INDIANA

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Access Plan

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(A blueprint for access to health care)

brought to you by:

in collaboration with:

Indiana State Department of Health

March 18, 2011

Ann Alley
Director, Office of Primary Care
Indiana State Department of Health
2 N. Meridian St., Section 2J
Indianapolis, IN 46204

Subject: Indiana Access Plan, ISDH Grant Agreements CHC 685-7 and 685-5

Dear Ms. Alley:

Access to primary care is a growing concern in Indiana, and throughout the nation. In the Hoosier state, there are numerous areas which have been designated as medically underserved, and for which there are no firm prospects for increasing such access in the near future. Such areas are found in both urban neighborhoods and rural communities. Other areas may be medically underserved, but have not been recently evaluated for such status. Community health centers are one effective response to the challenge of unmet need for primary care, but Indiana has lagged behind the rest of the nation in the establishment of such centers.

The Indiana Primary Health Care Association is pleased to provide the Indiana Access Plan as a contract deliverable. This plan provides a discussion of the leading factors which influence local access to primary care in Indiana, and points to areas of the state in which there remains significant unmet need. The plan will serve as a guide for IPHCA staff as we work to expand access to primary care through community health centers in Indiana. The reader will note the delineation of specific counties as priorities for community development activity in the near future.

This Plan will be distributed to all Indiana community health centers, appropriate federal authorities, and numerous community leaders. Feedback will be used to develop a five-year plan for further expansion of access to primary care throughout the state.

Thank you for giving us the opportunity to serve the citizens of Indiana through the development of this Plan.

Sincerely,

Philip L. Morphew, CEO

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Introduction

Since 1995, the growth of community health centers in Indiana has been remarkable; yet this growth has not kept pace with other states with similar populations. There remains a significant amount of work in order to meet the health care needs of the underinsured, the underserved, and the uninsured. The Patient Protection and Affordable Care Act (ACA) of 2010 provides an opportunity for Indiana to bring health care to all residents through the development of new Federally Qualified Health Centers (FQHCs) and through the expansion of services and sites of our present FQHCs.

The Indiana State Department of Health (ISDH) and the Indiana Primary Health Care Association (IPHCA) have worked together in developing this Indiana State Access Plan. Both are committed to responsible growth of health care for the growing numbers of the state's residents who presently lack affordable access. These organizations also recognize that health care access planning is a process and effective long-term planning requires commitment, vigilance, and continued reassessment. This Indiana State Access Plan serves as a guide, not a destination.

Health Reform and Impact on Indiana

FQHCs are entering a watershed period of growth and expansion. The ACA envisions the Health Center Program (Section 330 of the Public Health Service Act) as a cornerstone for achieving greater access to care; the Act includes provision for an $11 billion Health Center Trust Fund, and permanently authorizes the FQHC Program. Over the next five years (Federal Fiscal Years 2011 through 2015), the aforementioned $11 billion in additional funding for FQHC operations and facilities will be distributed to qualified organizations. Of this total, $1.5 billion will be available for capital funding ("bricks and mortar"), and $9.5 billion for operations. Out of the $9.5 billion total for operations, approximately $3.6 billion will go to grant applicants for new access points (NAP) and start-up FQHCs, and for expanded medical care (EMC) grants.

However, when it comes to Health Resources Services Administration (HRSA) funding, Indiana's record is anything but successful. The state ranks last in the nation in HRSA funding when measured on a per capita basis. [1] With two percent of the nation's population, Indiana has less than 1% of the nation's FQHC sites.

The next five years will be extremely important to Indiana's existing safety net primary care providers, and to communities in Indiana that lack adequate access to high quality primary health care services. This plan discusses and documents relevant factors in determining priority areas of health care need and access; these include unemployment, poverty levels, identification of distressed counties, health factors, and health outcomes. It is imperative for IPHCA to be proactive in assisting providers and communities to compete successfully to expand services.

[1] Trust for America's Health: "Shortchanging America's Health: A State-by-State Look at How Public Health Dollars Are Spent and Key State Health Facts." March 2010.

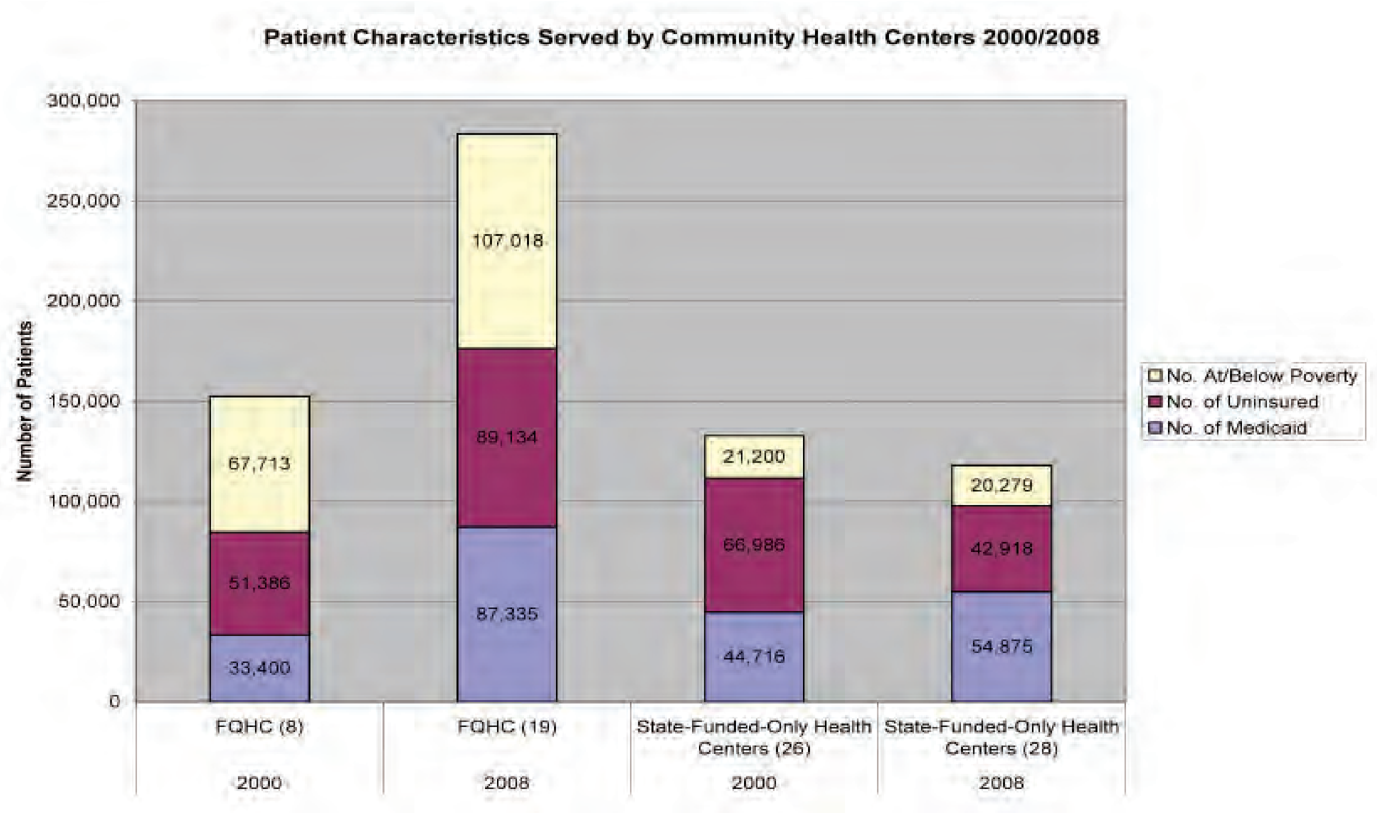
Documented Need for Expansion of Health Care Access

This Access Plan provides documentation of the need for expanded access to primary care. Currently, FQHCs in Indiana combined with Indiana state-funded health centers serve approximately 500,000 Hoosiers. IPHCA has established the goal to double that number so that by 2015 one million Indiana residents will have access to a medical home in Indiana's community health centers.

Health Centers in Indiana

Indiana has nineteen FQHCs and is fortunate to be one of a handful of states that has state-funded only community health centers. These twenty-eight community health centers, along with the nineteen Federally-Qualified Health Centers (FQHCs), provide primary care to approximately 500,000 Hoosiers and serve as the foundation for access to health care for all regardless of financial circumstances, race, sex, age, or geography. Indiana's CHCs served nearly 150,000 uninsured Hoosiers (16% of the uninsured), more than 61,500 Medicaid recipients (7% of the Medicaid population) and more than 163,000 individuals at/or below poverty level (15% of the total are at or below the FPL).

Over the last few years, Indiana's community health centers have seen a steady increase of patients. However, the need for the growth of CHCs and expanded primary care services around the state is considerable. Since 2000, nine state-funded only health centers became FQHCs. Existing health centers are functioning at capacity and there are large areas of the state that remain without this valuable community resource.



Indiana Will Double the Number of Patients Served in Health Centers by 2015

IPHCA, in concert with its partners, will facilitate increased access to care to Indiana residents statewide through the establishment of New Access Points and the expansion of primary care facilities in all areas of the state.

Determining Areas of High Need and Establishing Priorities for Expansion

The Indiana State Access Plan charts the course for Indiana to succeed in improving access to primary care while bringing its fair share of additional funding into the state for comprehensive and quality primary health care services for all its residents.

Through this plan:

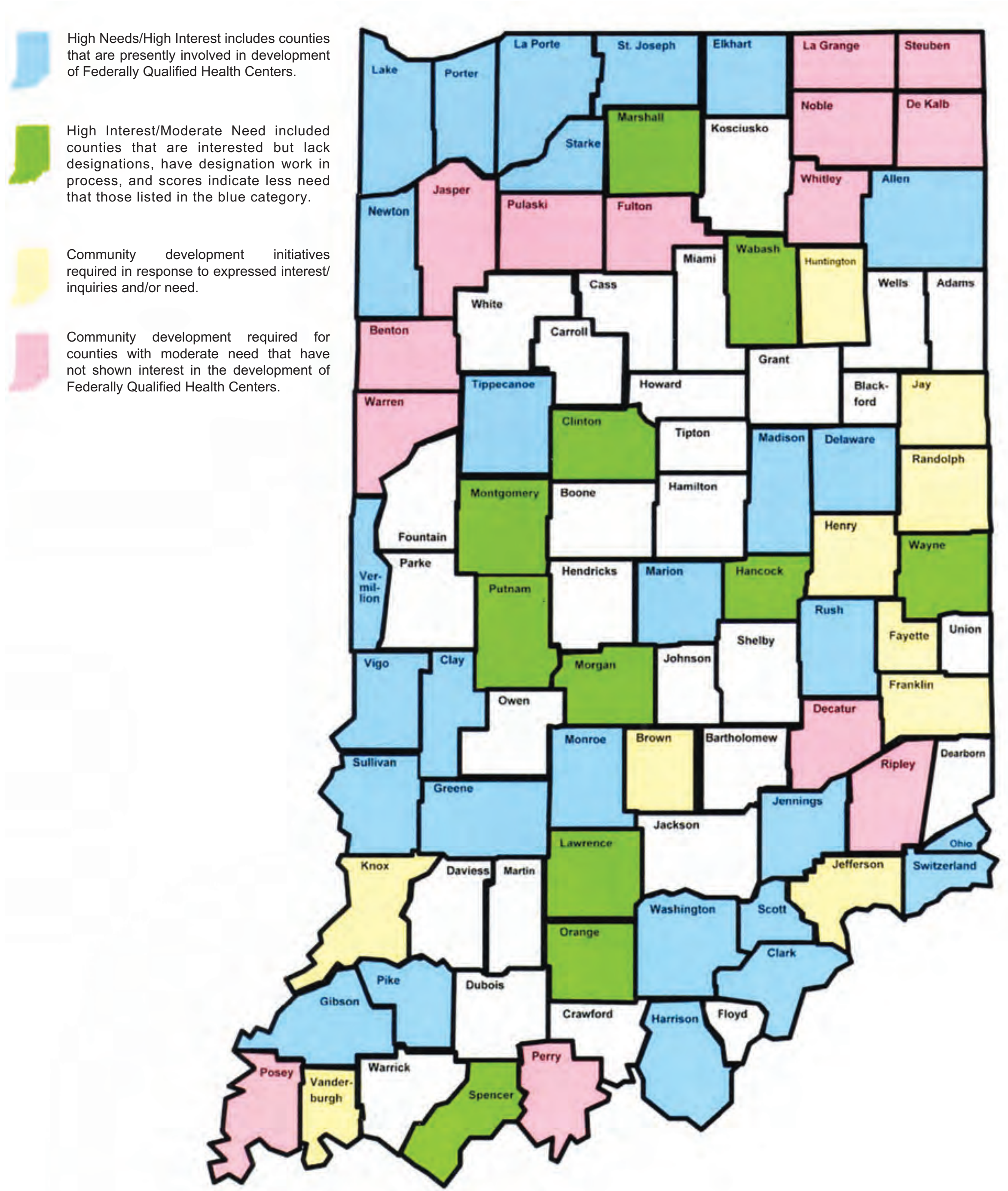
- Specific communities of high need in which a new FQHC or expansion of sites for existing FQHCs is appropriate have been determined and will continue to be refined.
- A plan for achieving success in those communities by the end of 2011 and community development work beyond 2011 is included.

