HMA

HEALTH MANAGEMENT ASSOCIATES

An Analysis of Health Services for the Uninsured and Underinsured in the River Region of Alabama

AUTAUGA, ELMORE, LOWNDES, MACON, AND MONTGOMERY COUNTIES

PREPARED FOR

ENVISION2020, MONTGOMERY, ALABAMA

MARCH 21, 2008

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

---

AUSTIN, TEXAS • CHICAGO, ILLINOIS • COLUMBUS, OHIO • INDIANAPOLIS, INDIANA • LANSING, MICHIGAN
SACRAMENTO, CALIFORNIA • SOUTHERN CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, D.C.

Table of Contents

Introduction

Envision 2020 contracted with Health Management Associates (HMA) in October 2007 to provide an in-depth analysis of how the indigent and uninsured population in the River Region access care and how that care is financed. The analysis also includes barriers to access, an assessment of the current supply of primary care physicians and specialty physicians, and a review of current clinic facilities to determine the scope of services available in the River Region. This study was funded by the City of Montgomery, the Montgomery County Commission, Jackson Hospital, The Health Care Authority for Baptist Health, the Joint Public Charity Hospital Board, the City of Prattville, the Autauga County Commission, the Elmore County Commission, and the Montgomery Area Chamber of Commerce. In order to accomplish this analysis, HMA assembled a team of senior staff representing a variety of disciplines, including health care finance, health systems operations and management, clinical care, health care architecture, and public and community health. This team worked closely with the staff of Envision 2020 to determine the issues facing the River Region. More than 100 people were interviewed including physicians, other providers, health care administrators, health center leaders, city and county officials, politicians, academic leaders, ministers, foundation leaders, and other prominent members of the community. All of those interviewed were asked to give their perspective on the issues we were told existed at the beginning of the project: unreimbursed health care for the indigent, inability to recruit professionals, lack of comprehensive approach to care delivery, lack of transportation for rural and poor, burdens on business to provide health care coverage, and the lack of coverage for adults aged 19 – 64. Hospital Financial Statements, Cost Reports, FQHC Financial Reports, Revenues by Payer Mix, and other data documents were carefully assessed. Health Centers and clinics in each of the River Region Counties (excluding Macon County) were toured and clinical operations were observed. Officials from Macon County were interviewed in Montgomery.

This process allowed HMA to view how health care is provided to the uninsured and the underinsured population in the River Region and to now provide our findings and recommendations for review by the many stakeholders committed to finding solutions to the problems facing a vulnerable population. As HMA noted on our first trip to Alabama to meet with the Health Care Task Force and Envision 2020: “You will find that the effort to find long term solutions takes sustained energy and almost always requires more than originally thought. But the solutions exist. The critical factor is the ‘want to.’” We believe this report will provide a basis for health care leaders and others in the River Region who “want to” to begin to develop a plan to transform how care is provided to the uninsured and insured in their communities.

While many people and organizations in the River Region contributed to this report, HMA would like to thank Dr. Donald Bogie and Envision 2020, especially Lynn Beshear and her staff, for assisting in numerous ways throughout the entire project.

Executive Summary

As in much of America, there is a health care crisis in Alabama's River Region. With a population of nearly 400,000 residents, the River Region is marked by high rates of poverty and limited access to medical care. Approximately 17.8 percent of area residents live below the federal poverty level, while 21.5 percent of the population between the ages of 18 and 64 is uninsured. The Kaiser Commission on Medicaid and the Uninsured estimates that 100,000 people in the region are medically indigent or underinsured. Those who do have coverage through Medicare or Medicaid often have difficulty accessing physicians, and others depend on local fire departments or ambulance services, either for transportation to routine medical care or for the care itself. River Region residents most in need of immediate care, and trauma care in particular, frequently travel more than two hours to Birmingham, regardless of their insurance coverage status. For the uninsured, dental care and mental health services are even more difficult to access than physical health services. The local physician community is aging, with an average age in the mid-fifties (and higher for certain specialties) and recruitment of younger physicians is lagging, as it is in many parts of the country.

Although the health care system in the River Region faces a host of challenges, there are positive aspects within the delivery system as well. There are a number of clinics dedicated to caring for the most vulnerable, some of which are staffed by volunteers and others which have relatively steady sources of operating funds. Organizations that were created in times of crisis to preserve critical services like obstetrical care and the Gift of Life Foundation have maintained their services, while others are working to develop better models of care, such as the Wellness Coalition's medical home. Other organizations, including strong churches, have stepped in to fill critical needs and help individuals navigate a complex system. Despite all these efforts, however, considerable work remains to be done.

Currently, the level of indigent care at the region's hospitals and major clinic system is above what would be expected in similar facilities nationally. While these providers are in no immediate financial danger, they have not been able to reinvest in their facilities or in needed services such as trauma care. The two Montgomery health systems have average age of plants above the desired norm, with one system above 12 years. The major site for the key Federally Qualified Health Center is in need of replacement. Trauma services in the region will require additional resources to reach optimal levels and to meet the state's goal of establishing a statewide trauma system. Additional resources will also be necessary over the long term if any significant effort to recruit new physicians is undertaken. (The investment in physician recruitment will pay dividends, however, as new physicians serve as major economic development engines in themselves. Each physician represents potentially a $1 million dollar enterprise.)

The following report makes a number of recommendations for increasing access to health care in the River Region, including extending hours, adding new sites for existing providers, improving recruitment of health professionals, and better coordination of

services for those in need. **However, without an influx of financial resources, coordination of efforts and the avoidance of unnecessary duplication, it is unlikely that any of these steps will be enough to preserve and enhance the delivery system in the River Region.**

Any new financial resources brought to bear on this issue should be leveraged through Medicaid whenever possible, since the federal government reimburses the state roughly 70 cents for every dollar spent in Medicaid. While Medicaid budget constraints and constitutional limitations of taxes and their use make it unlikely that any new funding will come from state general funds, options to provide match funds and increase coverage in the River Region still exist. Development of new funding approaches will not be easy and will require assistance and sponsorship from Alabama Medicaid, providers and local governments, but it can be done. Given the federal return on the state's investment, an increase in state matching funds of slightly more than $12 million would produce a $40 million program. If $30 million could be raised, nearly $100 million could be made available for programs to cover more than 25,000 people. Even if the amount is only $3 million, it would generate $10 million in new revenue to help address the issue. It is likely that this funding will need to be raised from several sources. Some of these funds could be used to create school-based health centers to benefit children, their parents, and teachers, while additional funds can be leveraged through an existing program of enhanced physician rates to make caring for Medicaid patients more viable for providers.

Specifically, we recommend that you work with Medicaid to expand coverage to parents up to 100 percent of the federal poverty level, and higher as more match becomes available. For childless adults, we propose a locally funded program with proceeds from a Medicaid supplementary payment program to private hospitals serving as the backbone of funding. Finally, we recommend increased physician rates from Medicaid for physicians providing the greatest access to these patients and expressing a willingness to be part of the trauma program. We believe these financial resources will make it possible to expand service hours and sites for existing providers, fund plant expenditures, trauma services, and additional physician recruitment. To ensure that local resources are found and to help coordinate future investments, we recommend the establishment of a coordinating council that recognizes through its membership that health care is a jointly held responsibility between providers, business, government, and the community at large.

A strong investment in the health care system is good economic development. There will always be individuals without coverage, but reducing that number makes it possible to provide care for them within a sustainable system. Seldom can an investment by the local community have such a high guaranteed return.

Section 1: Health Services for the Uninsured and Underinsured in the River Region

Envision 2020 contracted with Health Management Associates (HMA) in October 2007 to provide an in-depth analysis of how the indigent and uninsured population in the River Region access care and how that care is financed for this population. The analysis also points out barriers to access, an assessment of the current status and supply of primary care physicians and specialty physicians, and a review of current clinic facilities to determine the scope of services available in the River Region.

Vulnerable Populations

By a wide variety of measures – including rural composition and poverty – the River Region stands apart in terms of being home to some of the state's most vulnerable populations. This Region is defined as the five counties – Autauga, Elmore, Lowndes, Macon, and Montgomery – in central Alabama that are located around the tributaries and watershed of the Alabama River. The city of Montgomery is at the center of the River Region.

According to the Office of Primary Care and Rural Health, 55 of Alabama's 67 counties are considered rural, and 44% of the State's population lives in rural areas. Access to health care poses a challenge in rural Alabama. In the 2007 National KIDS COUNT Data Book, Alabama was ranked 48th (down from 43rd) in the nation on measures of child well-being. The percentage of children living in poverty in Alabama increased from 21% in 2000 to 25% in 2005 – a 19% increase in five years. The national percentage also increased over the same period from 17 % to 19%. Table 1 below summarizes some important demographics for the counties in the River Region.

Table 1

County	Ranking in Child Well-being (67 counties)	Total County Population	County Child Population	Median Household Income	All Persons Living Below Poverty Level	Children in Extreme Poverty (see * below)
Elmore	15	73,937	19,553	$43,645	12.5%	6.2%
Autauga	33	48,612	13,801	$45,379	11.6%	6.6%
Montgomery	54	221,619	63,887	$35,680	19.4%	12.9%
Macon	60	22,810	6,670	$23,378	28.3%	21.4%
Lowndes	61	13,076	4,022	$24,967	25.5%	27.1%
River Region Total population		**380,054**	**107,933**			

*** Number of children under 18 living in a household where the household income is less than 50% of the poverty threshold expressed as a percentage of all children under 18.**
Source: **VOICES for Alabama's Children**, *Alabama KIDS COUNT 2007 Data Book*

This HMA report focuses not only on children, but also their families and all vulnerable populations in the five county region; however, the data provided in the Alabama KIDS

COUNT Data Book is significant and needs to be kept at the forefront as we address the issues and problems facing the River Region related to access to quality health care. This is because a key way to improve the underlying socioeconomic structure of the state is to improve the education system. In turn, one of the pre-conditions for improving the educational system is to improve the health status of the students. If students are not well-fed and do not receive adequate health care, they will not be able to succeed in school or succeed later in life.

Teenage pregnancy is a significant concern and one important area where education makes a difference is in teen pregnancy. One of the highest correlations with teenage pregnancy is educational status. The less education an individual has, the higher the likelihood of teen pregnancy. Individuals who drop out of school as teens are much more likely to get pregnant. Individuals in this situation are also ill-prepared to take care of a child. According to the Alabama Campaign to Prevent Teen Pregnancy Fact Sheet, Social and Public Cost of Teen Childbearing, January 14, 2008, the pregnancy rate in Montgomery County in 2006 was 47.6 per 1,000 girls (ages 10 – 19). There were 507 births in 2006 in Montgomery County. Alabama has one of the highest teen pregnancy rates in the United States.
Resource: Alabama Campaign to Prevent Teen Pregnancy. www.acptp.org

There is also a high correlation between graduation from high school and future risk of incarceration. A high school graduate is four times less likely to ever be arrested, detained, and incarcerated than an individual who did not complete high school.

Because of the work of many statewide advocacy groups such as VOICES for Alabama's Children and Alabama Campaign to Prevent Teen Pregnancy, HMA found there is a relatively high degree of awareness and consensus about the need to expand access for quality health coverage for children. Nonetheless, the most frequent and the most expensive needs for additional coverage are for adults of all ages including even the Medicare population and the Veteran's population who supposedly have access to a system for their health care needs. Inadequate access to affordable, preventive care, prescription drugs, and appropriate care management systems encourage inappropriate use of ERs and scarce specialty care, thereby depleting both financial and human resources for health care coverage.

While there are currently many services provided to this population, there is a critical lack of coordination of the services and communication among service providers in the five counties. Existing services are disjointed and not well publicized. There is certainly willingness among some providers to collaborate and establish partnerships; however, the consistent leadership that would be needed is lacking. Some key questions:

What is the magnitude of the Indigent and Underinsured Population in the River Region Counties?

Although it is difficult to estimate with pinpoint accuracy the number of people in the River Region who are indigent and uninsured, according to HMA's best estimates there is a disproportionately high number. Medically indigent or uninsured are generally defined

as individuals and families without health insurance or health care coverage who cannot afford to pay for their health care. Underinsured are patients/families with limited health care coverage. They either can't afford the co-pay, their type of coverage is not accepted by a significant number of the health providers in their communities, or the benefit limits are inadequate for key services.

HMA attempted to quantify the number of indigent and underinsured individuals in the River Region Counties. As Table 2 indicates, it is conservatively estimated that there are 400,000 people living in these five counties. Based on data in the 2007 Kaiser Commission report, over 63,000 individuals in the River Region are medically indigent. However, this number does not reflect the true volume of individuals who have difficulty accessing health care because their coverage is inadequate or because their coverage is not readily accepted. A number of private primary and specialty care practices in the River Region either limit or restrict the availability of appointments to adults with Medicaid. Unlike most states and many other regions in Alabama, children with Medicaid and even adults with Medicare may also have limited choices of physicians who will accept these types of coverage.

TABLE 2

River Region Payor Status

Age Cohort	Private Insurance	All Kids Medicaid	Medicare	Uninsured	Other Govt	Total
Age 0-18	63,360	35,640	n/a	9,000	n/a	108,000
Age 18-64	162,260	20,984	n/a	52,460	8,296	244,000
Age > 65	7,000	n/a	38,000	2,000	1,000	48,000
Total Population 2006 #'s	232,620	56,624	38,000	63,460	9,296	400,000

Source: The Kaiser Commission on Medicaid and the Uninsured, October, 2007.

Conservatively, we estimate that over 25% (over 100,000) of persons living in the five counties in the River Region areas are medically indigent or underinsured.

What are the Sources of Care for the Indigent and Underinsured Population in the River Region Counties?

An important part of the HMA study was to develop a description of the variety of sources of care used by the target population. A cornerstone of health care is primary care. It is recommended that all individuals in all age groups have an identifiable source of primary care. There are data that indicate that patients with a medical home have better outcomes and improved quality of life.

The American Academy of Pediatrics has defined a medical home as: *Primary care that is accessible, continuous, comprehensive, coordinated, whole-person centered, compassionate and culturally effective.* "The patient-centered medical home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner."
Reference: http://www.NCQA.org

The Medical Home system of care is a concept that has been described as a model of health care delivery centered on the needs of the patient and family, and is guided by a personal primary care provider who partners with the patient to coordinate and facilitate care in order to help him or her navigate the complexities of the health care system. The medical home is not a "gatekeeper (who) restricts patient access to services," but rather facilitates and coordinates care. The Medical Home system of care provides an organized continuum of care that delivers accessible, evidence-based care extending from first contact primary care through referral to specialty consultation, inpatient admission when necessary, and follow-up care in a connected and coordinated manner.
Reference: Rosenbaum S., Shin P., Whittington R. Laying the Foundation: Health System Reform in New York State and the Primary Care Imperative, 2006.

The River Region has a limited number of clinical settings where the medically indigent and underinsured can opt to receive primary and specialty care services. Unfortunately, most of their options do not fully, or perhaps even marginally, qualify as "medical homes," even though many providers wish they could refer these patients to a true medical home.

Primary Care

Health Services, Incorporated (HSI)

One of the larger clinic providers is HSI. Incorporated in April 1968 as a non-profit organization with a mission to provide primary health care services primarily for underserved populations including the medically indigent, HSI is accredited by the Joint Commission and provides comprehensive primary health care and preventive services through nine (9) health centers serving six contiguous counties in south central Alabama. Four of the HSI health centers are located in Montgomery County, one in Elmore County, two in Lowndes County, one in Autauga County, and one in Chilton County. The FQHC designation is given to health centers that meet federal requirements including at least one site being physically located in a Medically Underserved Area (MUA) or serving a Medically Underserved Population (MUP), the latter a designation provided by the federal government at the request of a governor. The centers must provide comprehensive primary care and preventive services with established linkages to hospitals for inpatient care and processes to refer patients to specialty services. HSI provides on-site prenatal, gynecological, pediatric, dental, psychiatric, pharmacy, podiatry, and social services.

