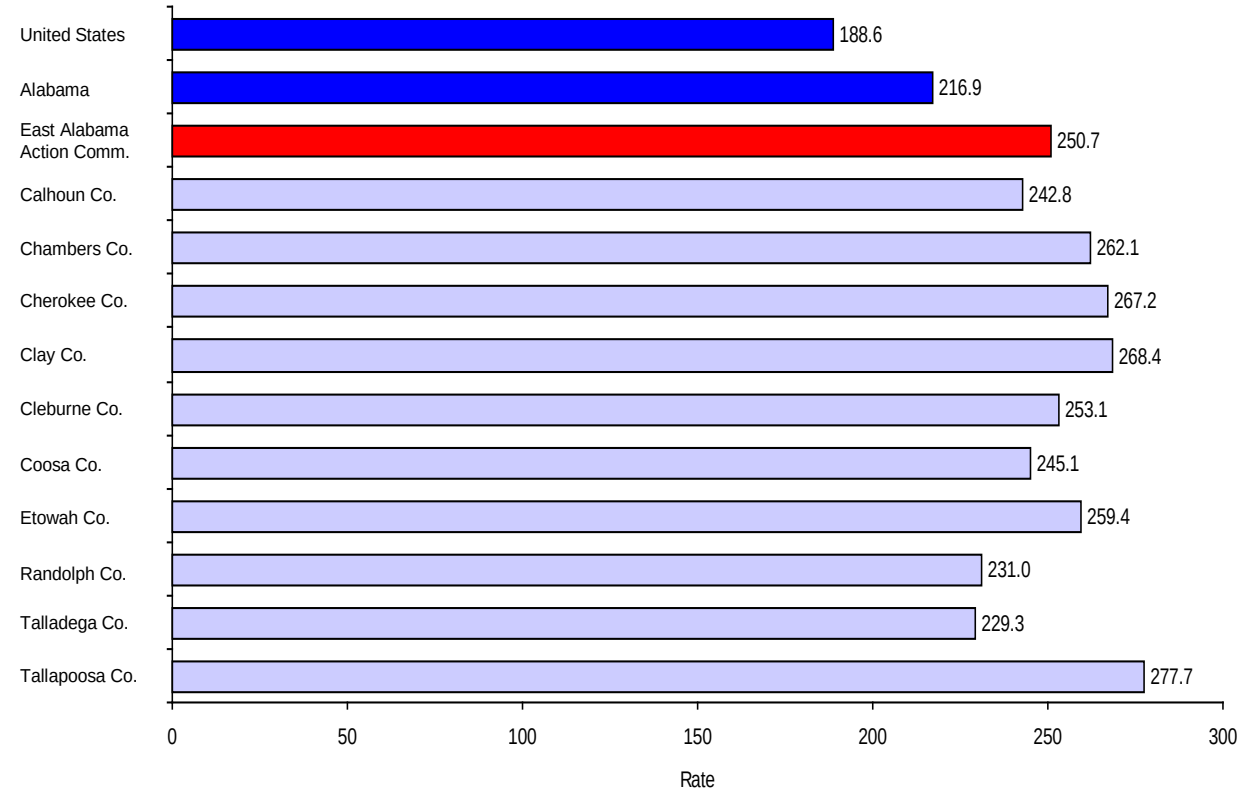
Area	Is County Rural?	Deaths	Rate Per 100,000
West Alabama Action Commission	**Not Applicable**	**1,702**	**210.7**
District's Rural Counties Combined	Not Applicable	765	248.9
District's Urban Counties Combined	Not Applicable	937	187.3
Bibb County	Yes	143	224.3
Fayette County	Yes	127	233.2
Greene County	Yes	54	186
Hale County	Yes	138	254.0
Lamar County	Yes	119	264.5
Pickens County	Yes	184	302.5
Tuscaloosa County	No	937	187.3



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Cancer Mortality and Mortality Rates
Central Alabama Action Commission Counties, 2003 – 2005

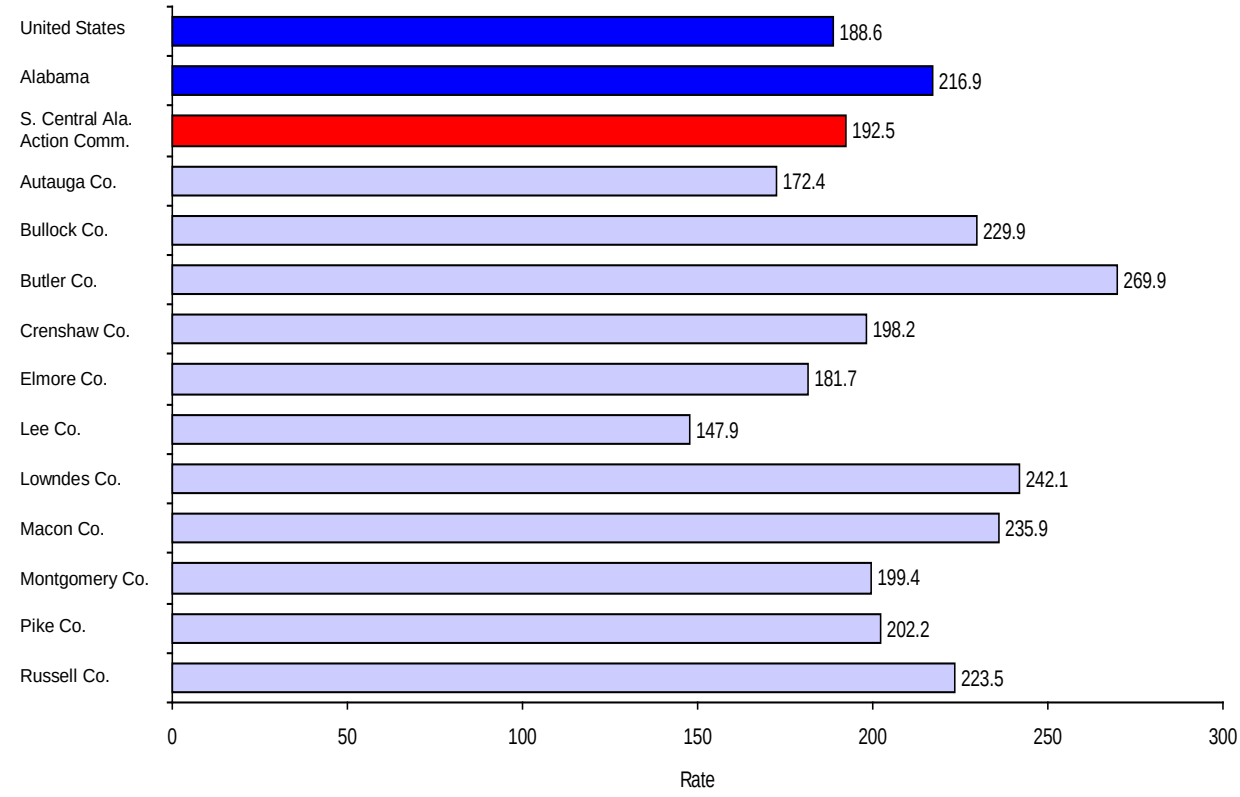
Area	Is County Rural?	Deaths	Rate Per 100,000
Central Alabama Action Commission	**Not Applicable**	**6,728**	**211.8**
District's Rural Counties Combined	Not Applicable	1,643	231.8
District's Urban Counties Combined	Not Applicable	5,085	206.0
Blount County	Yes	319	193.5
Chilton County	Yes	276	222.8
Jefferson County	No	4,365	221.4
St. Clair County	Yes	496	235.6
Shelby County	No	720	145.1
Walker County	Yes	552	263.6



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Cancer Mortality and Mortality Rates
East Alabama Action Commission Counties, 2003 – 2005

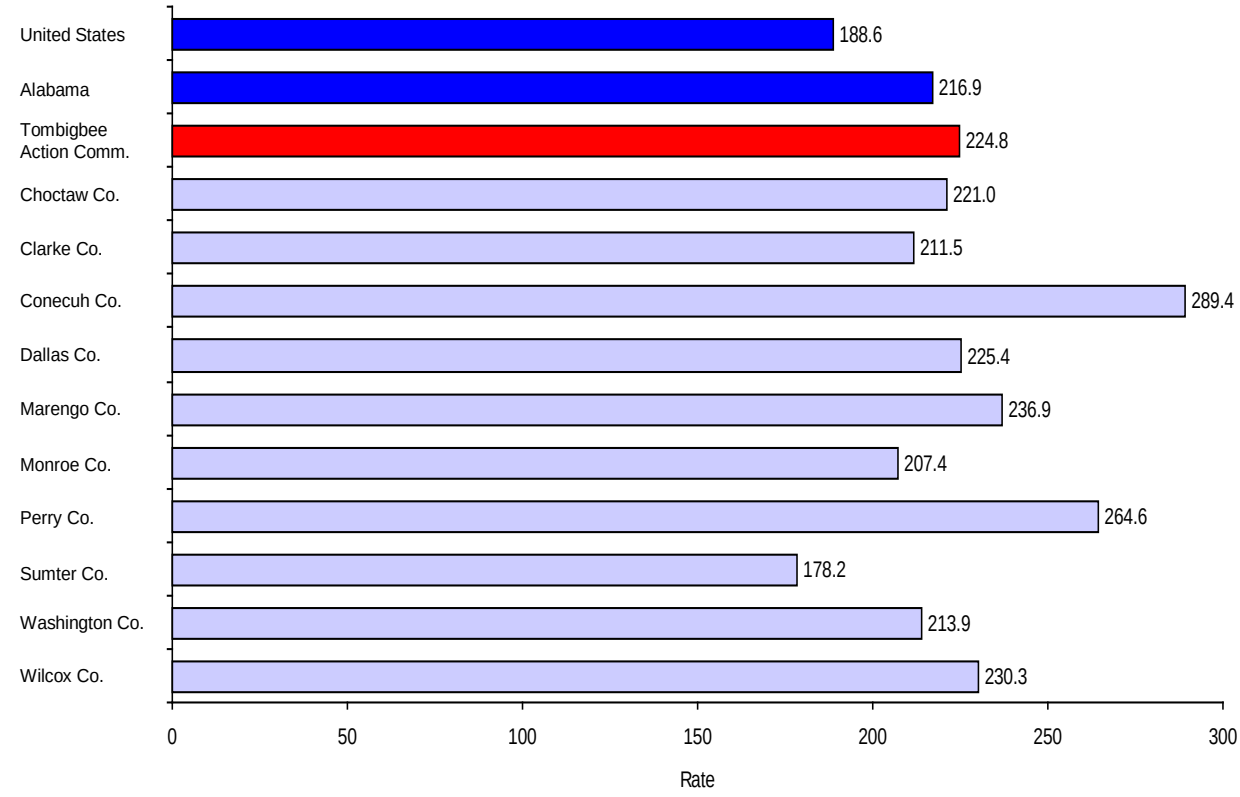
Area	Is County Rural?	Deaths	Rate Per 100,000
East Alabama Action Commission	**Not Applicable**	**3,442**	**250.7**
District's Rural Counties Combined	Not Applicable	1,826	250.6
District's Urban Counties Combined	Not Applicable	1,616	250.8
Calhoun County	No	815	242.8
Chambers County	Yes	279	262.1
Cherokee County	Yes	196	267.2
Clay County	Yes	113	268.4
Cleburne County	Yes	110	253.1
Coosa County	Yes	83	245.1
Etowah County	No	801	259.4
Randolph County	Yes	156	231.0
Talladega County	Yes	550	229.3
Tallapoosa County	Yes	339	277.7



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Cancer Mortality and Mortality Rates
South Central Alabama Action Commission Counties, 2003 – 2005

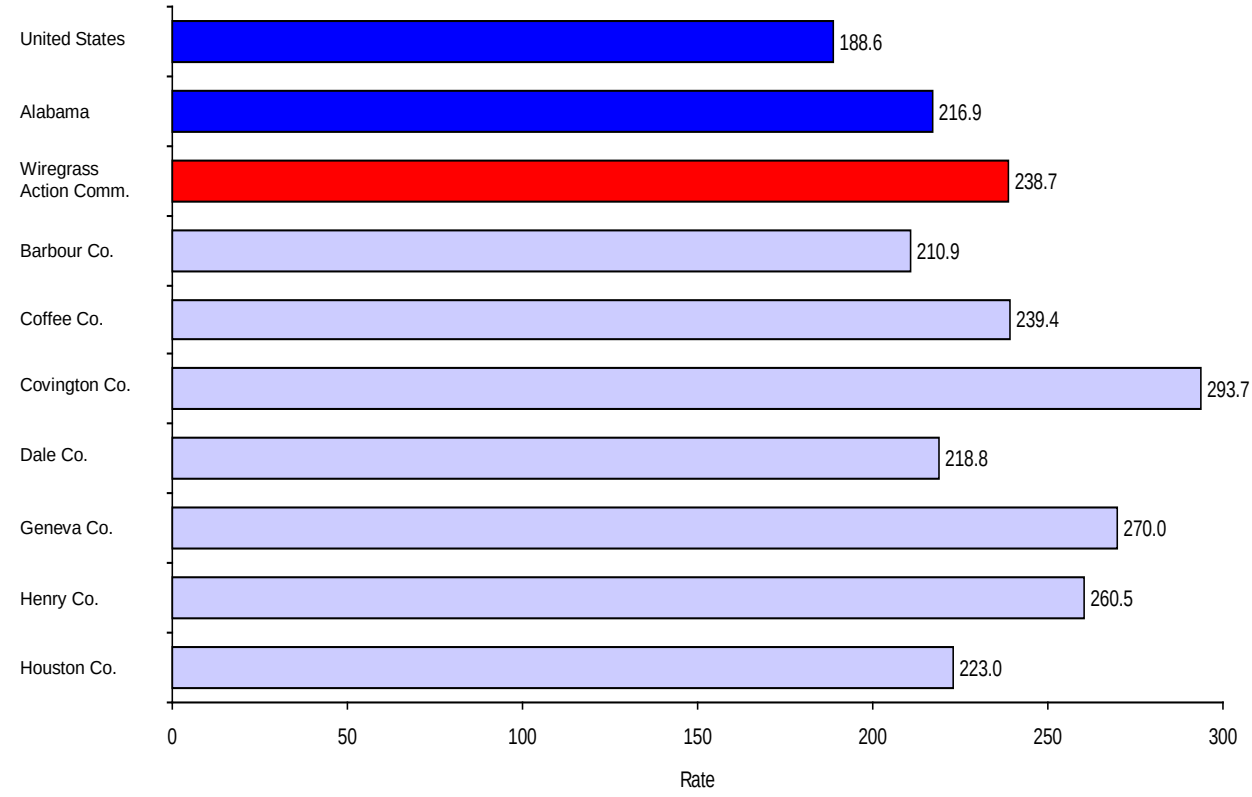
Area	Is County Rural?	Deaths	Rate Per 100,000
South Central Alabama Action Commission	**Not Applicable**	**3,582**	**192.5**
District's Rural Counties Combined	Not Applicable	1,726	206.2
District's Urban Counties Combined	Not Applicable	1,856	181.2
Autauga County	Yes	245	172.4
Bullock County	Yes	77	229.9
Butler County	Yes	167	269.9
Crenshaw County	Yes	81	198.2
Elmore County	Yes	391	181.7
Lee County	No	534	147.9
Lowndes County	Yes	95	242.1
Macon County	Yes	163	235.9
Montgomery County	No	1,322	199.4
Pike County	Yes	178	202.2
Russell County	Yes	329	223.5



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Cancer Mortality and Mortality Rates
Tombigbee Action Commission Counties, 2003 – 2005

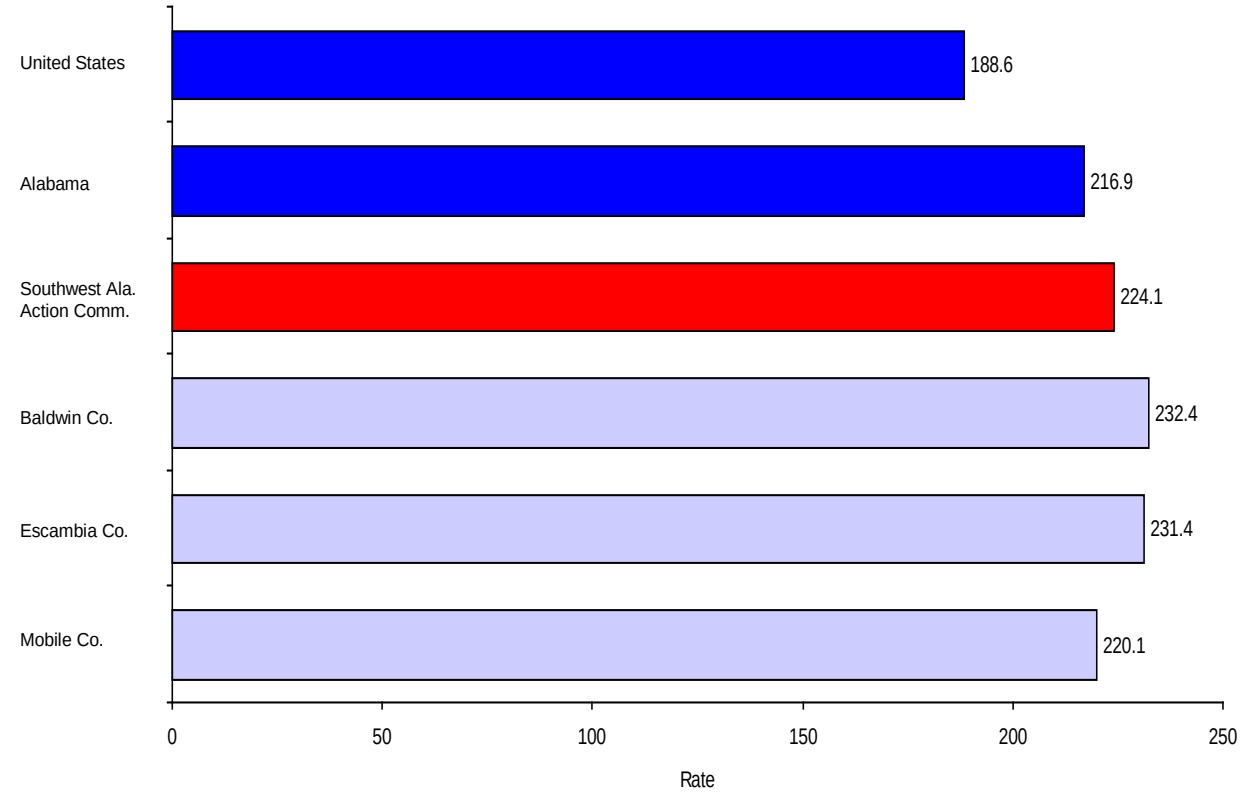
Area	Is County Rural?	Deaths	Rate Per 100,000
Tombigbee Action Commission	**Not Applicable**	**1,362**	**224.8**
District's Rural Counties Combined	Not Applicable	1,362	224.8
District's Urban Counties Combined	Not Applicable	No Urban Counties in District	
Choctaw County	Yes	100	221.0
Clarke County	Yes	173	211.5
Conecuh County	Yes	116	289.4
Dallas County	Yes	301	225.4
Marengo County	Yes	156	236.9
Monroe County	Yes	147	207.4
Perry County	Yes	91	264.6
Sumter County	Yes	75	178.2
Washington County	Yes	114	213.9
Wilcox County	Yes	89	230.3



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Cancer Mortality and Mortality Rates
Wiregrass Action Commission Counties, 2003 – 2005

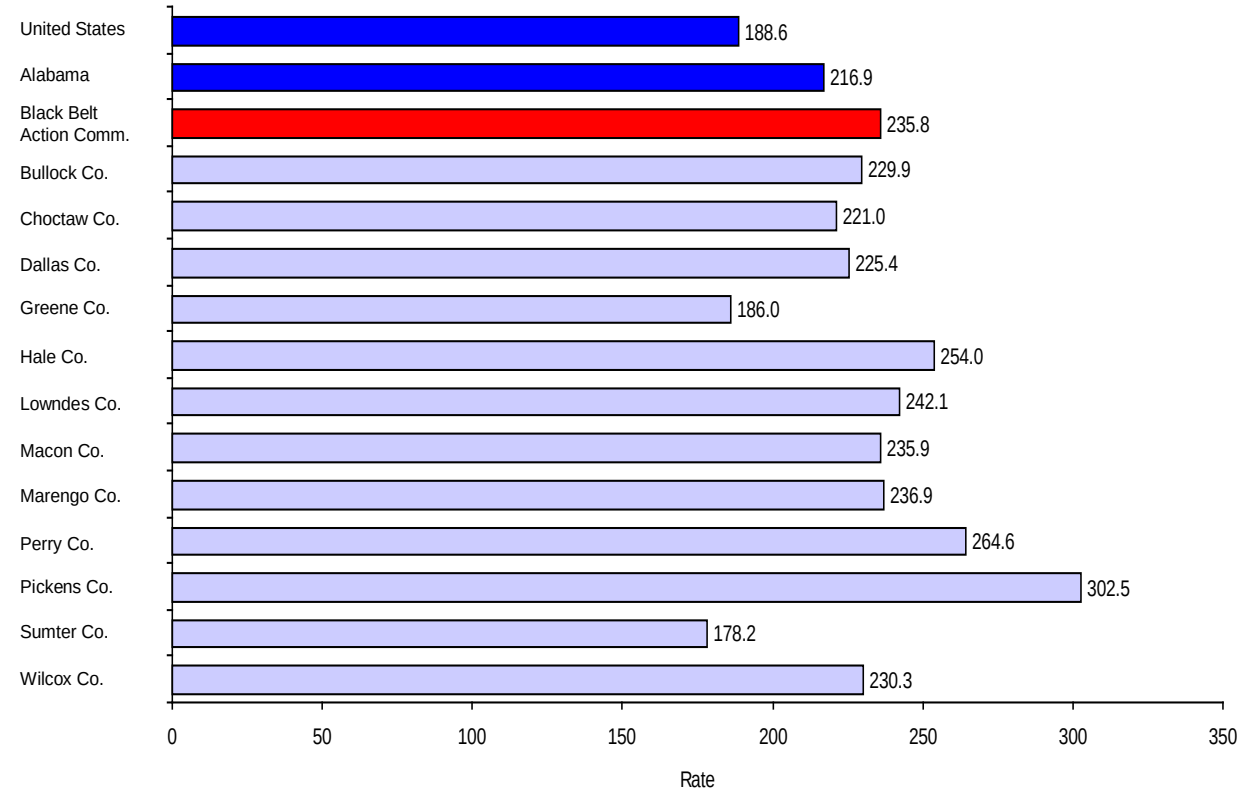
Area	Is County Rural?	Deaths	Rate Per 100,000
Wiregrass Action Commission	**Not Applicable**	**2,104**	**238.7**
District's Rural Counties Combined	Not Applicable	1,484	245.9
District's Urban Counties Combined	Not Applicable	620	223.0
Barbour County	Yes	180	210.9
Coffee County	Yes	323	239.4
Covington County	Yes	324	293.7
Dale County	Yes	321	218.8
Geneva County	Yes	207	270.0
Henry County	Yes	129	260.5
Houston County	No	620	223.0