Execution and achievement of these objectives requires collaboration among all stakeholders: HRSA, ISDH, IPHCA, Indiana's existing FQHCs and state-funded only CHCs, the Indiana House and Senate, the Governor's Office, community leaders throughout the state, and Indiana's health care network. Ultimately, the development of a community health center must be led by local community leaders, including consumers, government officials, health care professionals, clergy, and the business community.

Please see Appendix A regarding the methology used to establish priorities and the data used in the analysis.

Appendix D contains the rankings of all counties on health outcomes and health factors.

Map of Expansion of Health Care Access



IPHCA will provide leadership in promoting increased access to care through responsible growth of community health centers in areas of greatest need.

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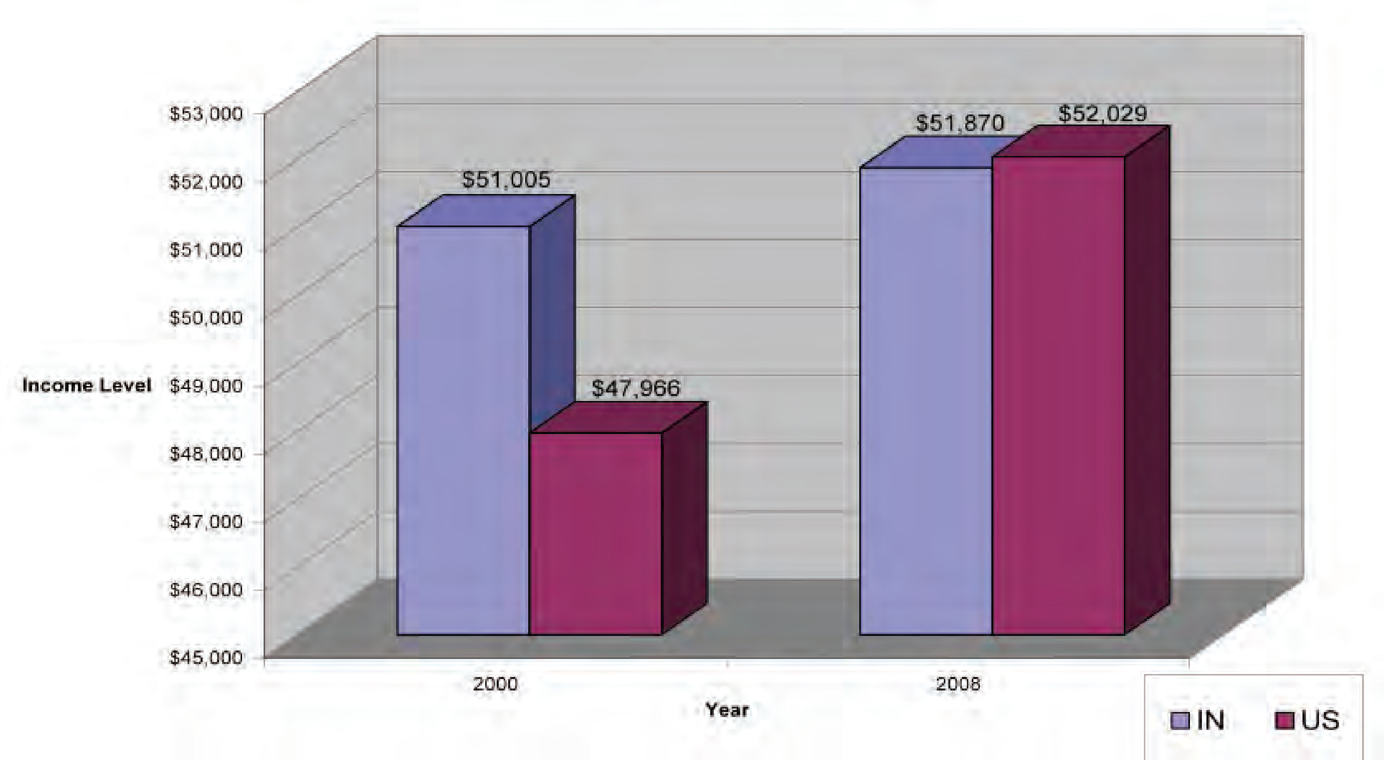
Economic Factors Impacting Health Care in Indiana

The Great Recession

While much continues to be written about the recent Great Recession, less attention has been paid to the downturn in Indiana's economic growth that began in the mid-2000s. Even before the Great Recession of 2007, Hoosiers were dealing with declining wages while the cost of living continued to increase. For example, in 2008, Hoosier workers earned less per hour than they earned in 2000. [2] Indiana's median household income of $47,966 in 2008 was six percent lower than in 2000. [3]



Since 2008, the financial condition of Hoosier workers has deteriorated. In spite of Indiana's 2000 economic downturn, the state was able to maintain an unemployment rate less than the national average and only one Indiana county suffered double-digit unemployment. (See Appendix B for unemployment figures by county.) However, 2010 presents a sharp contrast:

- a double-digit unemployment rate in 51 of Indiana's 92 counties and;
- an unemployment rate greater than the national average. [4]

[2] Sarah Downing. The Status of Working Families in Indiana, 2009. Indiana Institute for Working Families, Page 1

[3] Op Cit

[4] Indiana Department of Workforce Development – Research and Analysis

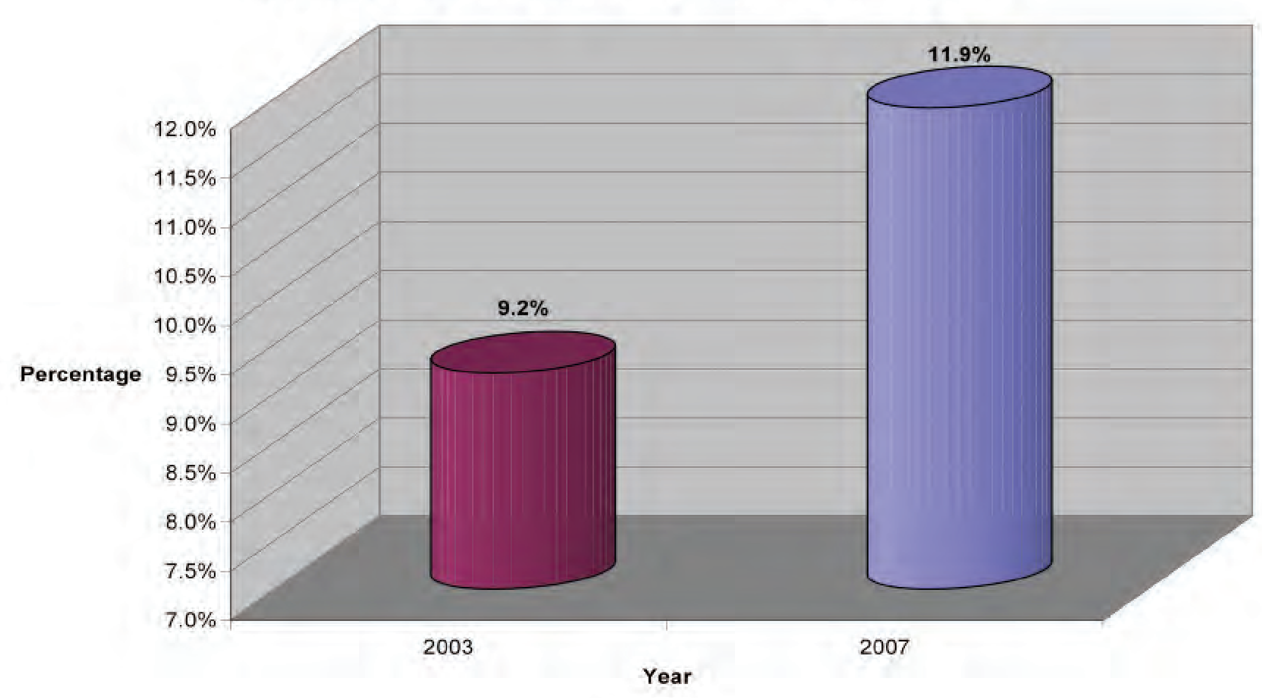
According to a recently released Kaiser Commission report, many Americans are putting off important health care because of cost.

Putting Off Care Because of Cost

In the past 12 months, have you or another family member living in your household put off getting health care because of the cost, or not?

	Percent saying "yes"
Relied on home remedies or over the counter drugs instead of going to see a doctor	38%
Skipped dental care or checkups	36%
Put off or postponed getting needed health care	30%
Skipped recommended medical test or treatment	28%
Not filled a prescription for a medicine	26%
Cut pills in half or skipped doses of medicine	21%
Had problems getting mental health services	10%
Did ANY of the above	67%

Source: Kaiser Family Foundation Health Tracking Poll (conducted March 10-15, 2010)