HSI receives an annual Section 330 grant from the federal government and receives Medicaid reimbursement at a higher rate than non-FQHC providers. HSI receives

approximately $875,000 from the city to operate the Montgomery Primary Health Center on Mobile Highway. They receive no other financial support from the city or the county. United Way provides HSI with a $25,000 annual grant to help coordinate and pay for specialty referrals. These contributions assist HSI in providing services to its impoverished patient population as documented in the table below.

Table 3
Federal Poverty Level (FPL) of HSI patients

Patient Profile	2006	2007
100% and below FPL	87%	83%
101-150	8%	7%
151-200	1%	2%
Over 200%	4%	8%

Source: UDS 2006 and 2007

In 2007, seventy six percent (76%) of HSI's patient population was African-American. Over 50% of HSI's medical and dental encounters in 2007 were to patients that lacked any form of health insurance. Patients without coverage are charged a sliding scale fee for clinical visits and laboratory services. The minimum fee is $20/visit. HSI is open Monday through Friday with one evening (Tuesday) session at the Lister Hill Health Center site. HSI medical and pediatric providers are available "on call" during the off hours.

HSI's patient population declined in 2007 after several clinical and dental staff created vacancies and the staff were not immediately replaced. In response, the Board of Directors authorized a reduction in expenses of $630,000.

Table 4
HSI Patients and Clinical Encounters

Year	Unduplicated Users	Medical/Dental Encounters
2005	30,633	94,679
2006	30,187	93,783
2007	28,833	88,869

Source: UDS 2007, 2006, 2005

In 2007, HSI provided prenatal care for 388 patients at the Montgomery Primary Care Center. Mothers are referred to Jackson Hospital for delivery. Inpatient care for adults and children is primarily provided at Baptist South. An HSI pediatrician makes rounds on HSI children at all three hospitals in the Montgomery area. The HSI health centers do not have an established computer linkage with the hospitals in the River Region area.

In September of 2006, HSI was one of four FQHCs in the nation funded as part of a federal demonstration project (Sickle Cell Disease Treatment Demonstration Program) to develop a collaborative approach to address the unique needs of persons suffering with sickle cell disease. HSI's collaborative partners include the Department of Pediatric Hematology/Oncology School of Medicine, University of AL at Birmingham; two other FQHCs; and three local sickle cell organizations.

HSI refers almost all uninsured specialty care to private practitioners with whom it has developed relationships. Case managers have been able to negotiate deep discounts with these providers and some providers take patients for free. HSI's leadership believes the current referral system works well and that the supply of specialists is adequate, but they also say that significantly more dollars are needed to pay for uninsured specialty care. As noted above, specialty referrals are financed through a $25,000 grant from the United Way.

HSI's dental operations primarily serve adults, though they would like to implement a consultant recommendation to provide more pediatric dental services. The ability to attract and retain medical providers willing to see the pediatric population has been a major obstacle. When compared to other FQHCs in Alabama and nationally, HSI's productivity exceeds or is comparable to other health centers.

Table 5

Productivity	**HSI (2007)**	**State of AL (2005)**	**National (2005)**
Physician productivity	3,989	4,522	3,944
Mid-level productivity	3,568	3,017	2,903
Medical Team productivity	4,790	4,791	4,338
Dentist productivity	2,115	2,941	2,727
Medical patients per medical provider	1,211	1,443	1,126
Dental patients per dental provider	897	1,121	986

Source: UDS 2007 (AL and national 2006 & 2007 comparables not available)
Numbers represent visits (patients) per provider (or team) per year

During 2007, 35% of HSI's charges were to Medicaid, 8% to Medicare, 6% to private insurance and 51% were self-pay charges. This compares to the FQHC national average payer distribution of 45% Medicaid, 9% Medicare, 12% private insurance and 31% uninsured. Clearly, HSI faces a challenge in expanding services to more medically indigent patients with this payer mix profile.

When compared to the Alabama and national cost averages, HSI's cost structure is comparable. (Note: State of AL and national comparisons unavailable for 2006 and 2007.)

Table 6

Costs per Patient	**HSI (2007)**	**State of AL (2005)**	**National (2005)**
Medical cost per medical patient	$341	$295	$380
Medical cost per dental patient	$252	$199	$318
Total cost per total patient	$496	$351	$514
Medical cost per medical encounter	$108	$94	$110
Dental cost per dental encounter	$132	$96	$134
Lab/ X-ray cost per medical encounter	$20	$11	$9
Pharmacy cost per medical encounter	$14	$9	$13

The HSI centers have a total of 70 exam rooms, which gives them sufficient space to accommodate more visits. However, the organization faces several significant obstacles to expanding services. Due to budget constraints and the recent loss of several providers, HSI currently does not have the staff to expand. While they have been successful at recruiting and retaining providers, they have yet to fully recover from the loss of providers last year and acknowledge that their salaries are not as competitive as they need to be.

Perhaps the most serious issue facing HSI is its payer mix. As noted above, more than 50 percent of HSI's charges were to self-pay patients, compared to approximately 31 percent nationally. Over the long term, this payer mix is unlikely to be sustainable, and HSI will need to attract more patients with a payer source, especially children and pregnant women covered by Medicaid. While HSI's leadership acknowledges its payer mix problem, they describe a very competitive market for pediatric and especially OB patients, who are currently triaged via the Gift of Life Foundation and have access to approximately 90 private physicians. They also believe that their Montgomery Primary Health Center site, which is located in a public health facility and serves as the only site providing OB care within HSI's network, carries with it a "public health department stigma" that keeps expectant mothers away. Safety is also a concern, especially at the Lister Hill site.

HSI's leadership believes that, in order to attract more pediatric and OB patients, a new safer site is needed. As a result, the organization has made replacement of the current Lister Hill site its highest priority. HSI's leadership believes the ideal location, for both safety and proximity reasons, is a plot of land adjacent to Jackson Hospital. They also cite a recent study showing that a large number of visits to the Jackson Hospital ER were for primary care and note that this location would position them to provide much-needed after hours care to help alleviate pressure on the ER.

Although HSI is the largest provider of primary care for the medically indigent population in the River Region, there are several others. These are described below.

Medical Outreach Ministries (MOM)

MOM is located on South Boulevard and provides primary care for people aged 18 – 64 who have no health insurance or whose income is less than 200% of the federal poverty level. They serve approximately 900 unique individual patients per year with over 5,200 annual visits. They give out $80,000 to $100,000 worth of free prescriptions per month. They are currently funded by grants and donations from area churches, local charitable and business organizations, Community Development Block Grant (CDBG) funds from the Department of Housing and Urban Development (HUD), and the Montgomery County Health Department. MOM has an agreement to admit its patients to the Baptist Health Family Medicine Clinic and its patients receive discounted rates for clinical services provided at Baptist South. MOM has a cadre of 10 volunteer physicians who augment its full time providers and has established relationships with over 50 specialists who will accept limited numbers of medically indigent referrals. MOM does not have a computer linkage with the hospitals in the River Region area.

Community Care Network (CCN)

The CCN provides monthly services with a Mobile Medical Clinic at four sites (two are in rural areas) each month. They see both insured and uninsured patients. Funding is a major problem. Most of CCN's funding comes from grants that require a re-application every year. CCN has a CDBG block grant and receives some financial support from churches, hospitals, and physicians. CCN sees a limited number of patients and has a low volume of patient visits.

Internal Medicine and Family Medicine Residency Training Programs at Baptist South

These training programs operate outpatient primary care clinics adjacent to each other in an ambulatory care center on Narrow Lane Road. The UAB Internal Medicine Resident Clinic sees 3,000 unduplicated patients per year and provides 12,000 annual visits. Approximately 15% (1,800) of the visits are patients who are uninsured and approximately 20% (2,400) have Medicaid. The medically indigent are generally seen for one post-hospitalization visit and then referred to an HSI health center. The Baptist Health Family Medicine Clinic also sees approximately 3,000 unduplicated patients per year with 12,000 annual visits. 5% (600 visits) of the patient visits are medically indigent. The Family Medicine inpatient service treats 100% of the admissions from the MOM clinic; 90% of these patients are uninsured. Upon discharge most patients are referred back to MOM.

Private Practices and Groups

Private practices in the River Region have very few, if any, medically indigent patients on their patient panels. Most private providers and groups who accept Medicaid actively limit the number and may have a strict quota on the percentage of Medicaid patients who can be given appointments. However, there is at least one private practice in Montgomery that provides primary care to a large pediatric and adolescent population with a significant portion of Medicaid coverage. This practice appears to be the exception in the Montgomery and River Region Counties.

Montgomery VA Health Care System

The Veterans Administration runs a single primary care center in the River Region that provides medical, mental health, dental care, and pharmacy services to veterans in the Montgomery area. This center serves approximately 6,000 of the 30,000 veterans in the Montgomery catchment area. This center sees its role as primarily serving veterans who are uninsured or underinsured. It has the capacity to see more patients and is accepting new patients. It currently has no ongoing relationship with the HSI primary care network, MOM, or the hospital emergency rooms.

Montgomery County Jail

Health care services at the Montgomery County Jail are contracted to a private correctional health care firm. The Jail has approximately 720 beds with an additional 700 currently under construction and has 10,000-12,000 new admissions annually, all of whom are given an intake screening assessment. The Jail offers daily primary health care services provided by its nursing staff and a physician on-site two days per week. Of all detainees, 85-90% are uninsured. An estimated 10-15% of the Jail's detainee population has a significant mental illness. The Jail has on-site dental and psychiatry clinics. The vast majority of the men and women admitted are discharged back to their home communities. Through its

mental illness and substance abuse court, the Montgomery Courts and the Jail have a facilitated referral process to send mentally ill patients to the mental health center in Montgomery upon release. Prescriptions for a two-week "bridge" supply of psychotropic medications written by the Jail provider can be filled without charge to the patient at a pharmacy in downtown Montgomery near the Jail. Medically ill detainees being discharged are advised to seek care at the HSI health centers. The Jail does not have a discharge coordinator to arrange follow-up medical care in the community. The Montgomery County Jail has no established relationship with the HSI health centers or with the MOM clinic, nor does it have computer linkage with the HSI health centers, MOM, the mental health center, or the hospitals in the River Region Counties.

Emergency Rooms

It is not by accident that the ERs are included in the section about primary care access for the medically underserved. The data in Appendix A indicates that a large number of medically indigent and Medicaid patients are using the ER, often for primary and non-urgent care. The ERs may in fact be their only source of primary care. Many of the uninsured patients go to the ER because they do not have access to a primary care provider or to obtain medication refills. Very often the ER will not ask patients to pay a fee prior to being seen. They also use the ER as a night and weekend clinic. Although primary preventive care should not be provided in the ER, hospitals are legally obligated to triage, assess, and treat everyone who comes through their doors.

As noted in the section on Emergency Room services below, an estimated 40-50% of the over 76,000 ER visits in 2007 by uninsured and underinsured patients could have been managed in a primary care or a walk-in center. This is a very costly and inappropriate way to deliver non-emergent care. This data reinforces the recommendations of all providers and health leaders interviewed in the River Region that primary care needs to be expanded in the same communities that generate high numbers of ER visits. There is also the need to create walk-in, non-urgent care capacity in the evening and weekend hours in the same communities where primary care is needed. It is important to note that a number of leading zip codes of patients receiving primary care in HSI centers matches directly with the zip codes of self-pay and Medicaid patients using ERs in high numbers. HSI centers appear to be situated in the right locations, but lack the capacity to entirely meet the non-emergent needs of its patients and/or are not open during hours that could better meet these needs.

Emergency Rooms in the River Region have become an integral component of the "safety net" for the uninsured. Using ERs in this manner as part of the safety net does not create a network of care; rather, it simply means the ERs serve as places to receive episodic care at a very high cost with very little follow-up and no continuity. ERs may be part of the safety net, but they will not replace the need for a "medical home."

Urgent and After-Hours Care

One reason individuals may seek non-emergency care in the ER is lack of availability of services during night and weekend hours, so this is an important part of the study. HMA included questions about after-hours care in its interviews of providers.

HSI's **Lister Hill Health Center** is open on Tuesday evening. Walk-in patients with or without insurance as well as patients with appointments are accepted at this session. There is a sliding scale fee with the lowest payment being $20 for the visit. Smaller co-pays are charged to patients with Medicaid and Medicare. The HSI system has one adult and one pediatric care provider on-call after-hours. The pediatric on-call provider is especially busy on the weekends and holidays.

American Family Care provides urgent care and primary care at two walk-in clinics in Montgomery County located on Marti Lane and Vaughn Road. The hours of operation are 8:00 am – 6:00 pm Monday to Friday. Medicaid and Medicare are accepted, but medically indigent patients are referred to the HSI health centers or other providers that accept indigent care patients. They only accept uninsured patients if they have the ability to pay. Only about 5% of their patients are on Medicaid.

Private physicians own and operate five urgent care centers **(PriMed**) in the River Region: three in Montgomery, one in Prattville and one in Wetumpka. All types of insurance are accepted, but the medically indigent must pay upfront. The hours of operation are 7:00 am – 9:00 pm Monday – Friday; 9:00 am – 6:00 pm Saturday and Sunday; Vaughn Road location 7:00 am – 9:00 pm Saturday and Sunday.

The **Emergency Rooms** at the Baptist Hospitals, Jackson Hospital, Elmore Community Hospital, and Tallassee Community Hospital are virtually the only after-hours care centers in the River Region where the medically indigent and underinsured can be seen and treated by paying at the point of service. Whether the visit is urgent or not, hospital ERs are mandated to screen and triage all patients irrespective of their ability to pay.

None of the hospitals maintain a non-emergency room after-hours care center for patients who are judged not to require the intensive services of an Emergency Room.

Emergency Room Services

The Emergency Rooms at Jackson, Baptist South, Baptist East, Baptist Prattville, Tallassee and Elmore Community Hospitals provide over 170,000 emergency room visits per year. (Data from Elmore Community Hospital was not available at the time this report was written.) Cumulatively, self-pay patients accounted for 23.9% of the ER visits to Jackson, Baptist, and Tallassee Hospitals, although the percent varied from hospital to hospital.

Table 7

Hospital	ER Visits	Self-Pay (overall 23.9% of ER visits)	Medicaid (overall 22.5% of ER visits)
Baptist South	50,633	13,102 (26%)	14,369 (28%)
Jackson	41,297	12,175 (30.5%)	7,559 (18%)
Baptist East	33,678	5,434 (16%)	6,294 (19%)
Baptist Prattville	26,770	5,524 (21%)	6,061 (23%)
Tallassee	12,603	3,261 (25.8%)	2,903 (23%)
Totals	164,981	39,496 (23.9%)	37,186 (22.5%)

Emergency Room specialists in the Montgomery area estimate that a minimum of 40-50% of all their ER visits could have been treated in a primary care setting.

Providers interviewed complained that the waiting rooms in the Jackson and Baptist South Emergency Rooms were crowded, undersized, and inappropriately mixed sick and healthy adults and children. It was repeatedly commented that children needed to have their own waiting and triage areas and that a walk-in center needed to be identified where triaged non-urgent patients could be sent, decongesting the ERs and providing a more suitable level of care at a lower cost. The ERs give uninsured and underinsured patients being discharged an informational sheet with the phone number of centers where follow-up care could be arranged. The ERs do not have a formal referral process for sending patients to HSI health centers or MOM. The ERs do not send any detailed medical information with patients being discharged to care in the community. The ERs do not have a computer linkage with the HSI or MOM community health centers.