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Cancer Mortality and Mortality Rates
Southwest Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Southwest Alabama Action Commission	**Not Applicable**	**3,993**	**224.1**
District's Rural Counties Combined	Not Applicable	1,359	232.2
District's Urban Counties Combined	Not Applicable	2,634	220.1
Baldwin County	Yes	1,094	232.4
Escambia County	Yes	265	231.4
Mobile County	No	2,634	220.1



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Cancer Mortality and Mortality Rates
Black Belt Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Black Belt Action Commission	**Not Applicable**	**1,523**	**235.8**
District's Rural Counties Combined	Not Applicable	**1,523**	**235.8**
District's Urban Counties Combined	Not Applicable	No Urban Counties in District	
Bullock County	Yes	77	229.9
Choctaw County	Yes	100	221.0
Dallas County	Yes	301	225.4
Greene County	Yes	54	186.0
Hale County	Yes	138	254.0
Lowndes County	Yes	95	242.1
Macon County	Yes	163	235.9
Marengo County	Yes	156	236.9
Perry County	Yes	91	264.6
Pickens County	Yes	184	302.5
Sumter County	Yes	75	178.2
Wilcox County	Yes	89	230.3

Cancer Mortality and Mortality Rates
Alabama's Appalachian Region Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Alabama's Appalachian Region	**Not Applicable**	**18,848**	**217.2**
Region's Rural Counties Combined	Not Applicable	8,328	232.4
Region's Urban Counties Combined	Not Applicable	10,520	206.5
Bibb County	Yes	143	224.3
Blount County	Yes	319	193.5
Calhoun County	No	815	242.8
Chambers County	Yes	279	262.1
Cherokee County	Yes	196	267.2
Chilton County	Yes	276	222.8
Clay County	Yes	113	268.4
Cleburne County	Yes	110	253.1
Colbert County	Yes	402	245.3
Coosa County	Yes	83	245.1
Cullman County	Yes	549	231.4
DeKalb County	Yes	404	201.3
Elmore County	Yes	391	181.7
Etowah County	No	801	259.4
Fayette County	Yes	127	233.2
Franklin County	Yes	223	242.5
Hale County	Yes	138	254.0
Jackson County	Yes	382	237.2
Jefferson County	No	4,365	221.4
Lamar County	Yes	119	264.5
Lauderdale County	No	591	225.5
Lawrence County	Yes	219	212.3
Limestone County	Yes	406	195.7
Macon County	Yes	163	235.9
Madison County	No	1,604	182.2
Marion County	Yes	254	281.2
Marshall County	Yes	583	229.3
Morgan County	No	687	202.9
Pickens County	Yes	184	302.5
Randolph County	Yes	156	231.0
St. Clair County	Yes	496	235.6
Shelby County	No	720	145.1
Talladega County	Yes	550	229.3
Tallapoosa County	Yes	339	277.7
Tuscaloosa County	No	937	187.3
Walker County	Yes	552	263.6
Winston County	Yes	172	234.2

For additional information on the Appalachian Region, visit the Appalachian Regional Commission's Web site at http://www.arc.gov/index.jsp; the Appalachian Regional Commission – Alabama Programs Office Web site at http://www.adeca.alabama.gov/default.aspx; or contact Bonnie Durham, Alabama Program Manager at (256) 845-3472.

Cancer Mortality and Mortality Rates
Alabama's Delta Region Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Alabama's Delta Region	**Not Applicable**	**3,014**	**231.7**
Region's Rural Counties Combined	Not Applicable	**3,014**	**231.7**
Region's Urban Counties Combined	Not Applicable	No Urban Counties in Region	
Barbour County	Yes	180	210.9
Bullock County	Yes	77	229.9
Butler County	Yes	167	269.9
Choctaw County	Yes	100	221.0
Clarke County	Yes	173	211.5
Conecuh County	Yes	116	289.4
Dallas County	Yes	301	225.4
Escambia County	Yes	265	231.4
Greene County	Yes	54	186.0
Hale County	Yes	138	254.0
Lowndes County	Yes	95	242.1
Macon County	Yes	163	235.9
Marengo County	Yes	156	236.9
Monroe County	Yes	147	207.4
Perry County	Yes	91	264.6
Pickens County	Yes	184	302.5
Russell County	Yes	329	223.5
Sumter County	Yes	75	178.2
Washington County	Yes	114	213.9
Wilcox County	Yes	89	230.3

For additional information on the Delta Region, visit the Delta Regional Authority's Web site at http://www.dra.gov/ or contact one of the Delta Regional Authority – Local Development District Offices as follows:

Alabama – Tombigbee Regional Commission, (334) 682-4234 (Choctaw, Clarke, Conecuh, Dallas, Marengo, Monroe, Perry, Sumter, Washington, and Wilcox counties)

Lee – Russell Council of Governments, (334) 749-5264 (Russell County)

South Alabama Regional Planning Commission, (251) 433-6541 (Escambia County)

South Central Alabama Development Commission (334) 244-6903 (Bullock, Butler, Lowndes, and Macon counties)

Southeast Alabama Regional Planning and Development Commission, (334) 794-4093 (Barbour County)

West Alabama Planning and Development Council, (205) 333-2990 (Greene, Hale, and Pickens counties)

Indicators of Health Status in Alabama:
CEREBROVASCULAR DISEASES MORTALITY

Stroke usually occurs in individuals who:

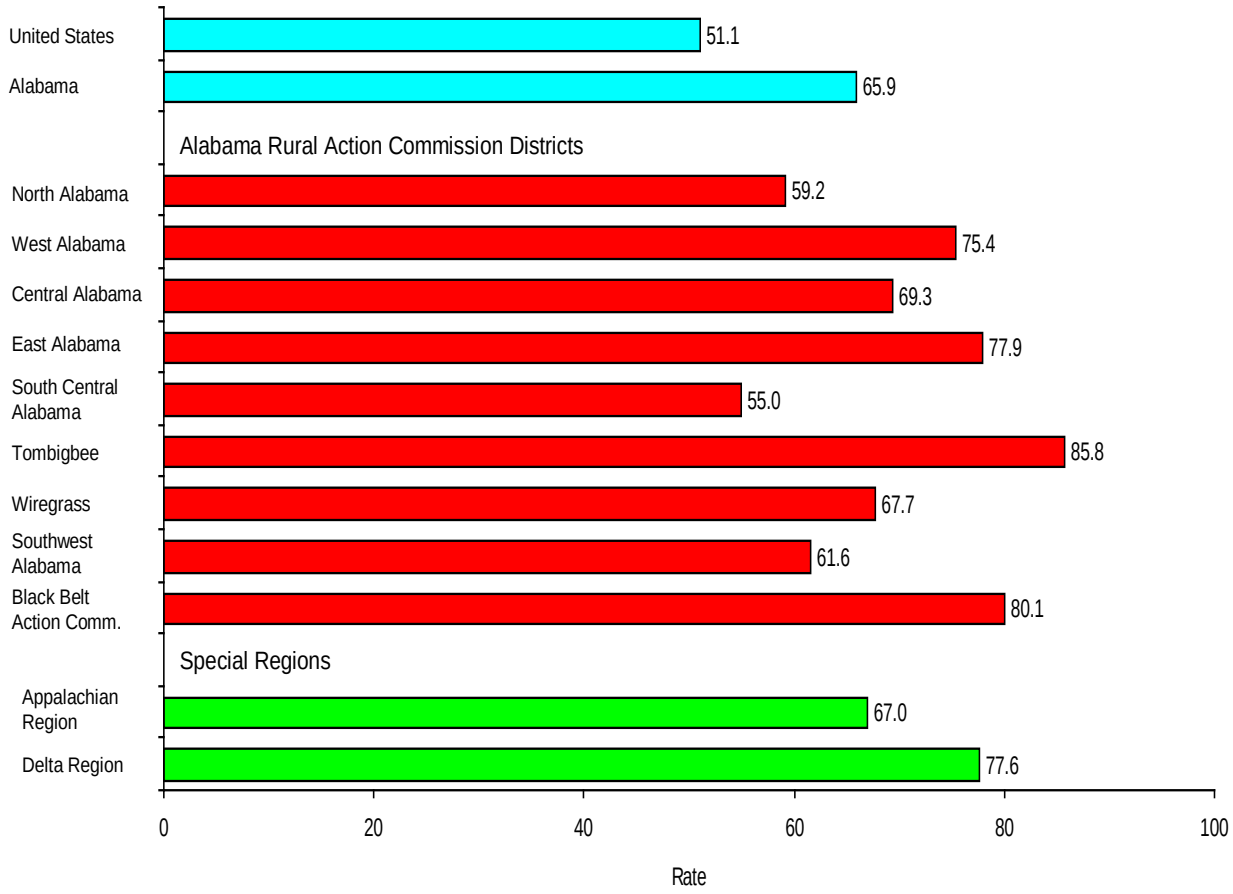
- have high blood pressure (hypertension).
- smoke.
- have elevated cholesterol.

To prevent stroke, individuals should:

- balance food and physical activity to maintain a healthy weight.
- eat 5 or more servings of fruits and vegetables daily.
- be physically active four to five times a week.

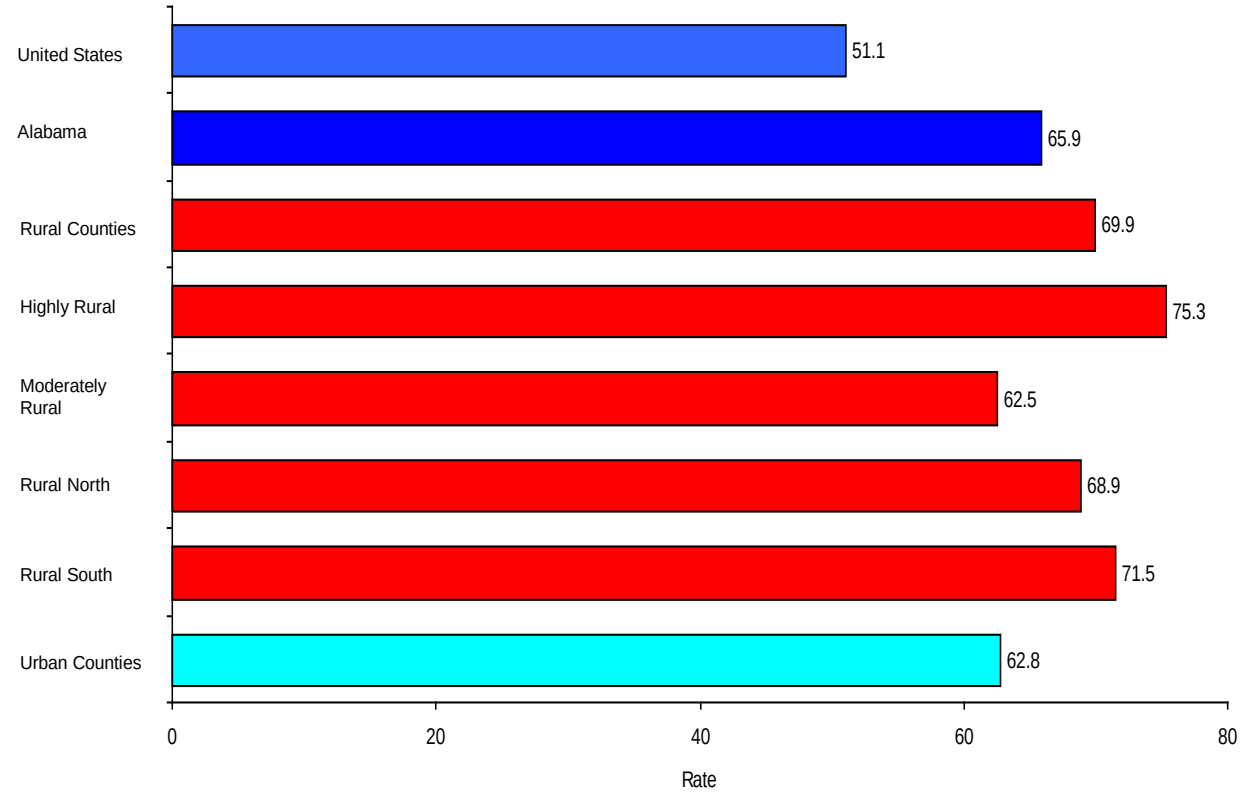
- use more non-meat main dishes such as dried peas and beans, and tofu.
- aviod or eliminate use of cigarettes, including exposure to environmental tobacco smoke (ETS).
- visit physician regularly to check blood pressure.
- take blood pressure medication as directed.
- take cholesterol lowering medications as directed.

Cerebrovascular Diseases Mortality Rates for 2003-2005
U.S., Alabama, Alabama Rural Action Commission Districts, and Special Regions In Alabama



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

- Alabama is a member of the "Stroke Belt," an area consisting of the southeastern U.S. and the Mississippi Valley with high stroke mortality. Cerebrovascular diseases have been the third leading cause of death in Alabama since 1966.
- Alabama currently has the 4th highest cerebrovascular disease mortality rate among all 50 states. Alabamians aged 25-64 years have the 3rd highest cerebrovascular disease mortality rate among all 50 states.
- Alabama lost 8,934 residents to cerebrovascular diseases during 2003-2005.
- 41 of the 45 Alabama counties with the highest cerebrovascular disease mortality rates are rural counties.



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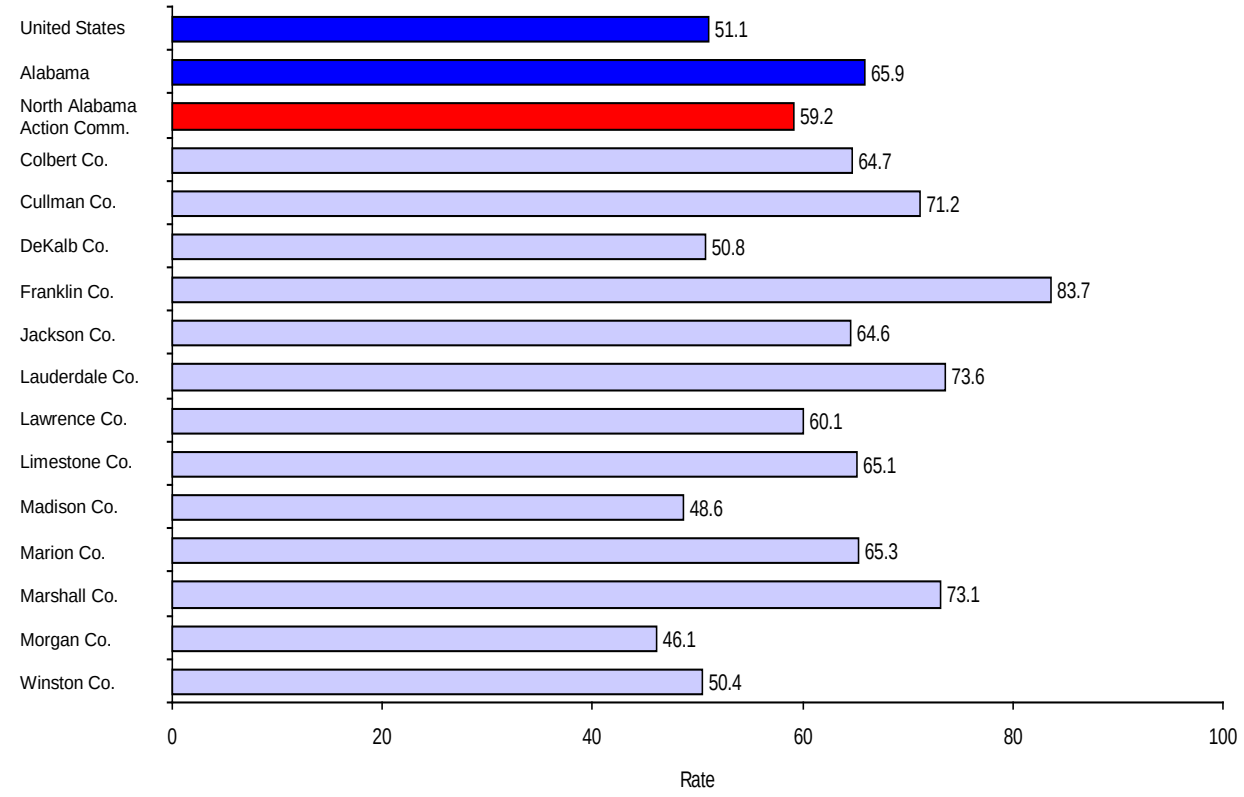
Cerebrovascular Diseases (Stroke) Mortality and Mortality Rates
U.S. and Selected Alabama Areas, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
United States	**Not Applicable**	**150,074**	**51.1**
Alabama	**Not Applicable**	**8,934**	**65.9**
Rural Alabama Counties	**Not Applicable**	**4,168**	**69.9**
Highly Rural Alabama Counties	**Not Applicable**	**2,601**	**75.3**
Moderately Rural Alabama Counties	**Not Applicable**	**1,567**	**62.5**
Rural North Alabama Counties	**Not Applicable**	**2,470**	**68.9**
Rural South Alabama Counties	**Not Applicable**	**1,698**	**71.5**
Urban Alabama Counties	**Not Applicable**	**4,766**	**62.8**



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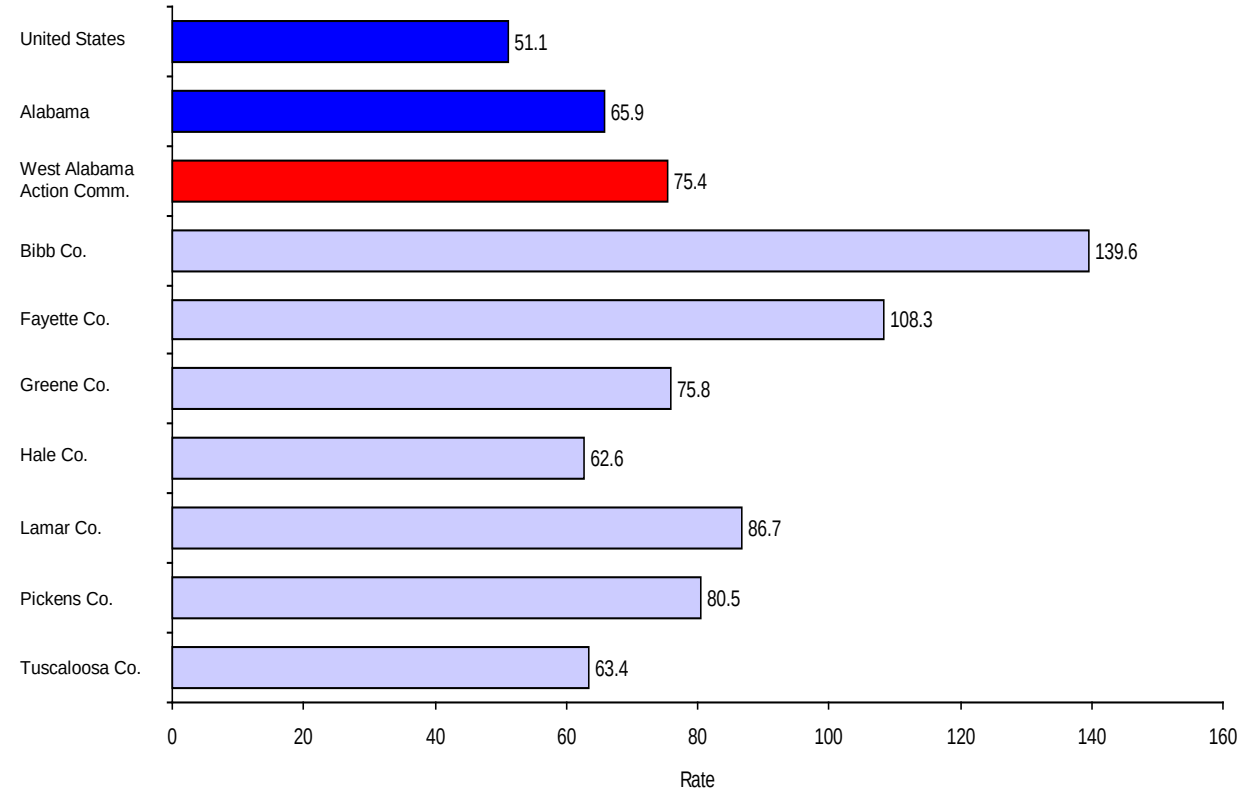
Cerebrovascular Diseases (Stroke) Mortality and Mortality Rates
North Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
North Alabama Action Commission	**Not Applicable**	**1,814**	**59.2**
District's Rural Counties Combined	Not Applicable	1,037	65.5
District's Urban Counties Combined	Not Applicable	777	52.5
Colbert County	Yes	106	64.7
Cullman County	Yes	169	71.2
DeKalb County	Yes	102	50.8
Franklin County	Yes	77	83.7
Jackson County	Yes	104	64.6
Lauderdale County	No	193	73.6
Lawrence County	Yes	62	60.1
Limestone County	Yes	135	65.1
Madison County	No	428	48.6
Marion County	Yes	59	65.3
Marshall County	Yes	186	73. 1
Morgan County	No	156	46.1
Winston County	Yes	37	50.4