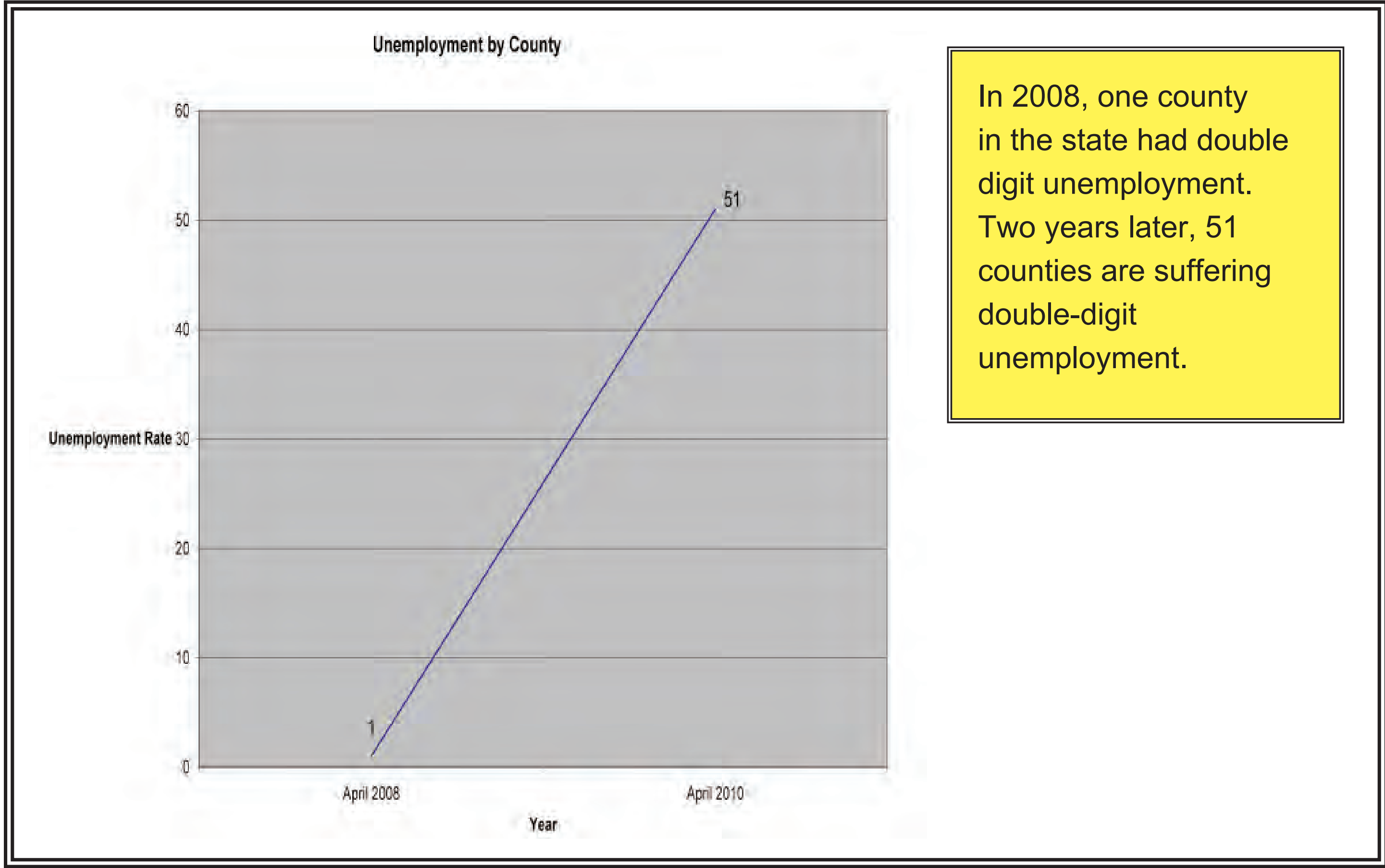


Indiana's Changing Workforce Needs

Prior to the Great Recession, Indiana was still reeling from the mid 2000's economic down turn. Employment in the state peaked in May 2000 with 3,015,200 jobs. Three years later that number dropped to 2,882,600. August 2007 marked the end of growth in Indiana and the four previous years' growth were eradicated by December of 2008. In 2009, the Great Recession worsened and by mid-2009, the number of available jobs reached a new low: 2,815,100. [5]

This shift in workforce needs away from manufacturing and knowledge base sectors left many highly paid, but only minimally educated, individuals without jobs. If history repeats itself, it will take many years for those manufacturing jobs to become available. However, since many were in the auto industry, it is unlikely those jobs will return to the state.

Source: Economic Policy Institute analysis of Current Population Survey Data



Source: Economic Policy Institute analysis of Current Population Survey Data
Note: For unemployment on a county-by-county basis, please refer to Appendix B.

[5] Economic Policy Institute analysis of Current Employment Statistics survey data. Reported in the Status of Working Families in Indiana, 2009. p 8-9.

Summary Regarding Unemployment and the Economy of Indiana in Relationship to Health Care

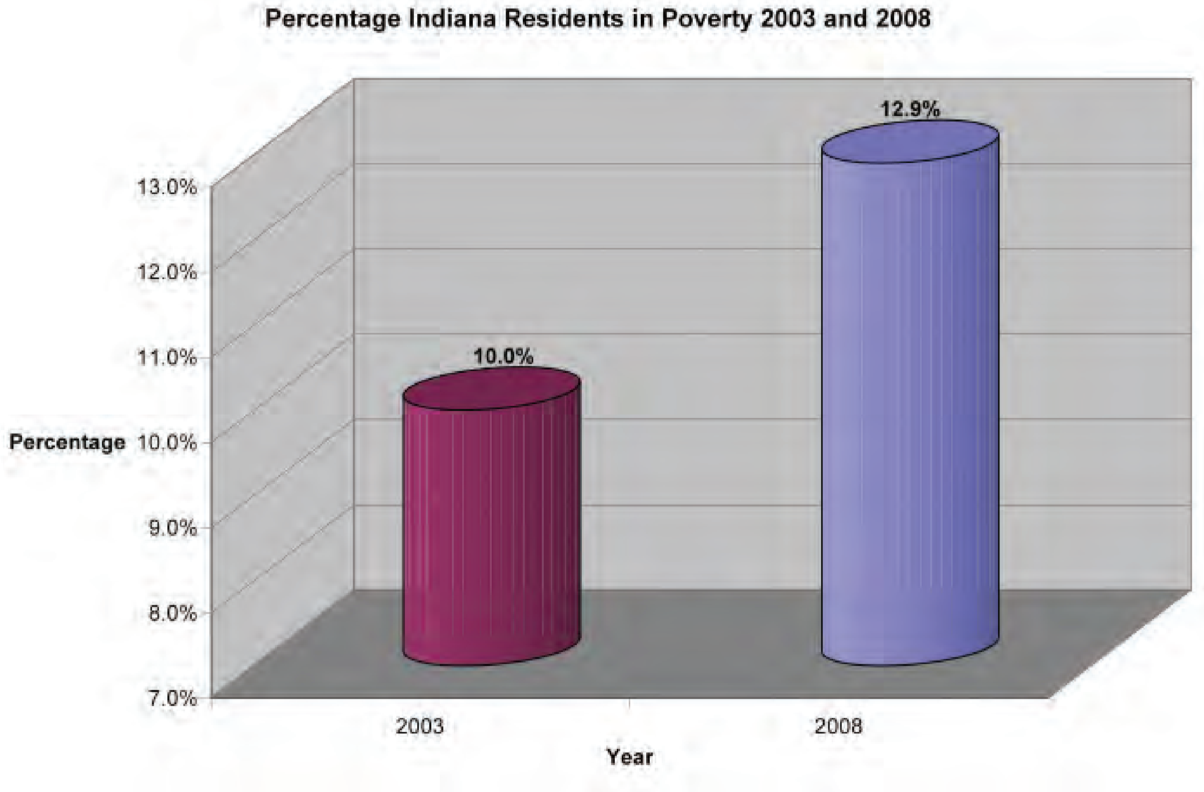
Based on present trends, it is expected that a growing number of Hoosiers will rely on safety-net health providers for their primary health care needs. Potential challenges for community health centers:

- Of particular importance is the growing number of unemployed residents between 16 and 25 years of age.
- A number of counties are suffering high unemployment due to the loss of jobs in the manufacturing industry section. These counties can expect additional strains on available resources and may require capacity building efforts, new access points, and development of new FQHCs in order to meet the increase in demand for primary care services.

Specific information on priority areas is addressed in another section of this report.

Poverty Trends in Indiana: 2003 through 2008

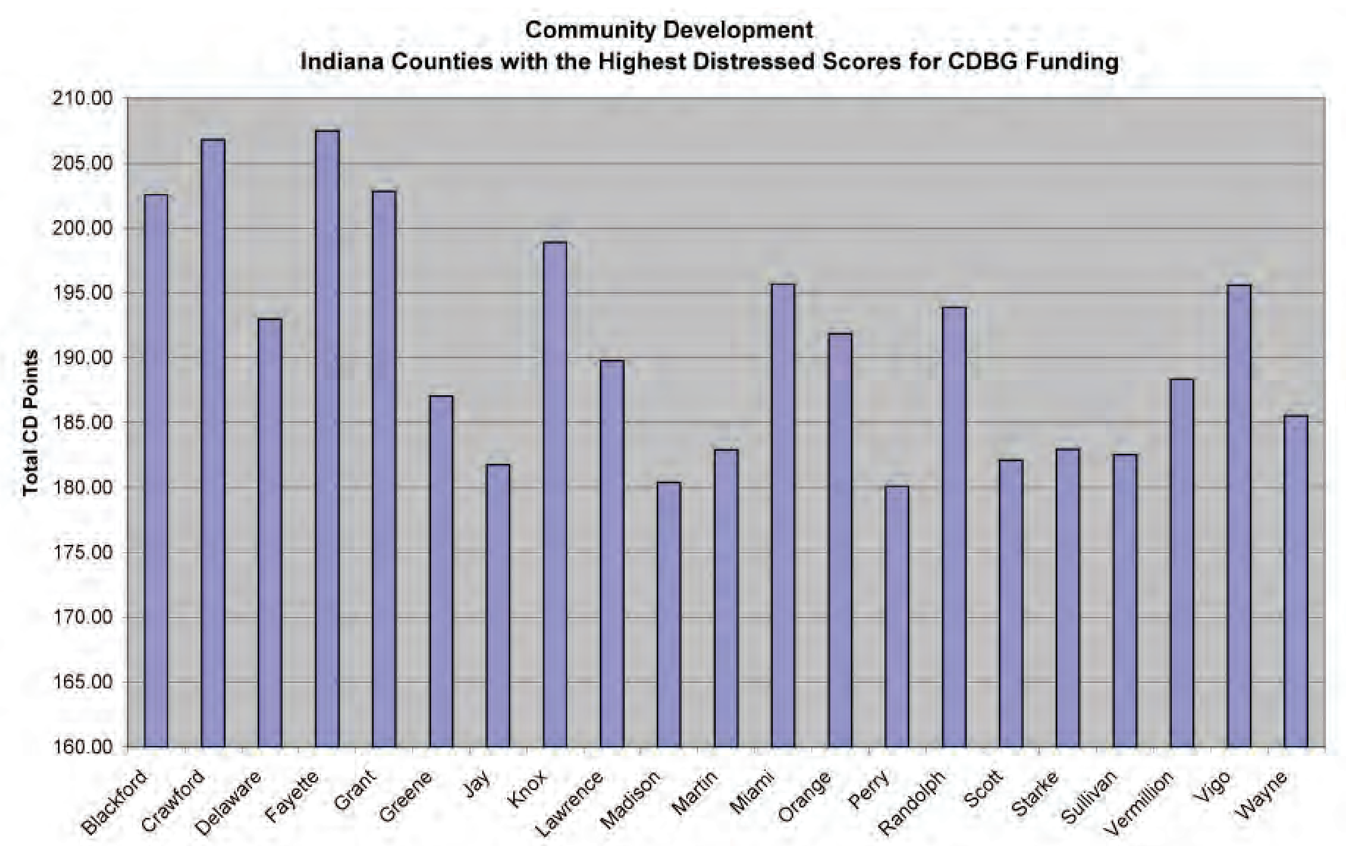
Poverty levels increased in Indiana from 2003 through 2006. In 2007, the poverty rate decreased by .2% and then the Great Recession began and poverty rates increased. A number of counties from 2003 through 2008 consistently have poverty rates above the state average. (For county-by-county data, please see **Appendix C**.)



The U.S. Census Bureau's Small Area Income and Poverty Estimates (SAIPE) program provides annual estimates of income and poverty statistics for all states, counties, and school districts. U.S. Census data 2003-2008. The U.S. rates for the same years were 12.5% and 13.2%

Distressed Counties in Indiana with Scores 180 and Higher

As expected, there is a strong correlation between the counties with high poverty and the counties designated as distressed counties by the economic development agencies. The highest scoring distressed counties are eligible for Community Development Block Grants (CDBG). These grants can provide infrastructure support for community health centers by providing funds for building/renovating.



Note: For an explanation of the scoring process, please see Appendix E.

Policy Issues

IPHCA will develop and maintain expertise in all relevant programs and related activities, including but not limited to HRSA developments, Medicare, Medicaid, Indiana's State Insurance Exchange, state and federal legislative activities.

Healthy Indiana Plan (HIP)

In January 2008, adults between 19 and 64 began enrolling in the Healthy Indiana Plan (HIP), which passed during the 2007 Indiana General Assembly session. HIP covers low-income uninsured caretaker adults and childless adults who do not have employer-sponsored coverage and those who are ineligible for traditional Medicaid and/or Medicare. HIP members receive full health benefits including hospital services, mental health care, physician services, prescriptions, diagnostic exams, and disease management. All preventive services are free, including smoking cessation costs. Participants pay between 2% and 5% of their gross family income for this insurance. The community health centers were instrumental in helping those qualified complete the paperwork for HIP eligibility. This is one important revenue source for community health centers and CHCs have played an important role in helping individuals apply for these benefits.