Hospital Inpatient Services

There are seven hospitals in the River Region. Four are in Montgomery County (Jackson, Baptist South, Baptist East, and the Veterans Administration), two are in Elmore County (Elmore Community and Tallassee Community), and one is in Autauga County (Baptist Prattville). The seven hospitals have 1,206 beds. There are 301.5 beds for every 100,000 residents in the River Region. The USA average is 270-280 beds per 100,000 residents. With the Region's current population of approximately 400,000, especially with the accessibility of the UAB super-tertiary medical center, the Region has an adequate number of hospital beds. Medically indigent and underinsured patients are admitted to these hospitals or transferred to a higher level of care if their condition so warrants. Elmore Community Hospital transfers patients to Baptist South or Jackson. All the hospitals send

patients to the University of Alabama – Birmingham (UAB) Medical Center for super-tertiary care.

The Veterans Administration Health Care System runs a 30-bed acute care hospital with a 24 hour per day, 7 day per week Emergency Room in Montgomery County that only serves veterans. The ER does not accept ambulances. It is classified as a "rural hospital." All complicated cases are either transferred to the VA in Birmingham or to contracted partners at Jackson and Baptist South hospitals. The University of Alabama at Birmingham Medical Center serves as an invaluable safety net inpatient tertiary and super-tertiary hospital for the under and uninsured not only for the River Region but also for a large portion of the State of Alabama. However, UAB Medical Center is nearly 120 miles away for patients living in the more distant section of the River Region. From 2005 through 2007, 332 indigent or true self-pay patients from the River Region Counties were hospitalized at UAB Medical Center.

Specialty Care Consultation

Even in instances where primary care is available, the next challenge is ensuring that specialty care, when needed, is readily available. The River Region has specialists in 36 different specialties and sub-specialties. The vast majority of the specialists are concentrated in the Montgomery area with very limited access to specialty care in the remainder of the River Region Counties. Even in Montgomery, it is difficult for the uninsured and underinsured to obtain specialty consultation. A number of specialists in the River Region refuse to accept Medicaid (primarily for adults) and some even reject Medicare patients. It was repeatedly heard during physician interviews that specialists in Montgomery see patients "out of their good will".

This impeded access to specialty care is compounded by the increasing age of the specialists. The average age of specialists in the River Region area is now in the mid-fifties and is even higher in select specialties. Older specialists tend to work fewer hours per week and are more reluctant to provide off-hours, on-call care for patients who are not in their established practices. This is the situation at Montgomery area hospitals and practices. **The extremely limited access to specialty care, especially for the uninsured and underinsured, has reached a crisis state in the River Region Counties.**

Specialists who do take hospital call will examine and treat the uninsured even though they receive no reimbursement. It is their perception that the uninsured patient population generates the majority of the after-hours inpatient and emergency room calls for specialty consultation. Specialists spoke of being exhausted post-call and that after being on-call they lack the energy that they had when they were younger physicians. Specialists stated that they will only see post-hospital medically indigent patients one time in their offices; thereafter, patients are advised to seek care in one of the HSI health centers. Specialists commented that it would minimize the growing unwillingness of specialists to provide inpatient care to the medically indigent if they could have a tax write-off or even limited reimbursement for their services.

Providers in the HSI community health centers repeatedly indicated it was relatively easy to obtain specialty consultations in 1-2 weeks for patients with private insurance or

Medicare, but difficult to find specialists who will accept Medicaid. If a specialist does accept Medicaid or in some cases Medicare, there is generally a much longer wait for the appointment (2-6 months). It is almost impossible to get a specialty consultation for medically indigent patients; however, according to HSI leadership, this is a function of a lack of resources to pay for specialty care rather than a shortage of specialists. In some circumstances, United Way will subsidize a visit to a specialist after the patient has been interviewed and approved by United Way's social workers. Most medically indigent patients are referred to UAB's Kirklin Outpatient Clinic with variable waiting times from weeks to months for the first appointment. Uninsured and underinsured are readily accepted at the Kirklin Clinic, but the travel to Birmingham creates a barrier to compliance for a number of referrals.

The Medical Outreach Ministries (MOM) has arrangements with 50 or more specialists in the Montgomery area who will accept carefully selected and limited numbers of referrals. The specialists generally provide these consultations to MOM patients without charge.

It was reported that Montgomery County has the highest incidence of HIV in Alabama. Providers interviewed stated that care was readily available, even for the uninsured, at the Montgomery AIDS Outreach Clinic in Montgomery. This organization has done a lot of work recently to stabilize their financial position. If they had an additional $250,000 in one time unrestricted grant monies, they could bring a like amount of additional federal funding to the community to pay for services for this population. In addition, women and children with HIV infection are treated in the grant-supported UAB Montgomery Family Clinic housed in the UAB Health Center Montgomery.

Cancer care for the uninsured and underinsured appears to be reasonably accessible either through referral to an oncologist at UAB or in Montgomery with the support of local agencies such as the Montgomery Cancer Wellness Foundation. The Foundation has a $500,000 budget and reports to have received nearly $250,000 of in-kind services from providers, the Montgomery Cancer Center, and other clinical entities. It was stated in interviews that "No patient with cancer is turned away." The Foundation's social worker and patient advocate try to match patients with needed services to help the patient maintain a standard of living, including assistance with transportation and drugs if so needed. The Foundation's number one issue is the variable flow of the grant and charitable support that it receives. Predictable sustained funding would significantly facilitate the ongoing care of uninsured cancer patients.

The UAB specialty care clinics at the Kirklin Clinic in Birmingham truly serve as a safety net of specialty consultation and care for the uninsured and underinsured in the River Region Counties. Although there are moderately long waits for the first appointment to some of the specialty clinics, the appointments to Kirklin are felt to be readily available. The distance and travel time to Kirklin makes it difficult for some patients to keep these valuable specialty appointments.

Dental Care

Access to dental care for the uninsured and Medicaid population is also a serious issue for the River Region. Alabama has 30% fewer dentists statewide than the United States

average. Alabama ranks the fourth lowest in the country for dental care spending. An estimated 40% of Alabama children have untreated dental decay. In addition, 35 – 40% of Alabama adults have unmet dental care needs. Last year 70% of Alabama children did not visit a dentist. There are a total of 159 dentists in River Region Counties, with 124 of them located in Montgomery. There are no dentists in Lowndes County. Of the dentists practicing in the River Region, 31% see Medicaid patients and 61% see ALL Kids patients.

Dental services for the medically indigent are provided at two HSI health centers in the Montgomery area: Lister Hill and the Montgomery Primary Health Center. The Lister Hill dental clinic is currently not fully staffed due to the resignation of a dental provider. Dental clinical services were discontinued at HSI health centers in Ramer and Hayneville.

The privately owned Small Smiles and Tooth Zone dental centers readily accept Medicaid patients.

Mental Health Care

While access to primary and specialty care is a challenge in the River Region, the situation with respect to mental health care is even more serious. Montgomery, Lowndes, Autauga, and Elmore Counties are designated as Mental Health Shortage Areas. These four counties are also designated as low income Mental Health Catchment Areas. There is only one Community Mental Health Center, the Montgomery Area Mental Health Authority, to serve the medically indigent and underinsured mentally ill patients in this four county region. The Montgomery Area Mental Health Authority has satellite offices in Prattville and Wetumpka.

The Montgomery Area Mental Health Authority (MAMHA) serves over 5,000 adults and 1,000 children and adolescents. It was reported that there are long waits to obtain an appointment. A significant number of MAMHA appointments are used to treat court ordered referrals and discharges from the State mental hospitals. MAMHA also accepts referrals from the Montgomery Jail, especially patients who are being adjudicated by the Mentally Ill and Substance Abuse Court. The Montgomery Area Mental Health Authority is staffed by psychiatrists, a physician assistant, a nurse practitioner and a number of social workers and mental health clinicians. The psychiatric staffing amounts to 3.7 FTEs (fulltime equivalents).

Inpatient mental health services are provided at the State Hospital (Greil) through court order and physician referral. Baptist South has a 37 bed mental health unit. Jackson Hospital has an 8 bed crisis unit that may be closed in the next 6 months. There is a geriatric mental health center in Tallassee and a unit is being planned in Prattville that will serve 19 geriatric patients (age 55+) and 29 adolescent patients (age 12-18). A private 60 bed mental health inpatient facility is under construction in Montgomery on Narrow Lane Road. With the exception of the State Hospital, all of these inpatient mental health units accept only insured patients.

The HSI health center at Montgomery Primary Care Center has a 0.11 FTE psychiatrist. This is the only psychiatric physician in the HSI network that accepts referrals from the

other 7 HSI community health centers. In 2007, the psychiatrist provided services to 335 patients.

The Montgomery County Jail has an on-site psychiatric clinic. It is estimated that 15% of the 720 (soon to be 1,420) men and women housed at the Jail on any given day have a serious mental illness. The Jail admits over 10,000 new admissions annually. Montgomery has an active Mentally Ill and Substance Abuse Court that deflects a number of mentally ill offenders into community based care at the Montgomery Area Mental Health Authority in lieu of incarceration. Upon discharge from the Jail, detainees who require mental follow-up have appointments arranged at MAMHA and a two-week "bridge" supply of psychotropic medications is provided at no charge to the patient at a nearby private pharmacy.

It was the opinion of providers interviewed that there is a terrible shortage of mental health services and professionals for both adults and children in the River Region Counties. This lack of access to psychiatrists and psychologists in the River Region is especially exaggerated for medically indigent patients of all ages.

Pharmaceutical Services

HSI has licensed pharmacies in its Lister Hill and Montgomery Primary Health Centers where prescriptions are filled on the same day for patients receiving care in these centers. The FQHC designation of its centers allows HSI access to 340B pricing for medications. Prescriptions are faxed from all the outlying HSI health centers and the medications are delivered to the originating clinic for pick-up by the patient in 1 to 3 days. All of the HSI centers maintain a limited supply of stock medications to cover patients who need their medication immediately. On an annual basis, through the Pharmacy Assistance Program, Pfizer donates approximately $1,500,000 of pharmaceuticals for HSI's uninsured patients.

Wal-Mart's provision of a variety of medications at the cost of $4 per prescription assists many patients in the River Region comply with the prescriptions ordered by their providers.

Catholic Charities, through its Direct Aid program, assists the uninsured and patients who cannot afford co-pays to help purchase prescribed medications. They have an agreement with a private pharmacy where prescriptions can be purchased with a 20% discount. This program assists approximately 30 patients per month to acquire 3-4 prescriptions per person.

Some of the churches in Montgomery have social support service programs that assist in the purchase of limited amounts of prescription medications. One church spends $1,500 per month assisting patients with pharmaceutical costs.

Medicare Part D was repeatedly criticized by health care providers and administrators. Elderly patients have found the program to be extremely complicated and difficult to understand and navigate. Cancer providers complained that Part D has been "awful for cancer patients."

It was somewhat surprising to HMA that there weren't more complaints about the ability of patients to acquire prescription medications. With the number of people living in poverty, clearly there are patients who can't afford to purchase medications. It is possible that the $4 prescriptions at a large national retail store has minimized the impact of pharmaceutical costs to the medically indigent and underinsured in the River Region Counties.

Other Social Service Agencies

There are a number of other social service agencies and foundations, other than those noted above, that provide services to the uninsured. Each one talked about the great need but the limited resources. None of them can meet the demand alone. But with more funding each of them could provide services to more people. Table 8 lists some (not all) of the agencies/foundations that HMA spoke to and the services they provide.

Table 8

Provider	Service
Montgomery Cancer Wellness Foundation	Social work, counseling, diet/nutrition, patient advocacy. Assists patients undergoing chemotherapy and/or radiation who have no access to drugs and transportation. Primarily serves the elderly on Medicare who have fallen into the Part D gap. "No patient is turned away."
The Joint Public Charity Public Hospital Board	Funds for specialty care.
AL Child Caring Foundation	Outpatient coverage; set up by BC/BS.
Catholic Social Services	*Direct Aid Program* provides medications, money for utilities, food, clothing, and dental care to all ages. Serves approximately 1,000 people at any one time. Provides bus tickets to Lister Hill Health Center. Has a large food pantry, and thrift store. Provides psychological and financial counseling. They are limited by lack of financial resources. *Frail Elderly Care* for clients age 60 and > who need help to stay independent with dignity and who need transportation. Services are provided through St. Margaret's Foundation. Other funding sources as well.
Churches	Support services for referrals and medications.
Gift of Life Foundation	Supports a network of OB physicians and pays for Maternity Care including delivery for women in the River Region through a global fee.
Montgomery AIDs Outreach	Provides a full service medical clinic. Montgomery Co. has the highest rate of HIV in the state.
Volunteer and Information Center (VIC)	Connects area residents to community service organizations. Dial 2-1-1 free for information on available community resources.

Note: The Community Resources Guide is an excellent resource for review of other service providers available in the region.

Barriers to Care

There is a semblance of a structure already in place in the River Region Counties, but there really is not an integrated network of care. As noted previously, there are health centers and clinics that are free, sliding scale, and walk-in. There is the ER. There appear to be multiple options for the vulnerable populations. However, due to various barriers these options are not always viable as a way to access care. Some of these barriers are:

- The indigent may not be able to provide the documents that would qualify them for free care.
- They may not be able to pay even a small fee based on a sliding scale.
- There are not enough primary care providers in their county.
- The clinics in their area do not have full time providers.
- They have trouble getting specialty care.
- They don't feel they are treated fairly.
- There is not a provider that speaks their language.
- They are not aware of their options.
- The hours are not convenient because they work during clinic hours.
- They do not have transportation.
- They go to the already over-crowded Emergency Room where they know they will not be turned away.

Access to Care

Medicaid for adults is not readily accepted by a number of providers in the River Region Counties. In fact, some providers do not accept Medicaid at all. Surprisingly, Medicare is also not being accepted by some physicians in these five counties. Pediatric Medicaid reimburses providers at a higher rate than adult Medicaid, but the majority of pediatric practices either do not accept Medicaid or have limited the number of patients with Medicaid and ALL Kids in their practices. Also, most of the services provided for this vulnerable population in the River Region are available Monday through Friday during the day. Due to lack of transportation and/or job responsibilities, many are not able to access care during these hours so they go to the ER for care, especially with their children. A number of the providers talked about having evening hours one day per week and a half day on Saturday, but in some cases these hours were discontinued due to the low number of patients who were utilizing them.

HSI, Inc. provided services to 18,327 adults in 2007 and Medicaid was the major payer. The payer status of the adults was 61% uninsured, 14% Medicare, and 13% Medicaid. While HSI has the physical space capacity to provide additional services, the financial reality is that existing resources are insufficient to support expansion given this payer mix. The table below illustrates this point. HSI must attract more patients with a payer source, or secure additional resources to support the expansion of services.

Table 9

Uninsured – Direct Costs and Grant Revenue	
Medical Cost Per Medical Encounter	$108
Lab & X-Ray Cost Per Medical Patient	$20
Pharmacy Cost Per Medical Encounter	$14
Total Direct Cost Per Medical Encounter	**$142**
Total Direct Cost Per Dental Encounter	**$132**
Medical Encounters	79,297
Dental Encounters	9,237
Estimated Uninsured Medical Encounters	40,441
Estimated Uninsured Dental Encounters	4,711
Total Direct Cost – Uninsured	**$6.3 million**
330 Grant	**$3.9 million**
Montgomery County Subsidy	**$0.9 million**
Difference (Cost vs Grant + Subsidy)	**($1.5 million)**

Source: 2007 UDS

Provider Workforce in the River Region Counties

Insufficient Number of Providers to Serve the Medically Indigent

There are an insufficient number of primary care providers in the River Region who are willing to accept uninsured or underinsured (and in some cases Medicaid) patients. Access to specialty care is also limited. Specialists will manage uninsured and underinsured in the hospital, but will provide only one post-hospitalization visit in the community. Some specialists also refuse to take call, so there is limited specialty coverage for the ERs unless they are willing to pay for call time. They are also less willing to take care of the uninsured. The average age of physicians in the five county region is in the mid to high 50s. Recruitment of providers to the River Region Counties is a major concern.

