

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
ALABAMA STATE HEALTH PLAN
2020-2023
ADMINISTRATIVE CODE

CHAPTER 410-2-2
HEALTH PRIORITIES

TABLE OF CONTENTS

410-2-2-.01	Introduction
410-2-2-.02	Maternal And Child Health
410-2-2-.03	Care Of The Elderly And Chronically Ill
410-2-2-.04	Rural Health Care
410-2-2-.05	Diseases - Prevention And Management
410-2-2-.06	Health Care For The Medically Indigent
410-2-2-.07	Substance Use Disorder
410-2-2-.08	Reserved

410-2-2-.01 Introduction.

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

(a) Unusual severity in our state, e.g. infant mortality;

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

(c) Problems of access to health care, e.g. the issue of the uninsured and the vulnerability of rural hospitals.

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

Author: Statewide Health Coordinating Council (SHCC)

Statutory Authority: Code of Ala. 1975, §22-21-260(4).

History: Effective May 18, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:**

Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020.

410-2-2-.02 Maternal And Child Health.

(1) **The Problem**

(a) Alabama's infant mortality was 9.0 per 1,000 live births in 2005. In 2014 the provisional rate improved to 8.7 deaths per 1,000 live births, a drop from the 2005 rate. Reasons for the improvements include a number of factors related primarily to improved Medicaid coverage.

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

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

3. The Alabama Medicaid Agency received a 1915(b) waiver to create the Alabama Coordinated Care Network for maternity, family planning, children, foster children, and eligible adults beginning October 1, 2019, for three (3) years. The objective is to better coordinate the care, follow-up, and follow-through for Medicaid recipients residing in any one of the seven (7) regions. Each region will have a contracted entity responsible for the coordination of care and services for Medicaid eligibles. Quality measures are key to the success of the waiver.

4. ADPH, in collaboration with the Alabama Department of Human Resources, implemented the Alabama Unwed Pregnancy Prevention Program (AUPPP) in 2001 and the Family Planning Teen Care Coordination Program in 2002. The AUPPP

addresses adolescent pregnancy and unwed pregnancy by providing funding support to community-based projects, a statewide teen pregnancy prevention campaign, and media outreach. The teen care coordination program provides medical social support to teens age eighteen (18) and under receiving family planning services in local health departments.

5. Other programs implemented by ADPH that are affecting infant mortality include the Alabama Child Death Review Program legislated in 1997, a campaign addressing "back-to-sleep", a "safety for sleeping babies" brochure, and folic acid outreach. According to the Alabama Child Death Review Program, approximately eighty percent (80%) of infant deaths in Alabama are attributable to unsafe sleeping conditions.

(b) Progress has been made in Maternal and Child Health in the state. In 2005, Alabama's infant mortality rate was 0.93%, and in 2014 declined to 0.87%. In "real terms", 517 of Alabama's babies failed to reach their first birthday in 2014. Those at highest risk for infant mortality are infants born to blacks, single mothers, teenagers, and the socio-economically disadvantaged. Over thirty percent (30%) of Alabama's population is black and other. Close to one-half (1/2) of the births in 2014 (43.2%) were to unmarried women, and 8.5% of infants resulted from teenage pregnancies.

(c) Infant death is not the only problem associated with high-risk birth. Research indicates that for every baby who dies, three (3) more are born with handicapping conditions. In 2014, 10.1% of babies were born with a low birth weight, putting them at greater risk for handicapping conditions. Ensure the newborn screening component is followed as it identifies problems in newborns early in their development so interventions and therapies can be applied for long term outcomes.

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

1. Outreach Efforts. Outreach efforts at the local community level are varied and sometimes nonexistent. Some children do not receive the minimal recommended number of preventive health care visits as outlined by the American Academy of Pediatrics, thus immunization rates for these infants

and young children are low, and conditions that could be identified through routine screening exams go untreated.

2. Diminishing Rural Health Services and Delivery Hospitals. Alabama continues to experience a decline in rural population and health providers. Hospitals are financially challenged due to declining population and reductions in federal reimbursement. Only twenty-nine (29) counties have a birthing hospital. Innovative means of delivering care to rural Alabama is needed for primary care, intermediate/interventional, and emergency or hospitalization.

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

4. Child Mental Health. A significant deficit of child mental health professionals, social workers, and residential resources continues for children under age eight (8). The lack of residential resources in Alabama for those with pure mental and behavioral health issues puts pressure on hospitals to retain them or send them several states away for long term rehabilitation or care.

5. Adolescent Mental Health. The resource deficit for adolescent trained professionals should be noted. As important is the lack of adolescent designed residential or mental/behavioral health rehabilitation, and in particular, for those with adolescents mental/behavioral health diagnoses and physical health needs such as gastrointestinal tubes.

(2) **Recommendations**

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

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

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

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

(c) Maintain and strengthen interagency and private sector efforts directed toward decreasing the amount and effects of substance abuse in women of childbearing age and their children. Efforts to increase intervention and treatments should be encouraged. Child abuse and neglect has risen significantly with the opioid and meth usage. DHR's foster care system is burdened with babies and children of substance abuse mothers. The affected newborns will experience some health care issues long term, though what those issues may be is unknown.

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

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

Author: Statewide Health Coordinating Council (SHCC)

Statutory Authority: Code of Ala. 1975, §22-21-260(4).

History: Effective May 18, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020.

410-2-2-.03 Care Of The Elderly And Chronically Ill.**(1) The Problem**

(a) The elderly comprise one of the most rapidly growing age groups in the United States. The same is true in Alabama. Since 1900, the state's total population (approximately 4.4 million people) has more than doubled and there are nearly ten times as many senior citizens. In 1900 persons 65 and older accounted for only 3% of the total population compared to 16.8% in 2019. This age group is expected to increase to over 22% by the year 2050.

(b) Improvements in lifestyle, changes in diet, and development of medical technology for identification and treatment of diseases have resulted in increased life expectancy. Because of this increase, a new phenomenon is occurring, aging of the aged. More persons are living well into their 80s and even 90s. Within the ten- (10) year period from 2013 to 2022, the 65 and older segment of the population is expected to increase by fifteen percent (15%). The special needs of these frail elderly will demand increased attention from service providers in the years ahead. The number of people aged 65 and older in Alabama is projected to be almost 900,000 by 2022.

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

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

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

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

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

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

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

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

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

(l) The availability of health care services has increased. Medicaid increased the payment to dentists and physicians in the last two years; the Medicaid drug formulary has been expanded and payments have been increased to nursing homes.

(2) **Recommendations**

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

1. Adult day care facilities to assist working families;

2. Assisted living facilities to provide housing for elderly and chronically ill who can no longer live alone;
3. Counseling services that deal with depression, alcohol and drug abuse, suicidal tendencies, mental health, nutrition, appropriate lifestyles, and self-care;
4. Geriatric training and education for caregivers;
5. Homemaker and chore services;
6. Home delivered meals;
7. Transportation services;
8. Emergency alert systems;
9. Dental care, including prosthodontics;
10. Audiology, including hearing aids;
11. Optometry services, including glasses;
12. Adaptive and assistive equipment;
13. Adequate housing for persons living below the poverty level.
14. Nursing Homes to provide housing and/or rehabilitative services for elderly and chronically ill patients who can no longer live alone and who require care at a level above and beyond that available in an assisted living environment.