In November 2009, the Family and Social Services Administration (FSSA) announced that 5,000 HIP enrollment slots opened to childless adults. The 34,000 cap for childless adults was reached earlier in the year. Federal regulations limit how many childless adults may be enrolled in the program. Although the HIP waiver does not expire until December 31, 2012, childless adults are no longer being enrolled due to Affordable Care Act.

The state is currently awaiting approval from CMS for use of the HIP criteria for the expansion of Medicaid in 2014.

Medicaid Enrollment Issues

All 19 FQHCs and many of the state-funded CHCs offer Medicaid outreach and enrollment services to Hoosiers – an important service to eligible patients, as well as an important revenue source for community health centers.

The process of applying for Medicaid, and other state programs, changed in the fall of 2007. In 2005 the Daniels administration, in order to improve the efficiency and effectiveness of the state programs, began the process of privatizing the eligibility system for many social service programs including Medicaid, TANF, and food stamps. By a bid process, IBM became the lead company to serve as the prime contractor for what was called the Eligibility Modernization project. In late 2007, the state initially implemented eligibility modernization in two of four regions of the state. Computerized enrollment methods, in place of caseworkers, were introduced; these created confusion and frustration on the part of those applying for benefits as well as authorized representatives attempting to help these individuals.

In January 2009, because of numerous complaints and problems, the state halted rollout to the other two regions. The contract with IBM was canceled and a new plan for eligibility programs, termed the Hybrid System, was developed. The biggest difference between the Hybrid System and the Eligibility Modernization Plan was a return to face-to-face contact. The state continues to expand the Hybrid System, and with pending approval from CMS, it will be expanded statewide.

Health centers had previously expressed great concern as to the impact of privatization on their patients, in particular maintaining coverage. It will continue to be an IPHCA priority to monitor the hybrid system and the effect it could have on Medicaid enrollment.

This issue is particularly important because of the projected increase in Medicaid enrollment in 2014 (300,000 to 500,000 additional enrollees) resulting from the Affordable Care Act. New solutions may be needed, and it may be necessary for health centers to play an even more significant role in outreach and enrollment.

The Affordable Care Act - Expansion of Medicaid and State Exchanges

Health reform legislation calls for Medicaid eligibility to be raised to 133% of the FPL by 2014. If this provision in the legislation has the effect of increasing Medicaid enrollment by almost 50 percent and requires additional support from state tax dollars as some predict, CHCs will be instrumental in lowering the cost burden represented by the increase in number of insured. Another opinion, one supported by historical analysis predicts that not all who are eligible will apply for Medicaid. In this case, modeling the State Children's Health Insurance Program Outreach programs, CHCs can be instrumental in helping Indiana ensure access is realized by covered populations including newly covered adults.

In addition, the Affordable Care Act provides funding assistance to the states for the planning and establishment of American Health Benefit Exchanges and Small Business Health Options Program. The Act provides that each state may elect to establish an exchange that would: 1) facilitate the purchase of qualified health plans; 2) provide for the establishment of a Small Business Health Options Program designed to assist qualified employers in facilitating the enrollment of their employees in services offered in the exchange; and 3) meet other requirements specified in the ACA. Federal funding will be made available to States for planning implementation of the exchanges. It will be important for IPHCA to monitor all elements regarding the ACA to be certain the interests of the community health centers are understood and considered.

IPCHA, and partners, will advocate for state and federal funding to expand the assessment and designation of sites as medically underserved areas (MUAs) or populations (MUPs) and health professions shortage areas (HPSAs).

Current Analysis of State Health (Shortage Designation Issues)

Medically Underserved Area (MUA)/ and Medically Underserved Population (MUP) designations are crucial to the development and sustainability of FQHCs. Underserved and shortage designations are prerequisites for a variety of federally funded programs available to both institutions and individuals. This access plan prescribes how IPHCA and partners may increase designations in order to increase the number of FQHCs so that access to healthcare may be expanded in Indiana.

In order for a community to develop a Federally Qualified Health Center, the community must have been designated an MUA or MUP. Once established, an existing FQHC can open a site in an undesignated area if a high need for health care access exists. This is one way access may be increased as FQHC satellite sites proliferate. Increasing the number of underserved and shortage areas in the State as a means to making health care available to all is a priority for IPHCA and the ISDH.

Health Professional Shortage Area (HPSA) – Medical, Dental and Mental Health

HPSA designations are a way to classify a certain area as having too few providers to serve the needs of the community in question. In order to identify these areas and to qualify them for certain federal programs, HPSA designations are used. The three types of designations define shortages in the primary care, dental, and mental health disciplines.

As of March 2011, Indiana had 39 primary care HPSA designations and 43 primary care facility HPSA designations spanning 50 counties; 13 dental HPSA designations and 25 dental facility HPSA designations spanning 21 counties; 12 mental health HPSA designations and 34 mental facility HPSA designations spanning 53 counties.

The maps and tables of the MUAs/MUPs and HPSAs are found in the Appendices.

Site Designation

IPHCA, through a contract with the ISDH, assists in creating and submitting shortage designation applications for the state of Indiana. These designations are used to qualify organizations or individuals in these areas for certain state and federal programs aimed toward providing care for the underserved. These programs include the National Health Service Corps (NHSC), Rural Health Clinics (RHCs), FQHCs, Indiana J-1 Visa Waiver Program, as well as the CMS Medicare Incentive Payments. Recently, there has been a sharp increase in the number of requests for MUA/P designations. This can be partially attributed to the increase in sites interested in becoming FQHCs, as a facility is required to be located in an MUA/P to receive FQHC status. FQHCs receive Federal benefits including enhanced reimbursement, medical malpractice insurance, and annual financial assistance. These benefits help offset the costs of providing health care to the uninsured. Often there is interest in establishing a new FQHC or a New Access Point, but the entity seeking that status is not in a designated MUA or MUP. HPSA designation requests are also consistently received, as the increased funding for the National Health Service Corps (NHSC) has provided a boost in interest.

The process of establishing a shortage or underserved area designation is labor intensive and often data necessary to make the argument are not readily available and must be supplemented with manual surveys of providers. As of March 2011, Indiana had 52 shortage designation requests on a waiting list. These requests span 47 counties across the state.

In order to support the projected growth in designated areas and entities that will be required by primary care providers by the end of 2015 IPHCA estimates that staff dedicated to this effort must be tripled.

Workforce Development

Rural and underserved communities today find themselves in a difficult situation when it comes to recruiting primary care providers. As more physicians choose specialty fields, these underserved and rural areas must compete with wealthier medical practices and communities for the small number of primary care physicians available. In 2009, only 14 of the 260 Indiana University School of Medicine graduates matched to a family medicine residency program. The Indiana University School of Medicine Rural Track Program in Terre Haute has accepted 14 medical students to begin in the fall of 2010. When the Terre Haute Rural Track Program was developed, the intention was for the rural track students to remain at the Terre Haute campus for all four years of their schooling. Due to various funding obstacles and the ever increasing number of physicians entering into specialty field CHCs, RHCs and community mental health centers (CMHCs) have continued to face challenges in recruiting and retaining practitioners to rural and underserved areas.

It is estimated that Indiana will have a shortage of roughly 2,000 primary care physicians by 2020. [6] A study released in March 2010 estimated the nursing shortage by the end of this year to be 8,200. [7]

To address the shortage of primary care physicians in the state, Marian University, a Catholic liberal arts college in Indianapolis, announced its plan to open the state's second medical school in January 2010. The osteopathic school will open in the fall of 2012 or 2013 and anticipates enrolling 150 students in its first class. While a step in the right direction, it will be years before the school can impact primary care shortages.

On June 16, 2010, U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius announced $250 million worth of investments to increase the number of primary care providers and strengthen the primary care workforce. These investments are the first allocation from the new $500 million Prevention and Public Health fund for fiscal year 2010, created by the Patient Protection and Affordable Care Act. These funds will go toward increasing the supply of primary care providers in the United States by providing resources for additional primary care residency slots, working to support physician assistant training, encourage full-time nursing careers, establishing new nurse practitioner-led clinics, and encouraging states to plan for and address health professional workforce needs. It is estimated that these investments will help to train and develop 16,000 new primary care providers, which is a crucial workforce increase when planning for the expansion of CHCs.

The NHSC is a division of the Health Resources and Services Administration (HRSA), part of the U.S. Department of Health and Human Services. The purpose of the NHSC is to match communities in need with compassionate health professionals and, by so doing, support efforts to strengthen systems of care. Helping medically underserved communities recruit and retain qualified health professionals is the driving force of this program and, in turn, rewarding these health professionals for their service.

The NHSC was created due to the health care crises that emerged in the U.S. during the 1950s and 1960s. Physicians who served rural communities began to retire, leaving many areas of the country without health care services. Several factors contributed to the crises including the increasing specialized nature of medical practices and rapid technological advances. Smaller proportions of medical students entered family medicine. Rural areas and inner-city neighborhoods competed unsuccessfully with affluent medical practices that offered higher compensation, more interaction with other professionals and job opportunities for spouses. Rural communities lacked resources to provide the technologically sophisticated facilities that many physicians desired. In 1970, rural states appealed to Congress for help thus establishing what is now known as the National Health Service Corps.

[6] Bowen Research Center's presentation: "Indiana's Physician Supply, Do We Have Enough?" Deborah I. Allen, MD; Terrell W. Zollinger, DrPH.

[7] Trust for America's Health: "Shortchanging America's Health: A State-by-State Look at How Public Health Dollars Are Spent and Key State Health Facts." March 2010.

The following health professionals are eligible to participate in the NHSC:

- Primary Care Physicians
- Nurse Practitioners
- Dentists
- Mental and Behavioral Health Professionals
- Physician Assistants
- Certified Nurse-Midwives
- Dental Hygienists

These clinicians can apply for either a NHSC Scholarship or Loan Repayment. Those receiving NHSC Scholarships are required to commit to sites with a HPSA score – an index of unmet need for health care professionals – of 14 or above for primary care, 17 or above for dental care, and 18 or above for mental care for a service contract equal to the term of the scholarship award. Health professionals already employed at an approved NHSC site are eligible to apply for the Loan Repayment Program. Loan Repayors must be fully trained, licensed and employed at the time of their application and are required to sign a contract for a minimum of two years with an award of $50,000. At the end of this contract, they are eligible to reapply for additional Loan Repayment.

As of March 2011, Indiana had 146 approved NHSC Sites. These include FQHCs, RHCs, CMHCs, as well as private practices. Additionally, Indiana had 105 providers receiving loan repayment and six practicing scholars. Forty-eight of the 111 NHSC providers were primary care clinicians, ten were dental and 53 were mental health. Forty-nine of these providers were practicing in urban areas, while 62 were practicing in rural areas.

The American Recovery and Reinvestment Act of 2009, which provided the NHSC with $300 million in additional funds, made available the resources to essentially double the previous field strength of the program. It was projected that 3,300 practitioners would receive loan repayment awards between 2009 and 2011. This increase in funding was a welcome relief to sites and clinicians located in rural and underserved areas. The Health Care Reform Bill of 2010 will provide the NHSC with additional funds to continue distributing loan repayment awards regardless of HPSA score.

IPHCA is committed to the successful growth and expansion of community health centers. IPHCA will play a leading role in workforce development to meet the needs of community health centers for health care professionals consistent with increased access to care.

Recruitment and Retention

To assist Indiana community health centers with the recruitment and retention efforts, IPHCA enlisted the help of a Workforce Development consultant in September 2009 with one-time funding.

Since September 2009, IPHCA has successfully placed 19 candidates within Indiana community health centers: 11 family practice physicians, two nurse practitioners, two physicians' assistants, three dentists, and one dental hygienist.

The consultant has made numerous presentations to residency programs and participated in residency fairs. Unfortunately the one-time funding has not been replaced and future development is uncertain. It is IPHCA's intention to provide the tools and technical assistance for CHCs in Indiana to become fully staffed in order to meet the demand of their patients. By providing these resources, the Indiana CHCs will have the opportunity to aggressively compete for candidates, regardless of any workforce shortage that exists.