Physicians, nurse practitioners, physician assistants, and administrators in the health care delivery systems in the River Region Counties were interviewed about the recruitment and retention of health care providers. All stated that there is a belief that physicians, both primary care and specialists, are difficult to recruit to the five counties in the River Region area. It was of interest that one nurse practitioner, who is on the local mid-level provider association, felt that nurse practitioners could be identified and hired in, at least, the Montgomery area. All expressed concern that the physician population is aging and that younger providers are not readily joining practices in the River Region area. Providers noted that as difficult as it was to find providers to work in Montgomery County, it was even more complex to convince physician and mid-level providers to practice in the more distant, rural areas of the River Region Counties.

Difficulty Recruiting

Reasons stated as barriers to recruitment include perceived and real isolation in rural areas, need for improvement in the public school system that results in providers having to pay for the cost of private grammar school and high school education, increasing work load when taking hospital call, increasing numbers of complex, uninsured patients with whom

the provider has not had a previous relationship when on-call, and a lingering negative perception about race relations in central Alabama. It was voiced by a number of the physicians interviewed that some providers over-emphasize to potential recruits their concerns about the public school system, never commenting on the recent development of magnet public high schools. We were also informed that some specialists are less than enthusiastic about young physicians in their specialty coming to Montgomery and potentially attracting patients away from their established practices.

The increasing average age of physicians is not unique to Alabama; rather, this is a nationwide phenomenon. According to data from the American Medical Association (AMA), the number of physicians in the US has nearly tripled in the 45-54, 55-64, and 65 and older age groups in the last 25 years. By contrast, the number of physicians aged 35-44 has not even doubled, and the number of physicians 35 years old and younger has only increased by 10%. Younger physicians are willing and able to work more hours. By age 55, the average US physician has decreased his/her work hours by 25%. The River Region Counties physician ages reflect those of physicians throughout the USA. It was estimated by a number of physicians that the average age of providers in the 5 county area is approximately 55 years. In certain specialties and sub-specialty groups in the Montgomery area, the majority of physicians are near or over 55 years of age. This is serious concern for the River Region area. It is also an opportunity to recruit providers who will realize that their services will be needed.

Table 10

Physician Age Distribution

Age	USA	River Region
<35	16%	8%
35-44	24%	24%
45-54	25%	35%
55-65	17%	27%
>65	19%	6%

This increasing age of the USA physician workforce is compounded by the fact that medical school enrollments have not proportionately grown with the increase in the USA population. This is in no small part due to decreased federal payments and subsidies and policies that have limited the ability of medical schools to increase in number and enrollment size even though there continues to be a qualified pool of medical school applicants who are rejected annually. It has resulted in 20-30% of all residency positions in US hospitals being filled by International Medical School graduates.
Reference: Helwick, Catherine. Shrinking Workforce: No Quick Fix. Internal Medicine World Report. Vol 22, No. 12. December, 2007, p. 1 & 6.

The River Region Counties are not unlike other cities and communities in Alabama and in other states. Many communities are having difficulty in recruiting primary care and specialty physicians.

Alabama has two medical schools, University of Alabama Birmingham (UAB) and University of South Alabama. UAB has three campuses – Birmingham, Huntsville, and Tuscaloosa. South Alabama's campus is in Mobile. Approximately 10-35% of students in

Alabama medical schools are from out-of-state. We were advised that Alabama is now exporting physicians to other states. The number of Alabama medical students in out-of-state medical schools was not available.

The State of Alabama has initiated some programs that are attempting to attract physicians to practice in both rural and micro-urban areas. The Rural Medical Scholars Program operated out of Tuscaloosa since 1996 identifies and recruits high school and college students from rural areas who have an interest in attending medical school. The students must be committed to returning to their rural communities to practice. Once accepted in medical school, the students do a pre-medical school year being trained and mentored in community rural health and rural sociology. Each class continues to meet and train on a regular basis throughout medical school. There are now 37 students from this program in medical school and 14 in the Family Practice residency in Tuscaloosa. There are currently 30 students in the recruitment phase and 3 medical students from the River Region Counties. Montgomery County is for the most part considered an urban area and does not qualify for this program. It costs an average of $30,000 per student per year for the 5 year program.

Federal Graduate Medical Education funding helps to finance the Family Medicine and Internal Medicine Residency training programs at Baptist South. One or the other, or both of these training programs, generate additional support from a variety of sources including Baptist South, the County of Montgomery, inpatient and outpatient billing, and others. These residency training programs recruit young physicians-in-training to Montgomery and the River Region Counties. A number of the graduates of these residency programs are subsequently recruited to practice in the River Region area. More than 30% of the graduates remain in the Montgomery area and 40-50% remain in Alabama. It is unknown whether some of the graduates who enter sub-specialty fellowship programs will be more willing to return to Montgomery in the future to set up their practices.

The nine Health Services, Inc. (HSI) Federally Qualified Health Centers have been designated as Health Manpower Shortage Sites (HMSA) serving underserved patient populations. This designation enables these community health centers to be eligible to recruit recent graduates of residency training programs who had received National Health Service Corps (NHSC) scholarships during medical school. Physicians without NHSC obligations who select to practice in the HSI centers can also apply for “loan repayment” stipends for payment of private loans that were used to finance medical school training. International graduates who desire to stay in the USA can also obtain J-1 work visas if they are selected to practice for 2-3 years in Health Manpower Shortage Centers such as HSI. Qualification as NHSC scholarship repayment and loan repayment sites are tremendously effective recruitment tools. Upon completion of their scholarship and loan repayment obligations, there is great opportunity to recruit these providers to remain in the River Region area. However, this past year HSI had difficulty replacing several physicians who left.

Alabama has also developed an Osteopathic Medicine –Alabama Consortium that is recruiting Alabama pre-medical students to apply for four or five out-of-state Osteopathic Schools with the expectation that these students will return to Alabama to complete their

residencies, hopefully in primary care programs. This is a new program and time will tell whether the students return to Alabama.

A 2006 Survey of Medical Students by Merritt, Hawkins & Associates revealed that residents primarily learned about practice opportunities from 1) the internet and 2) personal networking with additional significant input from physician recruiters and their residency programs. The majority start investigating practice opportunities one year or greater before completion of their residency programs. Other than quality of care considerations, their top four considerations in descending order were 1) geographic location/life style, 2) good financial package, 3) adequate call/coverage, and 4) loan forgiveness. Few recent graduates show interest in practicing solo. Over 70% expressed an interest in practicing in communities with populations between 50,000 and 500,000. Less than 1% voiced any interest in working in a community of less than 25,000. Availability of free time was a significant factor for 63% in selecting a practice. Merritt, Hawkins & Associates stated that residents select their initial practice based on "pre-determined geographic locations, usually close to where they trained, where they grew up, or where their spouse grew up."

Reference: Merritt, Hawkins & Associates. 2006 Survey of Final Year Medical Residents.

Transportation to Health Services for the Medically Indigent

Transportation, especially in the rural counties, appears to be a problem for many but not all of the indigent population. The transportation system in the city of Montgomery does not always provide access to the areas of the city where services are provided to this population. HMA heard many different opinions from service providers regarding transportation.

- "Transportation is not as big a problem as others may think. …. It is important to make appointment times convenient for the patient, so as to coincide with rides the patient may have from friends or family for other errands, such as trips to Wal-Mart."
- "In Montgomery the public transit is OK, but in other areas of the River Region it is a problem."
- "Transportation is a big issue as is the issue of medications, which are very expensive."
- "Autauga Rural Transport provides transportation, including wheelchair transport Monday through Friday from 8-5, through the use of 7 or 8 mini-buses."
- "Transportation is not that big a problem but access to primary care appointments is a big problem."
- "Many patients miss appointments because they don't have cash to pay neighbors or relatives to drive them."
- There are some assisted government –funded transportation options for special populations but these vans do not coordinate their times and routes. Collaboration between these special transportation services would maximize the number of patients served.

Even though conflicting opinions were voiced, HMA agrees there are huge problems with transportation and any proposed solution will have to identify the means to change the service or change the geographic distribution of the system.

Other Critical Issues Facing the River Region

Public Education

When talking with physicians and other business executives, it was clear to them that the lack of quality public education in Montgomery County was one of the main reasons it was difficult to recruit younger physicians and other health care professionals to the Montgomery region. While there are excellent private schools in the area, they are apparently expensive, costing as much as $10,000 per year per student. This needs to be addressed when thinking about recruitment issues for professionals in the River Region.

Medical Information Sharing

The HSI health centers have installed terminals in virtually all of their exam rooms and clinical support areas. The HSI health centers use a shared electronic scheduling system linked by servers housed on the second floor of the Lister Hill Health Center. Their two pharmacies are automated, but the prescriptions are hand-written and there is not access to patients' medication profiles in the clinics. The results of the laboratory tests performed by the HSI laboratories are not available electronically. HSI has not yet implemented an electronic medical record and has not created access to online medical references.

Medical information generated in the River Region clinics and hospitals is not electronically shared with other clinics and hospitals. Clinical data is only provided through the paper-driven "release of information" processes. Community health centers did note that hospital discharge summaries are reasonably easily obtained from their own physicians who are assigned to inpatient rounds. Clinical data from the hospital emergency rooms is difficult to retrieve. The Jail is not linked to the information systems of any of the private or public health systems in the River Region.

A cursory review of the zip codes of patient visits to the hospital ERs and the HSI centers revealed that patients who frequent HSI health centers originate from the same zip codes that generate large volumes of ER visits in the River Region. It is logical to project that visits to the MOM, the Montgomery AIDS Outreach Clinic, the Montgomery Area Mental Health Authority, the Montgomery Cancer Center, and other centers that treat the medically indigent and underinsured, and admissions to the Montgomery County Jail will undoubtedly have overlapping communities of origin with patients who are users of the hospital inpatient services and ERs and HSI health centers. There is a staggering amount of wasted clinical resources that are being duplicated when patients move back and forth between these various health settings.

Integrating the health information systems of the various hospitals and clinical services that provide care to the medically indigent and underinsured in the River Region Counties would have an immediate and ongoing positive impact on the continuity and quality of care throughout the River Region community**.** Having patients' laboratory and diagnostic tests and pharmacy profiles readily available at all points of care throughout the five counties would be a model for the USA. The avoidance of the duplication of testing

would result in significant savings for all entities involved in providing health care services to patients in the River Region.

The Montgomery Area Community Wellness Coalition has identified the development of region-wide health information sharing as one of its top priorities. A large amount of work has gone into planning such a system, but certain obstacles still need to be overcome prior to implementation. Shared River Region-wide health information that is accessible and still protects confidentiality is a goal that is attainable.

A Community Perspective

The Montgomery Area Community Wellness Coalition, as noted on their website, is a community-managed, non-profit organization of health and human service providers who share information and coordinate resources to increase quality, efficiency and effectiveness of services within the River Region. The coalition is comprised of members representing the hospitals in the River Region, the Joint Public Charity Hospital Board, Community Care Network, Medical Outreach Ministries, Montgomery AIDs Outreach, The Alabama Department of Public Health Area 8, Health Services, Inc, Mid-AL Homeless Coalition (in a collaborative partnership with the Volunteer and Information Center), the Family Guidance Center, and Montgomery Area Mental Health. Their mission is "To conduct and support activities and services that improve health and wellness through coordination and information-sharing; health promotion and disease prevention; and by providing wellness case management services that help individuals and families at risk of or having diabetes, obesity or asthma to make healthy lifestyle changes, and/or to find and use health services and community resources." As noted on the Wellness Coalition's website, the purpose of the Wellness Coalition is threefold: 1) Identify and quantify the needs of the medically uninsured and underinsured population in the Montgomery, Alabama area; 2) Strengthen the health services infrastructure by coordinating the efforts of various agencies providing services to this medically uninsured and underinsured population; and 3) Increase access to appropriate resources for improving health and wellness.

Reference: http://www.healthystepsalabama.com/

At a meeting of the Goals Committee of The Wellness Coalition in early November the members shared the goals they are currently focusing on. These include:

- Every person to have a medical home - Their community wellness advocates are focusing on helping patients find medical homes and coordinating appointments and also addressing avoidable ER visits. They are not able to track the impact of the advocates on decreasing ER visits as they have no way of tracking. It is currently a manual system.
- Funding the Montgomery Area Information Network (MAIN) - Finding funding for information technology (IT) will enable them to integrate patient information into a shared database. This would not only help to avoid duplication of services, but would provide the data needed to track important indicators of well-being in the uninsured population.
- Life style education - The Coalition is also working on lifestyle education with a special emphasis on the poor. This has apparently not been a priority for the city or county governments in the past.

- Transportation - Transportation has been mentioned a number of times as a barrier to receiving health care. The coalition believes this is more of a critical problem in the rural areas.
- Affordable medications - While many of the social service agencies and the clinics provide medications, many are only able to provide one month or "first doses" based on their limited supply and/or lack of resources. Wal-Mart offers $4 prescriptions and Publix offers specified antibiotics from a list for free with a physician's prescription. Obtaining medications and refills is a challenge for the uninsured.
- Funding for Specialty Care - Specialty care seems to be provided at the "good will" of the specialists. There may still be high out of pocket costs for the patient. Access to specialty care for the poor is "hit or miss".

River Region Stakeholders

The stakeholders in the River Region vary significantly on the perception of the status of the health system as it impacts the community, economic vitality of the region and, in particular, vulnerable populations. A number of initiatives have the attention of the stakeholders, but there is still a serious disconnect in the perceptions of community leaders.

Government

There is interest at all levels of government in the health care issues of the River Region. However, there is not consensus on the level of the problem, the need for intervention, or even whether there is a problem. Montgomery City and County officials have been asked to fund the replacement of one of the primary FQHC sites in the community as well as to dedicate more money to indigent care at the hospitals. Based on our discussions, we believe there is openness to attempting to help, but also a need to have the problem clearly laid out and the financial needs verified. This comes at a time when tax increases are not any more popular in the River Region than they are nationally.

Other government leaders in surrounding counties are also engaged. In Autauga County, there is a close relationship between the Baptist Prattville hospital and local leaders. At the city level they have also taken control of their own employee health costs in innovative ways gaining control of the previously spiraling increases by involving employees and stressing education and prevention. They feel they need an expanded hospital presence. The local providers don't necessarily disagree, but cite the payer mix as an issue that makes achieving the community's goals without aid from some source difficult to achieve.

In Elmore County, there are two small hospitals. These are Tallassee Community Hospital, a not-for-profit, and Elmore Community Hospital, a for-profit. County officials in Elmore know their hospitals are providing significant charity care, but believe they are managing and even improving.

In Macon County there appear to be sharp differences between the Mayor's call for a new hospital and the Health Authority Board which has built a modern clinic facility that stands empty as they pay the debt on the facility. It is questionable how a hospital will fare

if the community cannot support a clinic. It is important to note that Macon once had a hospital, but that too closed.

Finally, when we reviewed self-reported amounts budgeted by individual counties, the amounts were extraordinarily low. Montgomery County budgeted $107,955 and an additional $85,000 for the Joint Public Charity Hospital Board, Elmore County $1,000, Macon County $18,000 and $25,000 for the Health Authority. We do realize that other amounts go to mental health, public health, and support services for low income individuals, as well as indirectly help to fund Medicaid, but this overall level of support appears low compared to urban areas in Alabama, particularly Birmingham.

In terms of state officials, they are struggling with potential significant shortfalls in not just Medicaid funding, but in all general fund expenditures. The State of Alabama has had creative leadership in Medicaid and they have historically done a very good job of operating their program with a very tight state budget and only small growth in available funds. However, they may now be running out of ways to stretch their limited dollars and face challenges as do all states based on proposed new federal rules. Medicaid leadership remains very open to new ideas to help the River Region and other parts of the state. Legislatively, there is a feeling among some key leadership that until local government is willing to invest more money they are not inclined to help with state funds. They believe the need exists, but wonder if the community is prepared to step up. By contrast, a number of local officials believe they are already contributing in significant ways.