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

Author: Statewide Health Coordinating Council (SHCC)

Statutory Authority: Code of Ala. 1975, §22-21-260(4).

History: Effective May 18, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2, 2014; effective

January 6, 2015. **Repealed and New Rule:** Published
March 31, 2020; effective May 15, 2020.

410-2-2.04 **Rural Health Care.** Alabama has a Rural Health Plan developed with the assistance of the Alabama Department of Public Health's Office of Primary Care and Rural Health, the Alabama Hospital Association, and rural hospitals. The current State Rural Health Plan, published in 2008, was updated in both 2011 and 2016¹. This plan is incorporated into this State Health Plan by reference hereto.

(1) **The Problem.** Rural healthcare providers disproportionately serve individuals who are older, sicker, poorer and underinsured/uninsured as compared to people living in other parts of Alabama. Alabama's uninsured rate (19-64 years) is 15.8%². Policy makers anticipated a rate less than 10% after passage of the Affordable Care Act, but the take up in the Alabama Marketplace/Exchange is only 3%. Rural Alabamians (as well as Americans on the whole) often lack adequate primary care access and have higher rates of diabetes, heart disease, cancer, obesity, tobacco/opioid use, mental health issues and stroke³. The health issues plaguing rural Alabamians stress a fragile rural delivery system dealing with lower volumes, rising costs, increased regulations, lower negotiating power and a shortage of healthcare workers. As rural Alabama changes and evolves, so too must rural healthcare delivery in the state. The issues facing Alabama's rural care providers are multi-faceted:

(a) **Reimbursement and Operational Factors.** As a rule, providers in rural areas experience a higher mix of Medicare/Medicaid patients than do the facilities in urban areas; but rural hospitals receive a lower amount of reimbursement per patient from Medicare. Rural providers must have robust volume to thrive. But the healthcare system is shifting away from an inpatient-dominant and volume-driven system and consequently the state's rural delivery system is becoming increasingly brittle. To counter the loss in volume, many rural providers expand their service offerings which is

¹ <http://alabamapublichealth.gov/ruralhealth/assets/ALRuralHealthPlan2016Update.pdf>

²

https://www.alabamapublichealth.gov%2Fhealthrankings%2Faccess-to-care.html&usg=AOvVaw3CCf&-n_LelEqPqpwpkVg

³ https://www.arc.gov/research/researchreportdetails.asp?REPORT_ID=138

often not ideal because quality is correlated to volume in certain specialties⁴.

As healthcare shifts from volume-based reimbursement to a system based predominately on value, rural providers will continue to struggle if payors do not make a distinction between the unique operating context of a rural hospital and that of suburban and urban providers. Even when a distinction is made, oftentimes it is deleterious to the provider. For example, the Centers for Medicare and Medicaid Services (CMS) implementation of the Prospective Payment System (PPS) assumes hospitals in rural areas will not experience the same labor costs for health personnel services as do urban hospitals. Therefore, the component parts of the prospective payment formula provide for a lower wage allowance for rural hospitals. Another factor that tends to limit reimbursement for rural hospitals is that the PPS system assigns weights related to patient attributes to each diagnosis-related group (DRG). The higher the weight per DRG, the more reimbursement a hospital will receive if that hospital provides services to patients with higher weighted/reimbursed DRGs. Therefore, urban facilities may receive more reimbursement, although the weight assignment per DRG has not been proven as an accurate indicator of the consumption of resources. The bottom-line effect of Medicare reimbursement on rural hospitals is the payment rates are generally less for hospitals in rural areas, leading to a less than adequate payment system. According to the Alabama Hospital Association, in recent years approximately eighty-eight percent (88%) of rural hospitals in the state experienced a net operating loss.

(b) Demographic Factors. A low population density, worsened by the emigration of the younger population in search of employment in larger communities, results in a high proportion of the elderly and underinsured/uninsured remaining in rural communities. Alabama's overall population density in 2019 averaged 94.4 people per square mile, ranging from a low of 12.5 persons per square mile in Wilcox County to a high of 586.2 persons per square mile in Jefferson County. In this case a measurement of density may not be an accurate indicator as only 18 counties have a density factor equal to or above the average and 49 counties below the average. Rural facilities thus have a smaller market from which to draw patients and fewer patients who pay adequately as compared to the costs of providing the care. According to the Centers for Medicare and Medicaid

⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3336194/>

Services, in 2014 health care spending per capita for the 65 and older population was over five times higher than health care spending for children, and almost three times higher than for working-age adults⁵. The population 65 and older comprises 16.9% of the state population and 19.2% for the 49 rural counties, further emphasizing the need to develop and implement a rural health plan⁶. In addition, rural Alabama has a high percentage of Veterans and a low percentage of commercially insured residents.

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

(d) Insufficient Health Professional Supply. Data from the Alabama Department of Public Health indicates that every county in the state has at least some areas considered to be medically underserved, with fifty-eight (58) counties shown as completely medically underserved. While Alabama has made strides in licensure portability in recent years, there are still barriers to address, including portability within telehealth. Because of the problems attracting specialized professionals and obtaining new technologies, few rural hospitals can provide special services that might increase their revenue. The migration of young people to urban communities, lack of adequate reimbursement, and limited patient resources are other problems hindering the recruitment of professional personnel and fueling the state's health professional shortages. Government reports show that Alabama, like many other parts of the South, is experiencing a physician shortage.

Children living in rural areas have less access to routine primary care and, if they have a chronic condition or medically complex diagnosis, must drive long distances to urban centers for care. Many rural emergency rooms are not equipped for

⁵

<https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>

⁶ <https://www.census.gov/quickfacts/AL>

pediatric care, and those cases are often transferred to regional hospitals. In addition, much of the rural emergency care is through a volunteer EMS system, which could be enhanced.

Utilization of nurse practitioners, physician assistants, and nurse midwives meets a real need in addressing the access problem faced by many rural Alabamians. Health planners, providers, policy makers, and communities must approach the recruitment and retention of non-physician health professionals realistically. It is unrealistic to assume that every rural community will be able to recruit and retain a physician. In order to provide access to health care for the citizens of many of the state's most rural areas, the utilization of non-physician health professionals must be seriously encouraged. Also, payment for services provided by these non-physician health professionals must be made by third party payors and self-insured programs in order for their numbers to increase.

(e) No one strategy will solve the state's problems with rural health care. Rural healthcare delivery must evolve and the state must focus on appropriate and adequate access but untether from the idea of access equals an inpatient hospital.

(2) **Recommendations.** Using the Bipartisan Policy Center's 2018 Report, "Reinventing Rural Health" as a framework, the following are recommendations from the Committee:

(a) Communities should tailor available services to the needs of the community, which for many rural areas are driven by changing demographics. To build tailored delivery services, policies need to be flexible and not just have a "one-size-fits-all" approach.