IPHCA will seek funding to expand its community development services, and will establish an organizational unit dedicated to community development activities.

COUNTY	COMMENTS & STRATEGIES	ANTICIPATED OUTCOMES
Allen	Assist present FQHC in determining location of new site/provide assistance with application upon request. Staff met with CEO to determine priority area for New Access Point. Shortage Designations specialist looking at MUA data for expansion of the existing MUA est. in 1993.	Facilities expansion in 2011 NAP within 5 years
Boone	Has a state-funded CHC. Two census tracts indicate need. Shortage designation work to be completed. Interest in community.	Community Development
Clark	The Family Health Center of Clark County, an FQHC, is planning a new access point in Scott County. IPHCA staff members have met with FQHC on three occasions (as of 7/26/10) to provide assistance with the development of this new access point. A good partnering relationship exists between Family Health Center and Scott County community leadership. Application to be completed by Linda Codey, grant writer for Family Health Center of Clark County. IPHCA providing ongoing assistance, if requested, in setting priorities for the next five years.	New Access Point in 2011
Crawford	Crawford is an underserved county with poor health out comes (83 out of 92), poor health factors (86 out of 92), and over 7,000 unserved. It also has a high score on the "distressed counties" scale and, as a result, may be able to obtain facilities funding through CDBG grants. Southern Indiana Community Health Care is a nonprofit org. founded in 1974 by a small group of Mennonite physicians. IPHCA' s CEO met with group. Another meeting scheduled.	At this time, no plans for NAP
Daviess	Daviess presently has approximately 27,000 underserved. The entire county is a designated MUA. One state-funded CHC provides care in this area.	Community Development 2010-2011
Decatur	Providing education and technical assistance. Meeting with community representatives. Decatur has an MUA.	Community Development
Elkhart	State-funded CHC applying for FQHC status. Expansion of existing FQHC.	NAP 2010 Capacity Expansion
Gibson	One state-funded CHC in county. This CHC is interested in FQHC status and 12,034 people remained underserved in Gibson County. Other providers in the area are also interested. IPHCA will work with all parties.	Community Development
Greene, Sullivan, Clay	Presently completing planning grant work for this tri-county area. Non-profit corp. has been established. Executive Board and subcommittees are meeting. FQHC application to be submitted this year.	New Access Point 2010-2011
Hancock	Interest exists in county. Providing education to hospital administrators. Hospital and state-funded center meeting with Open Door for NAP.	New Access Point 2011-2012
Henry	Comm. Dev. work in process. FQHC and IPHCA meeting with county stakeholders. State-funded CHC in Knightstown interested in partnering with Open Door.	New Access Point due to recent developments in county
Jefferson	The FQHC in Clark County is considering a new site in Jefferson County.	Community Development
Knox	Present MUA designations and interest in FQHC. Provide education and TA.	Community Development
Lake	Unmet need. Existing FQHCs planning expansions.	NAP

COUNTY	COMMENTS & STRATEGIES	ANTICIPATED OUTCOMES
Lawrence	MUA designation presently being updated. Lawrence has a high "Distressed County" score, unemployment is high, and local reports indicate doctors have closed their Medicaid panels. IPHCA/ISDH recently got a Governor's Exception MUA approved.	Community Development Education with Hospital which was recently purchased by hospital group
Marion	Community Health/Jane Pauley Center applying for FQHC status Existing FQHCs applying for new sites. IPHCA provided TA to Jane Pauley.	NAP in 2010 Look-a-like status received Additional NAPs in 2010 in Marion County
Marshall	Existing FQHC considering establishing new site.	NAP in 2010
Montgomery	Presently no MUA/P. Shortage designation work.	Community Development
Morgan	Present FQHC plans new site in this county.	NAP 2010
Newton	IPHCA worked with Newton County through a planning grant for complete preliminary work on development of a FQHC. Comm. dev. work will continue.	Community Development 2010-2011
Ohio	One state-funded CHC is the only provider of primary health care in this county. This state-funded CHC is interested in FQHC status. Due to size of population, an existing FQHC would need to open a new site in this county.	New Access Point possible in the future
Owens	Has a large underserved population. Providing technical assistance and working with Centerstone Behavioral Health Services for development of area-wide FQHC.	New Access Point
Parke	MUA. One state-funded in County.	Community Development
Porter	Unmet need. NAP app. from existing FQHCs	NAP 2010
Ripley	MUA. Education and TA.	
Rush	Working with Centerstone in dev. of NAP.	No New Access Point
Scott	See above under Clark County.	New Access Point
Spencer	Community development work.	2011
St. Joseph	Interest in new FQHC or expansion of existing FQHC in this county Approximately 22,000 underserved presently providing technical assistance and will continue to do so.	New Access Point
Switzerland	One state-funded in county. Poor health outcomes. Large number of underserved.	Development
Vigo	MUA. Previous planning process indicated resistance to FQHC. IPHCA to revisit due to documented need.	Development
Washington	MUA. Development of FQHC site by existing FQHC located in nearby county.	Community Development
Wayne	Recently received MUA designation. Great need. Existing state-funded to apply for FQHC.	Community Development

Leaders of many communities in Indiana are considering the possibilities for establishing a new FQHC, or for applying for FQHC status through an existing State-funded only community health center. In most of these instances, IPHCA is providing support and consultation to these leaders, assisting them in reaching decisions about the path forward. However, there are many other communities which may be appropriate for FQHC activity, but in which the opportunities are largely unknown. IPHCA, with adequate funding, should establish a Community Development unit of 3.0 FTEs to assist communities throughout the state in identifying and taking advantage of the opportunities that await.

IPHCA will work with counties with high need (as shown on the map on page 4) that have not expressed an interest in developing FQHCs. Our work will include working with community leaders to educate them about FQHCs, discussion of the possible needs with medical professionals in the county, and meeting with potential stakeholders.

In conclusion, in order to successfully grow and expand CHCs around the state, a definitive departure from the past is needed in three areas: recruitment and retention of health providers, including physicians, nurse practitioners, dentists, and other health professionals when such are not locally available in communities; site designation of rational service areas as medically underserved; and community development activity to assist local communities in planning for and establishing new FQHCs or New Access Points for existing FQHCs. These basic building blocks are essential to achieving expanded access in Indiana, and in garnering the economic boost that will result from our success in competing for HRSA grants from the Health Center Trust Fund.

Summary of Action Plan/Recommendations

Strategies and recommendations to double the number of Indiana residents that have access to comprehensive primary care services:

- In the short run, IPHCA has developed community development capabilities to respond to phone calls and interest expressed by communities who contact the IPHCA office requesting information.

- IPHCA and the ISDH will continue to collaborate to meet the demands and needs of local communities. Additional funding is needed to gear community development activity up to a level that corresponds with demand and/or expressed need. In our proposed action, IPHCA would provide community development support to all communities requesting such support, to the extent that funding and staffing permit. Priority will be given to those counties identified as having the greatest need for increased access to quality health care. The aim will be to assist these counties in completing the requisite groundwork and preparing and submitting a competitive proposal for an FQHC. In some cases, the proposal may be submitted in 2010; in others, it may be necessary to delay grant proposal submission until 2011 or beyond.

- In some of these communities, work must be completed to designate the site as either MUA or MUP where no designation is in place. In most of these communities, community development work must include assistance to local leadership in planning for and proposing the new FQHC to HRSA.

- Contact communities that appear on the High Priority list because of high poverty, high health disparities, low unemployment, etc, as demonstrated by the Access Plan data.

- Long term, develop additional technical assistance capabilities to serve newly expanded FQHCs and newly funded FQHCs.

- Develop funding to continue to support already initiated workforce development activities. Add additional staff and expand services in order to double the number of new practitioners required in Indiana.

- Develop additional shortage designation staff at IPHCA and/or the ISDH to respond to communities that require an MUA/MUP for New Access Points, or a HPSA to attract needed primary care providers.

- In our proposed action, IPHCA would continue to work with ISDH in efforts to identify and designate sites as medically underserved areas or populations. This activity is viewed as a time-limited effort, as such designations, once approved, do not require renewal. We estimate that most of this work can be completed within a twenty-four month period.

- Support policy issues to monitor the implementation of the hybrid Medicaid enrollment system, the implementation of Medicaid to 133% of the FPL for adults, and the issues as they develop around the creation, or not, of a State Insurance Exchange.

Conclusions

Indiana's community health centers are a valued and valuable resource to local communities across the state. The community health centers provide quality primary health care to approximately 500,000 residents, provide local jobs, and contribute to the economic well-being of the communities in which they are located. However, Indiana ranks last in the nation in HRSA per capital funding, and still has more than one million residents without adequate access.

This Indiana Access Plan provides the foundation for on-going planned expansion of community-driven primary care services for residents. With expanded community development and site designation, with a focus on recruitment and retention of health care professionals, and by working with all partners, especially local communities, Indiana will double the present number of Hoosiers who have access to health care by 2015.

Appendix A: Prioritizing Expansion

Methodology

Areas of High Need and Priority/Expansion Opportunities and Plans

Through this plan, specific communities of high need are identified. IPHCA will work with these communities and with current FQHCs and state-funded community health centers in development and expansion of access to health care in high need areas. IPHCA provides a plan for achieving success in these communities. Priorities for expansion are located in Appendix D.

Prioritizing Expansion Opportunities

Selected variables used in establishing priority health care expansion needs include:

1. Present Medically Underserved Areas/Populations;
2. The presence of Federally Qualified Health Centers or state-funded community health centers in a county;
3. The number of remaining underserved;
4. Unemployment rates as of April 2010;
5. Percentage of individuals under 100% of the Federal Poverty Level;
6. Percentage of uninsured adults;
7. Distressed counties with scores above 180;
8. Health outcomes of each county by rank (one through 92);
9. Health factors of each county by rank (one through 92); and
10. Interest and planning presently within a community.

The factors included for the health outcomes and health factors rankings are numerous. These variables are listed below and the results are from a study completed by the Wisconsin University School Population Health Institute and funded by the Robert Wood Johnson Foundation.

Health Outcomes and Health Factors by County in Indiana

This publication, released in 2010, is the first of-its-kind in the U.S. This report contains health factors and outcomes for all U.S. counties and is a product of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The University of Wisconsin designed this research project and tested/used this process in Wisconsin for six years before implementing it on the national level.