Chamber of Commerce

In many communities the involvement of the Chamber of Commerce in identifying health care for vulnerable populations as an issue and supporting solutions is critical to success. This is true in Dallas County, Texas and looks to have that potential in Kansas City. In Montgomery, health care does not seem to be on the Chamber's radar as a critical issue. They have mobilized in past years to assist in getting their Medicare payment level, which remains among the lowest in the country, increased. And they have expressed interest in assisting when asked to help recruit physicians for the Region. However, they were not sure they would get a huge response from CEOs if they held a meeting on the subject. Anecdotally they indicated many people in leadership receive their health care in Birmingham, not locally, due to a perception of quality differences.

Ministerial Alliance

This group seemed most involved in the current problems of getting health care for low income people in their community and most willing to unite to find solutions. At least three of the churches offer assistance in finding health care and making appointments as well as obtaining pharmaceuticals. But information on how the system works was not universal even among this group.

Department of Public Health

There is a serious effort to create a trauma system in the State of Alabama and the River Region is seen as one of the most problematic areas of the state in which to accomplish that effort. This is consistent with other issues identified as challenges in the River Region in terms of physician services and recruitment. The River Region has a high uninsured rate and level of poverty and the new businesses that have been attracted to the state have had

less impact on these issues than expected. The Department of Public Health was extremely knowledgeable about the issues and is willing to help if there is a role for them.

Providers

There is significant strain between providers. The change in "ER of the day" practices seems to be a lightning rod in terms of disagreements amongst providers, but the issues appear to be deeper. Clearly, providers agree on the need for relief from the costs of indigent care; however, they disagree on many other key issues. The difficulty in recruiting primary care physicians was alternatively described as a large issue, or not an issue at all, depending upon who was speaking. The problems with trauma care and the long-term impact on referrals of all kinds was also approached very differently. Another area of disagreement was whether increasing reimbursement for current patients or expanding coverage was more critical.

Section One Recommendations

The recommendations that follow focus on expanding access to care by improving coordination and reducing duplication of services; expanding hours of services, especially during the critical evening hours; adding additional access points in communities of highest need; and improving recruitment of health professionals. It is extremely important to note, however, that these efforts are unlikely to be successful or sustainable in the absence of additional financial resources. In Section 3 below, HMA makes several specific recommendations to bring additional resources into the community, including targeted Medicaid coverage expansions and local coverage for the uninsured. These access recommendations must be viewed in the context of a concerted effort to bring substantial additional resources into the River Region.

Access to Health Care

- **Expand Hours of Service at Community Health Centers that Accept the Medically Underserved**

  There is no question that there is a palpable deficiency of evening and weekend hours where the uninsured and underinsured can receive primary care and low level urgent care. If in an after-hours clinic, sessions are simply shifted sessions from daytime to evening without adding additional numbers of sessions, there may be little notable gain to the primary care capacity for uninsured and underinsured patients. It is possible that there will be a somewhat different patient population that uses the evening clinic sessions (i.e. younger, working poor).

  Lister Hill Health Center is the only HSI health center with evening hours and only on Tuesday evenings. The Lister Hill zip code, 36104, had 5,028 ER visits from Medicaid (2,599) and uninsured (2,429) patients in 2007. With the proposed Medicaid expansions, it might be financially feasible for Lister Hill to expand into evening and weekend hours with a particular focus on providing non-urgent walk-in services. None of the HSI community health centers have weekend or holiday hours. Likewise, the Montgomery Primary Health Center is located in the zip code (36108) that generated the most Medicaid and self pay ER visits in 2007. These are two of the three health centers where it would be logical to expand the availability of health care services. The third is Chisholm Health Center that is predominantly a nurse practitioner pediatric center; Chisholm zip code (36110)generates the 3rd highest number of "self-pay" and Medicaid visits in the River Region (4,924). It would serve little to simply shift daytime clinic hours to evening hours in these three HSI health centers. There is no guarantee that more patients will be treated; maybe a small undetermined number of ER visits might be deflected to these evening sessions. HSI has limited capability to expand without additional staffing. These HSI health centers are struggling to fiscally survive, making it unlikely that they could actually add additional hours of service by expanding their hours to evenings and weekends unless additional funding is made through either the recommended Medicaid expansion and/or the federal government, local government, grants, or charitable organizations that underwrite care for the uninsured.

- **Expansion of Dental Services**

  Dental care for the underserved is considered to be the greatest unmet health care need in the USA. Given that the highest concentration of underserved live in the Montgomery area, it is important that the Lister Hill and the Montgomery Primary Health dental services, the only dental providers that serve the medically indigent, operate at full capacity. The dentist vacancy at Lister Hill needs to be expeditiously filled. The dental appointments at these two centers must be maximally booked. If staffing allows, evening and weekend hours need to be opened. The HSI health centers at Hayneville and Ramer have fully equipped dental suites that are currently unused due to budgetary limitations. With additional funding the three dental suites at Hayneville and the single suite at Ramer could be providing an additional 10,000 dental visits per year. It would cost approximately $500,000 per year to staff and supply these fully equipped 4 dental suites on a full time basis. Although the projected cost per visit of $132 would be a very affordable to the community given the huge amount of lost work time due to dental pain, it would be currently more cost effective to fund transportation from Lowndes and southern Montgomery County to the dental services at Lister Hill and Montgomery Primary Health Center than to hire the dental staff required to operate these two unused dental facilities. HSI needs to determine the payer mix they would need to have to make this service financially viable and set up appointment criteria to achieve it. For example, some clinics prioritize children and pregnant women. These are crucial populations to be served and also tend to have more funded patients. As money becomes available along with a plan for adult emergencies, dental care should be considered for covered services in the plan.

  There exists a wonderful opportunity for the Dental Society(s) in the River Region Counties to establish a volunteer dentist, dental hygienist, and dental assistant program that could allow the expansion of dental hours at Lister Hill and Montgomery Primary Health Centers and even open a number of dental sessions at Hayneville and Ramer Health Centers. If a moderate number of the >150 dentists in the River Region volunteered 1 four-hour session per quarter, there would a dramatic increase in the availability of primary dental care for the medically indigent and underinsured.

- **Refer Uninsured Veterans to the Veterans Administration Outpatient Health Center**

  The Veterans Administration has the capacity to treat and provide care to more outpatients at its Montgomery ambulatory care center. A system to identify veterans without adequate medical coverage in River Region hospitals and ERs, the MOM clinic, the HSI health centers, the UAB Internal Medicine Resident Clinic, the Baptist Health Family Medicine Clinic, the Montgomery County Jail, and the Montgomery Area Mental Health Authority (and others) must be instituted. Medically indigent veterans should be referred to the Veterans Outpatient Clinic for follow-up care. This could free up a number of appointments for uninsured and underinsured non-veterans in the already busy ambulatory health centers that provide care to the medically indigent. A meeting between the Montgomery Veterans Administration health care leadership and the medical leadership of HSI, MOM, the hospital ERs, et al to arrange a process that coordinates this process

needs to be arranged. The cost of implementing a medically indigent veteran's referral process in the River Region is negligible.

- **Establish Medical Home System**
  Strong support should be given to the Wellness Coalition as they continue efforts to meet their goal: "Every person to have a medical home." The foundation of the Medical Home System of Care is the primary care provider who partners with the patient to coordinate and facilitate care. The medical home networks would be made up of an integrated system of primary care services (including behavioral health services), specialty care groups, and hospital providers. Although anchored by a primary care provider, it will be important to view the entire network as the medical home to assure the greatest potential for coordinated management of care and services delivered.

- **Build New HSI Facility**
  The Lister Hill Health Center is housed in an aging structure whose maintenance will continue to consume already limited resources. The layout of the physical plant limits the ability of the Center to create an optimally efficient flow of patient services and interferes with the clinic's productivity. A new expanded Lister Hill that is located in a similar community, preferably the same or adjacent zip code, where there exists a patient population that is uninsured or underinsured and who currently utilize the expensive local ERs for services, could be provided in a primary care setting. It must be remembered that for an FQHC to survive it must attract significant numbers of patients who have medical coverage, especially Medicaid. While we understand that there is currently a request to directly fund a replacement facility (located near Jackson Hospital), we would recommend a new facility in or near Lister Hill's current location based on the zip code analysis. While this site may not necessarily attract the traditional Medicaid population, at least a modest increase in insured patients may result if several Medicaid expansions recommended in Section 3: Financing are implemented. HMA also believes this effort is worthy of community funding, either directly by foundations and/or governmental entities and/or bank financing and bridge financing to be arranged or guaranteed by local governments. However, any funding should be related directly to patient volume and/or expanded hours.

- **Construct Additional Comprehensive Primary Care Site(s) in Montgomery**
  The construction of additional health centers in or near zip codes that currently generate a large number of underinsured visits to the Montgomery area hospitals would definitely increase access to primary care for a number of uninsured patients. The largest number of underinsured patient visits to the three major hospitals live in zip codes 36108, 36116, 36110, 36104, 36105, 36107, and 36109.

Zip code	Jackson		Baptist South		Baptist Prattville		Baptist East		Totals	
	Medicaid	Self-pay	Medicaid	Self-pay	Medicaid	Self-pay	Medicaid	Self-pay	Medicaid	Self-pay
36108	1362	1991	2,900	2,422	162	171	572	327	4996	4911
36116	584	1015	3,178	2,911	22	39	867	728	4651	4693
36110	950	1205	754	531	69	81	840	494	2613	2311
36104	1326	1491	1,034	780	21	29	218	129	2599	2429
36105	607	863	2,014	1,641	16	27	187	169	2824	2700
36107	596	1102	338	413	22	30	310	311	1266	1856
36109	312	659	233	291	12	36	444	467	1001	1453
Subtotal	5737	7224	10,451	8,989	324	413	3,438	2,625	19950	20353

HSI currently has clinics in zip codes 36108, 36104, and 36110 (Chisholm site - mostly children). MOM's existing site is in zip code 36104. We are aware of the pending proposals to construct new facilities. HSI has a proposal to replace their Lister Hill site with a new facility near Jackson Hospital that would operate a comprehensive health center with an after-hours, non-urgent care alternative to the ER. MOM has a pending proposal to locate a facility in zip code 36116, one of the zip codes listed above that generated 4,693 uninsured visits to the ER last year. HMA believes that new facilities will need to be constructed to meet the primary care needs of the underserved populations in Montgomery and surrounding counties. This report provides the data to allow the community to make its own best decision on where additional and/or replacement facilities should be located.

- **Expand the Medical Outreach Ministries (MOM) Health Center at its Current Site**

  The MOM serves only adult patients without medical coverage. This is the patient population for whom it is most difficult to identify a consistent source of health care. These patients commonly do not have a medical home. The current MOM space limits the clinic's ability to expand services. As noted above, the location of the MOM existing site is a zip code in need of more primary care. With a physical expansion of the current space, MOM could provide services to more uninsured adults.

- **Increase the Number of Uninsured and Medicaid Patients on the Panels of the Residents at the Family Medicine and Internal Medicine Ambulatory Health Clinic**

  Both the Baptist Health Family Medicine Clinic and the UAB Internal Medicine Resident Clinic accept uninsured and Medicaid patients; however, due to the fiscal pressure of the programs, the numbers of patients in these categories are quite limited. Traditionally throughout the USA, resident outpatient clinics serve a high percentage of medically indigent patients. This is especially true in urban public hospital programs but is also the case in private and not-for-profit hospital programs. For these programs to expand the coverage of the uninsured and underinsured, they must be provided with a reliable funding source that will

support this needed service. It would be worthwhile to explore the feasibility of bringing these programs under the existing FQHC as a strategy to increase Medicaid revenues. However, there are federal requirements that must be considered as well as federal approval. It may also be worthwhile to see if there is any room for Medicaid to make IME payments to the hospital for indirect education costs with a portion to be directed here.

- **Implement School-Based Clinics**
  School-based health centers help to support treatment for relatively inexpensive services that treat children with acute and chronic illnesses. Most school-based clinics are staffed by a mid-level provider, nurses, and a clerk. They predominantly do school physicals, vaccinations, some acute care (minor injuries, viral syndromes, asthma care), and family planning education and interventions. They are most valuable in schools with a large number of children from low income families. School-based health centers have been shown to be instrumental in minimizing absenteeism for self-limited diseases. Because school-based clinics do not offer after-hours consultation or summer session services, they do not qualify as true medical homes for children; however, in partnership with an FQHC or similar partner, they have the potential to fill service gaps not only for children but for their parents as well.

- **Fund a Discharge Planner at Montgomery County Jail to Coordinate Follow-up Primary Care Appointments for Men and Women Being Released to the Community**
  The rates of acute and chronic medical and surgical illnesses in men and women detained in county jails are much higher than in similarly aged populations in the community. Coordinating needed medical care in the community for detainees being discharged from the Montgomery County Jail is part of any comprehensive safety network health care system. Sustained funding for a discharge medical care coordinator is needed.

- **Improve Access for the Medically Underserved to Specialty Services**
  With the exception of inpatient specialty consultation or an hour trip to Birmingham, the uninsured in the River Region have extremely limited access to specialty consultation and even patients with Medicaid and Medicare have diminished access to timely specialty appointments. Currently, funding from the Joint Public Charity Hospital Board, the United Way, and the "good will" of select specialists allow for some access to specialty consultation in the River Region counties. Ideally, increased federal, state, and local governmental funding for specialty care would allow for expanded or even partial financing of specialty care for the medically indigent. The potential for "write-offs" for medically indigent care is unlikely but is worth investigating.

- **Secure Grant Funding for AIDs and HIV Specialty Services**
  An additional $250,000 in one time unrestricted grant monies for the Montgomery AIDS Outreach Clinic in Montgomery would allow them to bring a like amount of additional federal funding to the community to pay for services for this population.

- **Expand Community-Based Outpatient Mental Health Services**
  Access to mental health services for the medically underserved in the River Region is extremely limited. The Montgomery Area Mental Health Authority, the Montgomery County Jail, the Veteran's Administration, and the Montgomery Primary Health Center provide mental health services to the medically underserved but the need far exceeds the capacity of these centers. This is a major public health deficiency that requires governmental attention and funding.

  In order to increase access to outpatient mental health care, there needs to be an expansion of numbers of all categories of mental health providers serving both adults and children in the River Region Counties. Additional psychiatrists, case managers, and direct care mental health workers are needed.

- **Improve Systemic Coordination of All Agencies Serving Mentally Ill Children**
  In order to effectively address the mental health needs of children, there needs to be systemic coordination by all agencies providing physical and mental health care to children. Given the limited resources, any duplication of services is wasteful and costly. All agencies must be electronically linked so that key information can be shared and readily available to maximize the delivery of care to this vulnerable population. This coordination is needed at the local, region, and state levels. Collaborating agencies should include the Department of Human Resources (DHR), Education, Public Health, Department of Youth Services, the Juvenile Judicial System, and private and public mental health centers and providers.

- **Increase Supported Housing and Community Beds for Mentally Ill Adults**
  Although there are inpatient beds being constructed to serve patients with adequate coverage, there exists a shortage of beds and supportive permanent and transitional housing for the medically indigent and underinsured. This results in the constant recycling of mentally ill adults through ERs, acute inpatient units, and Detention facilities. Until adequate access and fully staffed outpatient mental health services are available, protective and supportive housing and inpatient beds will be needed in the River Region Counties.