1. **Support Opportunities for Transformation.** The healthcare industry nationally continues to move toward the outpatient setting and towards a value-based approach. Rural hospitals feel the impact of this transformation even more acutely and face unique challenges given both their location and low patient volumes. Many of Alabama's rural hospitals rely on enhanced reimbursement programs (e.g. Critical Access Hospital, Medicare Dependent Hospital, Low Volume Hospital adjustment, etc.) to be able to offer key outpatient services, despite low patient volumes.

2. Overall health improvement and management of disease cannot be done when local access to basic services is lost. Lack of access, either to an inpatient hospital or to

urgent/emergent care, leads to increased time and cost of transportation to healthcare services (particularly among seniors, who experience an average of fourteen (14) additional minutes in an ambulance⁷); reduced per capita income (-4%) and increased unemployment (1.6%) due to the loss of jobs for hospital staff and outward migration of community members⁸.

3. For communities that cannot sustain their current healthcare delivery structure, the SHCC supports state regulatory and statutory allowances for the establishment of new types of access sites that support transformation while maintaining important access points to care. These provider types would provide services critical to any rural community including: primary care; urgent, emergency care and transportation (EMS); observation, outpatient and ambulatory services including basic ancillary services and minor procedures. Emergency services could be enhanced by having several paramedics trained to work alongside and within the volunteer EMS system. In addition, population health approaches, including chronic disease management and care coordination, would be required. Optional services could be provided if they are not locally available (e.g. patients who do not need acute care could be treated and receive skilled nursing and/or rehabilitation services, behavioral health, oral health or home health services).

4. The realities of the health care system are that form follows payment and shifting to more transformative models will require alternative and enhanced reimbursement models, recognizing the unique challenges of low patient volumes coupled with an increasingly large population of Medicare enrollees. All innovation models should ensure adequate reimbursement to support such models.

5. These new provider types would require strong relationships with an inpatient facility or partner organization, as well as a plan to assure emergent and non-emergent transportation in the area between the partner and the smaller entities as well as other service providers in the area.

(b) Maintain Certificate of Need (CON). The CON serves as an important guardrail against reducing access and

⁷ https://uknowledge.uky.edu/cgi/viewcontent.cgi?article=1007&context=rnhrc_reports

⁸ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1702512/>

should not be repealed or limited in scope. Repealing or limiting the scope of CON can reduce access to care for the most vulnerable by destabilizing safety net hospitals. This occurs through a further degradation of the payer mix among patients at safety net providers.

(c) Once the right system and services have been identified for a community, funding mechanisms and payment models should reflect the specific challenges that rural areas face - such as small population size and high operating costs. Sparse populations mean a small number of patients, so reimbursement metrics must consider low patient volumes. Rural health care providers are eager to participate in value-based alternative-payment models, but they need workable approaches and metrics. Policymakers should consider the unique challenges faced in rural areas when developing metrics and funding mechanisms.

1. Exploration and support should continue to identify and increase access to insurance and care for Alabama's uninsured.

2. Addressing Social Determinants of Health. A lack of focus on Social Determinants of Health translates into poor health status, which is borne out in Alabama's consistently low national ranking with respect to issues like obesity, substance use disorder and infant mortality. The SHCC supports the goals of the Alabama Coordinated Health Network (ACHN) and Integrated Care Networks (ICN) and the programs outlined in the Quality Improvement Programs (QIP) to address some of the higher impact health issues affecting many rural residents.

(d) With appropriate services and funding, rural communities can build sustainable and diverse workforces. Rural health can no longer survive on the back of one physician serving an entire community 24/7. Building and supporting the healthcare workforce should be a high priority, and the expectation of care quality should be comparable in rural as in more urban areas of the country. Also, alternative providers practicing at the top of their licenses, such as nurse practitioners and physician assistants, can fill vital primary care roles in the community. Communities should start young and think local for recruitment with pipeline programs that encourage interest in the health care sector in local middle- and high-school students. The State should adopt policies that increase the availability of and participation in rural residency programs. Providers are starting to think creatively

by employing case managers, community-health workers and in-home providers to help meet the needs of the community. Policies should support these efforts.

1. Rural Development. The SHCC encourages state policymakers' support and funding (where applicable) of targeted rural initiatives that would assist rural providers.

2. Support Additional Graduate Medical Education ("GME") Funding. Addressing the physician and nurse workforce shortage is a priority for all rural providers. Rural hospitals face unique recruitment challenges but increasing the opportunity for physicians to train in rural hospitals allows medical residents to see the impact they can have and the benefits of rural locations.

3. Promote Rural Practice and Retention. The SHCC encourages state policymakers to pass the Alabama Physician Initiative, which would provide scholarships for certain medical students who are enrolled in and attending any college of medicine in Alabama and who contract with the Alabama Medical Education Consortium to practice for five (5) years after the completion of their residency in rural areas of the state with the greatest need for physicians, with funds allocated through the Alabama Department of Public Health. The SHCC also supports funding and development of workforce development efforts between academic centers (e.g. community colleges, vocational schools, career centers, etc.) and healthcare providers to develop a pipeline of career-ready healthcare professionals.

4. Rural Tax Credits. The SHCC encourages renewal and/or passage of rural tax credits to primary care physicians and advanced practice providers ("APP") who practice in rural areas.

5. Physician Recruitment. The SHCC encourages the secondary school systems to coordinate medical student recruiting efforts with the medical schools.

6. APP Training. The SHCC encourages schools of higher education to develop and expand APP training programs for utilization of such personnel in rural hospital emergency departments and/or rural health clinics. Encourage the continued support and recruitment of nurse practitioners and nurse midwives and expand the number of nurse practitioner programs in the state.

7. APP Utilization. Develop and implement programs to promote the utilization of APPs by:

(i) Licensure and physician supervision requirements should be modified where access to care is hindered.

(ii) Promoting reimbursement by all payors.

(e) Health professionals working in rural areas need the right tools for success. Telemedicine is one tool that can be used to support both rural patients and rural providers. Not only do these services improve access by connecting remote patients with specialists located elsewhere, but they provide much-needed peer support to rural health professionals who often work in professional isolation. Telemedicine may prove to be critical in improving provider recruitment and retention, though challenges remain with broadband availability and reimbursement.

1. Expand Opportunities to Utilize Telehealth. Rural hospitals face unique challenges to provide access to care. Rural facilities are often located an hour or more away from the next closest hospital or clinic. Both providers and patients must travel greater distances to receive face-to-face care. Increasing the utilization of telehealth provides the opportunity to address these barriers to care. Telehealth services can include virtual visits originating at a patient's home or at a medical facility, remote patient monitoring and specialist consults between hospitals. The SHCC encourages policymakers to support innovation in telehealth in the following ways:

(i) Support reimbursement of telehealth services at the same rate as face to face services.

(ii) Expand the definitions to allow patients to receive services in their homes.