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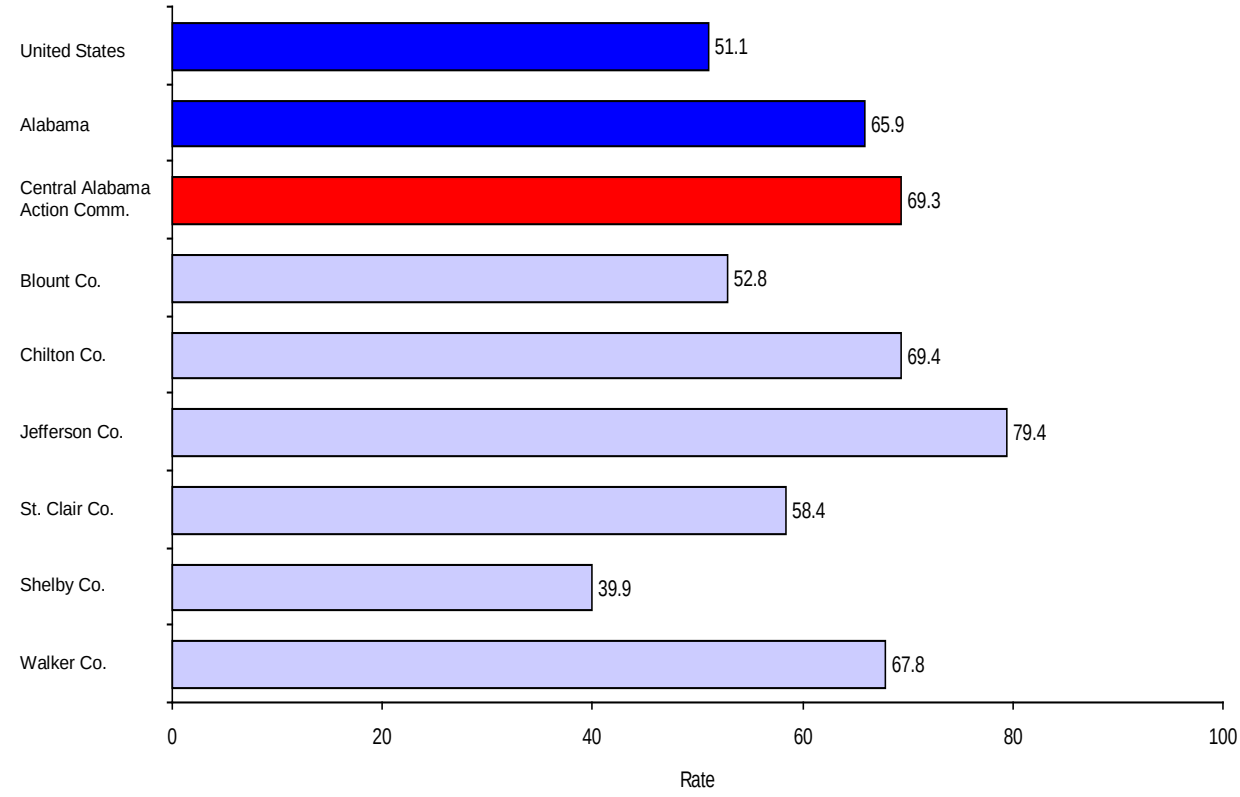
Cerebrovascular Diseases (Stroke) Mortality and Mortality Rates
West Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
West Alabama Action Commission	**Not Applicable**	**609**	**75.4**
District's Rural Counties Combined	Not Applicable	292	95.0
District's Urban Counties Combined	Not Applicable	317	63.4
Bibb County	Yes	89	139.6
Fayette County	Yes	59	108.3
Greene County	Yes	22	75.8
Hale County	Yes	34	62.6
Lamar County	Yes	39	86.7
Pickens County	Yes	49	80.5
Tuscaloosa County	No	317	63.4



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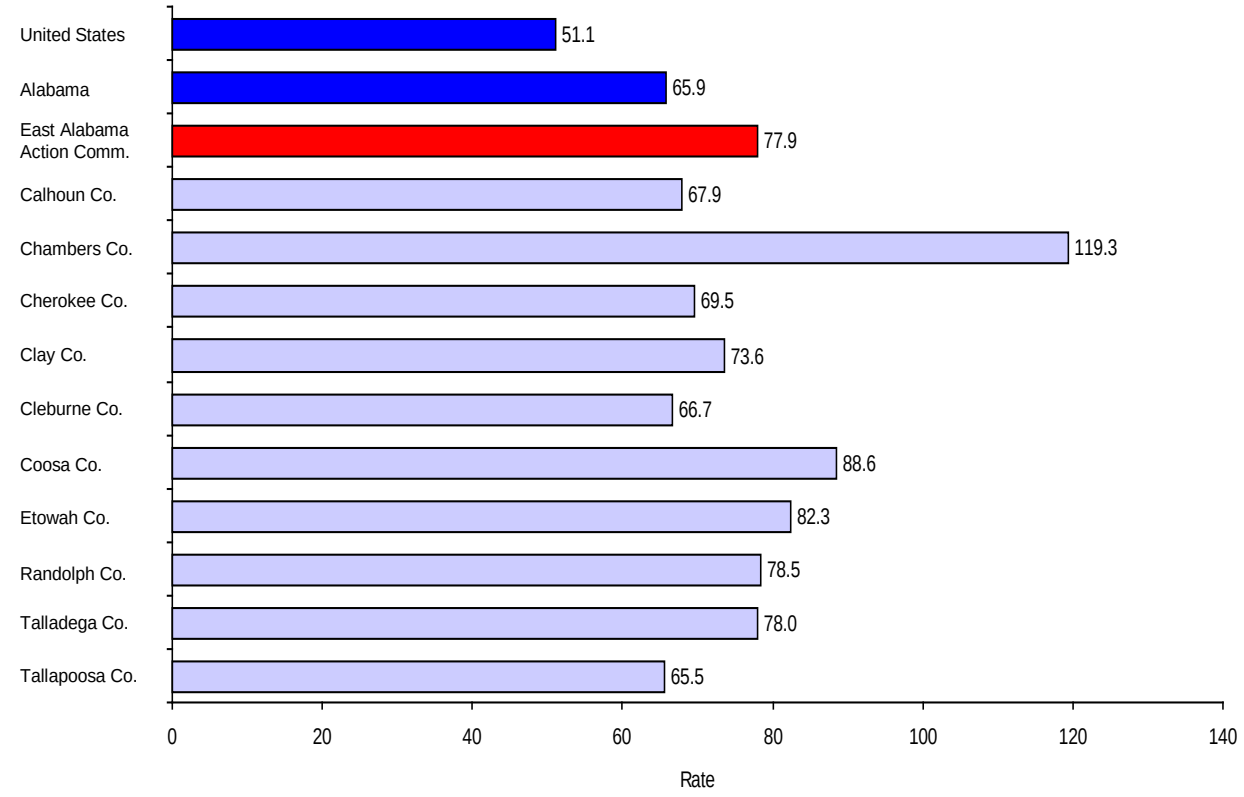
Cerebrovascular Diseases (Stroke) Mortality and Mortality Rates
Central Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Central Alabama Action Commission	**Not Applicable**	**2,202**	**69.3**
District's Rural Counties Combined	Not Applicable	438	61.8
District's Urban Counties Combined	Not Applicable	1,764	71.5
Blount County	Yes	87	52.8
Chilton County	Yes	86	69.4
Jefferson County	No	1,566	79.4
St. Clair County	Yes	123	58.4
Shelby County	No	198	39.9
Walker County	Yes	142	67.8



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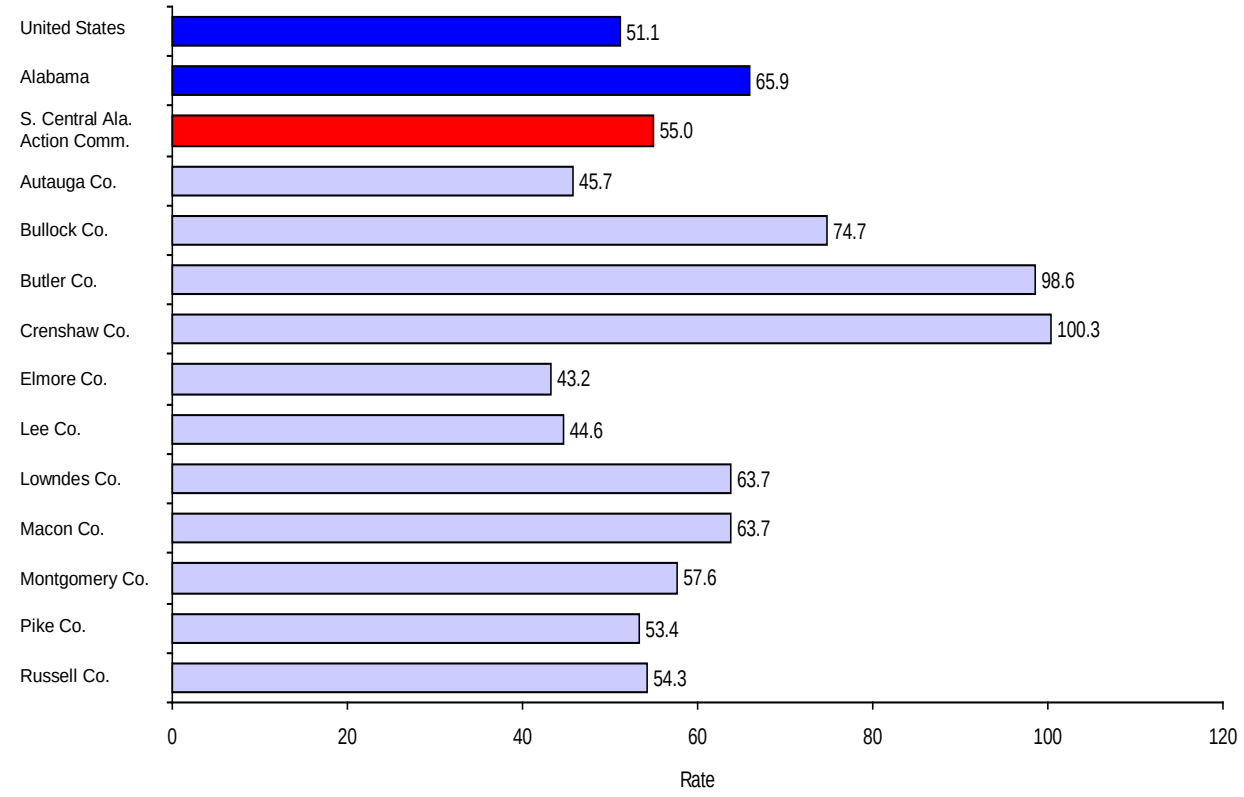
Cerebrovascular Diseases (Stroke) Mortality and Mortality Rates
East Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
East Alabama Action Commission	**Not Applicable**	**1,070**	**77.9**
District's Rural Counties Combined	Not Applicable	588	80.7
District's Urban Counties Combined	Not Applicable	482	74.8
Calhoun County	No	228	67.9
Chambers County	Yes	127	119.3
Cherokee County	Yes	51	69.5
Clay County	Yes	31	73.6
Cleburne County	Yes	29	66.7
Coosa County	Yes	30	88.6
Etowah County	No	254	82.3
Randolph County	Yes	53	78.5
Talladega County	Yes	187	78.0
Tallapoosa County	Yes	80	65.5



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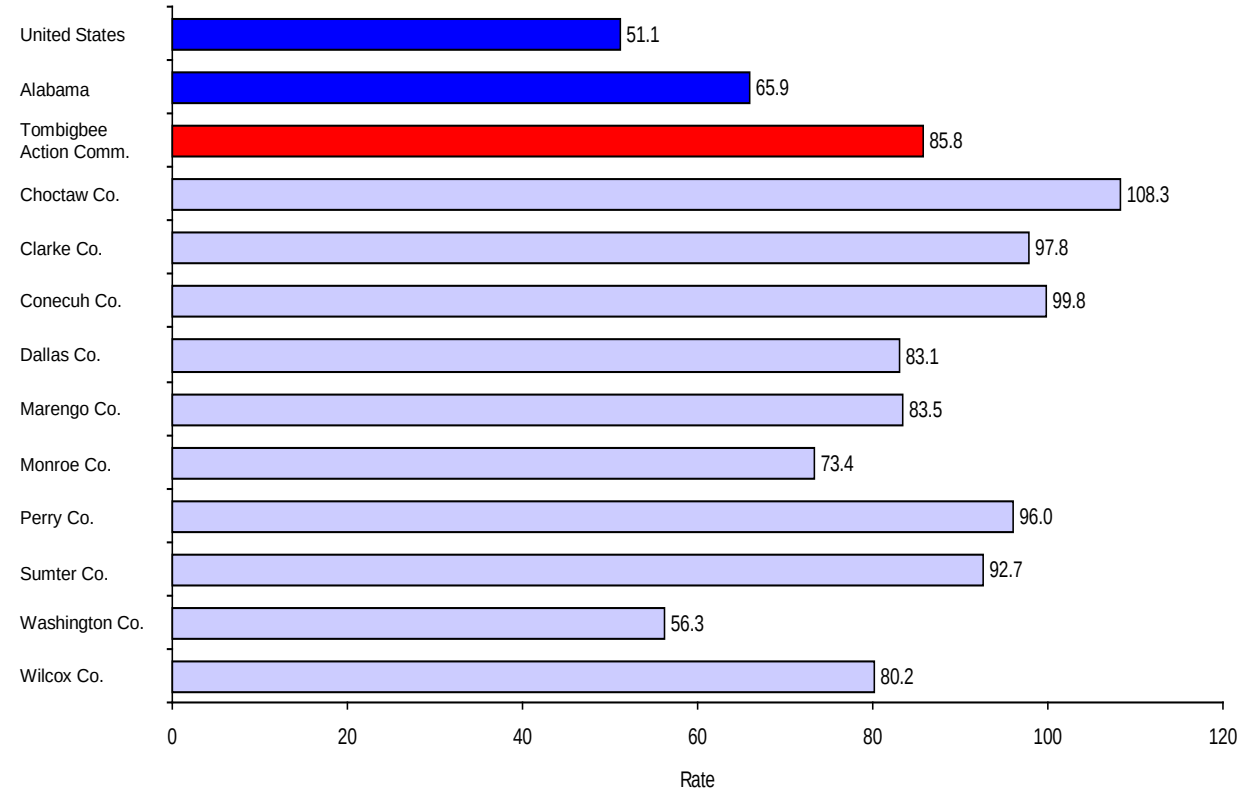
Cerebrovascular Diseases (Stroke) Mortality and Mortality Rates
South Central Alabama Action Commission Counties, 2003 – 2005

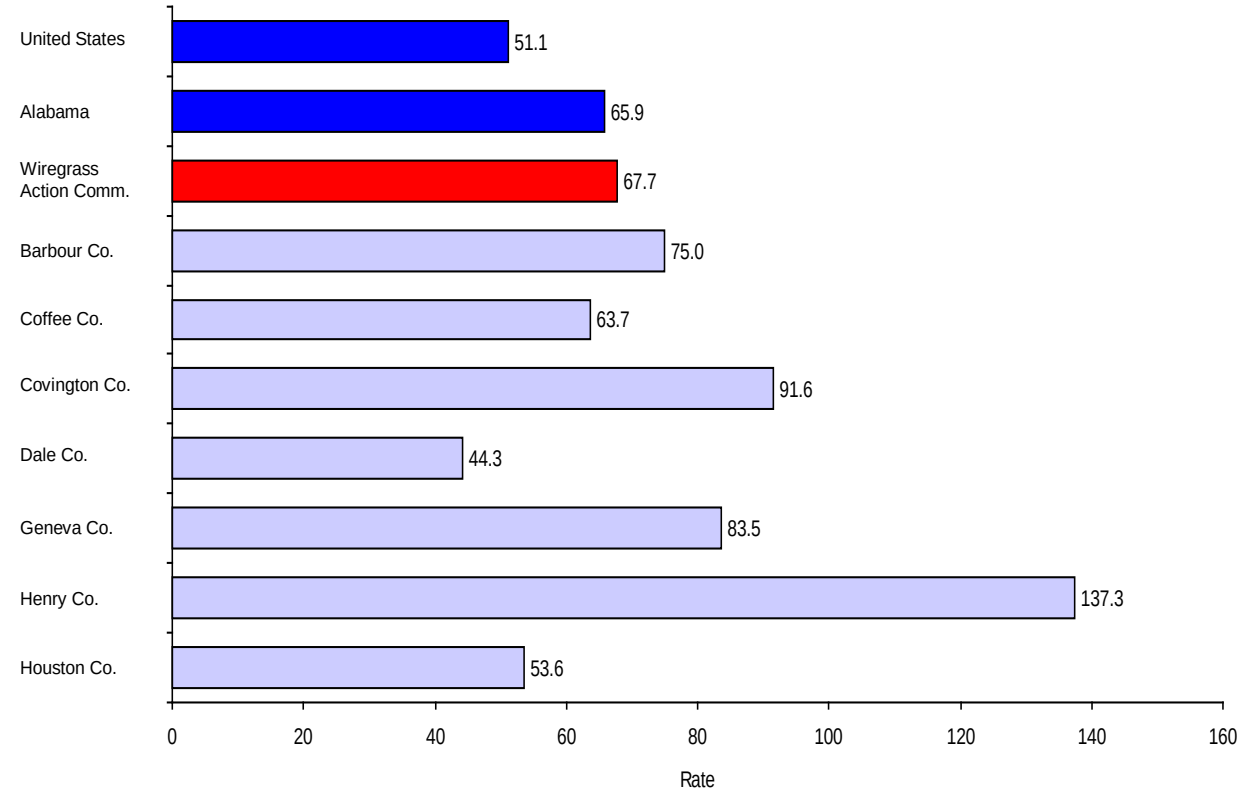
Area	Is County Rural?	Deaths	Rate Per 100,000
South Central Alabama Action Commission	**Not Applicable**	**1,024**	**55.0**
District's Rural Counties Combined	Not Applicable	481	57.5
District's Urban Counties Combined	Not Applicable	543	53.0
Autauga County	Yes	65	45.7
Bullock County	Yes	25	74.7
Butler County	Yes	61	98.6
Crenshaw County	Yes	41	100.3
Elmore County	Yes	93	43.2
Lee County	No	161	44.6
Lowndes County	Yes	25	63.7
Macon County	Yes	44	63.7
Montgomery County	No	382	57.6
Pike County	Yes	47	53.4
Russell County	Yes	80	54.3



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Cerebrovascular Diseases (Stroke) Mortality and Mortality Rates
Tombigbee Action Commission Counties, 2003 – 2005