The measured health outcomes are based on the following:

- Mortality rates
- Premature death
- Morbidity
- Poor/fair health
- Poor physical health days
- Poor mental health days
- Low birth rate

The measured health factors include:

Health Behaviors

- Adult smoking
- Adult obesity
- Binge drinking
- Motor vehicle crash death rate
- Chlamydia rate
- Teen birth rate

Clinical Care

- Uninsured adults
- Primary care provider rate
- Preventable hospital stays
- Diabetic screening
- Hospice use

Social and Economic Factors

- High school diploma
- College degrees
- Unemployment
- Children in poverty
- Income inequality
- Inadequate social support
- Single-parent household
- Homicide rate

Physical Environment

- Air-pollution-particulate matter days
- Air-pollution-ozone days
- Access to healthy foods
- Liquor store density

Appendix B

Unemployment by County in Indiana

COUNTY	UNEMPLOYMENT RATES APRIL 2010	UNEMPLOYMENT RATES APRIL 2008
INDIANA	9.8	4.7
Adams	10.4	5
Allen	10.2	4.9
Bartholomew	9.4	3.6
Benton	10	4.6
Blackford	12.6	6
Boone	8.1	3.4
Brown	9.5	4.5
Carroll	9.7	4.5
Cass	10.1	5.2
Clark	8.6	4.0
Clay	10	6.9
Clinton	10.1	4.8
Crawford	10.9	6.8
Daviess	5.7	3.0
De Kalb	11.1	5.7
Dearborn	10.7	4.4
Decatur	11.1	4.8
Delaware	10.8	5.6
Dubois	7.4	3.3
Elkhart	14.1	5.1
Fayette	13.9	10.5
Floyd	8.2	3.9
Fountain	10.8	4.1
Franklin	11.2	5.5
Fulton	10.8	5.4
Gibson	7.2	3.9
Grant	11	6.6
Green	8.8	5.0

Hamilton	6.9	3.1
Hancock	9.2	3.8
Harrison	8.7	4.9
Hendricks	7.9	3.6
Henry	12.6	5.9
Howard	12.2	7.1
Huntington	11.1	5.6
Jackson	9.6	4.2
Jasper	10.4	5.3
Jay	9.2	4.6
Jefferson	10.5	4.8
Jennings	11.5	5.5
Johnson	8.4	3.8
Knox	6.5	3.6
Kosciusko	9.8	4.3
LaGrange	11.6	5.1
Lake	10.6	5.0
LaPorte	11.9	5.2
Lawrence	11.2	6
Madison	11	5.8
Marion	9.7	4.6
Marshall	10.8	5.2
Martin	7	4.3
Miami	11.6	6.7
Monroe	6.6	3.4
Montgomery	9.3	4
Morgan	9.6	4.9
Newton	11.3	5.8
Noble	12.6	5.8
Ohio	11.7	4.3
Orange	10.7	5.6
Owen	9	5.2

Parke	9.6	5.1
Perry	9.4	3.9
Pike	8	4.4
Porter	8.8	3.8
Posey	7.2	4
Pulaski	8.9	4.5
Putnam	9.9	5.7
Randolph	11.6	5.9
Ripley	10.6	5.1
Rush	9.7	5
Scott	11.8	5.6
Shelby	9.9	5.1
Spencer	8.4	4.4
St. Joseph	11.4	4.9
Starke	12.5	6.3
Steuben	11.7	5.8
Sullivan	10.1	4.8
Switzerland	7.5	4
Tippecanoe	8.6	4
Tipton	11.5	5.5
Union	10	5.3
Vanderburgh	8.5	4.4
Vermillion	12.2	5.9
Vigo	10.6	5.3
Wabash	10.5	6.7
Warren	8.8	3.3
Warrick	7.2	3.9
Washington	10.1	5.5
Wayne	11.4	5.5
Wells	9.4	4.4
White	10.8	4.9
Whitley	10.7	5.5

Source: Indiana Department of Workforce Development: Research and Analysis

Appendix C

Percent in Poverty by Indiana County 2003-2008
The counties with poverty rates consistently above the state average are highlighted in yellow.

State and County	Percent in Poverty 2008	Percent in Poverty 2007	Percent in Poverty 2006	Percent in Poverty 2005	Percent in Poverty 2004	Percent in Poverty 2003
Indiana	12.9	12.3	12.5	12.2	11.1	10.0
Adams	12.7	12.5	13.5	11.5	10.1	9.8
Allen	11.5	10.9	11.6	11.8	11.3	10.2
Bartholomew	10.6	10.9	9.7	10.0	9.2	8.4
Benton	10.4	10.2	9.1	9.0	8.5	7.5
Blackford	13.9	12.6	13.0	11.7	11.0	9.3
Boone	6.4	6.6	6.0	5.6	6.0	5.8
Brown	10.5	10.3	10.7	10.5	9.3	8.2
Carroll	8.5	9.1	8.4	8.6	8.0	7.5
Cass	11.4	11.6	10.4	10.7	11.0	9.7
Clark	10.8	10.3	11.9	10.7	10.2	9.4
Clay	11.8	10.8	11.9	12.6	10.7	9.6
Clinton	14.5	11.2	11.9	11.1	10.3	9.2
Crawford	17.1	16.6	17.6	17.5	14.3	13.0
Daviess	14.6	15.0	14.5	16.1	13.1	12.4
Dearborn	8.1	7.2	7.2	8.1	7.4	6.8
Decatur	12.3	10.0	10.5	11.2	10.0	9.0
De Kalb	10.3	8.8	8.1	8.2	8.3	7.1
Delaware	17.2	18.0	19.8	18.3	15.3	13.5
Dubois	7.5	8.8	6.8	6.5	6.2	5.5
Elkhart	12.6	11.1	10.8	10.9	10.1	9.5
Fayette	15.2	14.2	12.7	13.7	11.6	10.4
Floyd	11.4	10.8	10.4	10.5	10.2	9.3
Fountain	11.5	12.2	11.2	11.0	10.1	9.3
Franklin	10.3	9.3	9.7	8.9	8.8	8.0
Fulton	12.2	10.8	10.6	11.4	10.2	9.5
Gibson	11.9	10.5	9.0	9.2	8.9	8.1

State and County	Percent in Poverty 2008	Percent in Poverty 2007	Percent in Poverty 2006	Percent in Poverty 2005	Percent in Poverty 2004	Percent in Poverty 2003
Grant	17.8	17.4	15.6	17.9	13.7	12.5
Green	13.7	13.3	16.1	15.1	11.6	10.9
Hamilton	4.2	3.9	3.9	3.9	3.9	3.6
Hancock	5.7	4.8	5.8	4.7	5.4	4.9
Harrison	9.7	9.7	8.7	9.0	8.8	8.1
Hendricks	5.2	5.0	5.6	4.7	5.2	4.6
Henry	12.3	10.3	11.5	10.4	10.5	9.5
Howard	13.3	13.0	16.7	12.8	11.9	10.3
Huntington	10.8	9.6	9.2	8.4	8.4	7.6
Jackson	10.5	11.8	10.4	11.1	9.4	8.8
Jasper	8.9	8.2	9.3	8.1	8.1	7.4
Jay	14.3	10.8	12.4	12.3	11.4	10.8
Jefferson	13.2	12.9	14.3	12.6	11.4	10.3
Jennings	12.3	11.9	12.2	10.8	10.4	9.7
Johnson	7.4	7.0	6.5	7.1	7.7	7.0
Knox	16.6	17.1	19.7	17.6	15.2	13.8
Kosciusko	9.0	8.6	9.1	8.6	7.9	7.5
Lagrange	10.2	9.0	10.7	8.5	7.6	7.9
Lake	10.2	9.0	10.7	8.5	7.6	7.9
La Porte	12.7	13.6	12.0	11.9	11.2	10.0
Lawrence	14.3	13.8	12.1	13.2	10.9	9.7
Madison	14.6	13.6	13.6	11.9	12.1	11.0
Marion	16.5	15.6	15.9	15.2	14.1	12.4
Marshall	9.6	9.4	10.4	8.0	8.1	7.4
Martin	12.9	12.3	12.3	12.2	11.1	10.0
Miami	14.2	12.1	12.9	12.2	11.1	10.0
Monroe	20.7	26.0	24.2	22.2	14.0	12.5
Montgomery	11.5	10.4	10.3	11.3	10.3	9.3
Morgan	10.6	8.7	9.6	7.8	8.9	7.8

State and County	Percent in Poverty 2008	Percent in Poverty 2007	Percent in Poverty 2006	Percent in Poverty 2005	Percent in Poverty 2004	Percent in Poverty 2003
Newton	9.7	9.3	9.2	8.7	9.0	8.2
Noble	10.0	10.1	10.1	8.9	8.7	8.1
Ohio	9.0	9.1	9.5	8.2	7.6	7.0
Orange	15.9	14.2	16.8	16.7	13.3	12.0
Owen	13.4	13.1	11.9	12.4	11.3	10.3
Parke	16.7	16.6	15.2	15.4	12.4	11.4
Perry	11.9	12.1	12.3	12.4	10.5	9.5
Pike	10.9	10.1	9.7	11.9	9.5	9.2
Porter	8.7	9.1	9.0	8.4	7.8	6.8
Posey	10.1	7.8	8.8	9.1	8.6	7.6
Pulaski	12.9	11.7	11.7	11.4	10.2	9.5
Putnam	11.7	11.5	9.9	11.1	9.9	9.2
Randolph	13.5	11.3	12.9	13.9	12.2	10.9
Ripley	10.4	10.7	9.2	9.6	8.8	8.1
Rush	10.9	11.6	10.0	9.2	9.3	8.6
St. Joseph	14.6	13.4	12.9	13.3	13.5	11.9
Scott	16.4	16.5	14.9	14.9	13.4	11.8
Shelby	10.8	9.8	10.0	10.1	9.7	8.5
Spencer	9.3	9.2	9.4	8.4	8.1	7.6
Starke	15.4	14.6	14.0	14.5	12.7	11.7
Steuben	9.2	11.6	10.5	10.2	9.0	8.0
Sullivan	15.2	13.7	14.5	14.3	13.0	11.9
Switzerland	16.3	14.4	14.5	13.6	12.0	10.9
Tippecanoe	18.2	19.0	17.0	17.9	13.4	12.0
Tipton	8.7	7.9	7.3	7.4	7.3	6.7
Union	11.9	11.7	11.9	11.0	9.7	9.1
Vanderburgh	16.9	13.9	14.6	13.4	12.9	11.8
Vermillion	12.2	10.7	12.0	11.8	10.3	9.3
Vigo	19.7	16.9	21.5	17.4	15.4	13.8

State and County	Percent in Poverty 2008	Percent in Poverty 2007	Percent in Poverty 2006	Percent in Poverty 2005	Percent in Poverty 2004	Percent in Poverty 2003
Wabash	12.0	9.8	10.9	10.1	9.4	8.7
Warren	8.8	8.3	8.3	8.2	7.8	7.2
Warrick	7.7	6.4	6.4	6.3	6.3	5.8
Washington	13.9	14.7	15.7	13.3	11.4	10.5
Wayne	17.2	14.9	14.2	14.4	13.2	11.8
Wells	8.6	8.5	7.6	7.4	7.6	6.8
White	11.4	9.4	9.2	10.3	9.3	8.3
Whitley	7.5	7.0	7.4	7.5	6.8	6.2

Appendix D

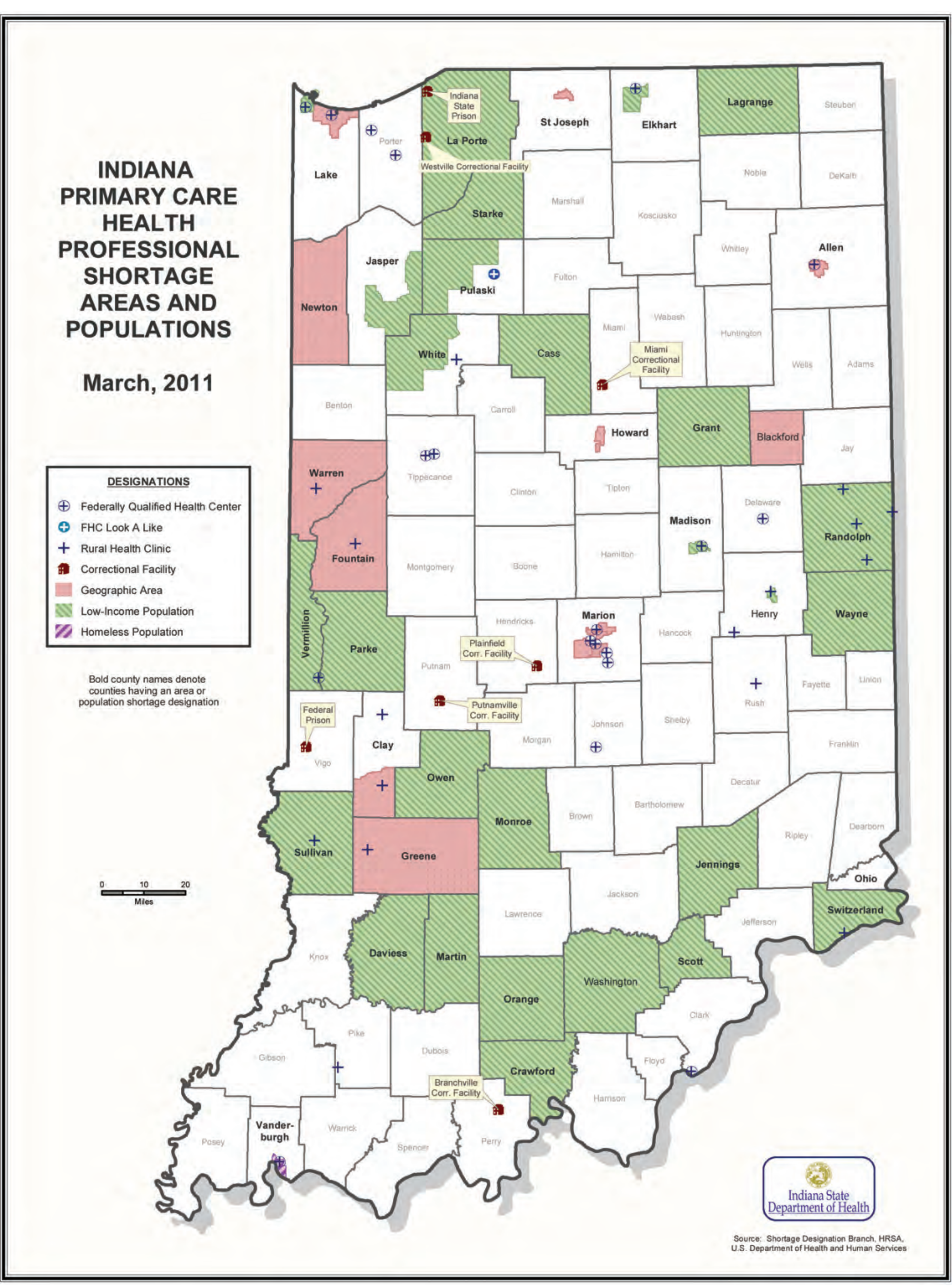
PRIORITIES FOR INDIANA STATE ACCESS PLAN