(iii) Continue to invest in high-speed broadband access.

(iv) Create and invest in communication and marketing materials on the benefits of telehealth and focus distribution of those materials in the rural underserved communities as part of the rural community plan.

(v) Financially support, fund and encourage rural community hospitals to provide telehealth education and develop telehealth portal locations for community access.

2. EMS Personnel. The SHCC encourages state stakeholders to determine how EMS personnel and certified paramedics could be utilized in rural areas beyond stabilization/transport and develop policies and reimbursement mechanisms for such paramedical professional utilization.

Author: Statewide Health Coordinating Council (SHCC)

Statutory Authority: Code of Ala. 1975, §22-21-260(4).

History: Effective May 18, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020.

410-2-2-.05 Diseases - Prevention And Management.

(1) Preventable Diseases

(a) Vaccine Preventable Diseases (Measles, Pertussis, HPV, Influenza, Shingles, etc.). With a more local and global transient population, diseases are resurfacing due to a lack of, and failure to immunize for childhood and seasonal diseases such as influenza.

1. Influenza Problem. Seasonal epidemics of influenza occur every year in the United States, beginning in the fall. Typically, the epidemics cause thousands to tens of thousands of deaths and approximately 200,000 hospitalizations annually.

(i) Since the 1940s, a vaccine has been available to prevent influenza; unfortunately, the vaccine is not used as much as it should be. To prevent hospitalizations and deaths caused annually by the influenza virus, the Centers for Disease Control and Prevention ("CDC") has recommended that all U. S. Citizens more than six (6) months of age receive the influenza vaccine.

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

(iii) The cost of vaccination is minimal (\$10 - \$18), depending on type (injection vs. nasal).

(iv) Side effects are minimal.

(v) Influenza causes children to miss school, usually up to one week, which in some cases can cause parents to miss work.

(vi) Recommendations:

(I) Consider adding the influenza vaccine to the required immunization schedule outlined in ALA. ADMIN. CODE r 420-6-1-.03.

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

(2) **Adult and Childhood Diseases Preventable with Immunizations.** Childhood diseases, such as measles, chicken pox, etc. are once again on the rise due to a mobile society and a failure to vaccinate. Vaccinations continue to be developed to prevent diseases such as shingles, HPV, etc.

(a) The State shall encourage compliance with the recommended vaccination schedules of the American Academy of Pediatrics and the CDC Advisory Council on Immunization Practices ("ACIP") to ensure Alabamians are protected from recognized and costly preventable diseases with a vaccination option.

(3) **Obesity**

(a) Discussion (source: www.cdc.gov)

1. In 2016, the prevalence of obesity (BMI > or = 30) among U. S. Adults was 39.8 %. By contrast, the prevalence of obesity in 2000 was 30.5 %.

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

3. In 2017, Alabama was one of only seven (7) states with an adult obesity prevalence of over 35%.

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

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

(4) **Diabetes**

(a) Discussion (sources: www.adph.org and www.cdc.gov)

1. Twelve percent (12%) of people in Alabama were diagnosed with diabetes in 2015. Thousands are unaware that they have the disease.

2. The increased incidence of diabetes often leads to obesity and kidney disease related issues, requiring additional dialysis centers and services for treatment.

(5) **Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)**

(a) The Problem

1. By December 2019, transmission of the AIDS virus occurs through sexual contact with an infected person, exposure to infected blood or blood products, and perinatally from mother to baby. Transmission patterns of the HIV virus have shifted over time. As of 2017, homosexual/bisexual men account for 66% of adult AIDS cases, with 3% occurring in homosexual/bisexual men who use intravenous drugs. Diagnoses attributable to injectable drug use alone have declined significantly over time and accounted for only 6% of new diagnoses in 2017. Twenty-four percent (24%) of new diagnoses come from among heterosexuals who have had sexual contact with infected partners. Unfortunately, as of 2016, 15% of people infected with HIV are unaware of their status, and 38% of new HIV infections resulted from individuals who were unaware of their HIV-positive status.

2. By the end of 2016, Alabama had reported 13,437 AIDS cases. Of these, 13,397 were in adults and adolescents and 40 were in children less than age 13. Alabama's AIDS cases by reported risk behavior are as follows: 45.3% homosexual/

bisexual male; 3.3% homosexual/bisexual with IV drug user; 5.6% IV drug abuse; 0.2% transfusion related/hemophiliac; 19.9% hetero-sexual contact with an infected person; and 24.9% were reported as undetermined. Additionally, according to the Alabama Department of Public Health, an estimated 1 in 6 people living with HIV in Alabama are unaware of their infection. Based on the current prevalence rate, this means that approximately 2,430 Alabama residents may have been infected and unaware of their positive HIV status at the end of 2016.

3. There are at least one million Americans silently infected with HIV. Most of them will get sick during the next decade. Nationally, over 700,000 people with AIDS have died since the beginning of the epidemic. Fifty-two percent (52%) of Alabama's reported AIDS cases have died. The development of antiretroviral therapy (ART) has substantially reduced AIDS-related morbidity and mortality and has improved long-term outcomes for people with HIV. According to the Kaiser Family Foundation, the age-adjusted HIV death rate has dropped by more than 80% since its peak in 1995. Because of this, people already diagnosed with the disease are living much longer. This combined with the fact that new infections continue to occur, and more people are diagnosed with HIV than die from complications due to the disease, means that more people are living with the HIV virus than ever before.

4. In November 1987, the Alabama Department of Public Health designated HIV infection reportable by provider and patient name and identifiers. By the end of 2016, ADPH had received reports of 7,460 persons who tested positive for HIV and 5,977 additional persons whose infection had advanced to Stage 3 (AIDS). Each one of these individuals is potentially capable of transmitting the virus to someone else and will ultimately have his/her life shortened due to virus infection.

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

(b) Recommendations

1. The state needs to pursue three primary goals to deal with the problem of HIV/AIDS infection:

(i) The elimination of HIV transmission from the infected population of Alabama to the uninfected population.

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

(iii) The provision of appropriate and necessary health care to infected individuals.

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

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

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

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

of Public Health should serve as the focal point for HIV/AIDS educational and informational activities.

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

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

Author: Statewide Health Coordinating Council (SHCC)

Statutory Authority: Code of Ala. 1975, §22-21-260(4).

History: Effective May 18, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020.

410-2-2-.06 Health Care For The Medically Indigent.

(1) **The Problem**

(a) There have been studies and estimates to determine the number of medically uninsured and underinsured, both in Alabama and nationally. Although the statistics may vary among the various studies, the conclusions are all consistent in that a large percentage of the population has either no health insurance coverage or the coverage is inadequate. According to the July 2018 U. S. Census Bureau's *Quick Fact Sheet on Alabama*, the uninsured population under age 65 is 12.0% of the total population of 4,887,871. Most of the uninsured were found in families where at least one person is employed, and most of the employed worked in small businesses. In 2010, the Congress passed the Patient Protection and

Affordable Care Act, which ensured coverage for pre-existing conditions and dependent coverage under a parent's policy through age 25, which reduced the number of uninsured.