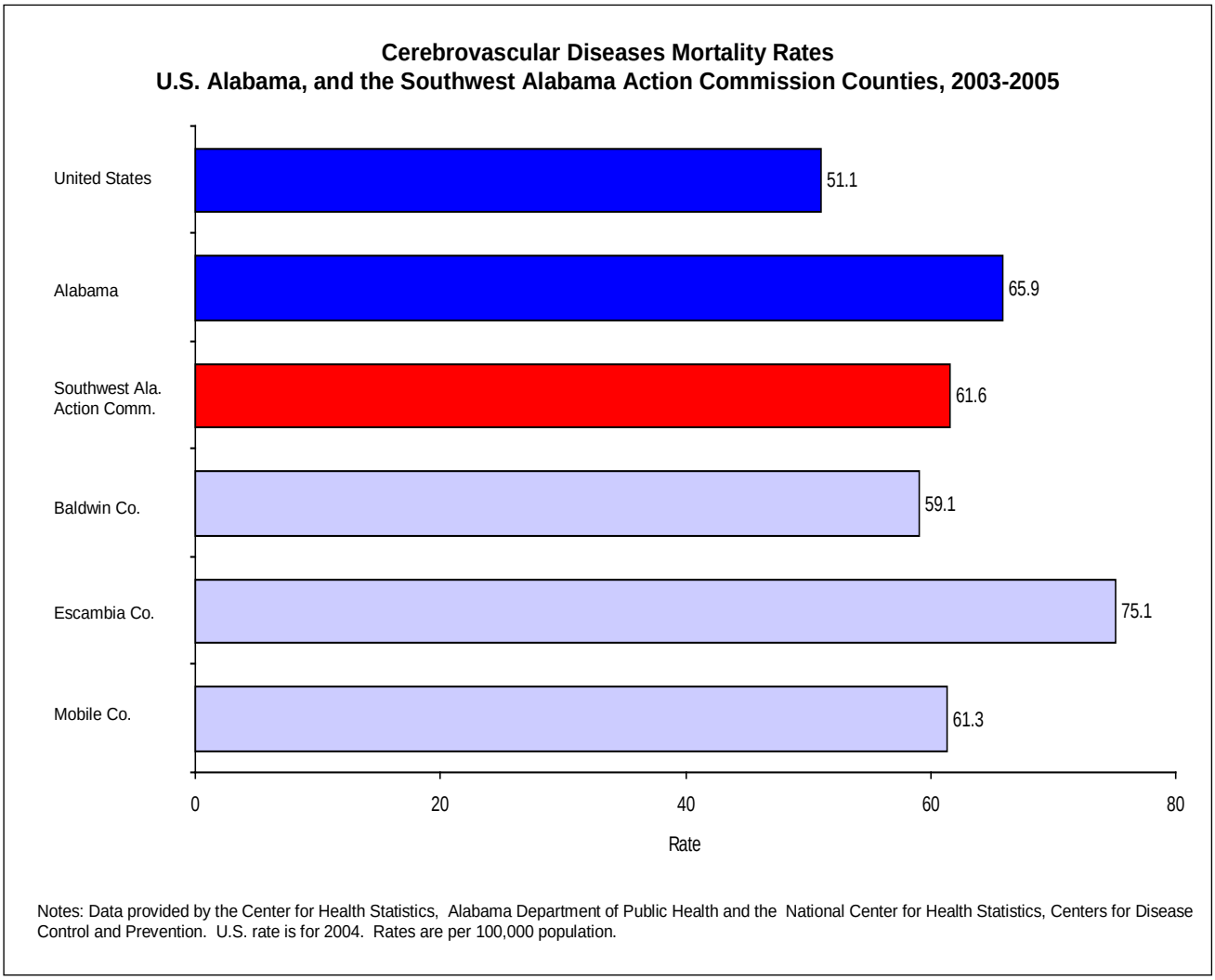
Area	Is County Rural?	Deaths	Rate Per 100,000
Tombigbee Action Commission	**Not Applicable**	**520**	**85.8**
District's Rural Counties Combined	Not Applicable	520	85.8
District's Urban Counties Combined	Not Applicable	No Urban Counties in District	
Choctaw County	Yes	49	108.3
Clarke County	Yes	80	97.8
Conecuh County	Yes	40	99.8
Dallas County	Yes	111	83.1
Marengo County	Yes	55	83.5
Monroe County	Yes	52	73.4
Perry County	Yes	33	96.0
Sumter County	Yes	39	92.7
Washington County	Yes	30	56.3
Wilcox County	Yes	31	80.2



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Cerebrovascular Diseases (Stroke) Mortality and Mortality Rates
Wiregrass Action Commission Counties, 2003 – 2005

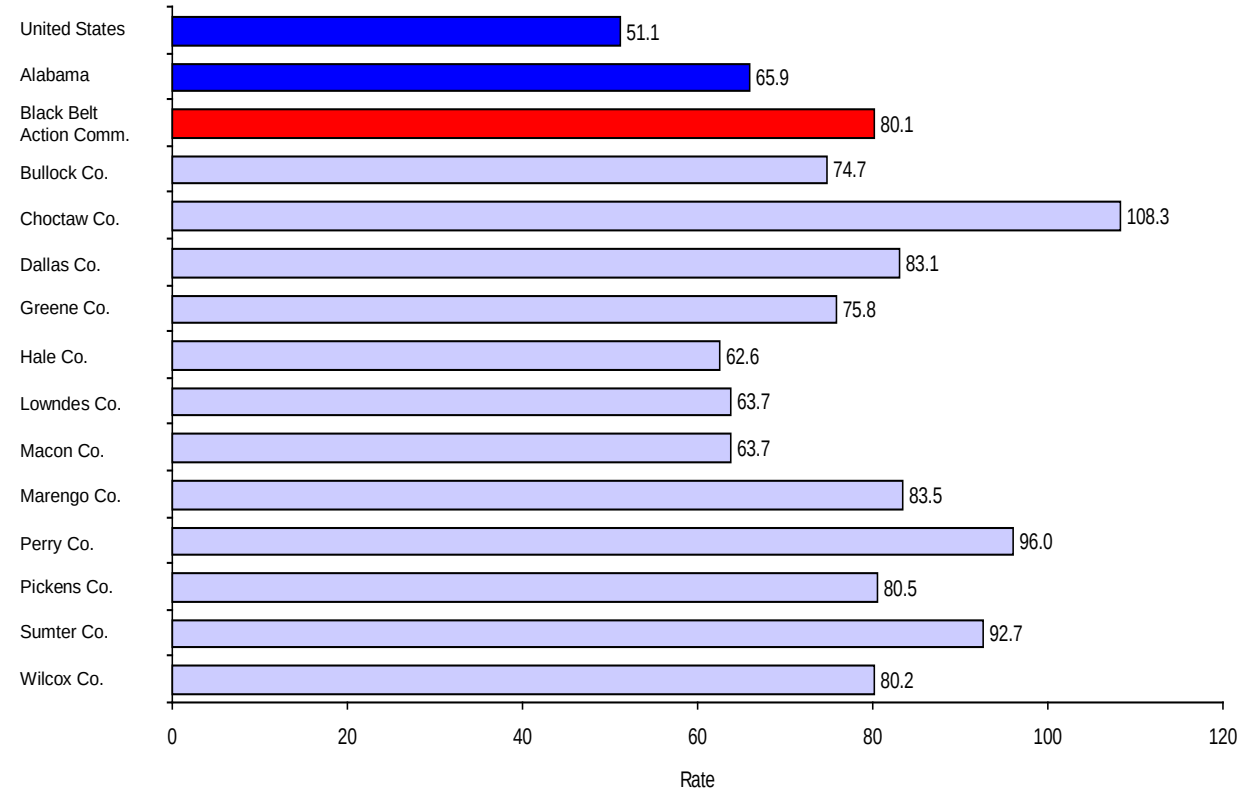
Area	Is County Rural?	Deaths	Rate Per 100,000
Wiregrass Action Commission	**Not Applicable**	**597**	**67.7**
District's Rural Counties Combined	Not Applicable	448	74.2
District's Urban Counties Combined	Not Applicable	149	53.6
Barbour County	Yes	64	75.0
Coffee County	Yes	86	63.7
Covington County	Yes	101	91.6
Dale County	Yes	65	44.3
Geneva County	Yes	64	83.5
Henry County	Yes	68	137.3
Houston County	No	149	53.6



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Cerebrovascular Diseases (Stroke) Mortality and Mortality Rates
Southwest Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Southwest Alabama Action Commission	**Not Applicable**	**1,098**	**61.6**
District's Rural Counties Combined	Not Applicable	364	62.2
District's Urban Counties Combined	Not Applicable	734	61.3
Baldwin County	Yes	278	59.1
Escambia County	Yes	86	75.1
Mobile County	No	734	61.3



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Cerebrovascular Diseases (Stroke) Mortality and Mortality Rates
Black Belt Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Black Belt Action Commission	**Not Applicable**	**517**	**80.1**
District's Rural Counties Combined	Not Applicable	**517**	**80.1**
District's Urban Counties Combined	Not Applicable	No Urban Counties in District	
Bullock County	Yes	25	74.7
Choctaw County	Yes	49	108.3
Dallas County	Yes	111	83.1
Greene County	Yes	22	75.8
Hale County	Yes	34	62.6
Lowndes County	Yes	25	63.7
Macon County	Yes	44	63.7
Marengo County	Yes	55	83.5
Perry County	Yes	33	96.0
Pickens County	Yes	49	80.5
Sumter County	Yes	39	92.7
Wilcox County	Yes	31	80.2

Cerebrovascular Diseases (Stroke) Mortality and Mortality Rates
Alabama's Appalachian Region Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Alabama's Appalachian Region	**Not Applicable**	**5,810**	**67.0**
Region's Rural Counties Combined	Not Applicable	2,470	68.9
Region's Urban Counties Combined	Not Applicable	3,340	65.6
Bibb County	Yes	89	139.6
Blount County	Yes	87	52.8
Calhoun County	No	228	67.9
Chambers County	Yes	127	119.3
Cherokee County	Yes	51	69.5
Chilton County	Yes	86	69.4
Clay County	Yes	31	73.6
Cleburne County	Yes	29	66.7
Colbert County	Yes	106	64.7
Coosa County	Yes	30	88.6
Cullman County	Yes	169	71.2
DeKalb County	Yes	102	50.8
Elmore County	Yes	93	43.2
Etowah County	No	254	82.3
Fayette County	Yes	59	108.3
Franklin County	Yes	77	83.7
Hale County	Yes	34	62.6
Jackson County	Yes	104	64.6
Jefferson County	No	1,566	79.4
Lamar County	Yes	39	86.7
Lauderdale County	No	193	73.6
Lawrence County	Yes	62	60.1
Limestone County	Yes	135	65.1
Macon County	Yes	44	63.7
Madison County	No	428	48.6
Marion County	Yes	59	65.3
Marshall County	Yes	186	73.1
Morgan County	No	156	46.1
Pickens County	Yes	49	80.5
Randolph County	Yes	53	78.5
St. Clair County	Yes	123	58.4
Shelby County	No	198	39.9
Talladega County	Yes	187	78.0
Tallapoosa County	Yes	80	65.5
Tuscaloosa County	No	317	63.4
Walker County	Yes	142	67.8
Winston County	Yes	37	50.4

For additional information on the Appalachian Region, visit the Appalachian Regional Commission's Web site at http://www.arc.gov/index.jsp; the Appalachian Regional Commission – Alabama Programs Office Web site at http://www.adeca.alabama.gov/default.aspx; or contact Bonnie Durham, Alabama Program Manager at (256) 845-3472.

Cerebrovascular Diseases (Stroke) Mortality and Mortality Rates
Alabama's Delta Region Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Alabama's Delta Region	**Not Applicable**	**1,010**	**77.6**
Region's Rural Counties Combined	Not Applicable	**1,010**	**77.6**
Region's Urban Counties Combined	Not Applicable	No Urban Counties in Region	
Barbour County	Yes	64	75.0
Bullock County	Yes	25	74.7
Butler County	Yes	61	98.6
Choctaw County	Yes	49	108.3
Clarke County	Yes	80	97.8
Conecuh County	Yes	40	99.8
Dallas County	Yes	111	83.1
Escambia County	Yes	86	75.1
Greene County	Yes	22	75.8
Hale County	Yes	34	62.6
Lowndes County	Yes	25	63.7
Macon County	Yes	44	63.7
Marengo County	Yes	55	83.5
Monroe County	Yes	52	73.4
Perry County	Yes	33	96.0
Pickens County	Yes	49	80.5
Russell County	Yes	80	54.3
Sumter County	Yes	39	92.7
Washington County	Yes	30	56.3
Wilcox County	Yes	31	80.2

For additional information on the Delta Region, visit the Delta Regional Authority's Web site at http://www.dra.gov/ or contact one of the Delta Regional Authority – Local Development District Offices as follows:

Alabama – Tombigbee Regional Commission, (334) 682-4234 (Choctaw, Clarke, Conecuh, Dallas, Marengo, Monroe, Perry, Sumter, Washington, and Wilcox counties)

Lee – Russell Council of Governments, (334) 749-5264 (Russell County)

South Alabama Regional Planning Commission, (251) 433-6541 (Escambia County)

South Central Alabama Development Commission (334) 244-6903 (Bullock, Butler, Lowndes, and Macon counties)

Southeast Alabama Regional Planning and Development Commission, (334) 794-4093 (Barbour County)

West Alabama Planning and Development Council, (205) 333-2990 (Greene, Hale, and Pickens counties)

Indicators of Health Status in Alabama:
ACCIDENT MORTALITY

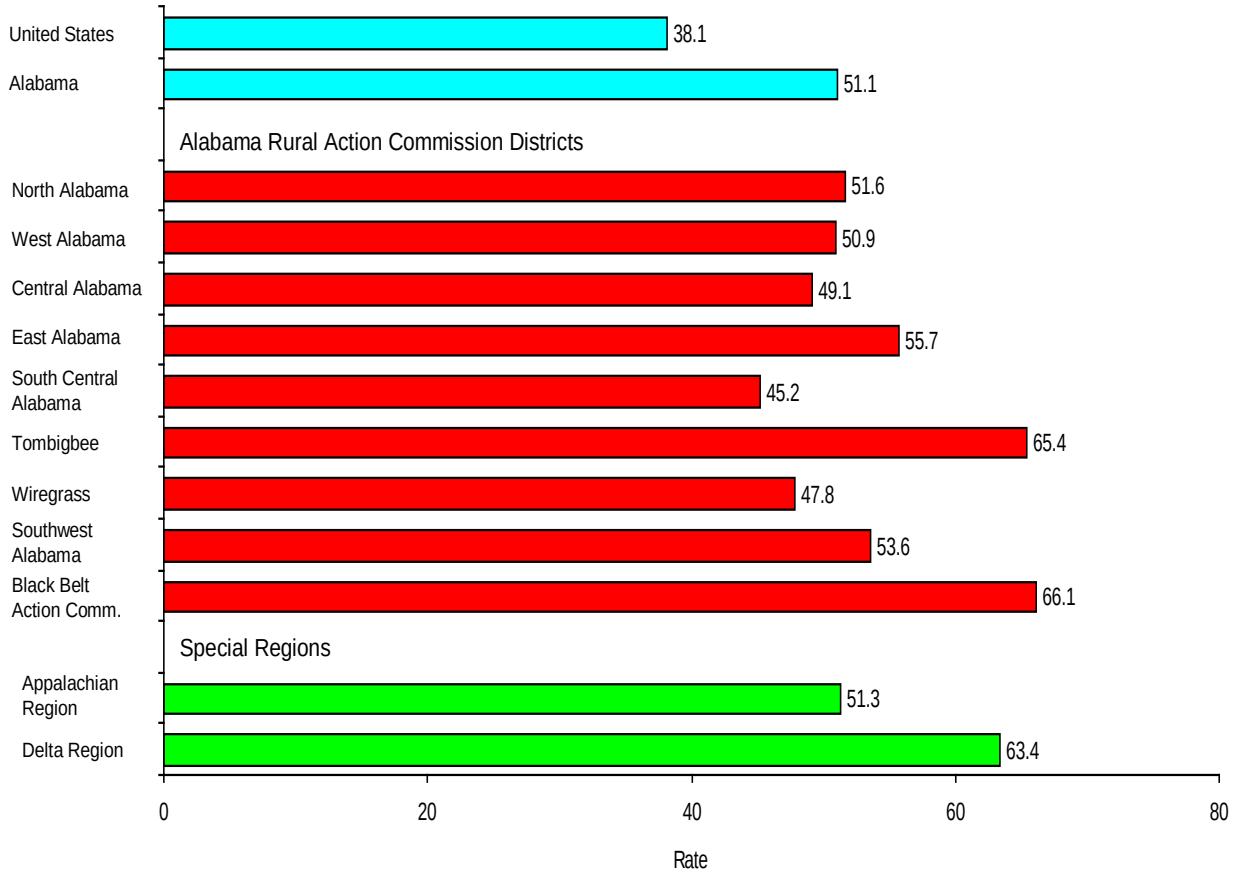
Individuals at risk of death from accidents usually:

- are over age 65 or are children.
- have underlying medical conditions which make accidents more hazardous.
- may be on sedative prescription medications which increase the chance of accidents.
- have medical conditions which predispose to an accident.
- have dwellings with poor lighting or objects such as throw rugs present which make accidents more likely to happen.
- operate vehicles, machinery, or equipment that they are not adequately trained to operate.
- ride with or work around those who operate vehicles, machinery, or equipment that they are not adequately trained to operate.

Individuals at risk for accidents should:

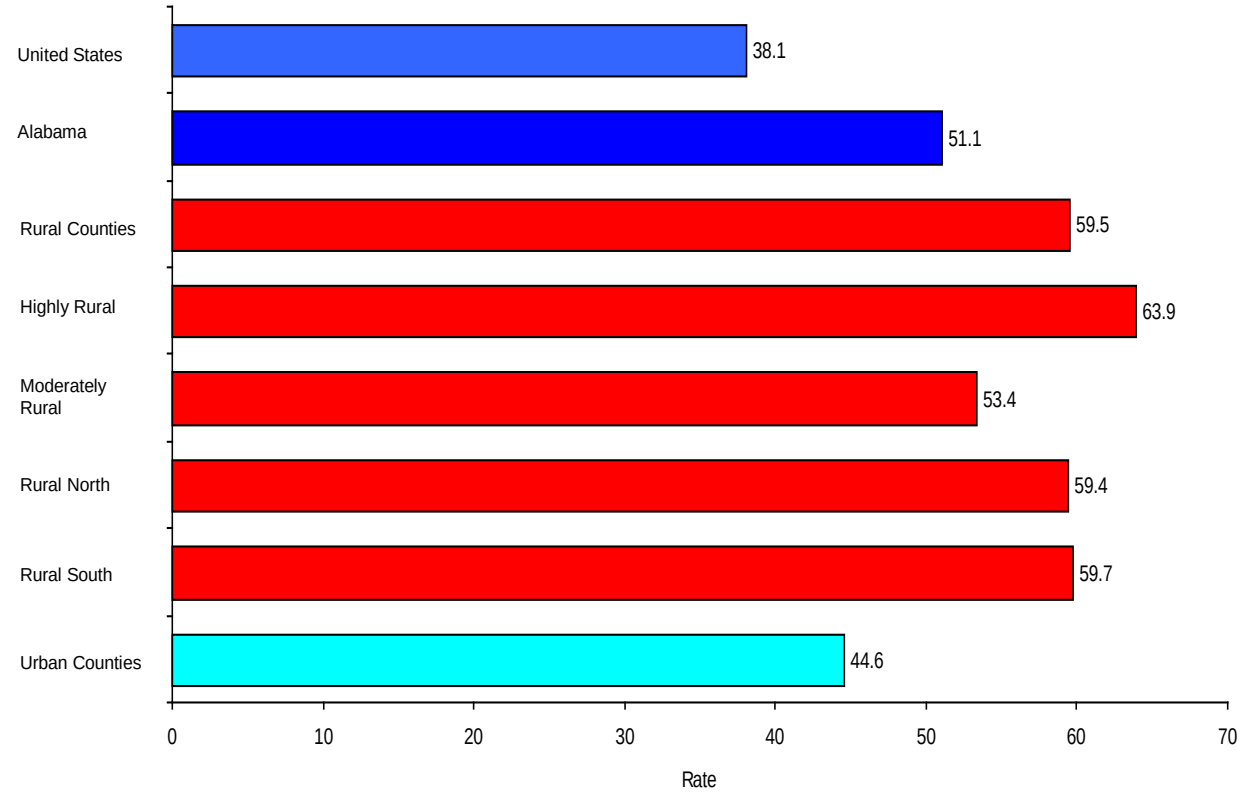
- use available safety devices such as seat belts, harnesses, and child restraints.
- operate vehicles that have safety devices installed and operational.
- have operating smoke detectors, safe playground equipment, and other safety promoting devices where possible.
- improve lighting in residences and remove throw rugs and loose wiring across floors which could cause an accident.
- review medications with physician to reduce or eliminate those which are sedating and substitute non-sedating medications when possible.
- ask a physician to determine if a condition is present which could contribute to the occurrence of accidents and take appropriate corrective measures.
- have persons present who are trained in responding to accidents, such as the Heimlich maneuver.

Accident Mortality Rates for 2003-2005
U.S., Alabama, Alabama Rural Action Commission Districts, and Special Regions In Alabama



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

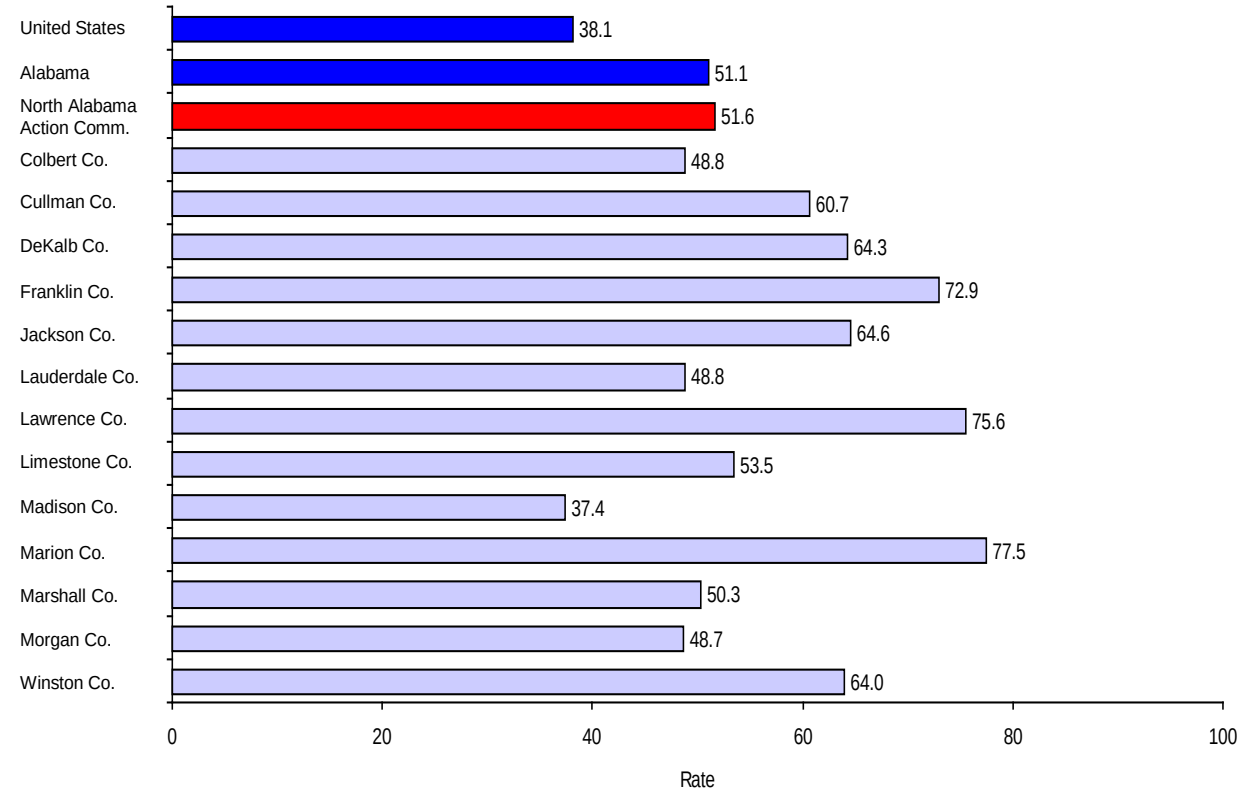
- Accidents have been the fourth leading cause of death in Alabama since 1949 with very few exceptions.
- Alabama currently has the 6th highest accident mortality rate among all 50 states, the 5th highest motor vehicle accident mortality rate among all states, and the 3rd highest fire-related accident mortality rate among all states.
- Alabama lost 6,931 residents to accidents during 2003-2005.
- 47 of the 50 Alabama counties with the highest accident mortality rates, including the 32 highest rates, are rural counties.