COUNTY	Medically Underserved Area (MUA) / Medically Underserved Population (MUP)	Presence of Federally Qualified Health Center Sites (FQHCs)	Presence of State-Funded-Only Health Centers Sites (SFHCs)	Number of People Not Served by FQHC or SFHC	Unemployment Rates April 2010	At or below 100% FPL 2008	% Uninsured Adults 2010 Report County Health Rankings	Distressed Counties Score Over 180	Health Outcomes by Rank	Health Factors by Rank	Interest
				1,595,592	9.8	12.9	14				
Adams	None	0	0	0	10.4	12.7	15		15	34	
Allen	MUA-P-H	1	0	17,228	10.2	11.5	14		33	39	
Bartholomew	None	2	0	0	9.4	10.6	14.4		34	20	
Benton	None	0	0	0	10	10.4	18.6		35	33	
Blackford	None	0	0		12.5	13.9	11.6	202	55	58	
Boone	None	0	1	0	8.1	6.4	13.6		4	4	
Brown	MUA-W	0	1	15,307	9.5	10.5	19.5		13	10	
Carroll	MUP-W	1	0	17,917	9.7	8.5	16.2		24	27	
Cass	MUA-W	1	0	37,417	10.1	11.4	16.5		38	54	
Clark	MUA-P-W	1	0	97,056?	8.6	10.8	14.1		59	63	
Clay	MUA-W, H-P	0	1	23,193	10	11.8	13.4		68	81	NAP
Clinton	MUA-P	0	0	3,576	10.1	14.5	17.7		51	28	
Crawford	MUA-W-H	0	1	7,378	10.9	17.1	17.5	207	83	86	Discussions
Daviess	MUA-W-H	0	1	27,482	5.7	14.6	13.6		48	35	
De Kalb	None	0	0	0	11.1	10.3	11.8		9	22	
Dearborn	None	0	0	0	10.7	8.1	13.6		25	17	
Decatur	MUA-P	0	0	0	11.1	12.3	12.5		31	44	
Delaware	MUA-P	1	0	29,634	10.8	17.2	14.6	193	81	71	
Dubois	None	0	0	0	7.4	7.5	14.4		3	5	
Elkhart	MUP-P-H	1	1	56,418	14.1	12.6	17.4		18	75	FQHC look-a-like/2 NAPs
Fayette	MUA-P	0	0	573	13.9	14.2	11.2	208	85	90	
Floyd	MUA-P	1	0	1,718	8.2	11.4	10.6		43	37	
Fountain	H-W	0	0	0	10.8	11.5	13.4		50	61	
Franklin	MUA-W	0	0	22,151	11.2	10.3	14.5		27	23	
Fulton	None	0	0	0	10.8	12.2	15.2		56	59	
Gibson	MUA-P	0	1	12,034	7.2	11.9	12.8		19	16	
Grant	MUA-P, H-W	1	0	17,412	11	17.8	12.7	203	77	84	
Greene	None	0	0	5,411	8.8	13.7	14.6	yes	78	69	NAP
Hamilton	None	0	0	0	6.9	4.2	10.4		1	1	
Hancock	None	0	0	0	9.2	5.7	14.9		22	6	Interest
Harrison	None	0	1	0	8.7	9.7	13.6		39	26	
Hendricks	None	0	0	0	7.9	5.2	13.9		2	2	
Henry	H-P	0	1	0	12.6	12.3	12.4		64	55	NAP
Howard	MUA-P-H	1	1	19,696	12.2	13.3	11		46	49	
Huntington	MUA-P	0	0	2,639	11.1	10.8	13.5		29	47	
Jackson	MUP-P	1	0	38,185	9.6	10.5	15.7		67	56	
Jasper	H-P	0	0	0	10.4	8.9	15.2		47	15	
Jay	None	0	0		9.2	14.3	14.7	182	75	64	
Jefferson	MUA-P	0	0	3,067	10.5	13.2	15.2		54	76	
Jennings	MUA-P, H-W	0	0	1,020	11.5	12.3	13.1		82	88	
Johnson	MUA-P	2	0	8,900	8.4	7.4	11.7		21	9	
Knox	MUA-P	0	0	30,735	6.5	16.6	14	199	76	60	
Kosciusko	None	0	0	0	9.8	9	17.5		23	38	
LaGrange	H-W	0	0	0	11.6	10.2	15.9		5	46	
Lake	MUA-P-H	3	0	147,203	10.6	16.7	14.1		84	92	New Sites
La Porte	MUP-W	1	1	105,472	11.9	12.7	14.1		61	77	New Site
Lawrence	None	0	1		11.2	14.3	13.5	189	66	74	Possible Designation
Madison	MUP-P	2	0	50,584	11	14.6	11.7	181	79	89	New Site
Marion	MUA/P-P-H	11	9	164,587	9.7	16.5	14.1		80	87	App in process for look-a-like NAPs
Marshall	None	0	0		10.8	9.6	18.1		8	25	NAP
Martin	MUA-P, H-W	0	1	0	7	12.9	14.2		89	43	
Miami	MUP-W	1	0		11.6	14.2	12.8	196	41	65	No data
Monroe	MUA	0	1	116,088	6.6	20.7	23.6		17	7	

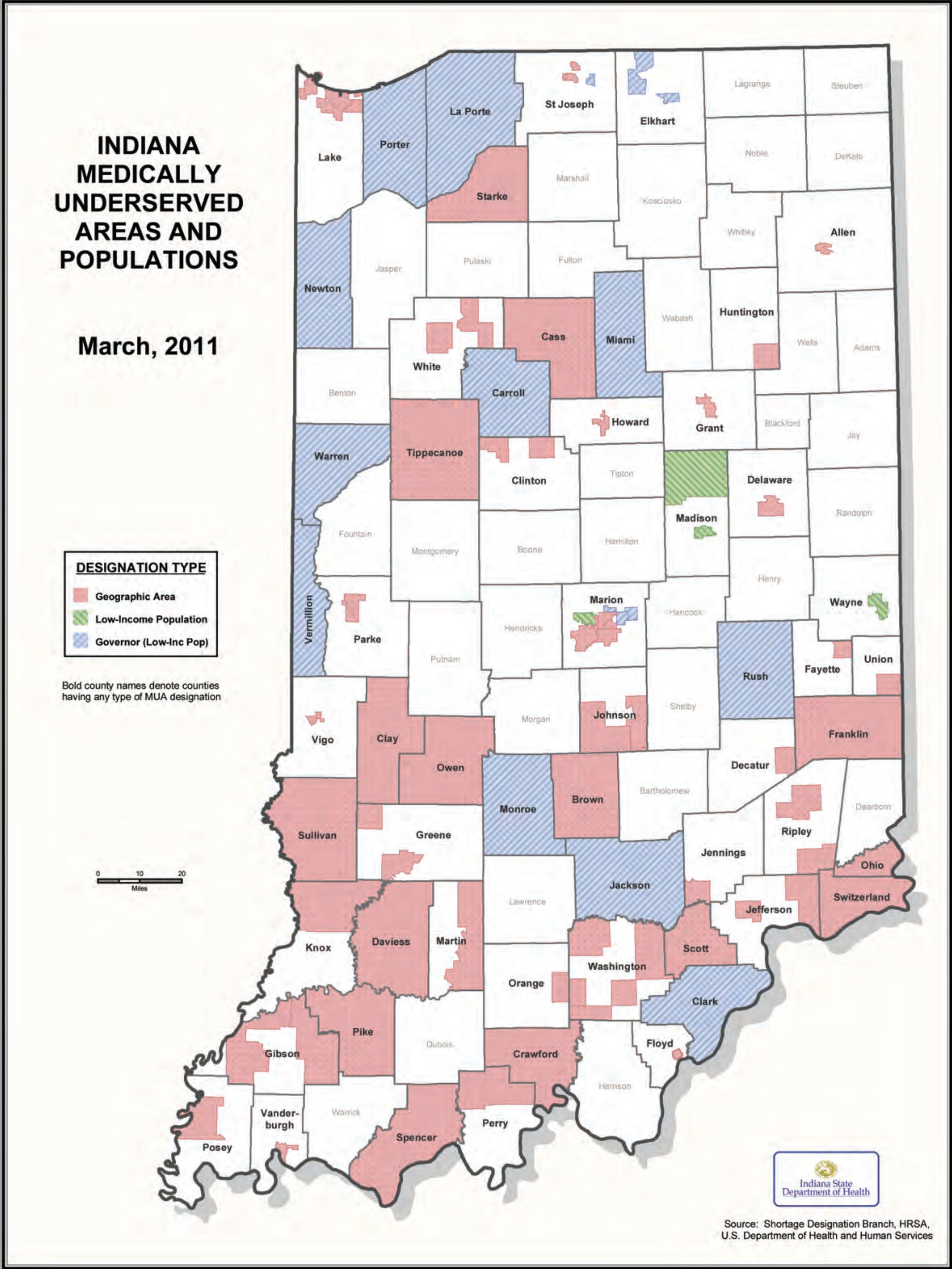
Montgomery	None	0	0	0	9.3	11.5	13		52	45	
Morgan	None	0	0	0	9.6	10.6	14.2		40	32	NAP
Newton	MUP-W-H	0	0	14,293	11.3	9.7	16.2		72	48	Interest
Noble	None	0	0	0	12.6	10	18.2		37	73	
Ohio	MUA-W	0	1	2,932	11.7	9	15.8		36	24	Interest
Orange	MUA-P, H-W	0	0	995	10.7	15.9	13.7	192	65	70	Planning
Owen	MUA-W-H	0	1	22,567	9	13.4	16.5		58	82	Planning
Parke	MUA-P, H-W	0	1	0	9.6	16.7	15.5		73	66	
Perry	MUA-P	0	0	3,364	9.4	11.9	12.7	180	86	52	
Pike	MUA-W	0	1	13,011	8	10.9	14.9		88	41	
Porter	MUP-W	4	0	134,039	8.8	8.7	15.3		16	13	
Posey	MUA-P	0	0	2,472	7.7	10.1	12.4		28	21	No Interest
Pulaski	H-P	0	1	0	8.9	12.9	15.4		57	42	
Putnam	None	0	0	0	9.9	11.7	16		11	29	
Randolph	H-W	0	1	0	11.6	13.5	15.8	194	53	53	
Ripley	MUA-P	0	0	0	10.6	10.4	14.1		26	36	
Rush	None	0	1	0	9.7	10.9	14.2		45	67	
Scott	MUA-W-H	0	0	23,577	11.8	18.4	12.6	182	92	79	Planning NAP
Shelby	None	0	0	0	9.9	10.8	13		70	51	
Spencer	MUA-W	0	0	20,395	8.4	9.3	16		44	12	Development
St Joseph	MUA-P-H	3	3	22,121	11.4	14.6	15.1		42	50	NAP
Starke	MUA-W-H	1	0	21,937	12.5	15.4	14.7	183	91	91	
Steuben	None	0	0	0	11.7	9.2	14.6		32	62	
Sullivan	MUA-W-H	0	0	21,356	10.1	15.2	14.2	183	87	72	NAP
Switzerland	MUA-W-H	0	1	7,589	7.5	16.3	16.9		90	68	
Tippecanoe	MUP-W	1	0	145,067	8.6	18.2	23.1		12	18	Expansion
Tipton	None	0	0	0	11.5	8.7	12.2		14	19	
Union	MUA-P	0	0	1,531	10	11.9	17.6		62	57	
Vanderburgh	MUA-P-H	3	0	18,637	8.5	16.9	12.7		71	30	
Vermillion	MUP-W-H	1	0	14,754	12.2	12.2	13.2	188	63	85	NAP
Vigo	MUA-P	0	0	10,329	10.6	19.7	13.6	196	69	78	Interest 2011 in NAP
Wabash	None	0	0	0	10.5	12	11		49	31	
Warren	MUP-W-H	0	0	8,970	8.8	8.8	17.3		20	14	Bedroom Community
Warrick	None	0	0	0	7.2	7.7	11.8		6	3	
Washington	MUA-P	0	0	10,393	10.1	13.9	14.4		60	83	
Wayne	H-W	0	1	0	11.4	17.2	14.4	186	74	80	
Wells	None	0	0	0	9.4	8.6	12		10	8	
White	MUA-P-H	1	0	3,975	10.8	11.4	17.7		30	40	
Whitley	None	0	0	0	10.7	7.5	13.3		7	11	