(b) Lack of health insurance coverage, including mental health coverage, contributes significantly to uncompensated care provided by those who deliver needed health care. The uninsured and underinsured often fail to seek needed health care services early when treatment is generally less expensive and more effective. The financial impact of the uninsured in Alabama is shown by 2018 data compiled by the Alabama Medicaid Agency. Total uncompensated care in Alabama was estimated to be \$712 million. This number represents the total cost of care for charity care and bad debt, as defined by Medicare, as reported on Medicare Cost Reports filed by the ninety (90) acute care hospitals in Alabama with Medicare, a copy of which is also filed annually with the Alabama Medicaid Agency. This number, however, only reflects the cost for hospital care (not charges) and does not include other uncompensated health care costs from other providers including: Community Mental Health Centers, Psychiatric Hospitals, Nursing Homes, clinics operated by the Alabama Department of Public Health, Federally Qualified Health Clinics (FQHCs), Residential Treatment Facilities, and others. Also, according to the Alabama Medicaid Agency, Medicaid is required to provide to the Centers for Medicare and Medicaid Services (CMS) an audit of uncompensated care, called a DSH (Disproportionate Share Hospital) audit. This audit is used to justify DSH payments from the Federal Government which are used to reimburse hospitals for uncompensated care provided to uninsured patients. The definitions for uncompensated care in this instance are different than those used in the Medicare Cost Reports, but is the amount that Medicaid is accountable for with respect to uncompensated care. Utilizing this measure, the total Uninsured Uncompensated care hospital cost included in the audit for Fiscal Year 2015 was \$510 million. Based upon this audit, hospitals in Alabama did receive a Federal DSH allotment of \$333 million to partially offset the cost. Without Congressional action, however, reductions amounting to approximately forty percent (40%) of the Federal DSH allotments are required to take place in Fiscal Year 2020. According to Medicaid, current expectations are that these scheduled reductions will be deferred for one or two years.

(c) Providers should pursue collections based upon economic-means based policies in order to recover part of the cost of uncompensated care, and according to generally accepted

standards. Bad debt is an increasing problem for Alabama providers.

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

(e) Charity care is defined as health services for which a provider's policies determine a patient is unable to pay. Charity care could result from a provider's policies to provide health care services free of charge to individuals who meet certain pre-established criteria as required by the 2010 Patient Protection and Affordable Care Act. Charity care is measured as revenue forgone, at full-established rates or charges. Charity care would not include contractual write-offs, but could include partial write-offs for persons unable to pay the full amount of a particular patient's bill.

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

(g) Each county is responsible for indigent residents.

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

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

(2) **Recommendations**

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

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

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

(d) The Statewide Health Coordinating Council believes that access to care, which is mandated as a part of the

Certificate of Need (CON) Review process shall include the historical and projected charity care provided by each CON applicant and the impact each CON approval will have on access to health care for the medically indigent.

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

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

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

Author: Statewide Health Coordinating Council (SHCC)

Statutory Authority: Code of Ala. 1975, §22-21-260(4).

History: Effective May 18, 1993. **Amended:** June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed

October 18, 2004; effective November 22, 2004. **Amended (SHP**

Year Only): Filed December 2, 2014; effective January 6, 2015.

Repealed and New Rule: Published March 31, 2020; effective May 15, 2020.

410-2-2-.07 Substance Use Disorder.

(1) According to the 2018 National Survey on Drug Use and Health nearly one (1) in five (5) people aged 12 or older (19.4%) used some form of illicit drug in 2018, which is an increase from 2015 - 2016. Deaths from opioid overdoses alone were more than 42,000 in 2016.⁹ In Alabama the death rate from drug overdoses climbed 82% from 2006 to 2014. The drug crisis affects Alabama hospitals, schools, prisons, and businesses.¹⁰ (Unless otherwise stated, all statistics related to substance use disorders quoted in this section come from the 2018 National Survey on Drug Use and Health).

(2) During 2018, approximately 20.3 million people aged 12 or older had a substance use disorder (SUD) related to use of alcohol or illicit drugs during the previous year, including 14.8 million people with an alcohol use disorder and 8.1 million people with an illicit drug use disorder. The most

⁹ *2018 National Survey of Drug Use and Health*, Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services (HHS). 2018.

¹⁰ *State of Alabama Opioid Action Plan*, produced by the Alabama Opioid Overdose and Addiction Council, 2017.

common illicit drug use disorder reported was the misuse of marijuana (4.4 million people). An estimated 2.0 million people reported an opioid use disorder, including 1.7 million people with a prescription pain reliever use disorder and an additional 500,000 people with a heroin use disorder.

(3) In terms of recent initiates (new users within the previous year) to use or misuse of substances, the substances most used or misused were alcohol (4.9 million new users), marijuana (3.1 million new users), prescription pain relievers (1.9 million new misusers), and cigarettes (1.8 million new users). According to the Substance Abuse and Mental Health Services Administration ("SAMHSA"), in 2018 more than 4 out of 5 people aged 12 or older perceived great risk of harm from weekly use of either cocaine (86.5%) or heroin (94.3%), while less than one-third of people perceived great risk of harm from weekly marijuana usage (30.6%). Approximately 2 out of 3 people perceived a great risk from daily binge drinking (68.5%), and nearly 3 out of 4 people perceived great risk from smoking one or more packs of cigarettes daily (71.8%).

(4) Substance abuse is more common among both adolescents and adults who have a co-occurring mental health issue than among those who do not. Adolescents with a mental health issue were reported as more likely to binge drink (8.5%) or use an illicit drug (32.7%) versus those who do not report a mental health issue (binge drinking 4.1%, illicit drug use 14%). Similar difference in use are reported for adults aged 18 and older.

(5) According to SAMHSA, in 2018 an estimated 21.2 million people aged 12 and older needed substance use treatment in America (7.8%). This includes approximately 3.8% of adolescents aged 12 - 17; 15.3% of young adults aged 18 - 25; and 7% of adults aged 26 and older. Of these, approximately 3.7 million people in America aged 12 and older received treatment for substance use (1.4%), 2.4 million of whom received treatment at a specialty facility. Among the estimated 18.9 million people aged 12 and older who needed substance use treatment but did not receive any, approximately 964,000 perceived a need for treatment. Of those, approximately 40% did not receive treatment because they were not ready to stop using, and approximately one-third had no health care coverage and were not able to afford the cost of treatment.

(6) The State should encourage and promote a variety of treatments for SUD. Traditional treatments for SUD include

abstinence-based systems such as 12-step programs. Methadone has been used successfully in recent years, especially for severe cases. SAMHSA has recently reported significant success with Medication-Assisted Treatment (MAT) which uses medications (primarily buprenorphine), in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery.