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Accidents Mortality and Mortality Rates
U.S. and Selected Alabama Areas, 2003 – 2005

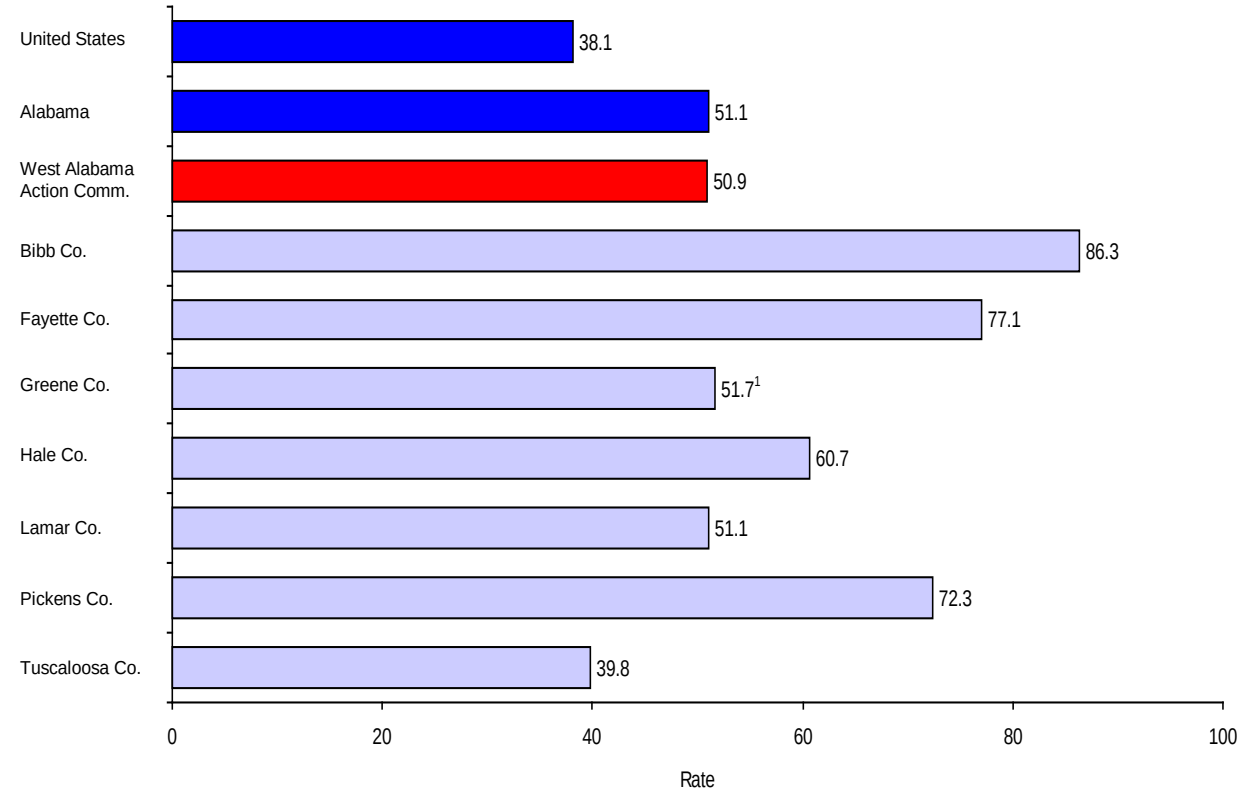
Area	Is County Rural?	Deaths	Rate Per 100,000
United States	**Not Applicable**	**112,012**	**38.1**
Alabama	**Not Applicable**	**6,931**	**51.1**
Rural Alabama Counties	**Not Applicable**	**3,546**	**59.5**
Highly Rural Alabama Counties	**Not Applicable**	**2,207**	**63.9**
Moderately Rural Alabama Counties	**Not Applicable**	**1,339**	**53.4**
Rural North Alabama Counties	**Not Applicable**	**2,128**	**59.4**
Rural South Alabama Counties	**Not Applicable**	**1,418**	**59.7**
Urban Alabama Counties	**Not Applicable**	**3,385**	**44.6**



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Accidents Mortality and Mortality Rates
North Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
North Alabama Action Commission	**Not Applicable**	**1,580**	**51.6**
District's Rural Counties Combined	Not Applicable	958	60.5
District's Urban Counties Combined	Not Applicable	622	42.0
Colbert County	Yes	80	48.8
Cullman County	Yes	144	60.7
DeKalb County	Yes	129	64.3
Franklin County	Yes	67	72.9
Jackson County	Yes	104	64.6
Lauderdale County	No	128	48.8
Lawrence County	Yes	78	75.6
Limestone County	Yes	111	53.5
Madison County	No	329	37.4
Marion County	Yes	70	77.5
Marshall County	Yes	128	50.3
Morgan County	No	165	48.7
Winston County	Yes	47	64.0



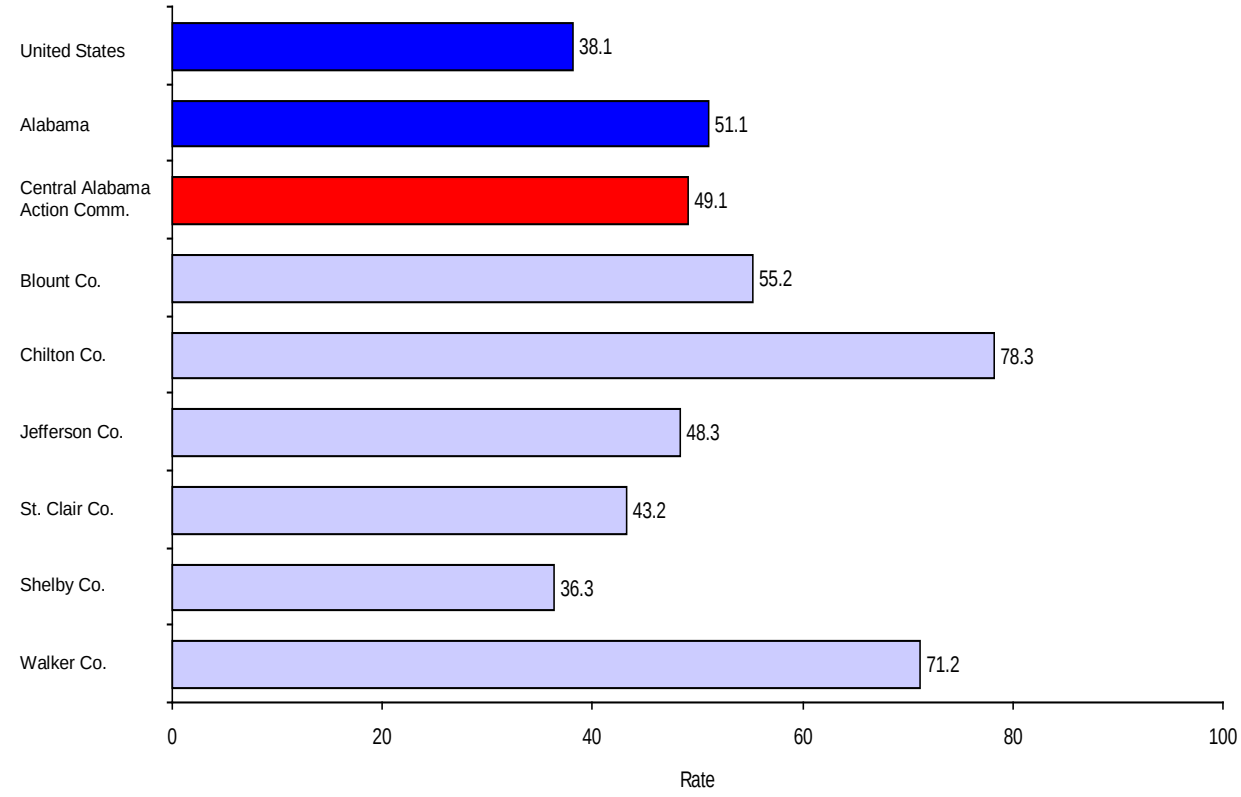
Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

[1] Caution should be used in interpreting this rate due to the small number of deaths from this cause.

Accidents Mortality and Mortality Rates
West Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
West Alabama Action Commission	**Not Applicable**	**411**	**50.9**
District's Rural Counties Combined	Not Applicable	212	69
District's Urban Counties Combined	Not Applicable	199	39.8
Bibb County	Yes	55	86.3
Fayette County	Yes	42	77.1
Greene County	Yes	15	51.7[1]
Hale County	Yes	33	60.7
Lamar County	Yes	23	51.1
Pickens County	Yes	44	72.3
Tuscaloosa County	No	199	39.8

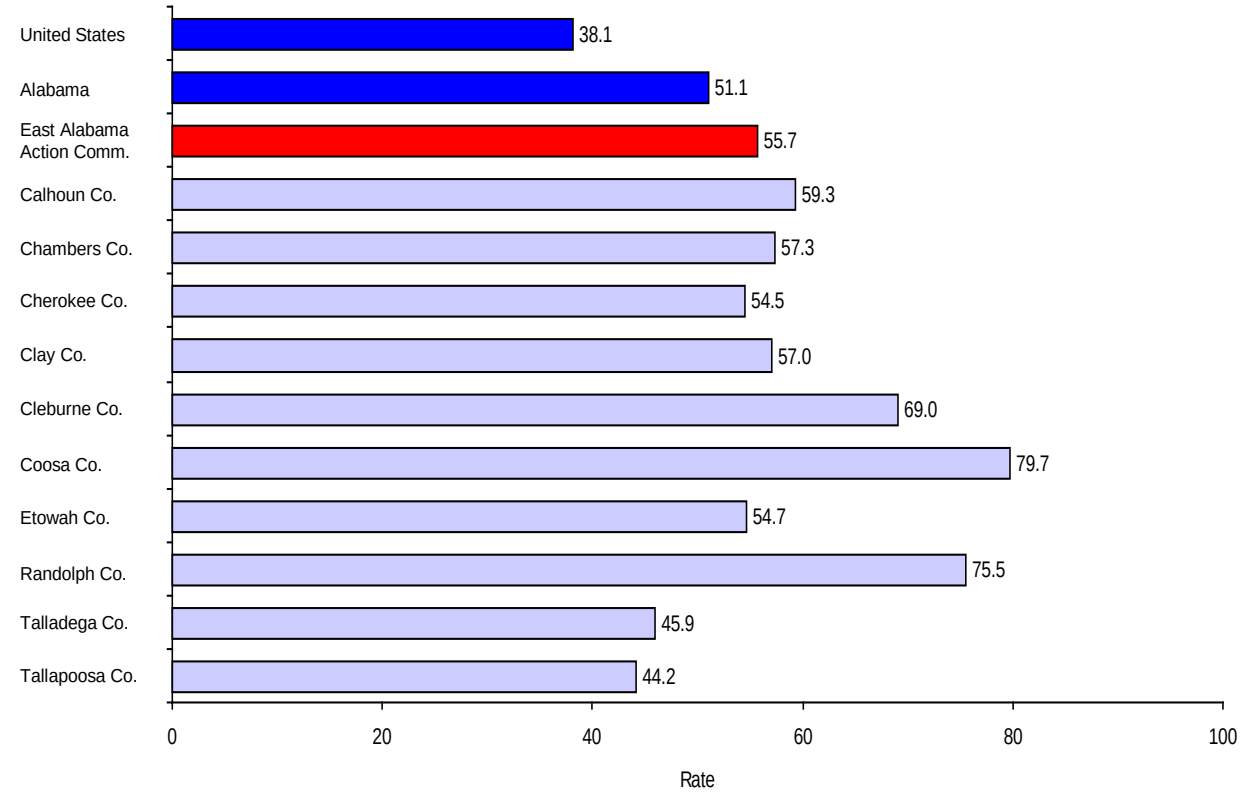
[1] Caution should be used in interpreting this rate due to the small number of deaths from this cause.



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Accidents Mortality and Mortality Rates
Central Alabama Action Commission Counties, 2003 – 2005

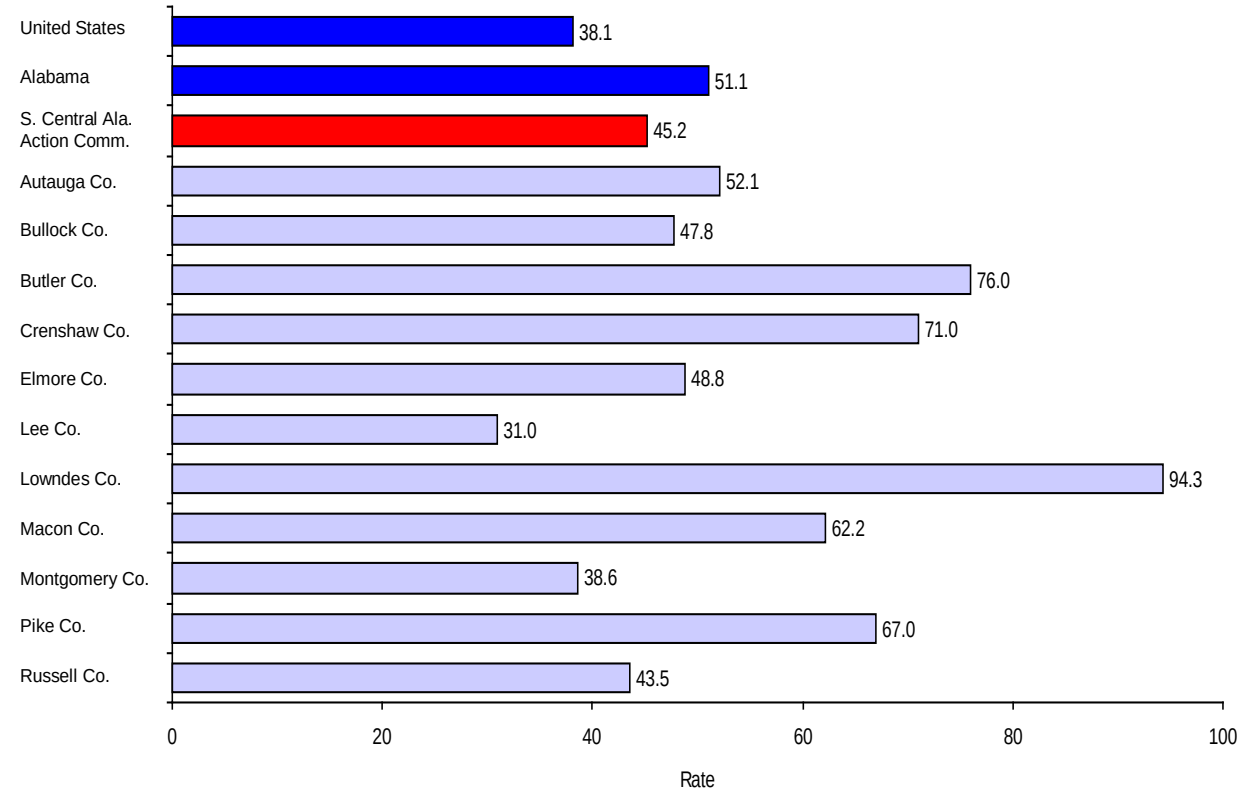
Area	Is County Rural?	Deaths	Rate Per 100,000
Central Alabama Action Commission	**Not Applicable**	**1,560**	**49.1**
District's Rural Counties Combined	Not Applicable	428	60.4
District's Urban Counties Combined	Not Applicable	1,132	45.9
Blount County	Yes	91	55.2
Chilton County	Yes	97	78.3
Jefferson County	No	952	48.3
St. Clair County	Yes	91	43.2
Shelby County	No	180	36.3
Walker County	Yes	149	71.2



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Accidents Mortality and Mortality Rates
East Alabama Action Commission Counties, 2003 – 2005

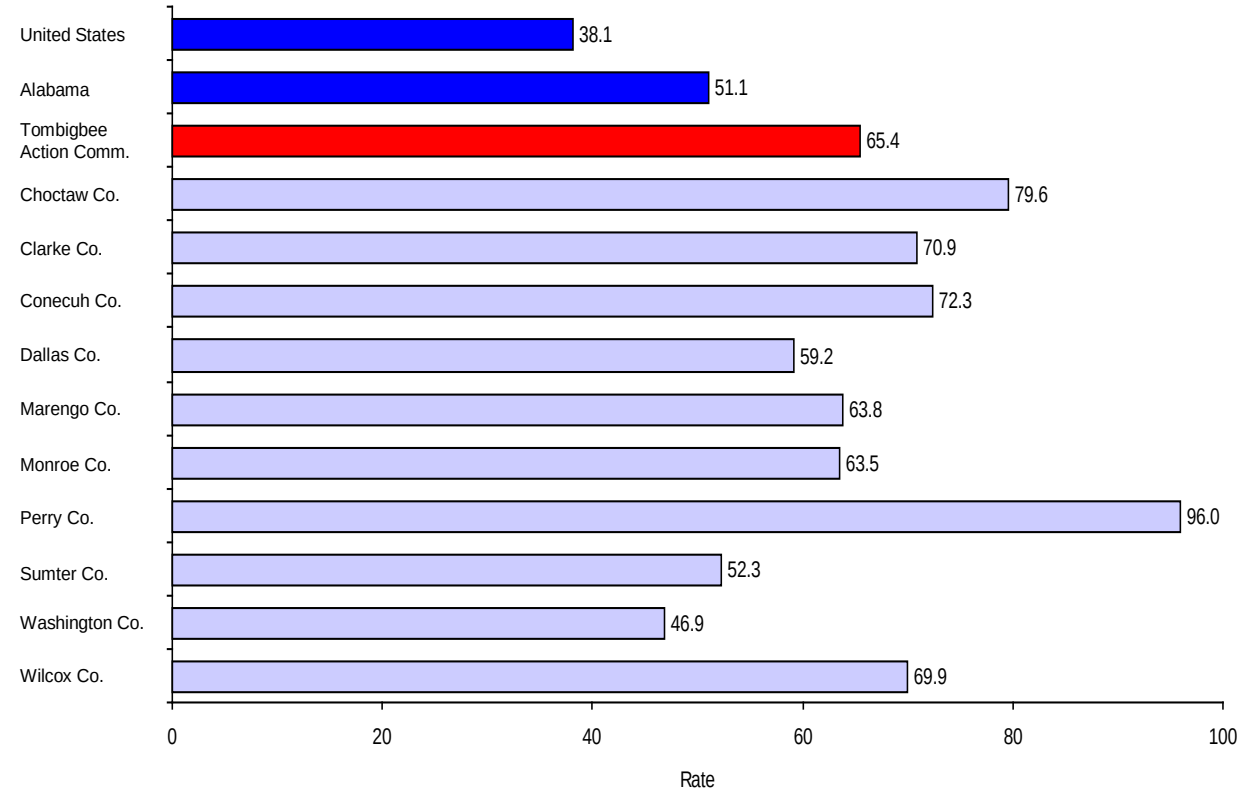
Area	Is County Rural?	Deaths	Rate Per 100,000
East Alabama Action Commission	**Not Applicable**	**765**	**55.7**
District's Rural Counties Combined	Not Applicable	397	54.5
District's Urban Counties Combined	Not Applicable	368	57.1
Calhoun County	No	199	59.3
Chambers County	Yes	61	57.3
Cherokee County	Yes	40	54.5
Clay County	Yes	24	57.0
Cleburne County	Yes	30	69.0
Coosa County	Yes	27	79.7
Etowah County	No	169	54.7
Randolph County	Yes	51	75.5
Talladega County	Yes	110	45.9
Tallapoosa County	Yes	54	44.2



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Accidents Mortality and Mortality Rates
South Central Alabama Action Commission Counties, 2003 – 2005