- **Support the Recommendations of the Region III Mental Health Taskforce**
  The State Department of Mental Health and Mental Retardation Region III Taskforce is in the final stages of formatting its recommendations concerning the mental health needs in the River Region. Their recommendations should be used to prioritize efforts to improve the access of the mentally ill to services in the River Region. *(HMA did not meet with the Taskforce but received a copy of the Taskforces' potential recommendations.)*

Emergency Room Services

- **Open Non-Urgent Care Opportunities on Campus at Baptist South and Jackson Hospitals**
  The Emergency Rooms at both Jackson Hospital and Baptist South are extremely busy. Both ERs serve a large number of patients who are "self-pay" or have Medicaid coverage. ER specialists stated that more than 40% of the ER visits are for conditions that could have been managed in a less intensive clinical setting. It is in the best interest that the hospitals develop and fund on-campus or near-campus urgent care capabilities. For example, Jackson may be able to fund an Urgent Care physician in its primary clinic setting. Baptist South could place an Urgent Care physician at one of its residency sites to deflect non-emergent patients from the ER. This, combined with the recommendations above on Access will help alleviate the issue of ER overcrowding. In addition, ERs should establish protocols to ensure that patients who present and/or are treated in the ER are referred back to a primary care setting to establish a regular medical home for these patients.

- **Create Separate Emergency Room Waiting Areas for Adults and Children at both Baptist South and Jackson Hospitals**
  Multiple providers strongly voiced their dissatisfaction with the physical environment in the ER waiting rooms at Baptist South and Jackson Hospital. The mixing of pediatric and adult patients in very congested waiting and treatment areas was unacceptable, not only to these providers, but also to many of their patients. There was discussion about the need to create different triage and treatment areas for children and adults in these Emergency Rooms.

Recruitment and Retention

- **Establish an Ongoing Health Professional Recruitment Taskforce for the River Region**
  The River Region should establish an ongoing Health Professional Recruitment Taskforce. The Taskforce will implement and track progress on the recommendations noted in this section and work closely with all the local hospitals. The Taskforce should have representation of business, government, education, medical professional education, health professional societies including medical, dental, mental health, nursing, mid-level societies, local hospitals, HSI, and other community leadership groups. Interactions with the state and federal governmental entities will require the active involvement of the Montgomery Area Chamber of Commerce and local elected officials.

- **Emphasize Positives of the River Region Counties as a Practice Choice**
  Beautiful topography
  Bountiful outdoor recreation opportunities
  The presence of the State Capitol creates a stable economic practice environment
  Even rural practices are within 30-45 minute drive of Montgomery
  2 hours from Gulf of Mexico

Variety of education choices
Proximity to Birmingham/Atlanta
Expanding cultural, recreational, culinary opportunities
Increasing community development

- **Involve Entire Community in Recruitment Process**
  The business, church, political, educational, and community leaders must participate in the recruitment of health care professionals to the River Region Counties. Hospital, group practices, and health systems must remember that they are "not just recruiting a doctor but an entire family". The Montgomery Area Chamber of Commerce, which fully understands that each physician is a million dollar business, should be fully engaged in this process and has indicated a willingness to do so if asked.

- **Continue to Expose and Encourage Young Students in the River Region to Select Careers in Health Care**
  Health professionals should regularly lecture about their careers and the health career opportunities in grammar schools, high schools, and local colleges. One of the leading reasons that medical providers and other health professionals choose a practice site is the proximity to their parents and siblings. The leaders in the River Region Counties must continually encourage and support high school, college, and health professional school students who are most likely to return to the River Region area. The River Region's Health Profession Societies must be actively involved in the coordination and ongoing implementation of this recommendation.

- **The River Region Should Provide Scholarships/Financial Assistance to Medical and Dental Students and Advanced Practice Providers (Nurse Practitioners and Physician Assistants) Students From These Five Counties**
  Even students from the River Region who are enrolled in out-of-state health profession schools should be eligible for these scholarships. Students with these scholarships will be obligated to return to the River Region for a defined number of years. Although the yearly cost per professional scholarship can exceed $30,000, it will be cost effective in the long run for the health care system in the five -county region. The Chamber of Commerce and the business community should take the lead in identifying funds for the establishment of this scholarship program.

- **Track Medical, Dental, Nursing, Health Professional Students from Alabama**
  The River Region should work with the State of Alabama to maintain a list of the students with an Alabama, and especially a River Region County, home address who are enrolled in medical, dental, nursing, and health professional schools. These students should receive ongoing communication advising them of opportunities and advantages of eventually working in central Alabama.

- **Alabama Medical, Dental, and Other Health Professional Schools Should Give Preferential Admission to Qualified In-State Students**
  This may already be happening, but qualified River Region students must be equitably represented in the enrollment classes of all the professional schools in the State of Alabama.

- **Alabama Medical, Dental, Nursing, and Allied Health Professional Schools Must be Encouraged and Pressured to Instill Medical, Dental, Advanced Practice, Nursing, Ancillary Health Students with an Accountability to Their Home Communities and Foster Linkages with Existing Health Care Providers and Hospitals in Medical Students' Home Communities**
  The State of Alabama academic health training schools have a primary obligation to strive to recruit students who represent all the communities of Alabama and to have elements of their training programs that continually expose students to the value and importance of serving their home communities.

- **Continue to Support Residency Training Programs in the River Region Area and Expand the Opportunity for Residents in Primary Care and Specialty Residencies to do Rotations in the Montgomery and River Region Practices/Hospitals**
  Physicians very commonly decide to stay in the community or hospital system where they did some or all of their residency training. Young physicians find it very attractive and less anxiety provoking if they join practices near their training programs. It is not uncommon for them to have had interactions with the area's providers and therefore to be somewhat "known quantities" to some of the physicians in the community. Residents with families may have already bonded and developed roots in the community.

- **The River Region Leadership Needs to Implement a Long Term Plan, Vision, and Commitment to the Recruitment of Health Professionals to the Five County Area**
  This will demand patience and persistence. Contact may begin with high school or college students, continuing through medical school and then 3+ years of residency. Although results may begin to be seen in 2-4 years, the lag time may be as long as 8-10 years before there would be a steady stream of physicians, dentists, and nurses back into the River Region.

- **Advocate the State and Federal Level for an Increase in the Availability of National Health Service Corps (NHSC) Scholarships and Loan Repayment Options**
  Federal scholarships during medical and dental school commit medical students to serving in underserved communities and centers for a number of years after the completion of residency training. Loan repayment programs can be obtained by physicians with outstanding private loans that financed their graduate education, if they commit to working for a specified duration of time in health manpower shortage communities and centers. These scholarships are invaluable in recruiting young physicians into needy communities. Some of these providers will stay after their obligation to the government is fulfilled.

- **Advocate at the State and Federal Levels for Medical School Expansion**
  The entire country is competing for a limited number of physicians. The medical schools are not expanding at the rate the US population is growing. A large number of qualified medical school applicants are turned away each year because

there are not enough available openings. Yet each year US hospitals have to recruit internationally to fill 20-30% of their residency positions. This issue needs to be immediately addressed at the national level. The River Region's elected officials and the business and medical leadership must be directly engaged in this recommendation that will have long range impact on the availability of health care services in the River Region.

Transportation

- **Communication Regarding Existing Services**
  During our discussions with state, regional and local transportation leaders, it was clear that there are services currently available that not everyone understands are there or how to access them. It also appeared that there is additional federal funding available for some communities to add services. While there is work going on in the community to better understand the options, this information needs to be communicated to the wider community. Churches, United Way, provider groups, and others need to fully understand the current realities and possibilities. Any forum on health care should have a transportation component. The leadership people in this area appear very knowledgeable and willing to help.

- **Improved Coordination of Services**
  Many states have gone to a network management system or "brokerage" concept for Medicaid transportation. This could be expanded to all populations in the River Region, assuming a funding source can be found for indigent care transportation. This "broker" would be responsible to assure the underserved, "hard to reach" geographical areas had adequate options for transportation to medical appointments. The network manager would establish a call center to manage the efficient operation of the type of transportation needed and to make sure it was timely. The broker would be responsible for the quality of service provided through a network of commercial, not-for-profit, and volunteer resources. It could also work cooperatively with Medicaid to compare transportation claims to medical claims to not only identify fraud, but also guarantee program integrity.

  The state pilot program in Lee and Russell Counties should also be monitored for potential implementation in the River Region. This program breaks down the funding silos that have limited certain transportation based on population group or service creating inefficient use of scarce resources.

IT Infrastructure

- **Implement an Information System to Effectively Share Clinical Information Between the Providers of Care to the Medically Indigent**
  Integrating the health information systems of the various hospitals and clinical services that provide care to the medically indigent and underinsured in the River Region Counties would have an immediate and ongoing positive impact on the

continuity and quality of care throughout the River Region community. There would be significant cost savings. If the existing systems cannot be readily integrated, then placing a computer terminal or linkage in each clinical setting where care is frequently provided to the medically indigent should be done. Clinical sites that should be priorities for the sharing of medical information include the hospital Emergency Rooms, the HSI health centers, MOM, Montgomery AIDS Outreach, the Montgomery Area Mental Health Authority, the Montgomery County Jail, and other private and public clinical settings where the uninsured and underinsured receive care. Medicaid currently has a number of initiatives in this area. To the extent it involves patients who receive Medicaid funding, one of these initiatives may help or a new initiative could receive some federal reimbursement if coordinated through Medicaid.

- **Support Wellness Coalition Efforts**
  The Coalition has a goal to identify funding for information technology (IT) that will enable them to integrate patient information into a shared database. This would not only help to avoid duplication of services but would provide the data needed to track important indicators of well-being in the uninsured population. This is a superb project that needs to be aggressively encouraged and supported.

Community Wellness and Health

- **Teach, Facilitate, Encourage, Enable, and Legislate Healthy Lifestyles**
  There is universal agreement that teaching, facilitating, encouraging, and enabling healthy lifestyles is the most cost effective and logical approach to improving the health of all individuals and communities. Healthy children are better positioned to succeed in school and are more likely to become healthy adults. Healthy adults are more productive members of the workforce and consume fewer health care resources. It is the obligation of levels of society, business, and government to insure that all communities have accessible and safe parks, walking paths, bike paths, community centers and recreation centers. All individuals of all ages must be consistently provided with information about healthy diets and promote healthy foods. Schools are important settings to provide health education and serve only healthy lunches and snacks. Health is the responsibility of everyone in every community.

- **Support Community Efforts to Establish Youth Fitness Centers in the River Region**
  Children who complete programs that encourage fitness and healthy lifestyles will not only be better prepared to maintain a healthy lifestyle, but may also be an effective conduit for bringing healthy education and healthy habits back into their families. The YMCA is implementing one example of such an effort. They are establishing Youth Fitness Centers at nine YMCA's in Montgomery and Elmore Counties. After-school programs of eight weeks duration will be given to groups of 8-12 primary school children. The program will include exercise training and

exercise habit development, use of exercise equipment, utilization of interactive exercise video games, provision of nutritional snacks, and health food education.

Section 3: Financial Analysis

Medicaid

To understand the financing of health care for low income individuals, it is important to understand a little about Alabama Medicaid, the state and federal partnership that funds health care for low-income populations.

In 2006, the most recent year for which data is available, total state and federal Medicaid spending in Alabama was nearly $3.9 billion. Of this amount, approximately $2.1 billion was spent on acute care services, while $1.3 billion was spent on long term care services. An additional $416 million in disproportionate share hospital (DSH) payments were also made. With a federal matching rate of 69.51 percent in 2006, the state share of overall Medicaid spending was roughly $1.2 billion.

The state's share of Medicaid spending is funded through two primary sources: general fund appropriations and "other state funds". General fund appropriations represent only 32 percent of the state share, with the remainder composed of public hospital transfers (36 percent), departmental receipts and intergovernmental transfers (17 percent), other sources, such as drug rebates and the Medicaid Trust Fund (11 percent) and the Alabama Health Care Trust Fund (4 percent). The Medicaid Trust Fund is supported by funds appropriated to the Medicaid Agency from any source which has not been expended or encumbered at the end of any fiscal year, while the Alabama Health Care Trust Fund is supported by a tax levied on all providers of pharmaceutical services and nursing home care.

Because a relatively small percentage of Alabama's Medicaid program is financed through general fund appropriations, the state's use of "other state funds" has come under considerable federal scrutiny. In particular, the state's aggressive use of the DSH program, intergovernmental transfers (IGTs) and provider taxes to finance the bulk of the state match for Medicaid has been subject to a number of reviews by federal oversight agencies. Reports issued in 2004 and 2005 by the Department of Health and Human Services Inspector General's office called into question the state's compliance with federal DSH and upper payment limit rules and recommended that the state return more than $73 million in overpayments to Alabama health care providers. The primary objection raised by the federal government was the lack of transparency in the state's distribution of DSH funds and Upper Payment Limit (UPL) payments. Under the state's current payment structure, DSH funds are folded into the capitation rates paid to the state's eight prepaid health plans (PHPs). This structure enables the PHPs to distribute DSH payments as they choose and without regard to federal rules.

While the state has historically disagreed with the federal government's assessment, the state has agreed to eliminate the PHP hospital reimbursement program and replace it with a new hospital payment system. At the outset of the planning for this new system in January 2008, the state has announced its intention to implement a system that will be "budget neutral" for the hospital program.

In addition, the state has undertaken a number of redesign initiatives, ranging from pharmaceuticals to IT infrastructure. The state has been and continues to be a creative and resourceful organization. Our discussions with them indicated they were willing to listen to new ideas and implement them if practical and within federal constraints.

State Budget and Constitutional Issues

No discussion of public financing of health care in Alabama would be complete without a discussion of the constitutional impediments to developing a new health care financing strategy.

Unlike the United States Constitution, which delegates taxing authority to Congress, the Alabama Constitution contains hundreds of tax provisions that limit the type and level of taxes that can be imposed. Among other provisions, the Constitution caps the state's income tax rate, mandates certain deductions, delineates the process for assessing the value of property and strictly limits property tax rates. Neither the state legislature nor local governing bodies have taxing authority, leaving many changes in the tax system subject to a constitutional amendment passed by voter referendum. As a result, Alabama's constitution has more amendments than any other state constitution.

Expenditures of tax revenues are similarly restricted, as the state earmarks more of its revenue through constitutional or statutory provisions than any other state. With nearly 90 percent of state revenues earmarked, flexibility to reallocate tax revenue to meet changing financial needs is severely restricted. Constitutional impediments to taxing and spending have limited the state's ability to respond to the needs of its people, particularly those related to health care. While this has been a longstanding problem in the state, it is likely to be felt more acutely as the state begins to examine options for replacing its current hospital payment system. The share of state general funds allocated for Medicaid is already low in comparison with other states and the potential loss of DSH and UPL payments supported by "other state funds" could have a devastating effect on the Medicaid program.

Hospitals

The financial health of a community's hospitals is often seen as a barometer for the soundness of the health care system at large, and in some cases, is a predictor for issues that will arise in the future. Therefore, any financial analysis related to health care in a particular region must include the area's hospitals. An analysis of issues affecting hospital finances reveals some issues that will bear watching; however, it does not appear necessary to push the "panic button" at this time. This does not mean there are not issues, nor does it mean that there are not steps that should be taken to shore up the financial situation of the hospitals. It may be the case, however, that there are other issues extrinsic to the hospitals themselves that have a greater impact on the indigent and uninsured populations of the area.

Since the Baptist hospital system and the Jackson hospital system are the two major hospital providers in the River Region, the bulk of this discussion focuses on these two players. In addition to representatives from Baptist and Jackson, HMA met with

executives from both Hospitals in Elmore County and conducted a desk review of documentation from these hospitals. Representatives of Community Hospital in Tallassee indicated a desire to improve that hospital's financial situation. Specifically, while they expressed concern over their ability to maintain their capital assets, carry indigent patient loads, and recruit physicians, our review indicates that they appear stable at this point. Both hospitals in Elmore County, as well as the Baptist Prattville facility, are affected by the decisions made by providers based in Montgomery in the area of trauma care, primary care competition and specialty physician services. These will be discussed later in this section.