(7) **Marijuana.** The primary illicit drug used in 2018 was marijuana, with more than 43.5 million reported users within the previous year. The percentage of people aged 12 or older reporting marijuana usage within the previous year (15.9%) was higher than percentages reported to SAMHSA from 2002 - 2017. The increase is primarily due to increases reported in young adults (aged 18 - 25) as well as in adults (aged 26 or older). By comparison, and in contrast to these numbers, adolescents aged 12 - 17 did not show an increase in usage between 2014 - 2018.

(8) **Prescription Drugs.** The second most reported form of illicit drug usage in 2018 was misuse of prescription pain relievers, with 3.6% of the population reporting illicitly using prescription pain relievers within the last year. For all people aged 12 or older, and for young adults aged 18 - 25, the percentage of the population reporting illicit usage of prescription pain relievers decreased in 2018 compared to 2015 - 2017. Similar decreases were reported for adolescents aged 12 - 17 and for adults aged 26 or older compared to 2015 - 2016 but are similar to the percentages reported in 2017. Among all people aged 12 or older in 2018 who misused pain relievers in the last year, a significant majority (63.6%) reported that the main reason for misuse was to relieve physical pain. More than half of people who misused pain relievers in the last year (51.3%) reported obtaining the pain relievers from a friend or relative.

(9) According to the Alabama Department of Public Health ("ADPH") 2017 Overdose Surveillance Summary, 836 people in Alabama died of an overdose, 419 of which involved opioids. The top four (4) drugs related to overdose deaths in 2017 were fentanyl (161 deaths); heroin (128 deaths); methamphetamine (110 deaths); and cocaine (98 deaths). Additionally, in 2018 there were 11,081 visits to hospital emergency departments in Alabama related to overdoses, with, 2,180 involving opioids. There was

a total of 20,353 overdose-related 911 runs in 2018, with 4,373 involving opioids. In 2017, the rate of drug overdose deaths in Alabama was 17.1 per 100,000 population, an increase from both 2016 (15.4 per 100,000) and 2015 (14.9 per 100,000). The rate for opioid deaths in Alabama in 2017 (8.6 per 100,000 population) was also an increase from both 2016 (7.0 per 100,000) and 2015 (5.7 per 100,000).

(10) **Opioid Abuse**

(a) Opioids are a class of drugs that include heroin as well as prescription pain relievers such as oxycodone, hydrocodone, morphine and fentanyl. These drugs work by binding to the body's opioid receptors in the reward center of the brain, diminishing pain as well as producing feelings of relaxation and euphoria. While most overdose deaths are caused by illegal drugs, many people first become addicted to opioids by using prescription drugs that were legally obtained.

(b) According to the Alabama Opioid Overdose and Addiction Council, over 42,000 Americans died from opioid overdoses in 2016. According to SAMHSA, approximately 10.3 million people aged 12 or older misused opioids in 2018. This number corresponds to approximately 3.7 percent of the population. Of these, the vast majority (9.9 million users) misused prescription pain relievers, compared to a much smaller population (808,000) who used heroin. The majority of people who misuse prescription pain relievers (9.4 million) had not used heroin, but a small number (506,000) misused prescription pain relievers and used heroin within the last year. Among those 12 - 17 years old, approximately 699,000 adolescents misused opioids within the last year, with another 1.9 million young adults between the ages of 18 - 25 also misusing opioids.

(c) In the state of Alabama, the number of drug overdose deaths, including opioid deaths, climbed eighty-two percent (82%) from 2006 to 2014. According to the Alabama Department of Mental Health ("ADMH") Substance Abuse Division, in 2018 4,546 individuals were treated by the department, or by entities contracted by the department, for heroin addiction with an additional 7,082 treated for addiction to other opiates and synthetics. These statistics, however, do not include individuals not treated by the department or its contracted entities. These individuals make up approximately thirty-four percent (34%) of the patients that received treatment for substance use related disorders by ADMH or contracted entities.

(d) Currently ADMH works with eighty-three (83) Certified and Contract entities to provide services to individuals suffering from substance use disorders, providing substance abuse treatment, medication assisted therapy and prevention services. An additional eleven (11) providers are certified to provide prevention or treatment services to patients, but do not receive funding from the Department. There are twenty-one (21) Opioid Replacement Therapy (ORT) clinics throughout the state that specifically target individuals suffering from Opioid Use Disorders. Additionally, there are nineteen (19) public, non-profit regional mental health boards, called 310 boards, throughout the state. Of these, fourteen (14) provide substance abuse treatment services. Birmingham and Tuscaloosa have regional boards, with additional mental health centers attached to them.

(e) Governor Ivey created the Alabama Opioid Overdose and Addiction Council through Executive Order 708 on August 8, 2017. The Council, co-chaired by the Commissioner of the Alabama Department of Mental Health, the Attorney General of Alabama, and the State Health Officer, was created to "study the State's current opioid crisis and identify a focused set of strategies to reduce the number of deaths and other adverse consequences of the opioid crisis in Alabama." The Council was given a set of directives related to this purpose, including:

1. Advise and assist the Governor in the development of a comprehensive, coordinated strategy to combat Alabama's opioid crisis;

2. Gather and review data characterizing the opioid crisis facing Alabama, including the threat of synthetic opioids;

3. Review strategies and actions already taken in Alabama to combat the opioid crisis;

4. Review strategies and actions of other States and the National Governor's Association Compact to Fight Opioid Addiction; and

5. Develop a comprehensive strategic plan to abate the opioid crisis in Alabama.

(f) The State of Alabama Opioid Action Plan, created by the Alabama Opioid Overdose and Addiction Council and published December 31, 2017, describes a four-pronged approach

to addressing the current opioid crisis in Alabama. The four prongs to the approach described by the council are:

1. Prevention of opioid misuse. Including strategies to modernize the state's Prescription Drug Monitoring Program (PDMP) to fully realize technological improvements in how prescription opioids are prescribed and dispensed, continuing improvements in the education of prescribers and prescribers-in-training, the reduction of stigma attached to opioid addiction, and the development of a centralized data repository that can be used to understand and combat the problem;

2. Intervention within the law enforcement and justice systems. Addressing drug trafficking laws and working with drug courts in Alabama to encourage the use of medication assisted treatment (MAT) for those with Opioid Use Disorders (OUD);

3. Treatment of those with OUDs. Increasing access to care for those with OUD in Alabama and encouraging the use of evidence-based practices to improve the identification and treatment of those with OUD; and

4. Community Response that engages ordinary Alabamians to become involved with finding solutions at a local level. Focus on expanding the availability and usage of naloxone (a potentially life-saving opioid reversal drug); the building of partnerships with businesses, educational institutions and community organizations to improve awareness and involvement; and encouragement for counties to adopt the Stepping Up Initiative, which provides tools to create data driven strategies that work within the judicial system.

(g) ADMH has received several grants in recent years in order to combat substance use disorders, including the State Opioid Response Grant, the Medication Assisted Treatment Prescription Drug Opioid Abuse grant (in specific counties), another grant to expand Drug Courts into specific rural counties, as well as grants from both the USDA (to provide telehealth equipment in specific counties) and the CDC (in partnership with ADPH to provide peer counseling in Emergency Departments).