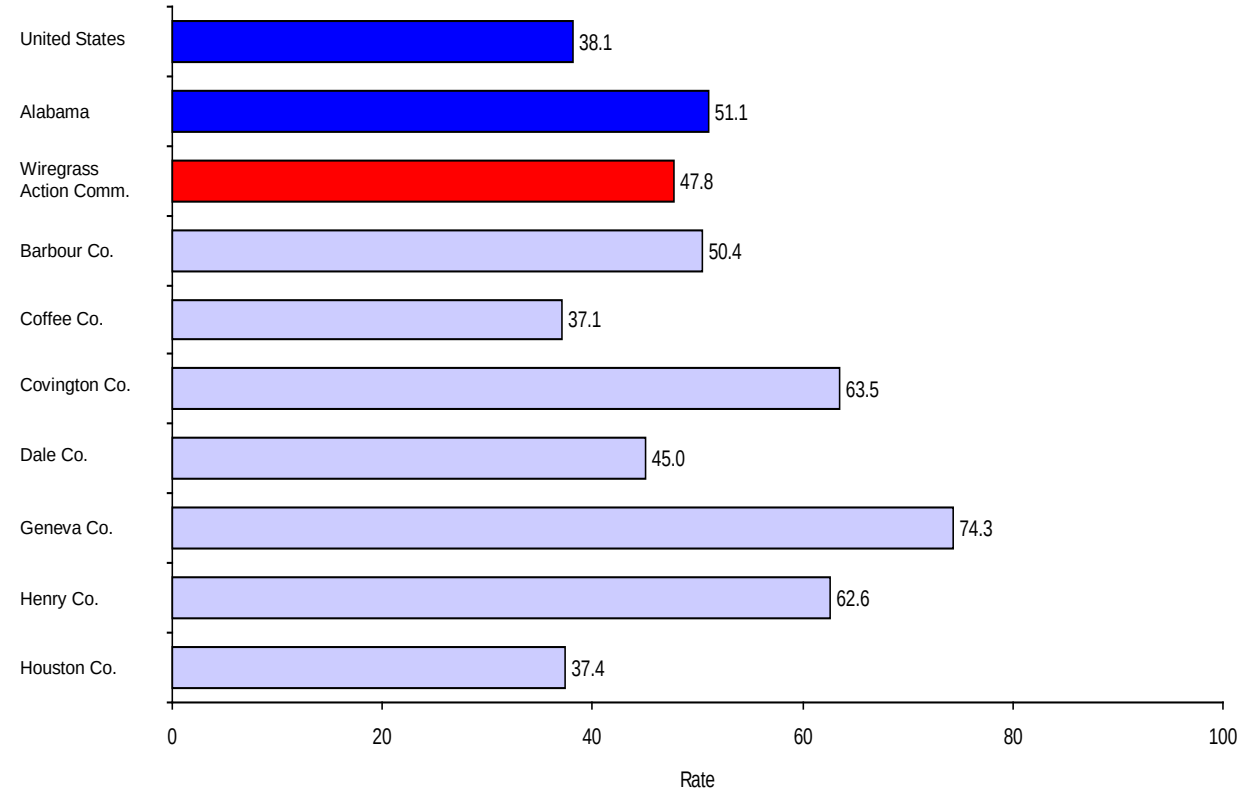
Area	Is County Rural?	Deaths	Rate Per 100,000
South Central Alabama Action Commission	**Not Applicable**	**842**	**45.2**
District's Rural Counties Combined	Not Applicable	474	56.6
District's Urban Counties Combined	Not Applicable	368	35.9
Autauga County	Yes	74	52.1
Bullock County	Yes	16	47.8
Butler County	Yes	47	76.0
Crenshaw County	Yes	29	71.0
Elmore County	Yes	105	48.8
Lee County	No	112	31.0
Lowndes County	Yes	37	94.3
Macon County	Yes	43	62.2
Montgomery County	No	256	38.6
Pike County	Yes	59	67.0
Russell County	Yes	64	43.5



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Accidents Mortality and Mortality Rates
Tombigbee Action Commission Counties, 2003 – 2005

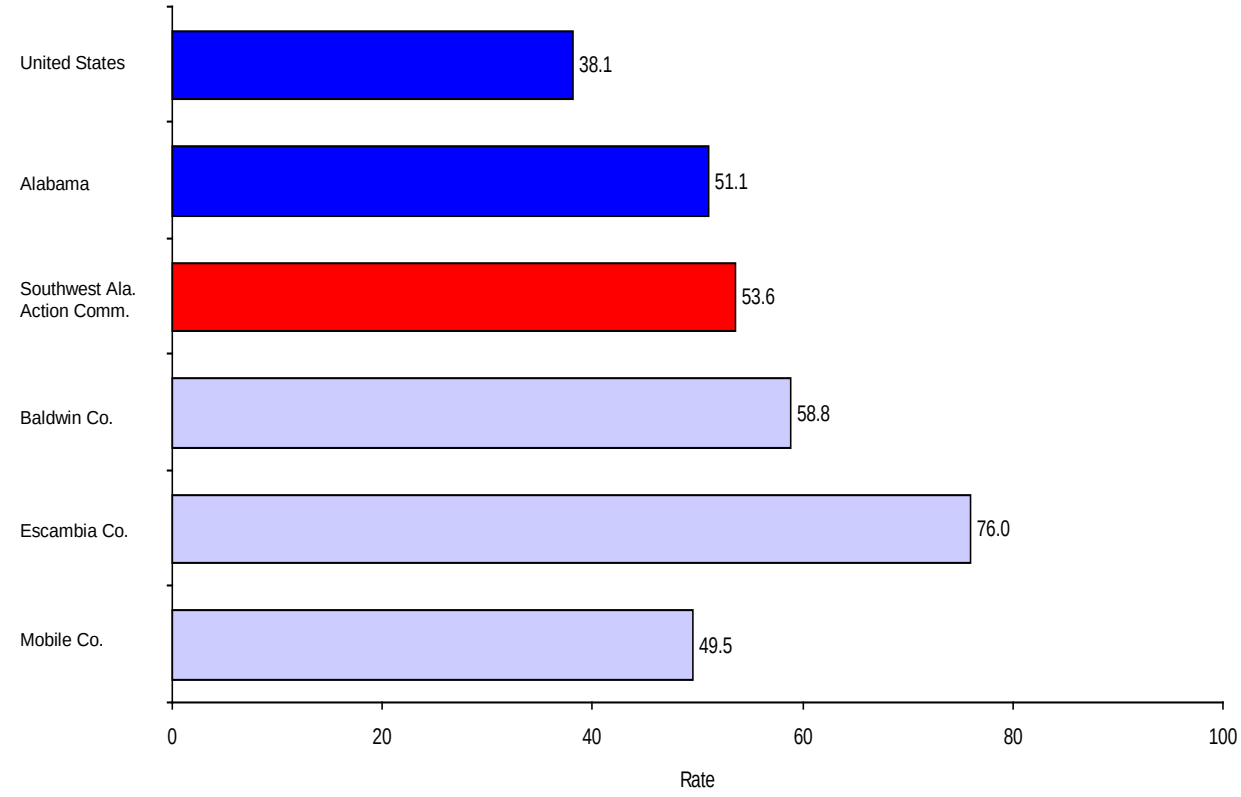
Area	Is County Rural?	Deaths	Rate Per 100,000
Tombigbee Action Commission	**Not Applicable**	**396**	**65.4**
District's Rural Counties Combined	Not Applicable	396	65.4
District's Urban Counties Combined	Not Applicable	No Urban Counties in District	
Choctaw County	Yes	36	79.6
Clarke County	Yes	58	70.9
Conecuh County	Yes	29	72.3
Dallas County	Yes	79	59.2
Marengo County	Yes	42	63.8
Monroe County	Yes	45	63.5
Perry County	Yes	33	96.0
Sumter County	Yes	22	52.3
Washington County	Yes	25	46.9
Wilcox County	Yes	27	69.9



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Accidents Mortality and Mortality Rates
Wiregrass Action Commission Counties, 2003 – 2005

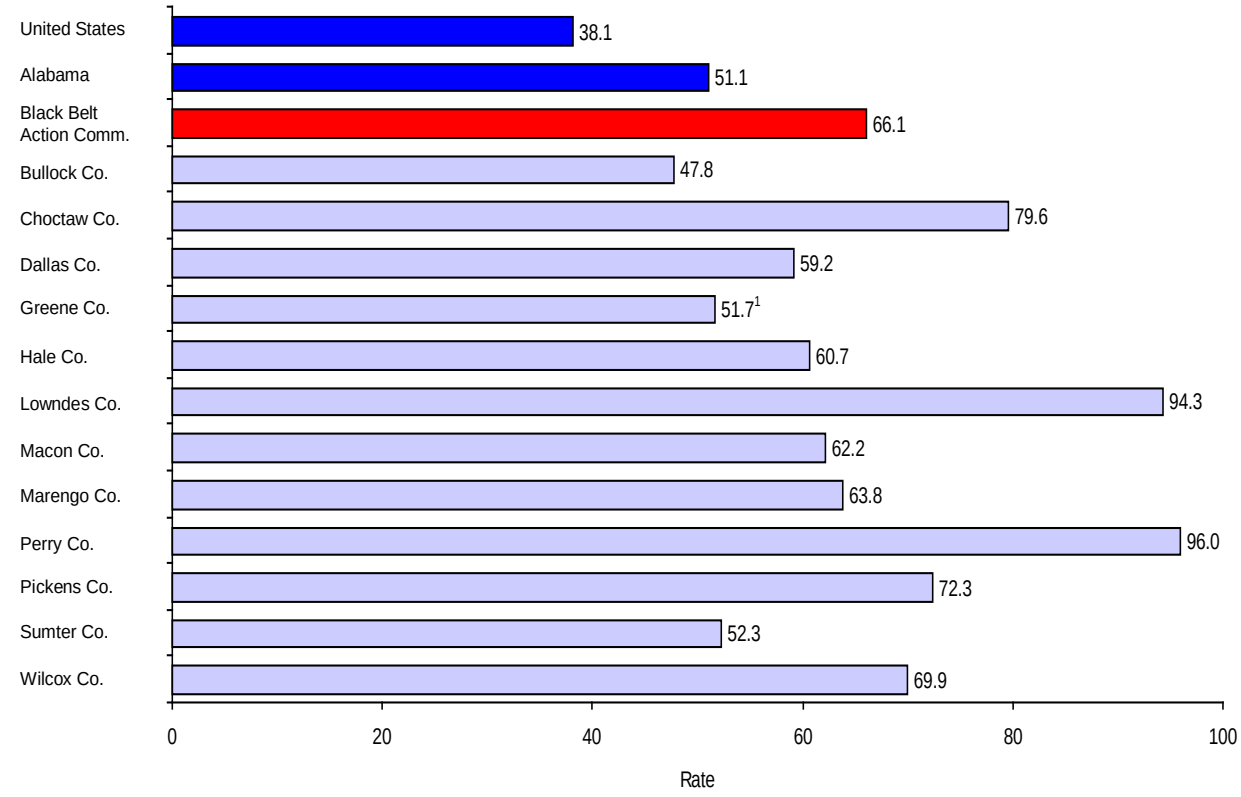
Area	Is County Rural?	Deaths	Rate Per 100,000
Wiregrass Action Commission	**Not Applicable**	**421**	**47.8**
District's Rural Counties Combined	Not Applicable	317	52.5
District's Urban Counties Combined	Not Applicable	104	37.4
Barbour County	Yes	43	50.4
Coffee County	Yes	50	37.1
Covington County	Yes	70	63.5
Dale County	Yes	66	45.0
Geneva County	Yes	57	74.3
Henry County	Yes	31	62.6
Houston County	No	104	37.4



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Accidents Mortality and Mortality Rates
Southwest Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Southwest Alabama Action Commission	**Not Applicable**	**956**	**53.6**
District's Rural Counties Combined	Not Applicable	364	62.2
District's Urban Counties Combined	Not Applicable	592	49.5
Baldwin County	Yes	277	58.8
Escambia County	Yes	87	76.0
Mobile County	No	592	49.5



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

[1] Caution should be used in interpreting this rate due to the small number of deaths from this cause.

Accidents Mortality and Mortality Rates
Black Belt Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Black Belt Action Commission	**Not Applicable**	**427**	**66.1**
District's Rural Counties Combined	Not Applicable	**427**	**66.1**
District's Urban Counties Combined	Not Applicable	No Urban Counties in District	
Bullock County	Yes	16	47.8
Choctaw County	Yes	36	79.6
Dallas County	Yes	79	59.2
Greene County	Yes	15	51.7[1]
Hale County	Yes	33	60.7
Lowndes County	Yes	37	94.3
Macon County	Yes	43	62.2
Marengo County	Yes	42	63.8
Perry County	Yes	33	96.0
Pickens County	Yes	44	72.3
Sumter County	Yes	22	52.3
Wilcox County	Yes	27	69.9

[1] Caution should be used in interpreting this rate due to the small number of deaths from this cause.

Accidents Mortality and Mortality Rates
Alabama's Appalachian Region Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Alabama's Appalachian Region	**Not Applicable**	**4,449**	**51.3**
Region's Rural Counties Combined	Not Applicable	2,128	59.4
Region's Urban Counties Combined	Not Applicable	2,321	45.6
Bibb County	Yes	55	86.3
Blount County	Yes	91	55.2
Calhoun County	No	199	59.3
Chambers County	Yes	61	57.3
Cherokee County	Yes	40	54.5
Chilton County	Yes	97	78.3
Clay County	Yes	24	57.0
Cleburne County	Yes	30	69.0
Colbert County	Yes	80	48.8
Coosa County	Yes	27	79.7
Cullman County	Yes	144	60.7
DeKalb County	Yes	129	64.3
Elmore County	Yes	105	48.8
Etowah County	No	169	54.7
Fayette County	Yes	42	77.1
Franklin County	Yes	67	72.9
Hale County	Yes	33	60.7
Jackson County	Yes	104	64.6
Jefferson County	No	952	48.3
Lamar County	Yes	23	51.1
Lauderdale County	No	128	48.8
Lawrence County	Yes	78	75.6
Limestone County	Yes	111	53.5
Macon County	Yes	43	62.2
Madison County	No	329	37.4
Marion County	Yes	70	77.5
Marshall County	Yes	128	50.3
Morgan County	No	165	48.7
Pickens County	Yes	44	72.3
Randolph County	Yes	51	75.5
St. Clair County	Yes	91	43.2
Shelby County	No	180	36.3
Talladega County	Yes	110	45.9
Tallapoosa County	Yes	54	44.2
Tuscaloosa County	No	199	39.8
Walker County	Yes	149	71.2
Winston County	Yes	47	64.0

For additional information on the Appalachian Region, visit the Appalachian Regional Commission's Web site at http://www.arc.gov/index.jsp; the Appalachian Regional Commission – Alabama Programs Office Web site at http://www.adeca.alabama.gov/default.aspx; or contact Bonnie Durham, Alabama Program Manager at (256) 845-3472.

Accidents Mortality and Mortality Rates
Alabama's Delta Region Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Alabama's Delta Region	**Not Applicable**	**825**	**63.4**
Region's Rural Counties Combined	Not Applicable	**825**	**63.4**
Region's Urban Counties Combined	Not Applicable	No Urban Counties in Region	
Barbour County	Yes	43	50.4
Bullock County	Yes	16	47.8
Butler County	Yes	47	76.0
Choctaw County	Yes	36	79.6
Clarke County	Yes	58	70.9
Conecuh County	Yes	29	72.3
Dallas County	Yes	79	59.2
Escambia County	Yes	87	76.0
Greene County	Yes	15	51.7[1]
Hale County	Yes	33	60.7
Lowndes County	Yes	37	94.3
Macon County	Yes	43	62.2
Marengo County	Yes	42	63.8
Monroe County	Yes	45	63.5
Perry County	Yes	33	96.0
Pickens County	Yes	44	72.3
Russell County	Yes	64	43.5
Sumter County	Yes	22	52.3
Washington County	Yes	25	46.9
Wilcox County	Yes	27	69.9

[1] Caution should be used in interpreting this rate due to the small number of deaths from this cause.

For additional information on the Delta Region, visit the Delta Regional Authority's Web site at http://www.dra.gov/ or contact one of the Delta Regional Authority – Local Development District Offices as follows:

Alabama – Tombigbee Regional Commission, (334) 682-4234 (Choctaw, Clarke, Conecuh, Dallas, Marengo, Monroe, Perry, Sumter, Washington, and Wilcox counties)

Lee – Russell Council of Governments, (334) 749-5264 (Russell County)

South Alabama Regional Planning Commission, (251) 433-6541 (Escambia County)

South Central Alabama Development Commission (334) 244-6903 (Bullock, Butler, Lowndes, and Macon counties)

Southeast Alabama Regional Planning and Development Commission, (334) 794-4093 (Barbour County)

West Alabama Planning and Development Council, (205) 333-2990 (Greene, Hale, and Pickens counties)

Indicators of Health Status in Alabama:
DIABETES MORTALITY

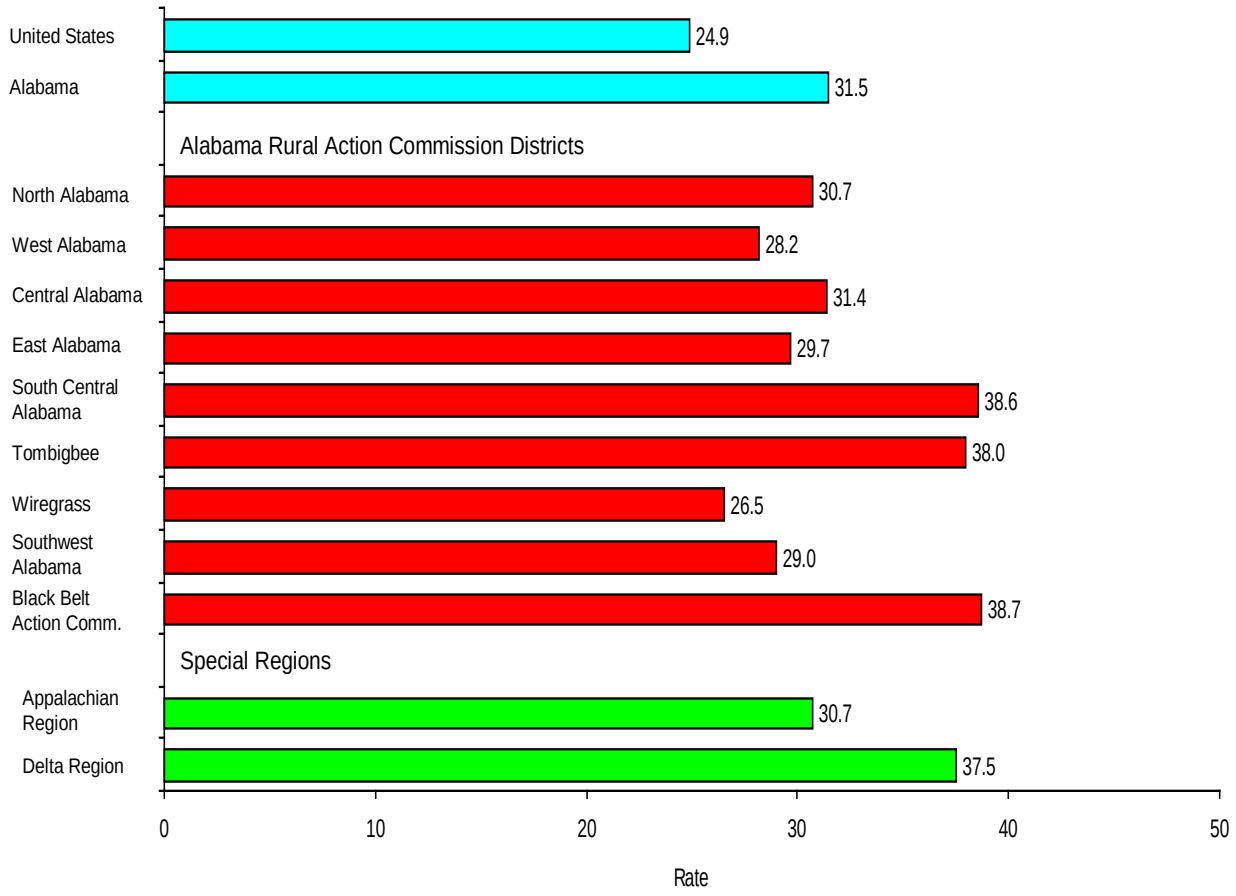
People who are most likely to get diabetes:

- are overweight.
- are 40 years of age or older.
- have a family history of diabetes.
- do not perform physical activity regularly.
- have had a baby weighing more than 9 pounds at birth.
- have had diabetes during pregnancy.
- have high blood pressure.
- are African American, Hispanic American, or Native American.