Baptist Hospital System

Baptist recently became part of a Health Authority under the University of Alabama-Birmingham (UAB). In addition to creating changes in leadership and governance, this new arrangement bestows some financial advantages on the hospital. The Baptist system history is not recounted here; however, it is important to note that the system expanded during a period when market prices for hospitals were at a premium, and there was a later retrenchment when the market was down. The net result is that the system has an unusually high debt load for an organization with its asset profile. At the same time, Baptist has significant cash and investment balances – that are well above similarly situated providers. While the cash on hand gives the system a cushion in the short run, the debt load will continue to be a long-term challenge. The net result is that the trend in payer mix and the age of the physical plant, while important to all providers, is especially important to Baptist. In addition it will be critical to maintain volume to keep the capital cost component from increasing.

While patient volumes in the facilities have been consistent and growing, the average age of plant is 12.2 years which is much higher than desired. Payer mix has also weakened. While the proportion of self-pay patients has climbed at all facilities over the past three years, it is of particular concern at South and Prattville, where it has reached 11% and 12% respectively. While these would be exceptionally positive numbers at a public hospital receiving tax support, they are more than double what is expected at a private hospital. This issue is compounded by the fact that Medicare rates in this metropolitan statistical area (MSA) are lower than most of the rest of the country. It should also be noted that South and East have Medicaid utilization rates of 16% and 14%, respectively. The private insurance numbers for Baptist in 2007 ranged from a low of 35% at South to a high of 49% at East. The dominant commercial carrier is Blue Cross, which represents about 75% of the commercial business at these hospitals. This extraordinary leverage position most likely leads to less cost shifting opportunity than in most markets. An added challenge is the need for the State to restructure some critical programs, particularly inpatient and supplemental payments including disproportionate share hospital payments.

In spite of the challenges cited above, Baptist has been able to maintain good financial performance. Prattville's margin was only in the 2.5% range in 2007. While this performance is good, it may not be strong enough to justify building a new hospital. Baptist East has performed most strongly, with a margin of almost 11% in 2007. While this margin is budgeted to decrease in 2008 to around 8%, it is still a very strong

performance. Baptist South lost money from operations in 2007 for the first time in the last three years. While the Hospital is budgeting an improvement in 2008, it still projects a loss from operations. The facility's non-operating earnings, including investments, more than made up for the loss. While the operating income has been eroding, the non-operating income has kept their total net income above 10% for the last two years. It is important to note that the 2008 budget projects this margin to drop to just over 6% in 2008.

The Baptist system is critical to the stability of the health care system in the River Region. Based on the financial information we have reviewed, it appears to be a stable system in no immediate jeopardy, however, there are long term issues related to a continued decline in payer mix, the plant age, and debt structure. These factors make it more difficult for the system to move quickly to invest in services needed by the community, particularly trauma, without some relief in the future.

Jackson Hospital

Jackson Hospital has experienced improved financial results over the last three years despite a growth in self-pay patients as a percentage of total volume. The hospital's operating margin has only been around 2%, but the total margin has climbed above 3.5% for the year that ended in February 2007. Uncompensated care, including bad debts has grown from 6.7% in 2006 to 7.8% in 2007, with all the growth attributed to charity care. It is important to note that, through the first 6 months of the 2008 fiscal year, uncompensated care returned to a level more consistent with prior periods despite a growth in self pay revenue. Still, the level of uncompensated care is above national averages for private hospitals. Both Medicare and Medicaid revenues have been relatively stable, although Medicare revenues have shifted somewhat to HMOs. Consistent with the Baptist experience, however, Blue Cross is the dominant commercial payor, accounting for 75% of the hospital's commercial insurance (including HMOs) volume. This level of dominance limits the hospital's ability to cost shift to assist in caring for patients funded through governmental sources or without coverage. Jackson's cash balances, while not as strong as Baptist's, are consistent with a healthy hospital, even after coping with a transition to a new IT system. Volumes continue to improve, although the average age of the plant remains a concern. While lower than Baptist, at 9.3 years, it remains higher than the ideal average age.

On balance, Jackson Hospital has seen its financial situation improve over the last few years. While the high self pay volume is less than ideal and has contributed to a less than optimal margin, Jackson's financial viability may be somewhat at risk. Further, its average age of plant exceeds the desired level. However, with strong days, cash on hand and improving margins, it appears stable. This can all change when Medicaid makes its required changes in response to federal rules, as Medicaid accounts for nearly 10% of the volume at Jackson.

Other Regional Hospitals

Decisions made in Montgomery, along with the status of Baptist and other hospitals, have significant impact on all patients in the region. The lack of a strong trauma service in Montgomery has created problems for the surrounding hospitals' emergency departments

and for their overall ability to provide care. HMA heard anecdotal accounts of individual cases that were held up in emergency rooms in smaller communities because no hospital in Montgomery hospital would accept the patient, creating situations in which the physicians were kept from being available to other patients. Smaller community Emergency Rooms are increasingly busy due to population changes and changes in practice patterns of primary care doctors. More and more emergency patients are being transferred to Birmingham or even out of state, and this trend is seen in elective care as well. If this trend continues, it will become even more difficult to maintain specialty services in Montgomery at the current levels.

Specialist Community

The stronger the specialist community is in Montgomery, the more likely some specialty services can be provided in more rural settings leading to increased vitality for providers and a steady referral base for Montgomery. It is important to coordinate and not duplicate services, since in areas where resources are always going to be thin, any duplication is problematic. This can be especially true in primary care, where the need for resources closer to the patients will always exceed the ability to pay for them. Past practices such as locating competing practices in close proximity to each other in very small communities are unacceptable, and should be avoided through improved communication and planning.

Section Three Recommendations

As stated above, issues identified in other sections of the report may have a more immediate impact on the ability of the uninsured and underinsured residents of the River Region to access care. Chief among these are workforce issues, including the increasing average age of primary care providers and specialists. Clearly, these issues are intertwined with the financial health of hospitals and the system at large. Sections 1 and 2 include specific recommendations relating to these issues. If some or all of these recommendations can be implemented, then the strain on hospitals that is created by over-utilization of the ER can be reduced. Without some attention to increasing the amount of sustainable financing for the system at large, however, the efficacy of the strategies identified elsewhere will be limited.

The goal of these strategies is to protect and sustain the region's financial resources in the long term, thus allowing the flexibility to more aggressively recruit health care professionals to the community and provide needed expensive services like trauma.

Creation of a Health Authority

The first issue to be explored is one that has already been utilized in the case of Baptist: converting to a Health Authority. The immediate benefits of this approach are an exemption from sales tax and a likely exemption from antitrust regulations in working with other providers in the region. A Health Authority also carries with it a potential to increase some reimbursements. There are two types of Health Authorities: one organized under a city or county, which appoints the majority of the Board, and another organized under one of the Universities, which would appoint the majority of the Board.

While the sales tax savings alone is significant, there are other advantages to converting to a health authority as well. Private hospitals that can coordinate with public hospitals for the provision of care create both positive reimbursement potential and flexibility in meeting the needs of the community. Potential barriers to pursuing a health authority strategy are presented by Jackson Hospital, which is clearly not interested in ceding control to a Health Authority Board and new federal rules regarding reimbursement to public entities, which need to be taken into consideration.

Expansion of Medicaid Eligibility

Another strategy with significant potential to increase funding to the entire system is to expand Medicaid eligibility. Under federal law, Medicaid eligibility can be conferred to groups of individuals considered "categorical," i.e., children, parents, pregnant women, and the aged, blind and disabled. Non-pregnant, non-disabled adults without dependent children cannot be made eligible for Medicaid without a waiver of federal Medicaid rules.

In light of the discussions above regarding the constitutional financing structure and the current status of the Medicaid budget, HMA understands that there is no appropriation of general fund monies available to pay for an expansion. The potential tripling of available resources resulting from a Medicaid expansion must be strongly considered, particularly since there are a variety ways of creating the state share of payments. Currently, many county tax revenues are utilized to generate match. While the local tax situation does not make it reasonable to expect new taxes to be raised for this purpose, as funds become available at the county level (primarily through expiring debt payments), Montgomery County should consider redirecting this money to a local Medicaid expansion. HMA's discussions with representatives of the State Medicaid agency indicate they would be willing to consider this approach, and we believe that other communities would choose to participate as well, creating a statewide network. In the meantime, the match for an expansion should be sought by re-examining all funding streams for matchability and considering a regional hospital tax to pay for coverage.

It is also important to understand that Medicaid expansions bring the added benefit for hospitals of potentially increasing their Medicare reimbursement. This occurs because the Medicare program pays an additional amount for the care of Medicare recipients to hospitals with higher Medicaid utilization. If the goal is to spread Medicaid patients to all providers willing to care for them, then a regional tax will make the most sense. If this is not possible due to constitutional constraints or other hospital tax issues, another option would be to involve the state to assume a portion of the costs of educating health care professionals at state supported schools. In either case, a certain amount of state match can be generated. Using rough calculations, if the State could generate $12 million in match, it would create $40 million to cover approximately 10,000 people. As explained above, this approach works for categorically covered individuals. Another way to finance the expansion would be to limit the network for this new group of eligibles to Health Authority hospitals and clinics. This would require a waiver to limit choice, but could be replicated across Alabama. Health Authority providers could certify the match for this population and be paid about 70% of their cost for serving this expansion population.

Childless adults would still not be covered under these plans. It is not practical to seek a federal waiver to cover these populations due to the impact on the entire provider community in Alabama, as funding for this program would require coordination between the hospitals. If the Health Authority would fund the state share of a Medicaid supplementary payment which would be limited to the state upper payment limit for private hospitals, additional funds would flow to Jackson Hospital. If Jackson were willing to fund a program for indigent health care purchased from a third party, it would be possible to create an insurance-like program for childless adults. The funding here will not be able to meet all the need, but by covering some patients an opportunity is created for HSI and others to direct the limited resources available to the remaining indigent.

These programs would not only benefit the Hospitals, but would also move many HSI and UAB Residency patients from indigent care to Medicaid. They would also create a payment source for specialists, although, many specialists would still be reluctant to care for these patients at the reimbursements available. At the same time an enhancement to physician rates could also be created. Euphemistically called the physician UPL program, many states provide higher rates for those who treat larger than average Medicaid populations. This approach has been primarily utilized for Faculty practice plans, but it could be adapted here as required, possibly for specialists willing to take trauma call or more than a specified number of Medicaid referrals. Our understanding from another consultant active in Alabama is that Alabama has a program, but it has not been available in the River Region because of a lack of a host partner.

Coordination of Action

If the community is going to make the health care system for all residents of the River Region a priority, then some method for monitoring progress and assuring the system works must be implemented. Avoiding duplication of effort and unnecessary and unproductive meetings is critical to continued buy-in by stakeholders. We recommend taking advantage of existing resources wherever possible. The leadership group must have broad representation, but be small enough to get things done. It must also have the ability to develop influence or actual authority over resources, and balance provider needs, community needs, and the requirements of government. We would suggest the following structure:

Coordinating Council

Representatives from:

1) Montgomery County Commission
2) Montgomery Mayor's office
3) Rotating member from one of surrounding counties governments
4) A primary care physician
5) Two specialists, one hospital based and one other
6) HSI
7) Ministerial group
8) Montgomery Area Chamber of Commerce
9) Rotating member from Gift of Life/MOM/etc
10) Montgomery hospitals' CEOs

11) Rotating member from Elmore County hospitals' CEOs
12) River Region United Way
13) Envision 2020
14) State Public Health Department

This group should be chaired by a non-provider as recognition that this is a community issue and not solely a health care system issue. The *chairperson* should be a strong leader who is respected by the community and has recent experience in both business and government.

Committees will be key to move the agenda forward. HMA's recommendations for the committee responsibilities appear below. In cases where HMA has a recommendation regarding who should chair the committee, this is included in the recommendation.

Research and Education should be chaired by Envision 2020. ARISE may be the organization to be hired to do particular pieces of the research. This committee should be charged with public awareness campaigns as well as reporting on progress of health status.

Transportation should be a committee until a broker type arrangement could be created.

Finance committee should be created to follow up on expansion and physician UPL programs. It should also be their responsibility to work with Medicaid and local players to assure the match mechanism works and provides sufficient match.

School-Based Health should be chaired by a representative from the Public School District and should include both Hospitals and HSI. (Note: there are a number of funding sources available through Medicaid and others and we would be willing to give them people they can talk with.)

Physician Recruitment coordinating group should not interfere with individual efforts to recruit physicians, but should help coordinate efforts to organize the efforts of the community. These would include the business community, churches, social organizations and schools.

These committees would need to meet at least monthly to start, with most of the work conducted outside the meetings. Once operational, these committees would either disappear or reduce to quarterly meetings.

The childless adult medical program will require a small infrastructure of its own. Ideally, someone like Blue Cross/Blue Shield of Alabama would donate or at least significantly discount the enrollment and third party administrator functions. If not them, potentially UAB or the Public Health Department might have these resources within their system. While the results of this activity should be reported to the larger group, this work is not for committees.

Appendices

Appendix A: Top 22 Service Sites by ER Visits/Zip Codes, 2007

Top 22 Service Sites by ER Visits/Zipcodes 2007

	Jackson		Baptist South		Baptist Prattville		Baptist East		Totals		HSI unique
Zip code	Medicaid	Self-pay	Medicaid	Self-pay	Medicaid	Self-pay	Medicaid	Self-pay	Medicaid	Self-pay	Patients by Zip
36108	1362	1991	2900	2422	162	171	572	327	4996	4911	4978
36116	584	1015	3178	2911	22	39	867	728	4651	4693	3646
36110	950	1205	754	531	69	81	840	494	2613	2311	2857
36104	1326	1491	1034	780	21	29	218	129	2599	2429	2477
36105	607	863	2014	1641	16	27	187	169	2824	2700	2336
36040	125	143	369	302	3	3	80	29	577	477	1423
36107	596	1102	338	413	22	30	310	311	1266	1856	1370
36117	190	452	320	350	6	35	944	884	1460	1721	1146
36067	137	232	238	201	2637	2171	109	102	3121	2706	1037
36111	141	303	725	706	11	10	155	99	1032	1118	846
36109	312	659	233	291	12	36	444	467	1001	1453	782
36092	109	209	147	139	168	164	174	175	598	687	701
36106	247	526	229	242	12	8	137	121	625	897	512
36054	61	127	118	117	852	687	76	69	1107	1000	422
36069	19	26	114	87	1	1	38	24	172	138	418
35045	1	5	7	9	25	65	1	3	34	82	378
36043	64	106	165	147	16	11	41	33	286	297	
36785	16	21	44	30			7	6	67	57	
36752	32	26	64	50	11	10	20	15	127	101	
36078	31	53	42	28	4	2	64	66	141	149	283
36024	7	22	25	30	8	9	33	15	73	76	263
36003	0	0	20	16	224	148	1	6	245	170	262
Subtotal	6917	10577	13078	11443	4302	3737	5318	4272	29615	30029	
Total ER Visits	7559	12175	14369	13102	6061	5524	6294	5434			