(h) In 2019, Governor Ivey secured funding in the state's operating budget to improve the Prescription Drug Monitoring Program to, in part, make it easier to use for both

physicians and pharmacists. Also, Governor Ivey signed a law making it a crime to traffic in either fentanyl or carfentanil, which are synthetic opioids with a higher potency than heroin. The new law makes it a felony to knowingly possess more than a half gram of fentanyl or a related synthetic opioid or to possess, sell, or deliver a mixture containing fentanyl or a related synthetic opioid. Both Acts were directly recommended by the Alabama Opioid Overdose and Addiction Council.

(i) ADMH recently partnered with Auburn University to create the Opioid Training Institute, providing education to both community members and health care professionals about the current status of opioid abuse in Alabama and to provide strategies and solicit ideas on how to combat the crisis moving forward. The Department has also worked with ADPH to supply naloxone to first responders throughout the state in order to improve access to a potentially life-saving drug to any law enforcement or medical professional who may be called upon to assist an individual suffering from an opioid overdose.

(11) **Methamphetamine Use**

(a) Methamphetamine is a potent stimulant with high abuse potential that can be smoked, snorted, injected, or taken orally. The desirable short-term effects of Methamphetamine or initial "rush" is characterized by increased energy and alertness, elevated positive mood state, and decreased appetite.¹¹

(b) According to SAMHSA, in 2018 approximately 1.9 million people aged 12 or older used methamphetamines in the past year. This number corresponds to approximately 0.7% of the population. These numbers have not appreciably changed between 2015 and 2018. Among younger users, approximately 43,000 adolescents between the ages of 12 and 17 used methamphetamine in the last year, and approximately 237,000 young adults between the ages of 18 and 25 used methamphetamines in the last year. In both cases, the percentages of the population using methamphetamines in the last year have not appreciably changed between 2015 and 2018.

(c) In the last two years, the number of people abusing methamphetamine in Alabama has outnumbered the number of

¹¹ Rawson RA, Gonzales R, McCann MJ, Obert J. *Methamphetamine use among treatment-seeking adolescents in Southern California: participant characteristics and treatment response*. Journal of Substance Abuse Treatment. 2005; 29:67-74.

people abusing other drugs such as cocaine, heroin and marijuana. Most of the users of crystal meth in Alabama are people between 18 and 25 years of age.

(12) **Ecstasy.** Ecstasy abuse in Alabama continues to increase. Ecstasy, as well as similar drugs such as LSD, GHB, and ketamine are primarily abused in night club settings and are often referred to as "club drugs." Arrests, overdoses and emergency room visits for club drugs have mirrored the increase in use. Ecstasy remains the leading number one club drug, followed by GHB.¹² GHB overdoses have been reported in several areas of the state.

(13) **Cocaine.** Cocaine is among Alabama's most significant drug threats. Cocaine is widely available throughout Alabama, as it ranks second for the number of drug addiction treatment admissions. In 2010, 2,108 individuals were treated for smoking cocaine with an additional 842 people treated for using cocaine through other routes of ingestion.

(14) **Heroin.** Heroin abuse, use, and sales have skyrocketed across the nation. In fall of 2015, police departments across Alabama were expressing concern over the growing number of deaths across all counties.

(15) **Alcohol Abuse**

(a) According to SAMHSA, in 2018 approximately 139.8 million Americans aged 12 and older used alcohol in the month prior to being surveyed, 67.1 million were binge drinkers during the same time period, and 16.6 million were heavy drinkers during the same time period. Approximately 2.2 million adolescents aged 12 - 17 drank alcohol within the previous month, with 1.2 million of those binge drinking. For the purposes of the survey, binge drinking was defined having had five (5) or more drinks on the same occasion on at least one (1) of the previous thirty (30) days. Heavy alcohol use is defined as binge drinking on five (5) or more days during the previous thirty (30) days.

(b) SAMHSA data from 2015 - 2016 indicates that approximately 43.94% of Alabamians ages 12 and older reported using alcohol within the previous month. For adolescents aged 12 - 17, the same survey indicates that 8.08% used alcohol within the previous month, and for young adults ages 18 - 25,

¹² Downloaded from Addictionrecovery.net, November 11, 2019.

approximately 50.76% used alcohol within the previous month. Approximately 4.16% of Alabamians ages 12 and over were reported to suffer from alcohol use disorder in 2015 - 2016, with adolescents aged 12 - 17 being affected at a rate of 1.67% and young adults aged 18 - 25 affected at a rate of 9.08%¹³. All of these rates are reported as being lower than the national and regional averages for both alcohol use and alcohol use disorder.

(16) **Tobacco**

(a) More people die every year from smoking than from murder, AIDS, suicide, car crashes, and alcohol combined.¹⁴ Alabama has the 8th highest adult smoking prevalence rate in the nation.

(b) ADPH reports that 21.5% of adults in Alabama are current cigarette smokers. An estimated 23.3% of males and 20.0% of females smoke. From 1996 to 2016 adult smoking prevalence fell on average only 0.2% per year and 10.9% of high school students are current smokers.¹⁵ According to the 2018 National Center for Health Statistics, 10.1% of mothers reported smoking during pregnancy.

(c) A key focus area for the state should be the impact of smoking on Alabama's youth. According to the 2016 Youth Tobacco Survey (YTS), 10.9% of high school students are current smokers. There was a significant difference in smoking prevalence between males (12.9%) and females (8.8%) in high school whereas the prevalence in middle school were very similar (3.4%). Also, the smoking disparity among racial/ethnic groups increased in high school where white students (14.3%) were twice as likely to smoke compared to African American (5.4%) and Hispanic students (7.5%).

(d) Additionally, secondhand smoke creates significant problems for Alabama citizens. Secondhand smoke kills over 750 nonsmoking Alabamians each year. Children exposed to secondhand smoke are at an increased risk for Sudden Infant Death Syndrome, acute respiratory infections, ear problems, severe asthma, and reduced lung function.

(e) The use of tobacco creates an economic burden on the State as well. ADPH estimates that \$5.16 billion in excess

¹³ *Alabama Drug Abuse Statistics*, 2019, www.recoveryconnection.com: owned and operated by Lakeview Health.

¹⁴ Alabama Department of Public Health. 2019

¹⁵ 2016 Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control.

personal medical care expenditures were attributable to smoking. There are an estimated \$887.9 million in productivity losses as a result of smoking-attributable premature death. An additional \$1.33 billion in productivity losses were estimated as a result of smoking-attributable illnesses. And \$187.5 million in economic costs were attributed to personal medical costs and productivity losses associated with secondhand smoke. The total annual economic impact of smoking in Alabama is estimated to be \$7.6 billion.¹⁶

(f) Recent research has shown that youth prevalence rates in Alabama have decreased substantially, although this is known to be somewhat offset by a rise in the use of e-cigarettes among young people in particular. The increase in the state's tobacco tax rate is expected to continue to help reduce young people's initiation of tobacco use and will likely generate an estimated \$62 million of revenue annually.