To prevent or delay the complications of diabetes, persons with diabetes should:

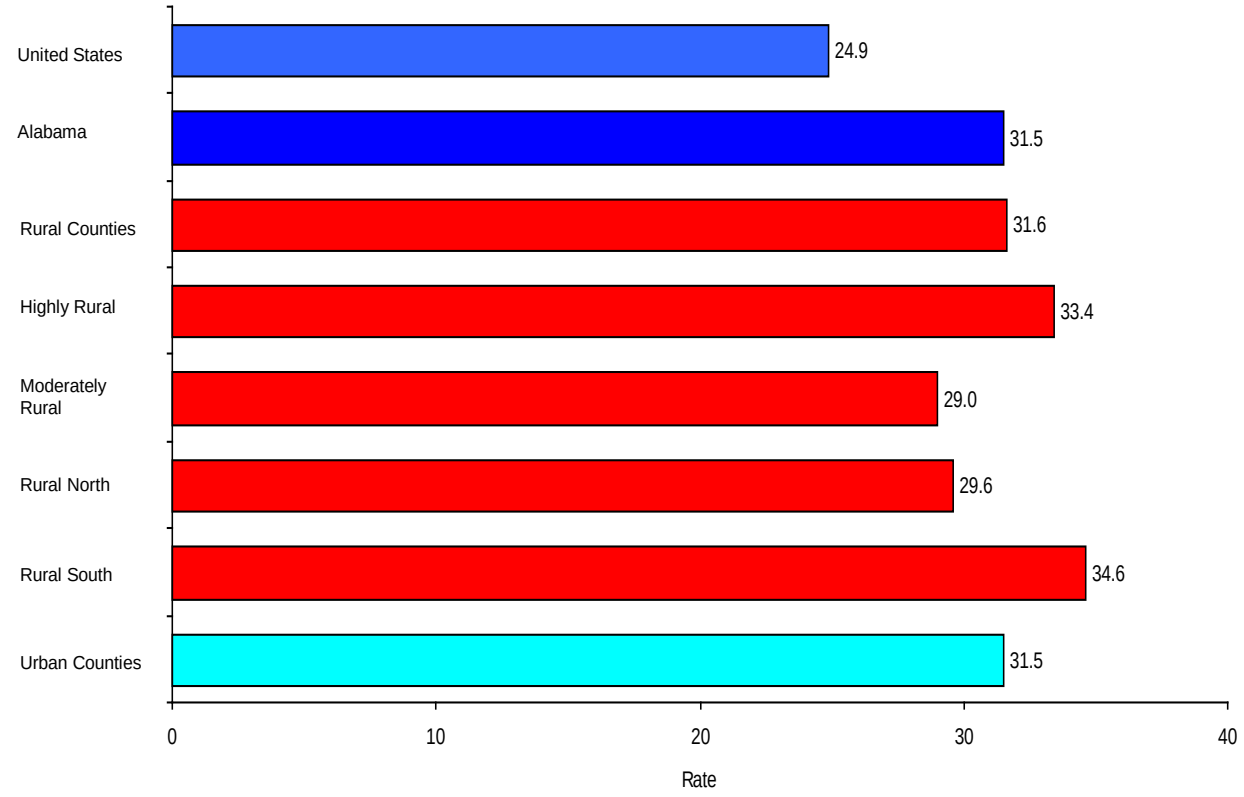
- maintain optimal blood sugar control through diet, physical activity, and medication.
- test blood sugar daily and have dilated eye exams.
- visit a physician frequently and have foot exam on each visit.
- check their own feet frequently, preferably daily.
- maintain ideal body weight, normal blood pressure, blood sugar, and cholesterol.
- avoid tobacco and alcohol.
- have an annual microalbumin and assessment of chronic kidney disease with estimated glomerular filtration rate (eGFR).
- have a Hemoglobin A1c test performed at home or in a physician's office at least every 6 months.
- check blood cholesterol and other blood lipids at least once a year.

Diabetes Mortality Rates for 2003-2005
U.S., Alabama, Alabama Rural Action Commission Districts, and Special Regions In Alabama



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

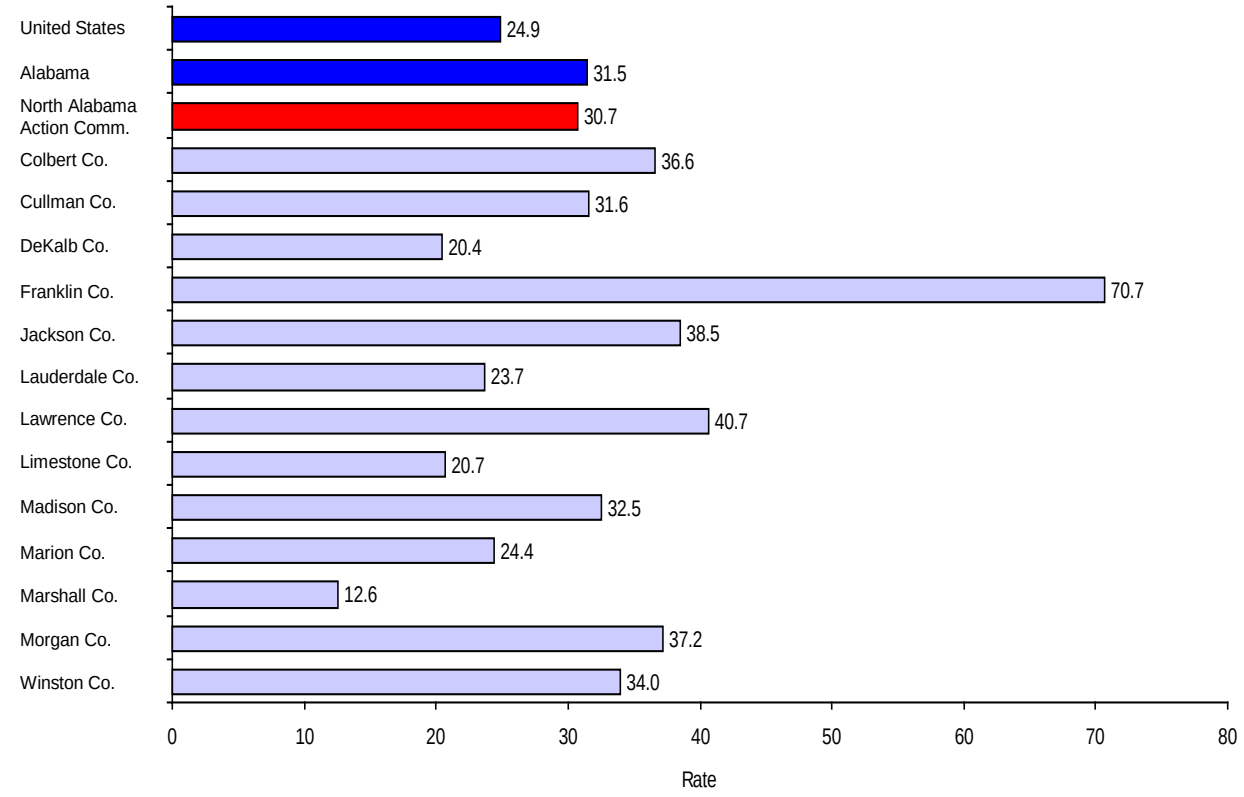
- Diabetes mortality in Alabama is consistently over 50 percent higher among Alabama's African American population than among its White population.
- Alabama currently has the 5th highest diabetes mortality rate among all 50 states. Alabamians aged 25-64 years have the 2nd highest diabetes mortality rate among all 50 states.
- Alabama lost 4,273 residents to diabetes during 2003-2005.
- 29 of the 32 Alabama counties with the highest diabetes mortality rates are rural counties.



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Diabetes Mellitus Mortality and Mortality Rates
U.S. and Selected Alabama Areas, 2003 – 2005

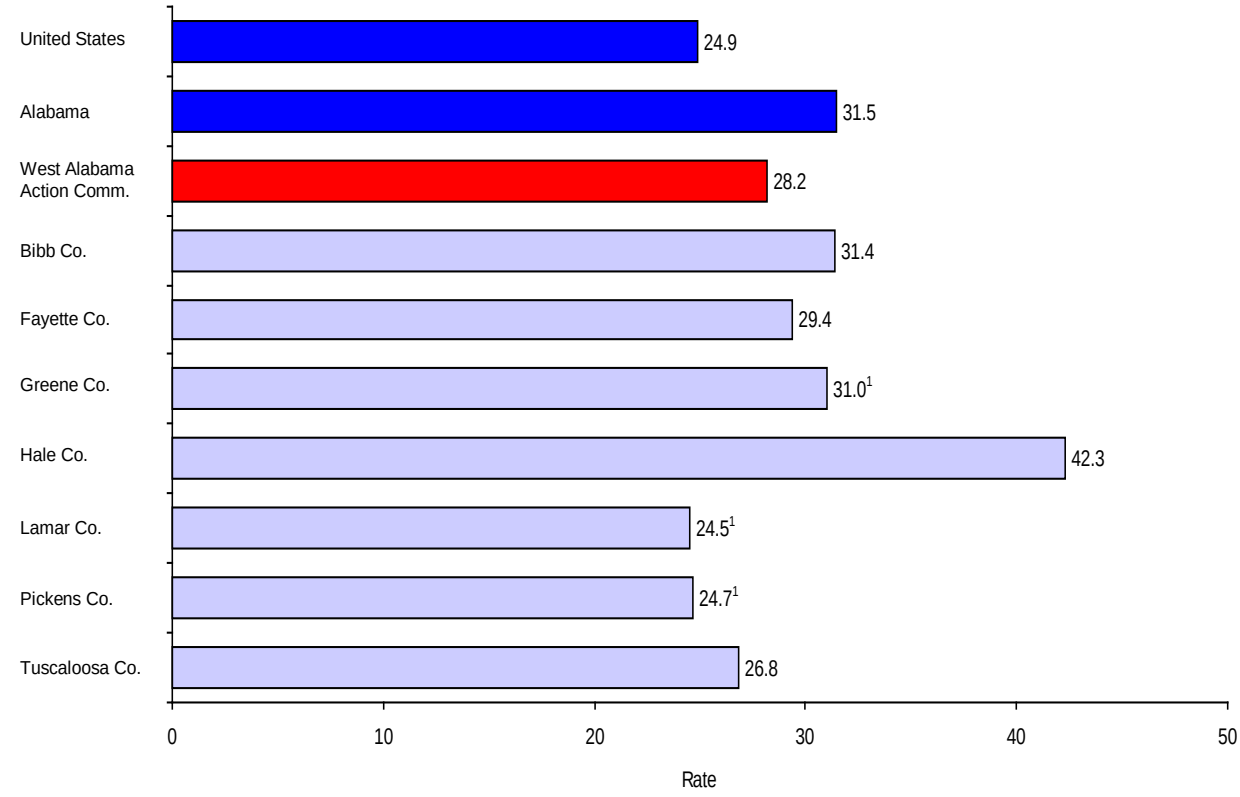
Area	Is County Rural?	Deaths	Rate Per 100,000
United States	**Not Applicable**	**73,138**	**24.9**
Alabama	**Not Applicable**	**4,273**	**31.5**
Rural Alabama Counties	**Not Applicable**	**1,881**	**31.6**
Highly Rural Alabama Counties	**Not Applicable**	**1,154**	**33.4**
Moderately Rural Alabama Counties	**Not Applicable**	**727**	**29.0**
Rural North Alabama Counties	**Not Applicable**	**1,059**	**29.6**
Rural South Alabama Counties	**Not Applicable**	**822**	**34.6**
Urban Alabama Counties	**Not Applicable**	**2,392**	**31.5**



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Diabetes Mellitus Mortality and Mortality Rates
North Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
North Alabama Action Commission	**Not Applicable**	**941**	**30.7**
District's Rural Counties Combined	Not Applicable	467	29.5
District's Urban Counties Combined	Not Applicable	474	32.0
Colbert County	Yes	60	36.6
Cullman County	Yes	75	31.6
DeKalb County	Yes	41	20.4
Franklin County	Yes	65	70.7
Jackson County	Yes	62	38.5
Lauderdale County	No	62	23.7
Lawrence County	Yes	42	40.7
Limestone County	Yes	43	20.7
Madison County	No	286	32.5
Marion County	Yes	22	24.4
Marshall County	Yes	32	12.6
Morgan County	No	126	37.2
Winston County	Yes	25	34.0



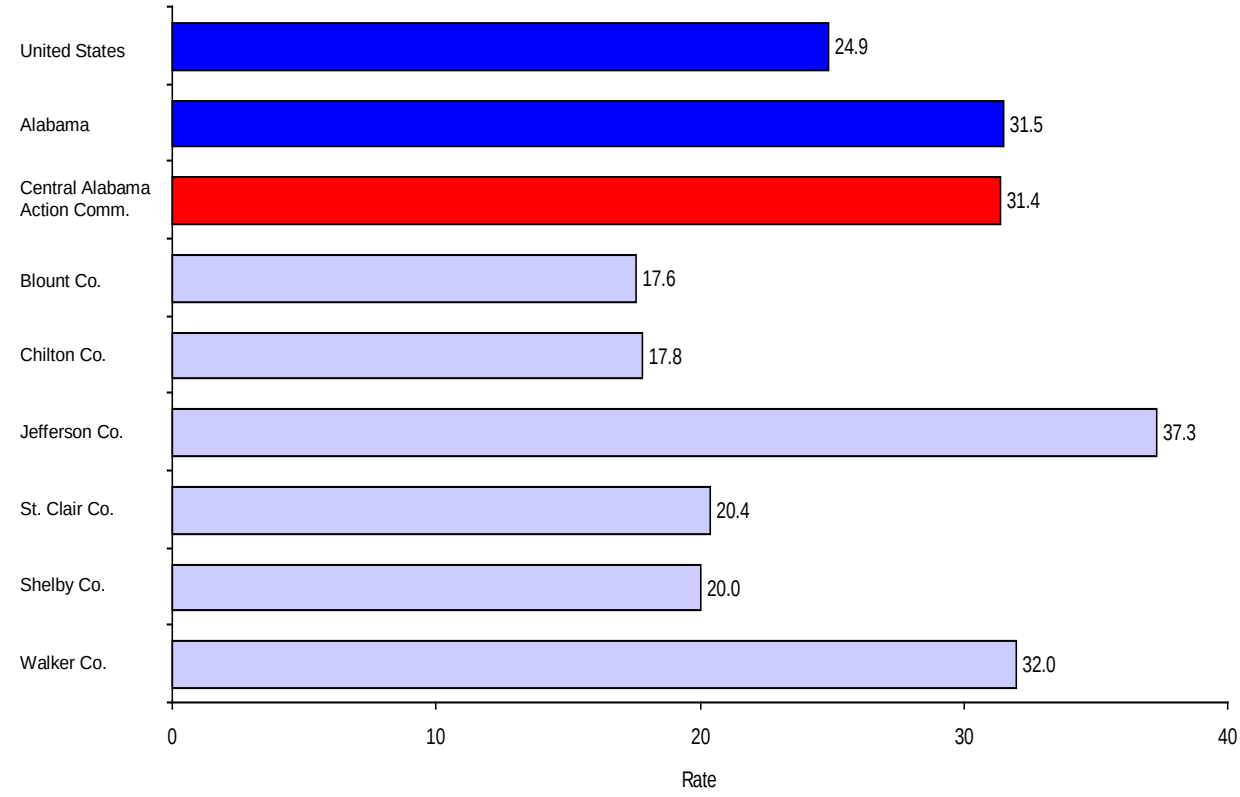
Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

[1] Caution should be used in interpreting this rate due to the small number of deaths from this cause.

Diabetes Mellitus Mortality and Mortality Rates
West Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
West Alabama Action Commission	**Not Applicable**	**228**	**28.2**
District's Rural Counties Combined	Not Applicable	94	30.6
District's Urban Counties Combined	Not Applicable	134	26.8
Bibb County	Yes	20	31.4
Fayette County	Yes	16	29.4
Greene County	Yes	9	31.0[1]
Hale County	Yes	23	42.3
Lamar County	Yes	11	24.5[1]
Pickens County	Yes	15	24.7[1]
Tuscaloosa County	No	134	26.8

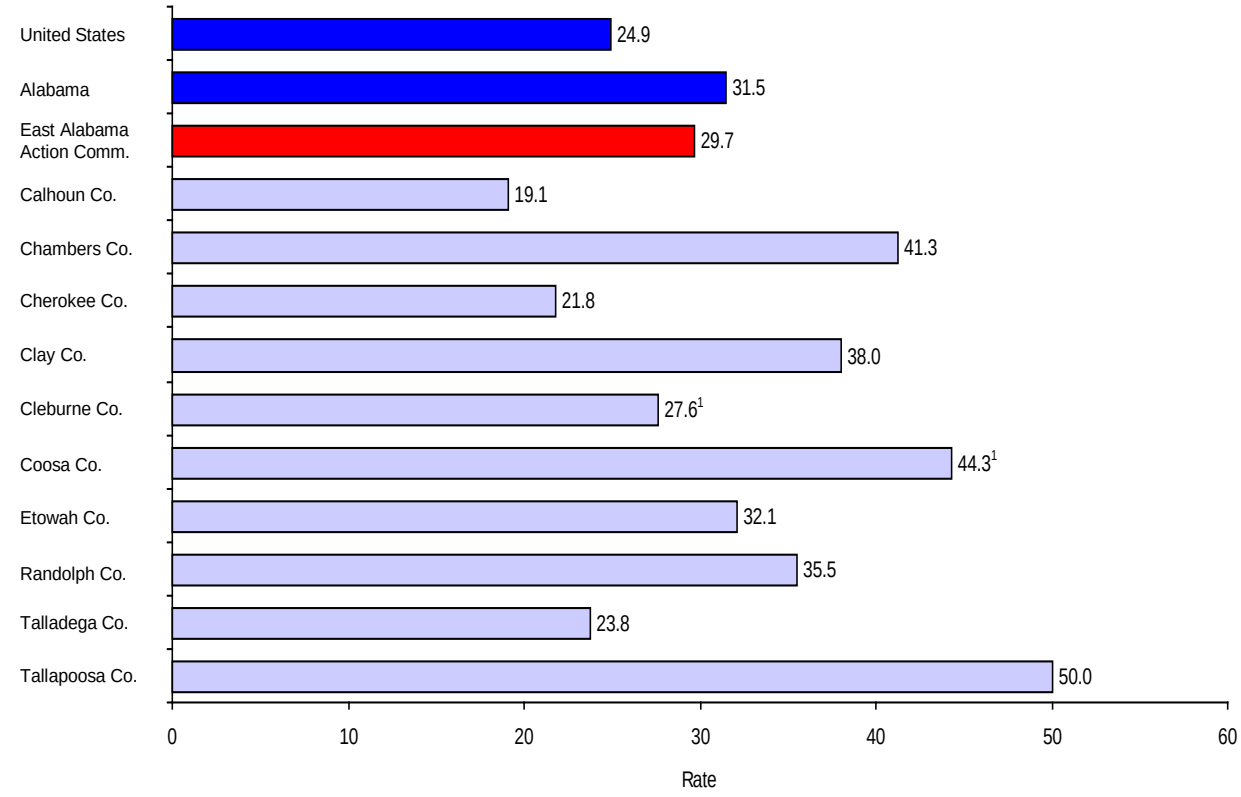
[1] Caution should be used in interpreting this rate due to the small number of deaths from this cause.



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Diabetes Mellitus Mortality and Mortality Rates
Central Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Central Alabama Action Commission	**Not Applicable**	**996**	**31.4**
District's Rural Counties Combined	Not Applicable	161	22.7
District's Urban Counties Combined	Not Applicable	835	33.8
Blount County	Yes	29	17.6
Chilton County	Yes	22	17.8
Jefferson County	No	736	37.3
St. Clair County	Yes	43	20.4
Shelby County	No	99	20.0
Walker County	Yes	67	32.0



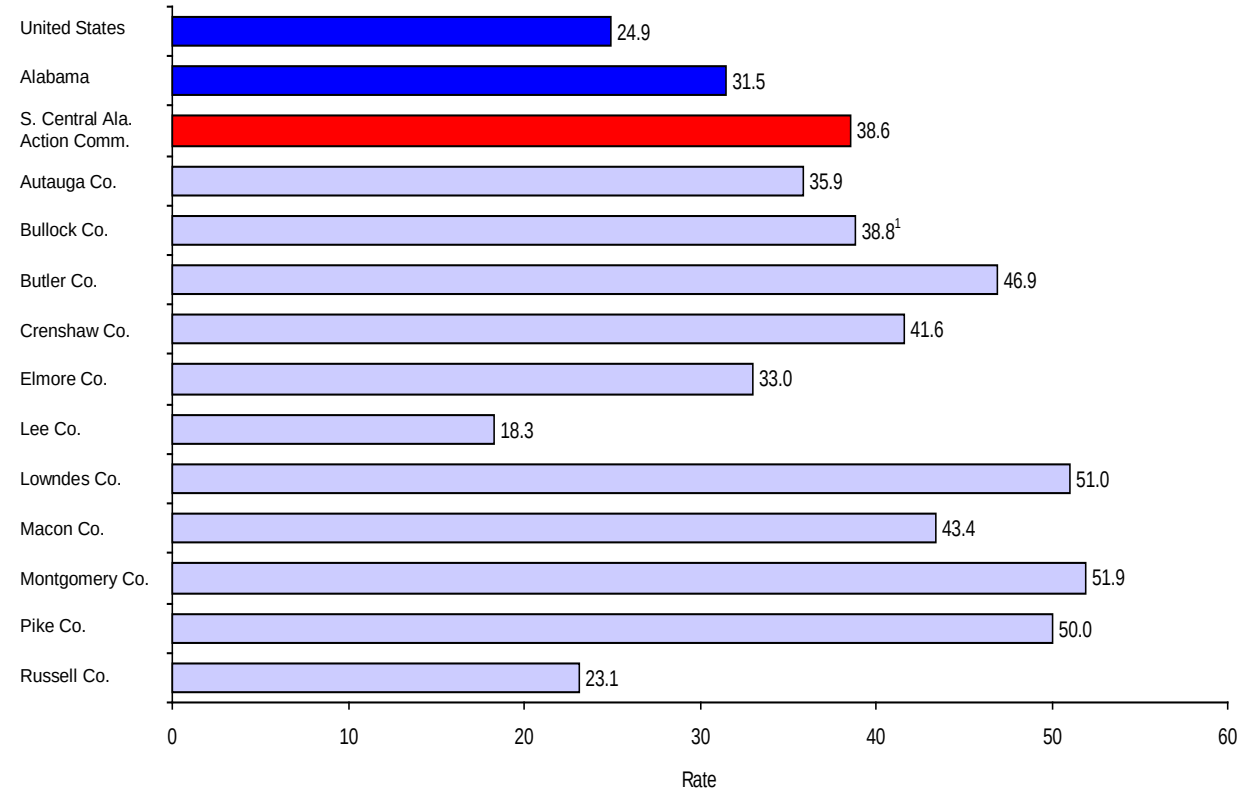
Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

[1] Caution should be used in interpreting this rate due to the small number of deaths from this cause.