KEY

Color	Meaning
Blue	High Interest/High Need
Green	High Interest/Less Need
Yellow	Community Development/High Need
Pink	Community Development/ Less Need



INDIANA PRIMARY CARE HEALTH PROFESSIONAL SHORTAGE AREAS AND POPULATIONS
March, 2011
DESIGNATIONS
Federally Qualified Health Center
FHC Look A Like
Rural Health Clinic
Correctional Facility
Geographic Area
Low-Income Population
Homeless Population
Bold county names denote counties having an area or population shortage designation
0 10 20
Miles
Indiana State Prison
Westville Correctional Facility
Miami Correctional Facility
Plainfield Corr. Facility
Putnamville Corr. Facility
Federal Prison
Branchville Corr. Facility
Lake
Porter
La Porte
St Joseph
Elkhart
Lagrange
Steuben
Noble
DeKalb
Marshall
Starke
Kosciusko
Whitley
Allen
Newton
Jasper
Pulaski
Fulton
Miami
Wabash
Huntington
Wells
Adams
White
Cass
Benton
Carroll
Howard
Grant
Blackford
Jay
Warren
Tippecanoe
Clinton
Tipton
Madison
Delaware
Randolph
Fountain
Montgomery
Boone
Hamilton
Henry
Wayne
Vermillion
Parke
Hendricks
Marion
Hancock
Putnam
Fayette
Union
Rush
Vigo
Clay
Morgan
Johnson
Shelby
Franklin
Owen
Monroe
Brown
Bartholomew
Decatur
Ripley
Dearborn
Sullivan
Greene
Jennings
Ohio
Lawrence
Jackson
Jefferson
Switzerland
Knox
Daviess
Martin
Orange
Washington
Scott
Clark
Pike
Dubois
Gibson
Crawford
Floyd
Harrison
Posey
Vander-burgh
Warrick
Spencer
Perry
Indiana State Department of Health
Source: Shortage Designation Branch, HRSA, U.S. Department of Health and Human Services



INDIANA MEDICALLY UNDERSERVED AREAS AND POPULATIONS
March, 2011
DESIGNATION TYPE
Geographic Area
Low-Income Population
Governor (Low-Inc Pop)
Bold county names denote counties having any type of MUA designation
0 10 20
Miles
Lake
Porter
La Porte
St Joseph
Elkhart
Lagrange
Steuben
Noble
DeKalb
Starke
Marshall
Kosciusko
Whitley
Allen
Newton
Jasper
Pulaski
Fulton
White
Cass
Miami
Wabash
Huntington
Wells
Adams
Benton
Carroll
Howard
Grant
Blackford
Jay
Warren
Tippecanoe
Clinton
Tipton
Delaware
Madison
Randolph
Fountain
Montgomery
Boone
Hamilton
Vermillion
Parke
Hendricks
Marion
Hancock
Henry
Wayne
Putnam
Rush
Fayette
Union
Vigo
Clay
Owen
Morgan
Johnson
Shelby
Decatur
Franklin
Sullivan
Greene
Monroe
Brown
Bartholomew
Ripley
Dearborn
Jennings
Ohio
Jackson
Lawrence
Jefferson
Switzerland
Knox
Daviess
Martin
Scott
Washington
Orange
Clark
Gibson
Pike
Dubois
Crawford
Floyd
Harrison
Posey
Vander-
burgh
Warrick
Spencer
Perry
Indiana State Department of Health
Source: Shortage Designation Branch, HRSA, U.S. Department of Health and Human Services

Appendix E

Explanation of the Distressed Counties Scoring

COMMUNITY DISTRESS FACTORS (250 POINTS):

The community distress factors used to measure the economic conditions of the applicant are listed below. Each is described with an explanation and an example of how the points are determined. Each factor can receive a maximum of 50 points with the total distress point calculation having a maximum of 250 points. The formula calculation for each measure is constructed as a percentage calculation along a scale range. The resulting percentage is then translated into a point total on a fifty point scale for each measure.

Unemployment Rate (50 points maximum): Unemployment rate for the county of the lead applicant. The most recent average annual rate available is used.

a. If the unemployment rate is above the maximum value, 50 points are awarded.
b. If the unemployment rate is below the minimum value, 0 points are awarded.
c. Between those values, the points are calculated by taking the unemployment rate, subtracting the minimum value, dividing by the range, and multiplying by 50.

Unemployment Rate Points = [((Unemployment rate – minimum)/range) X 50]

For example, if the unemployment rate is 4.5%, the minimum value is 2.6%, maximum value is 9.7%, and range is 7.1%, take unemployment rate of 4.5%, subtract the minimum value of 2.6%, divide by a range of 7.1%, and multiply by 50. The score would be 13.38 point of a possible 50; [((4.5 – 2.6)/7.1) X 50].

Net Assessed Value/capita (50 points maximum): Net assessed value per capita (NAV pc) for lead applicant. [8] The most recent net assessed valuation figures, [9] as well as the most recent population figures are used.

To determine the NAV pc, divide the net assessed valuation by the population estimate for the same year. For example, for 2002 NAV pc, you would divide the 2002 NAV by the Census Bureau's estimate of the population on July 1, 2002.

NAV per capita = NAV/Total Population

d. If the net assessed value per capita for the lead applicant is above the maximum value, 0 points are awarded.
e. If the net assessed value per capita for the lead applicant is below the minimum value, 50 points are awarded.
f. Between those values, the points are calculated by subtracting 50 from the NAVpc minus the minimum value, divided by the range and multiplied by 50.

NAV per capita points = 50 – [((NAV pc – minimum)/range) X 50]

For example, if the NAVpc is $29,174, the minimum value is $2,589 (excluding outliers), maximum value is $75,524 (excluding outliers), and the range is $72,935, take 50, subtract the NAV/capita of $29,174 minus the minimum value of $2,589, divide by the range of $72,935, and multiply by 50. The score would be 31.78 points of a possible 50 points; 50 – [((29,174 - 2,589)/72,935) X 50].

Median Housing Value (50 points maximum): Median Housing Value (MHV) for lead applicant. [10] Data from the most recent census are used.

Median Housing Value Points = 50 – [((MHV – minimum)/range) X 50]

g. If the median housing value for the lead applicant is above the maximum value, 0 points are awarded.
h. If the median housing value for the lead applicant is below the minimum value, 50 points are applicant.

[8] For unincorporated areas, the NAV pc will be calculated based on data at the township level.

[9] All applicants will utilize the same basis, i.e., true tax value or market value, for the NAV pc calculation.

[10] For unincorporated areas MHV will be calculated based on data at the township level.

For example, if the median housing value is $79,000, the minimum value is $24,300 (excluding outliers), maximum value is $246,300 (excluding outliers) and the range is $222,000. Take the MHV of $79,000 minus the minimum value of $24,300, divide the difference by the range of $222,000, and multiply by 50 then subtract this amount from 50. The score would be 37.68 points out of a total possible of 50; 50 – [((79,000 – 24,300)/222,000) X 50].

Median Household Income (25 points maximum): Median household income (MHI) for the lead applicant. [11] Data from the most recent census are used.

Median Household Income Points = 25 – [((MHI – minimum)/range) X 25]

i. If the median household income is above the maximum value, 0 points are awarded.
j. If the median household income is below the minimum value, 25 points are awarded.
k. Between those values, the points are calculated by subtracting 25 from the MHI minus the minimum value, divided by the range, and multiplied by 25.

For example, if the Median Household Income is $35,491, the minimum value is $16,667 (excluding outliers), maximum value is $97,723 (excluding outliers), range is $81,056, take 25, subtract the MHI of $35,491, minus the minimum value of $16,667, divide by the range of $81,056, and multiply by 25. The score would be 19.19 points out of a possible 25; 25 – [((35,491 – 16,667)/81,056) X 25].

Family Poverty Rate (25 points maximum): Family poverty rate for the lead applicant. [12] Data from the most recent census are used.

Family Poverty Rate Points = [((Family Poverty Rate – minimum)/range) X 25]

l. If the family poverty rate is above the maximum value, 25 points are awarded.
m. If the family poverty rate is below the minimum value, 0 points are awarded.
n. Between those values, the points are calculated by subtracting the Family Poverty Rate from the minimum value, then dividing by the range, and multiplying by 25.

For example, if the family poverty rate is 1.4%, the minimum value is 0% (excluding outliers), maximum value is 25% (excluding outliers), and range is 25%, take family poverty rate of 1.4%, subtract the minimum value of 0%, divide by a range of 25%, and multiply by 25. The score would be 1.4 points of a possible 50; [((1.4 – 0)/25) X 25]

Percentage Population Change (50 points maximum): Percentage population change from 1990 to 2000 for the lead applicant. [13] The percentage change is computed by subtracting the 1990 population from the 2000 population and dividing by the 1990 population. Convert this decimal to a percentage by multiplying by 100.

Percentage Population Change = [(2000 population - 1990 population)/1990 population] X 100

o. If the population changed above the maximum percentage value, 0 points are awarded.
p. If the population changed below the minimum percentage value, 50 points are awarded
q. Between those values, the points are calculated by subtracting 50 from the percentage population change minus the minimum value divided by the range, and multiplied by 50.

Percentage Population Change points = 50 – [(Percentage population change – minimum)/range) X 50]

For example, if the population increased by 16.61%, the minimum value is –61.33% (excluding outliers), maximum value is 181.27% (excluding outliers), range is 242.60%, take 50, subtract 16.61% minus the minimum value of –61.33%, divide the range of 242.60%, and multiply by 50. The score would be 33.94 points out of a total possible of 50; 50 – [((16.61 – (-61.33)/242.60) X 50].

Source: State of Indiana: FY 2010 Program Design and Method of Distribution
State Community Development Block Grant (CDBG) PROGRAM (CFDA: 14-228)
Indiana Office of Community and Rural Affairs

[11] For unincorporated areas MHI will be calculated based on data at the township level.

[12] For unincorporated areas Family Poverty Rate will be calculated based on data at the township level.

[13] For unincorporated areas percentage population change will be calculated based on data at the township level.

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