Appendix C: Interview List

Title	First	Last	Business Title	Organization
Ms.	Robin	Barca	Chief Operations Officer	Baptist Health
Mr.	Stan	Barnard	Clinical Director	Montgomery Area Mental Health Authority
Dr.	Harry (Mac)	Barnes	Executive Director	Montgomery Cancer Center
Dr.	Steve	Barrington		Orthopedics
Dr.	Johnny	Bates	Inmate Physician	Montgomery County and Autauga County Jails
Ms.	Tracey	Bates	RN	Montgomery County Jail
Ms.	Carolyn	Bern	Outreach Coordinator, Office of Primary Care & Rural Health	AL. Dept. of Public Health
Ms.	Lynn	Beshear	Executive Director	Envision 2020
Dr.	Robert	Beshear	Pediatrician	Children's Hospital of AL
			Co-Founder	Gift of Life Foundation
Dr.	Cynthia	Bisbee, PhD	Acting Executive Director	Montgomery Area Community Wellness Coalition
Ms.	Rosemary	Blackmon	Chief Operations Officer	Alabama Hospital Association
The Honorable	Bobby	Bright	Mayor	City of Montgomery
Rev.	Paul	Britner	Minister	Unitarian Universalist Fellowship
Ms.	Carol	Brown	Partner (lobbyist)	Southern Strategy Group of Alabama
Mr.	Jim	Brown	Sr. Vice-President of Customer Relations & Information Services	Blue Cross Blue Shield of Alabama
Ms.	Susan	Bruchis	Director	Montgomery Cancer Wellness Foundation
The Rev.Dr.	Lawson	Bryan	Senior Minister	First United Methodist Church
Ms.	Anna	Buckalew	Senior Vice-President	Montgomery Area Chamber of Commerce
Ms.	Mindy	Burdick	Administrator	Baptist Health East
Councillor	David	Burkette		Montgomery City Council
Ms.	Carol	Butler	Executive Director	Central Alabama Community Foundation
The Honorable	Jim	Byard	Mayor	City of Prattville
Mr.	Billy	Canary	CEO	Business Council of Alabama
Mr.	Jim	Carnes	Publications Director	Alabama ARISE & Arise Citizens' Policy Project
Mr.	Doug	Carter	Chief Financial Officer	Baptist Health
Mr.	Barry	Cavan	Director	Catholic Social Services
Ms.	Susan P.	Chambers	Assoc. Commissioner for Mental Illness	AL Dept. of Mental Health and Mental Retardation
Mr.	Jeff	Clark		Catholic Social Services
Ms.	Pat	Clay	Chair	Macon County Healthcare Authority
Ms.	Irene	Collins	Commissioner	Alabama Department of Senior Services
Mr.	Charlie	Colvin	Executive Director	River Region United Way
Ms.	Portis	Cunningham	Social Worker	First United Methodist Church
Dr.	Leon	Davis	Founder & Director	Community Care Network
Commissioner	Elton	Dean	Vice-Chair	Montgomery County Commission
Ms.	Tracy	Delaney	Consultant	South Central Alabama Regional Planning Commission
Rev.	Susan	Diamond	Minister	First Christian Church
Mr.	John	Dilworth	Superintendent	Montgomery Public Schools
Senator	Larry	Dixon	Executive Director	Alabama Board of Medical Examiners
Dr.	Jayson	Dorey	Radiology; President	Medical Society of Montgomery County
Mr.	Jeff	Downes	Assistant to the Mayor	City of Montgomery
Dr.	Olan	Evans		Otolaryngology
Mr.	Gordon	Faulk	CEO	Elmore County Community Hospital

Mr.	Joe	Faulk	Chair	Elmore County Commission
Mr.	Lloyd	Faulkner	Finance Director	City of Montgomery
Ms.	Jane	Ferguson	Social Worker	First Baptist Church
Ms.	Mary	Finch		AL. Primary Health Care Association
Mr.	Kimble	Forrister	State Coordinator	Alabama ARISE
Mr.	Doug	Freeman	Civil Law Clerk	Office of Judge Tracey McCooey
Mr.	Dell	Gamble	Director of Operations	Care Ambulance Service
Mr.	Thomas	Gilliland	Incoming Chair	Montgomery Cancer Wellness Foundation
The Honorable	Jo	Glenn	Mayor	City of Wetumpka
Mr.	Steve	Golson	Finance Director	Autauga County Commission
Ms.	Bianca	Granger	Clinical Operations Director	Health Services Inc.
Mr.	Joe	Greene	VP of Military & Government Affairs	Montgomery Area Chamber of Commerce
Mr.	Ken	Groves	Director	City of Montgomery Planning & Development Department
Ms.	Patsy	Guy	VP of Member & Investor Relations	Montgomery Area Chamber of Commerce
Dr.	Ellis	Hall	Board of Directors	Macon County Healthcare Authority
Ms.	Sallie	Hand	Asst. Treasurer/ Administrator	Autauga County Commission
Dr.	David	Harwood		Psychiatry
Ms.	Dawn	Hathcock	VP of Convention & Visitor Bureau	Montgomery Area Chamber of Commerce
Mr.	Don	Henderson	President & CEO	Jackson Hospital & Clinic, Inc.
Ms.	Ginger	Henry	Administrator	Baptist Health Prattville
Ms.	Carol	Hermann-Steckel	Commissioner	Alabama Medicaid Agency
Dr.	David	Herrick		Anesthesiology & Pain Management
Ms.	Carol	Herron		Catholic Social Services
Rev.	John	Hillary	Minister	Love & Peace Baptist Church
Dr.	Albert Z.	Holloway	Chair	Joint Public Charity Hospital Board
			President	AL Chapter of American Academy of Pediatrics
Mr.	Mike	Horsley	CEO	Alabama Hospital Association
Mr.	John	Houston	Commissioner	AL Dept. of Mental Health & Mental Retardation
Mr.	Tyson	Howard	Executive Director	South Central Alabama Development Commission
Mr.	J. Kent	Hunt	Assoc Commissioner for Substance Abuse	AL Dept. of Mental Health and Mental Retardation
Mr.	David	Ingram	Area Manager	Care Ambulance Service
Commissioner	Reed	Ingram		Montgomery County Commission
Councillor	Charles	Jinright	President	Montgomery City Council
Ms.	Martha	Jinright	Executive Director & Program Director	Gift of Life Foundation
Commissioner	Carl	Johnson		Autauga County Commission
Ms.	Heather	Johnson	Clinical Quality Management	Tallassee Community Hospital
			Board Member	Montgomery Area Community Wellness Coalition
Dr.	Henry	Johnson		OB/GYN
Rep.	Ronald	Johnson	Vice Chair	House Committee on Health
Mr.	Douglas	Jones	VP of Small & Minority Business Development	Montgomery Area Chamber of Commerce
Ms.	Vicky	Jones	Vice-President	Jackson Hospital & Clinic, Inc.
			Board Member	Montgomery Area Community Wellness Coalition
Mr.	Mike	Jordan	Associate Executive Director	Alabama Nursing Home Association
Mr.	Ben	Kelley	Vice-President	Baptist Health

			Executive Director	Baptist Health Care Foundation
			Board Chair	Montgomery Area Community Wellness Coalition
Rev.	Charlie	Kendall	Minister, Community Ministries	Frazer Memorial United Methodist Church
Dr.	Thomas G.	Kincer	Program Director	Family Medicine Residency Program
Rep.	John	Knight	Chair	AL House Committee on Government Appropriations
Mr.	Cary	Kuhlmann	Executive Director	Medical Association of the State of Alabama (MASA)
Mr.	Chuck	Lail	Director	Office of Primary Care & Rural Health
Rep.	Richard	Laird	Member	AL House Committee on Health
Councillor	Tracy	Larkin		Montgomery City Council
Dr.	Stuart	Lockwood	State Dental Director	AL Department of Public Health
Dr.	Rick	Love		Otolaryngology
Dr.	Wick	Many	Program Director	UAB Health Center Montgomery Internal Medical Residency Program
Mr.	Bernell	Mapp	CEO	Health Services Inc.
Ms.	Amanda	Martin	Director, Health Professional Shortage	AL. Dept. of Public Health
Mr.	Gordon	Martin	Immediate Past Chair	Montgomery Area Chamber of Commerce
Mr.	James	Martin	Administrator	Montgomery County Health Department
			Board Member	Montgomery Area Community Wellness Coalition
Mr.	Maurice	Mayes	Clinic Director	American Family Care Bellwood
Judge	Tracey	McCooey	Circuit Judge	15th Judicial Circuit
Mr.	Bob	McGaughey	President, CEO	Montgomery YMCA
Mr.	Chris	McInnish	Deputy Commissioner	AL Dept. of Children's Affairs
Dr.	Julian	McIntyre	Chief Medical Officer	Health Services Inc.
Ms.	Margaret	McKenzie	Policy Analyst	Advisor to Gov. Riley on Health & Human Services
Dr.	Wayne	McMahan	Executive Director	Alabama Dental Association
Ms.	Tina	McManama	VP of Marketing & Communications	Montgomery Area Chamber of Commerce
Ms.	Jeanette	Medders	County Administrator	Elmore County
Mr.	Kelvin	Miller	General Manager	Montgomery Area Transit Authority
Rep.	Michael	Millican	Chair	AL House Committee on Health
Mr.	Donnie	Mims	County Administrator	Montgomery County Commission
Dr.	David	Montiel		Radiology
Dr.	John	Moorehouse	President	Alabama Emergency Room Services
Mr.	Rod	Morgan	Finance Director	City of Prattville
Mr.	Mike	Murphree	Executive Director	Montgomery AIDS Outreach
Dr.	Steven	O'Mara	Medical Director	Jackson Hospital ER Department
Dr.	Kevin	Pace		Anesthesia
Ms.	Lynne	Parker	Administrator	Baptist Health South
The Honorable	Bobby	Payne	Mayor	City of Tallassee
Dr.	Dennis	Pearman	Medical Director	Medical Outreach Ministries
Mr.	Mark	Platt	Chief Operations Officer	Baptist Health
Ms.	Karina	Polen-Davis	Executive Director	Community Care Network
			Goals Committee Member	Montgomery Area Community Wellness Coalition
Commissioner	Dimitri	Polizos		Montgomery County Commission
Ms.	Camilla	Prince	Executive Director	The Volunteer & Information Center
Dr.	Walter	Pugh	Volunteer Director	Medical Outreach Ministries (MOM)
Dr.	Robert	Ratliff	Interim Medical Director	VA Health Care System

Ms.	Jennie	Rhinehart	CEO	Tallassee Community Hospital
Dr.	Kanini	Rodney	Chief Medical Officer	Community Care Network
Ms.	Sharon	Roten	Clinic Director	Medical Outreach Ministries (MOM)
Dr.	Patrick	Ryan		Neurosurgery
Mr.	Lee	Sanders	Coordinator	United We Ride, AL Dept of Senior Services
Ms.	Pat	Schloeder	Nurse Manager	Montgomery County Health Department
Mr.	Ed	Scholl	Chief Financial Officer	Jackson Hospital & Clinic, Inc.
Councillor	Charles	Smith		Montgomery City Council
Mr.	Robert	Smith	Transportation Planner	City of Montgomery - Department of Panning & Development
Dr.	Wil	Smith		Orthopedics
Rabbi	Elliot	Stevens	Rabbi	Temple Beth Or
Mr.	Allen	Stewart	Director	Greil Memorial Psychiatric Hospital
Mr.	Henry	Stough	Executive Director	Mid-Alabama Coalition for the Homeless
			Board Member	Montgomery Area Community Wellness Coalition
Commissioner	Todd	Strange	Chair	Montgomery County Commission
Dr.	Gerald	Sweeney	ER Director	Elmore Community Hospital
Dr.	Stewart	Tankersley		Family Practice
Mr.	Jim	Taylor		Care Ambulance Service
Dr.	David	Thrasher		Pulmonologist
Mr.	Bill	Tucker	Director	Central Alabama Regional Planning & Development Commission
Ms.	Ruby	Turner		Freewill Baptist Church
Mr.	Russ	Tyner	President & CEO	Baptist Health
Ms.	Julia	Ventress	System Vice-President	Baptist Health
Ms.	Michelle	Waren	Communications Director	Alabama Dental Association
Ms.	Mary	Weidler		Joint Public Charity Hospital Board
			Board Member	Montgomery Area Community Wellness Coalition
Mr.	George	Waldrop	Chief Financial Officer	Health Services Inc.
Lt.	Michael	Whaley		Prattville Fire Department (Ambulance Service)
Dr.	John	Wheat	Director	Univ. of AL College of Community & Rural Medicine
Dr.	Walter	White	Executive Director	Family Guidance Center
Dr.	Donald	Williamson	State Health Officer	Alabama Department of Public Health
Mr.	Tommy	Wright	Executive Director	Montgomery Area Mental Health Authority

Appendix D: Documents Reviewed

1. Experimental Small Area Health Insurance Estimates by County; *US Census Bureau Health Insurance Coverage Status by Age for Counties and States: 2000 Census Bureau Website*

2. Aged-2005 Enrollment, Reimbursement, Per Capita Cost (Monthly) and 2005 Demographic factors for Hospital and Supplementary Medical Insurance by State and County of Residence, Persons Aged 65 and Older

3. Age by Ratio of Income in 1999 to Poverty Level [144]; *US Census Bureau 2000 Census for Population and Housing, Summary File 4, Table PCT144, Census Bureau Website* (8 charts detailed by race)

4. Estimated Population by Age and Race, 2006; *US Census Bureau, County Population by Age, Sex, Race, and Hispanic Origin: April 1, 2000 through July 1, 2006, Census Bureau Website*

5. The Status of Primary Healthcare in Macon County; *The Alabama Medical Consortium*

6. The Status of Primary Healthcare in Lowndes County; T*he Alabama Medical Consortium*

7. Selected health status indicators, Central Alabama action commission; *The Office of Primary Care and Rural Health, Alabama Department of Public Health and The Alabama Rural Health Association*

8. Indicators of Health Status in Alabama, Health Diseases Mortality; *The Office of Primary Care and Rural Health, Alabama Department of Public Health and The Alabama Rural Health Association*

9. Selected Health Status Indicators, County Specific Data; *The Office of Primary Care and Rural Health, Alabama Department of Public Health and The Alabama Rural Health Association*

10. Physicians' Alabama Opportunity Fair; *Informative Pamphlet*

11. A Snapshot of the Alabama Office of Primary Care Rural Health; *Alabama Department of Public Health, Office of Primary Care and Rural Health*

12. Community Health Centers, Meeting America's Most Pressing Health Needs; *National association of Community Health Centers*

13. Physician Interview Form; *Alabama Department of Public Health, Office of Primary Care and Rural Health*

14. Alabama Mental Health Catchment Area, November 2007

15. 2004-2005 Community Resources Directory for Autauga, Elmore, Lowndes, and Montgomery Counties; *The Volunteer & Information Center, Inc.*

16. Community Counts Report; *PARCA*

17. Alabama Dental Statistics Fiscal years: 1998-2007

18. Comparison of Physicians in Practice as of 2006

19. Prisons Becoming Mental Health Centers, Officials Say; *Montgomery Advertiser, Dec 21, 2007*

20. Funding for Mental Health Lacking*; Montgomery Advertiser, Nov 16, 2007*

21. Understanding the Shortage of Psychiatrists in Alabama; *Richard E. Powers MD, April 2,5 2007*

22. Defining the Mental Health Manpower Crisis in Alabama*; Power point Presentation*

23. Baptist Health Workload Statistics

24. Baptist Health Payor Mix

25. Consolidated Statements of Net Assets June 30, 2007 and 2006; *The Health Care Authority for Baptist Health, An Affiliate of UAB Health Systems*

26. Baptist Medical Center East Hospital and Hospital Health Care Complex Cost Report, Certification and Settlement Summary

27. Prattville Baptist Hospital and Hospital Health Care Complex Cost Report, Certification and Settlement Summary

28. Baptist Medical Center East Hospital and Hospital Health Care Complex Cost Report, Certification and Settlement Summary

29. Baptist Medical Center South Settlement Summary

30. Jackson Hospital ER Visits by Financial Class and Zipcode. 10/1/06 - 9/30/07

31. *The Kaiser Commission on Medicaid and the Uninsured.* October, 2007

32. *2006 Survey of Final Year Medical Residents.* Merritt, Hawkes & Associates

33. Helwick, Catherine. Shrinking Workforce: No Quick Fix. *Internal Medicine World Report. Vol.22, no.12. December, 2007. p.1 & 6*