Diabetes Mellitus Mortality and Mortality Rates
East Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
East Alabama Action Commission	**Not Applicable**	**408**	**29.7**
District's Rural Counties Combined	Not Applicable	245	33.6
District's Urban Counties Combined	Not Applicable	163	25.3
Calhoun County	No	64	19.1
Chambers County	Yes	44	41.3
Cherokee County	Yes	16	21.8
Clay County	Yes	16	38.0
Cleburne County	Yes	12	27.6[1]
Coosa County	Yes	15	44.3[1]
Etowah County	No	99	32.1
Randolph County	Yes	24	35.5
Talladega County	Yes	57	23.8
Tallapoosa County	Yes	61	50.0

[1] Caution should be used in interpreting this rate due to the small number of deaths from this cause.



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

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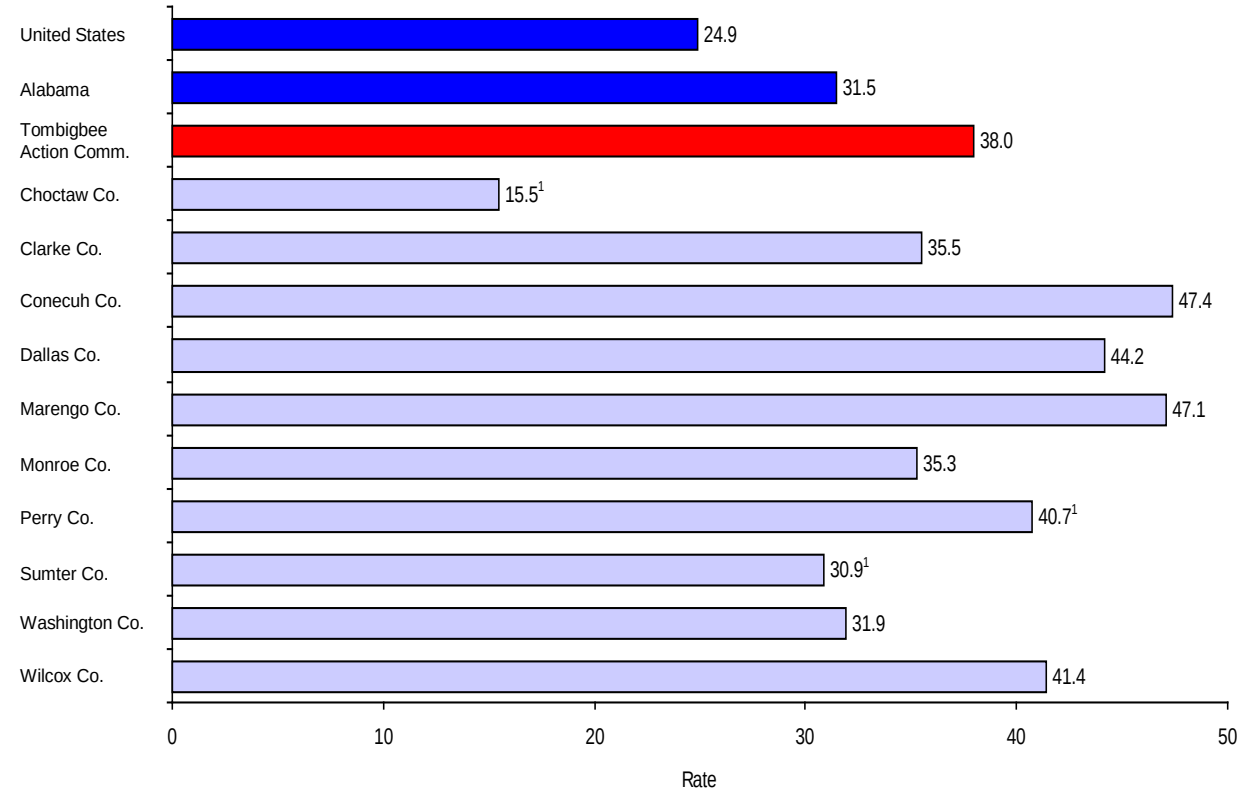
Diabetes Mellitus Mortality and Mortality Rates
South Central Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
South Central Alabama Action Commission	**Not Applicable**	**719**	**38.6**
District's Rural Counties Combined	Not Applicable	309	36.9
District's Urban Counties Combined	Not Applicable	410	40.0
Autauga County	Yes	51	35.9
Bullock County	Yes	13	38.8[1]
Butler County	Yes	29	46.9
Crenshaw County	Yes	17	41.6
Elmore County	Yes	71	33.0
Lee County	No	66	18.3
Lowndes County	Yes	20	51.0
Macon County	Yes	30	43.4
Montgomery County	No	344	51.9
Pike County	Yes	44	50.0
Russell County	Yes	34	23.1

[1] Caution should be used in interpreting this rate due to the small number of deaths from this cause.



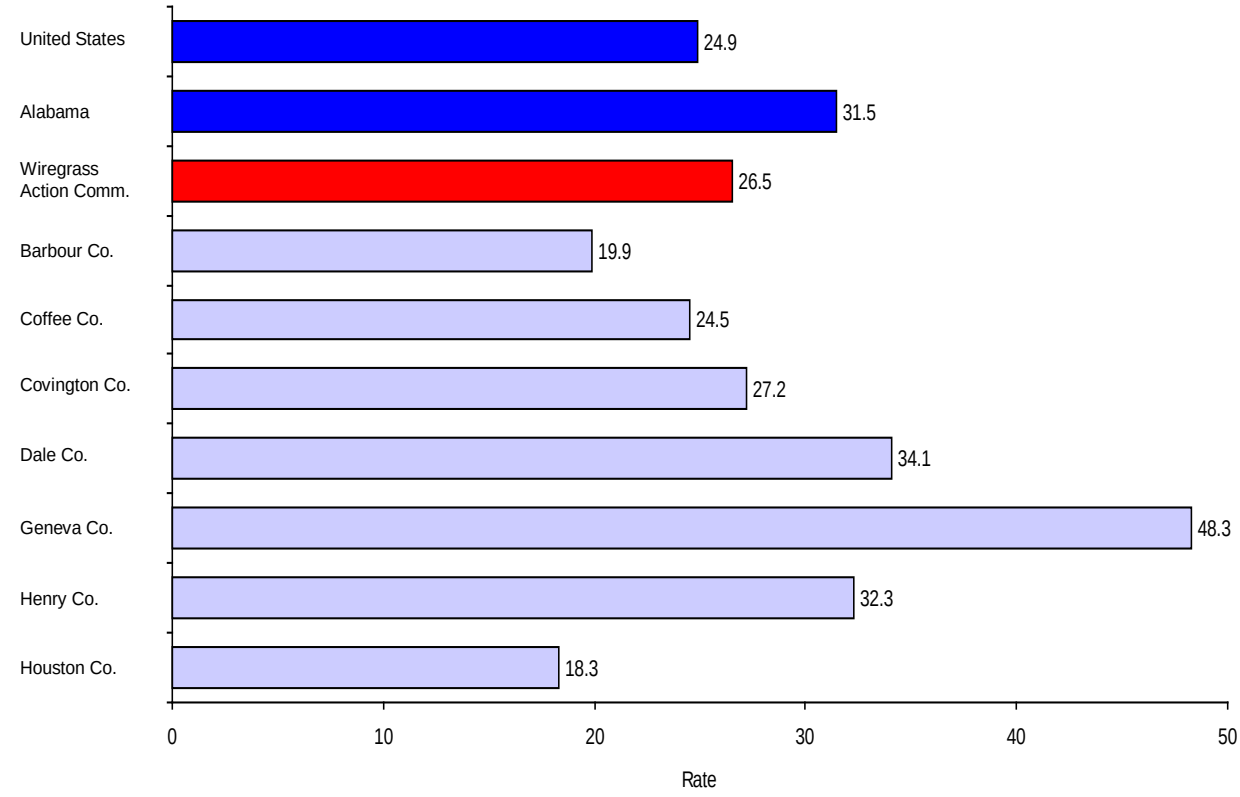
Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

[1] Caution should be used in interpreting this rate due to the small number of deaths from this cause.

Diabetes Mellitus Mortality and Mortality Rates
Tombigbee Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Tombigbee Action Commission	**Not Applicable**	**230**	**38.0**
District's Rural Counties Combined	Not Applicable	230	38.0
District's Urban Counties Combined	Not Applicable	No Urban Counties in District	
Choctaw County	Yes	7	15.5[1]
Clarke County	Yes	29	35.5
Conecuh County	Yes	19	47.4
Dallas County	Yes	59	44.2
Marengo County	Yes	31	47.1
Monroe County	Yes	25	35.3
Perry County	Yes	14	40.7[1]
Sumter County	Yes	13	30.9[1]
Washington County	Yes	17	31.9
Wilcox County	Yes	16	41.4

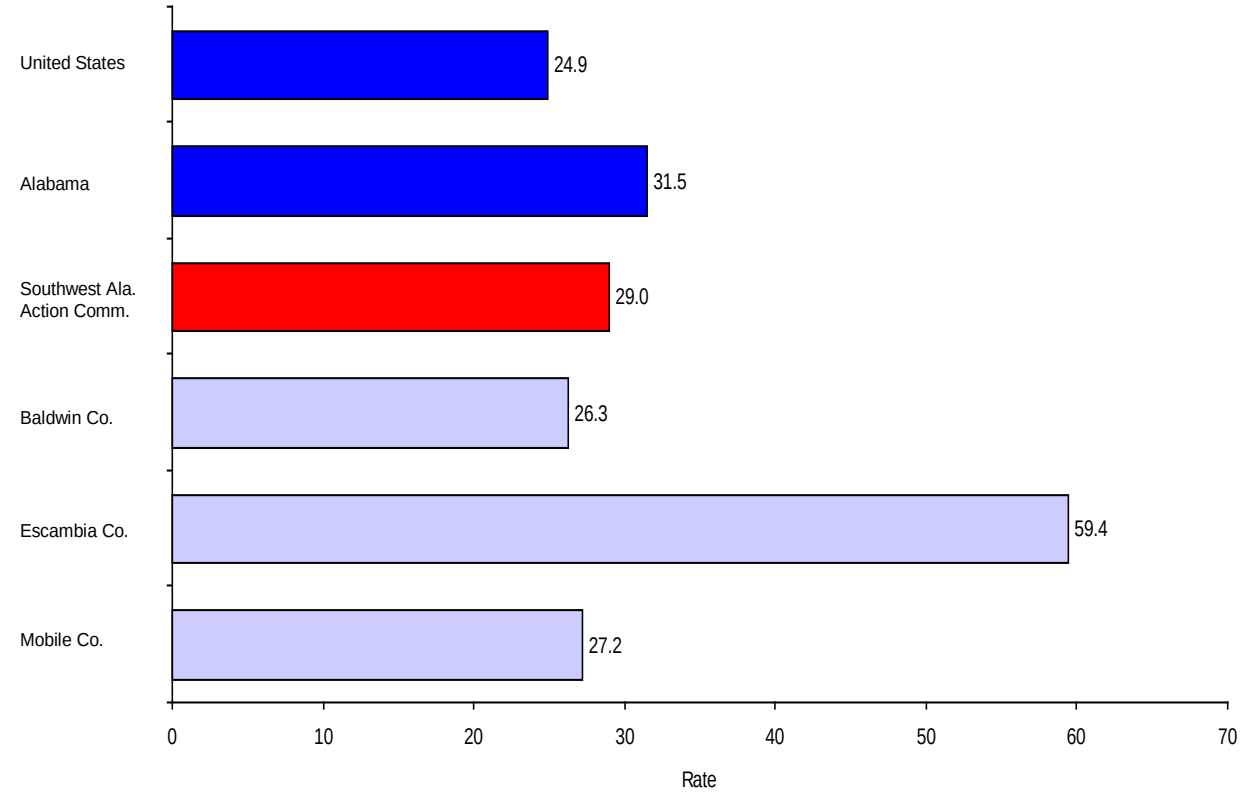
[1] Caution should be used in interpreting this rate due to the small number of deaths from this cause.



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Diabetes Mellitus Mortality and Mortality Rates
Wiregrass Action Commission Counties, 2003 – 2005

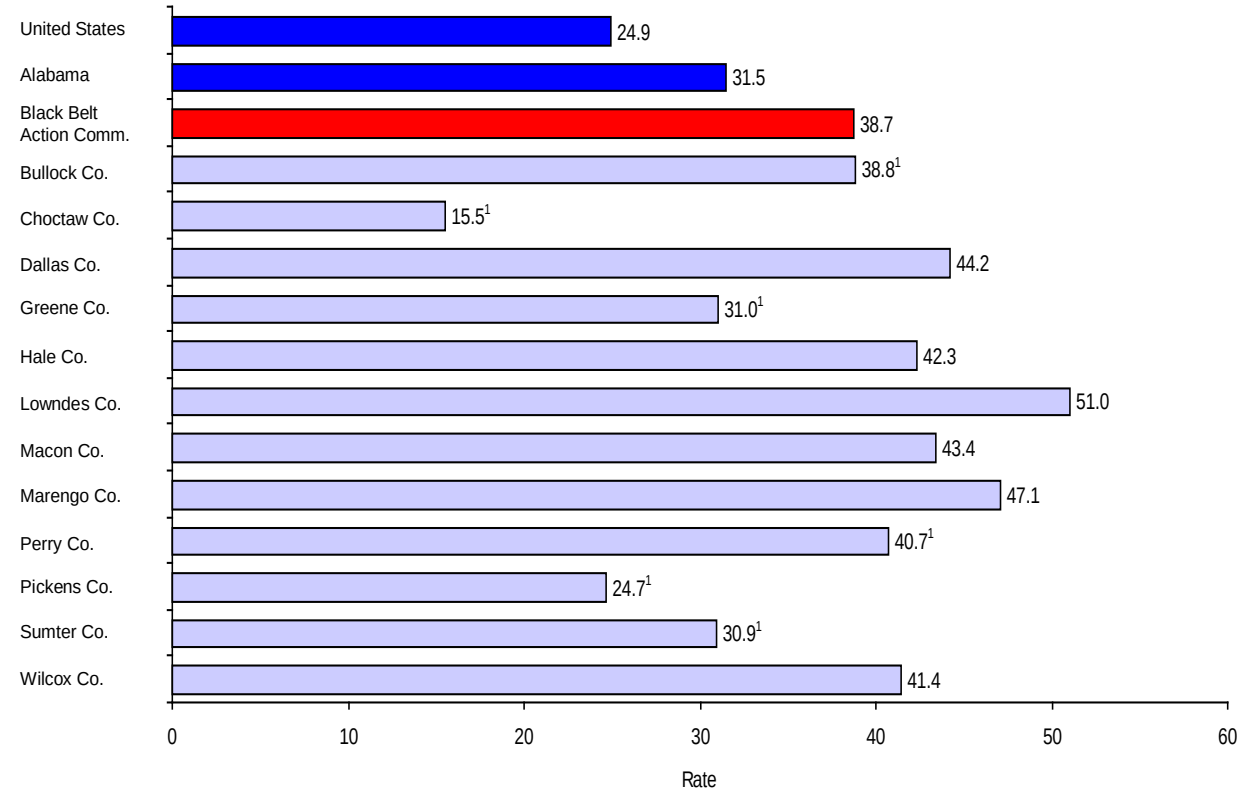
Area	Is County Rural?	Deaths	Rate Per 100,000
Wiregrass Action Commission	**Not Applicable**	**234**	**26.5**
District's Rural Counties Combined	Not Applicable	183	30.3
District's Urban Counties Combined	Not Applicable	51	18.3
Barbour County	Yes	17	19.9
Coffee County	Yes	33	24.5
Covington County	Yes	30	27.2
Dale County	Yes	50	34.1
Geneva County	Yes	37	48.3
Henry County	Yes	16	32.3
Houston County	No	51	18.3



Notes: Data provided by the Center for Health Statistics, Alabama Department of Public Health and the National Center for Health Statistics, Centers for Disease Control and Prevention. U.S. rate is for 2004. Rates are per 100,000 population.

Diabetes Mellitus Mortality and Mortality Rates
Southwest Alabama Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Southwest Alabama Action Commission	**Not Applicable**	**517**	**29.0**
District's Rural Counties Combined	Not Applicable	192	32.8
District's Urban Counties Combined	Not Applicable	325	27.2
Baldwin County	Yes	124	26.3
Escambia County	Yes	68	59.4
Mobile County	No	325	27.2



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Diabetes Mellitus Mortality and Mortality Rates
Black Belt Action Commission Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Black Belt Action Commission	**Not Applicable**	**250**	**38.7**
District's Rural Counties Combined	Not Applicable	**250**	**38.7**
District's Urban Counties Combined	Not Applicable	No Urban Counties in District	
Bullock County	Yes	13	38.8[1]
Choctaw County	Yes	7	15.5[1]
Dallas County	Yes	59	44.2
Greene County	Yes	9	31.0[1]
Hale County	Yes	23	42.3
Lowndes County	Yes	20	51.0
Macon County	Yes	30	43.4
Marengo County	Yes	31	47.1
Perry County	Yes	14	40.7[1]
Pickens County	Yes	15	24.7[1]
Sumter County	Yes	13	30.9[1]
Wilcox County	Yes	16	41.4

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Diabetes Mellitus Mortality and Mortality Rates
Alabama's Appalachian Region Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Alabama's Appalachian Region	**Not Applicable**	**2,665**	**30.7**
Region's Rural Counties Combined	Not Applicable	1,059	29.6
Region's Urban Counties Combined	Not Applicable	1,606	31.5
Bibb County	Yes	20	31.4
Blount County	Yes	29	17.6
Calhoun County	No	64	19.1
Chambers County	Yes	44	41.3
Cherokee County	Yes	16	21.8
Chilton County	Yes	22	17.8
Clay County	Yes	16	38.0
Cleburne County	Yes	12	27.6[1]
Colbert County	Yes	60	36.6
Coosa County	Yes	15	44.3[1]
Cullman County	Yes	75	31.6
DeKalb County	Yes	41	20.4
Elmore County	Yes	71	33.0
Etowah County	No	99	32.1
Fayette County	Yes	16	29.4
Franklin County	Yes	65	70.7
Hale County	Yes	23	42.3
Jackson County	Yes	62	38.5
Jefferson County	No	736	37.3
Lamar County	Yes	11	24.5[1]
Lauderdale County	No	62	23.7
Lawrence County	Yes	42	40.7
Limestone County	Yes	43	20.7
Macon County	Yes	30	43.4
Madison County	No	286	32.5
Marion County	Yes	22	24.4
Marshall County	Yes	32	12.6
Morgan County	No	126	37.2
Pickens County	Yes	15	24.7[1]
Randolph County	Yes	24	35.5
St. Clair County	Yes	43	20.4
Shelby County	No	99	20.0
Talladega County	Yes	57	23.8
Tallapoosa County	Yes	61	50.0
Tuscaloosa County	No	134	26.8
Walker County	Yes	67	32.0
Winston County	Yes	25	34.0

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For additional information on the Appalachian Region, visit the Appalachian Regional Commission's Web site at http://www.arc.gov/index.jsp; the Appalachian Regional Commission – Alabama Programs Office Web site at http://www.adeca.alabama.gov/default.aspx; or contact Bonnie Durham, Alabama Program Manager at (256) 845-3472.

Diabetes Mellitus Mortality and Mortality Rates
Alabama's Delta Region Counties, 2003 – 2005

Area	Is County Rural?	Deaths	Rate Per 100,000
Alabama's Delta Region	**Not Applicable**	**488**	**37.5**
Region's Rural Counties Combined	Not Applicable	**488**	**37.5**
Region's Urban Counties Combined	Not Applicable	No Urban Counties in Region	
Barbour County	Yes	17	19.9
Bullock County	Yes	13	38.8[1]
Butler County	Yes	29	46.9
Choctaw County	Yes	7	15.5[1]
Clarke County	Yes	29	35.5
Conecuh County	Yes	19	47.4
Dallas County	Yes	59	44.2
Escambia County	Yes	68	59.4
Greene County	Yes	9	31.0[1]
Hale County	Yes	23	42.3
Lowndes County	Yes	20	51.0
Macon County	Yes	30	43.4
Marengo County	Yes	31	47.1
Monroe County	Yes	25	35.3
Perry County	Yes	14	40.7[1]
Pickens County	Yes	15	24.7[1]
Russell County	Yes	34	23.1
Sumter County	Yes	13	30.9[1]
Washington County	Yes	17	31.9
Wilcox County	Yes	16	41.4

[1] Caution should be used in interpreting this rate due to the small number of deaths from this cause.

For additional information on the Delta Region, visit the Delta Regional Authority's Web site at http://www.dra.gov/ or contact one of the Delta Regional Authority – Local Development District Offices as follows:

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APPENDIX D:

Below are links to CAH Eligibility and Conversion Information:

Application for Change in License

Application Instructions for Supplement A - Conversion to a CAH

Change in License Supplement A Application

CMS Clarification of the CAH Criteria for Rural Location and Mountainous Terrain Distance Standard, April 19, 2013. Ref: S&C: 13-26-CAH **(Note:** The term RO on page 3 is defined as the CMS Regional Office)

CMS Clarification of the CAH Criteria regarding rural and metropolitan locations and primary roads, June 26, 2015. Ref: S&C: 15-45-CAH