(g) Efforts to address the tobacco problem in Alabama have been led by ADPH. The Alabama State Plan for Tobacco Prevention and Control is the result of the efforts of the Alabama Tobacco Use Prevention and Control Task Force. The task force is composed of agents of ADPH and its national, state, and local partners. Representatives of task force partner organizations met in March of 2015 to review the state's progress regarding tobacco prevention and control and update the previous plan drafted in 2010.

(h) One of the key partners ADPH is coordinating with is the Tobacco Prevention and Control (TPC) Branch of North Carolina Department of Health and Human Services. The TPC works with local coalitions, community agencies, and state and national partners to implement and evaluate effective tobacco prevention and cessation activities that meet the following goals:

1. Eliminating environmental tobacco use exposure.
2. Promoting quitting among adults and youth.
3. Preventing youth initiation.
4. Identifying and eliminating disparities among populations.

¹⁶ Dunlap, S.T. & McCallum, D. (2019). *Update: The Burden of Tobacco in Alabama, 2019*. Tuscaloosa, AL: Institute for Social Science Research, University of Alabama.

(i) Another initiative that Alabama should support is the Federal Drug Administration's Youth Tobacco Prevention Plan, a series of actions to stop youth use of tobacco products, especially e-cigarettes, with special focus on three key areas:

1. Preventing youth access to tobacco products.
2. Curbing marketing of tobacco products aimed at youth.
3. Educating teens about the dangers of using any tobacco product, including e-cigarettes, as well as educating retailers about their key role in protecting youth.

(j) While the ADPH efforts have had some minor success, the state still trails the country in its efforts to reduce tobacco related illness and death. The State Plan for Tobacco Prevention and Control may be seen as an important step in the process of moving the state along the right track toward reaching those goals.

(17) **Vaping**

(a) E-cigarettes are battery-powered devices that allow users to inhale aerosolized liquid. E-cigarettes are also called vapes, vape or hookah pens, electronic nicotine delivery systems (ANDS), mods, vaporizers, and tank systems. Even though e-cigarettes do not contain any tobacco, the Food and Drug Administration (FDA) classifies them as "tobacco" products. The amount of nicotine provided by e-cigarettes varies by device.

(b) These devices have become the most used tobacco product among Alabama youth in the past few years. Until recently these devices were not regulated as typical tobacco products. In fact, the e-cigarettes are not currently listed in any sections of the State's statutes included in the definition of "Tobacco Products." Originally e-cigarettes were offered as an alternative to regular tobacco products as a means of assisting in smoking cessation. Their popularity, especially among youth, has overtaken any effort to reduce smoking and tobacco addiction.

(c) According to the American Cancer Society the possible long-term health effects of e-cigarettes aren't yet clear, but there have been recent reports of serious lung

disease in some people using e-cigarettes or other vaping devices. Symptoms have included:

1. Cough, trouble breathing, or chest pain;
2. Nausea, vomiting, or diarrhea; and
3. Fatigue, fever, or weight loss

(d) Furthermore, recent reports show nicotine exposure can harm brain development and as a result is more harmful to adolescents. Nicotine can also cause harmful physical effects to the cardiovascular and central nervous system. Eating, drinking, or absorbing nicotine in any way can lead to nicotine poisoning, especially in children. If used during pregnancy, nicotine may also cause premature births and low birthweight babies.

(e) Nicotine, the main drug in tobacco products and e-cigarettes, is known to be highly addictive. Developing adolescent and young adult brains are even more susceptible. In addition to being highly addictive, the American Cancer Society reports that nicotine is a major carcinogen and can cause lung disease, heart disease, and cancer.

(f) Besides nicotine, e-cigarettes and e-cigarette vapor contain propylene glycol and/or vegetable glycerin. These are substances which have been found to increase lung and airway irritation after concentrated exposure.

(g) In addition, e-cigarette and e-cigarette vapor may contain the chemicals or substances listed below:

1. Volatile organic compounds (VOCs): at certain levels, VOCs can cause eye, nose and throat irritation, headaches and nausea, and can damage the liver, kidney and nervous system.

2. Flavoring chemicals: some flavorings are more toxic than others. Studies have shown that flavors contain different levels of a chemical called diacetyl that has been linked to a serious lung disease called bronchiolitis obliterans.

3. Formaldehyde: this is a cancer-causing substance that may form if e-liquid overheats or not enough liquid is reaching the heating element (known as a "dry-puff").

(h) The FDA does not currently require e-cigarette manufacturers to stop using potentially harmful substances. And, it is difficult to know exactly what chemicals are in an e-cigarette because most products do not list all of the harmful or potentially harmful substances contained in them.

(i) The Stringer-Drummond Vaping Act, HB41, passed in May 2019. It requires the Alabama Alcoholic Beverage Control Board to regulate retail sales of alternative nicotine devices like sales of tobacco products and prohibits the sale or transfer of alternative nicotine products to minors. The law also prohibits retailers and manufacturers of alternative nicotine products and electronic nicotine delivery systems from advertising the products near schools; and to prohibit specialty retailers of electronic nicotine delivery systems from opening new places of business near schools, childcare centers, churches, and other facilities. The law prevents retailers and manufacturers of alternative nicotine products or electronic nicotine delivery systems from advertising those products as tobacco cessation devices as a healthy alternative to smoking. E-cigarettes may only be sold in tobacco, mint, or menthol flavors.

(j) The Stringer-Drummond Act also requires retailers of alternative nicotine products or electronic nicotine delivery systems to obtain a tobacco permit, to comply with FDA regulations governing the retail sale of alternative nicotine products and electronic nicotine delivery systems. Vendors must post warning signs in their stores regarding the dangers of nicotine use and potential risks associated with vaping.

(k) Under the Act, anyone selling e-cigarettes is prohibited to sell or transfer alternative nicotine products or electronic nicotine delivery systems to minors; and in connection therewith would have as its purpose or effect the requirement of a new or increased expenditure of local funds within the meaning of Amendment 621 of the Constitution of Alabama of 1901, now appearing as Section 111.05 of the Official Recompilation of the Constitution of Alabama of 1901, as amended.

(l) ADPH recently recommended that all consumers consider refraining from the use of electronic cigarette and vape products until national and state investigations into vaping-related deaths and illnesses are complete. This recommendation came after the Centers for Disease Control and

Prevention reported a cluster of severe pulmonary disease among people who use e-cigarettes or vape products, with more than 800 cases of lung injury reported from forty-six states and one U. S. territory. Two-thirds of cases are 18 - 34 years old, and twelve (12) deaths had been confirmed by September 2019 in ten (10) states.

Author: Statewide Health Coordinating Council (SHCC)

Statutory Authority: Code of Ala. 1975, §22-21-260(4).

History: New Rule: Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020.

410-2-2-.08 **Reserved.**

Author: Statewide Health Coordinating Council (SHCC).

Statutory Authority: Code of Ala. 1975, §22-21-260(15).

History: New Rule: Filed February 13, 2014; effective March 20, 2014. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Repealed:** Published March 31, 2020; effective May 15, 2020.