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St. Vincent Mercy Strategies

FY11-FY13

SVH Goal: Achieve 100% access to appropriate healthcare and wellness in collaboration with our communities and partners for more compassionate and just society.

1.1 Identify appropriate target populations and resources needed to improve access

Measures of success:

- Increased number of people assisted
- Enhanced level of assistance resulting in improved access
- Preserve outreach initiatives

1.2 Improve access to needed services and programs within the community

Measures of success:

- Increased number of people assisted
- Enhanced level of assistance resulting in improved access
- Preserve outreach initiatives

Original long-range hospital objectives for charity care

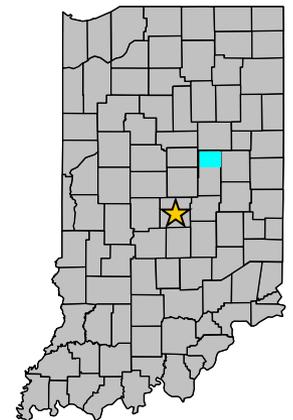
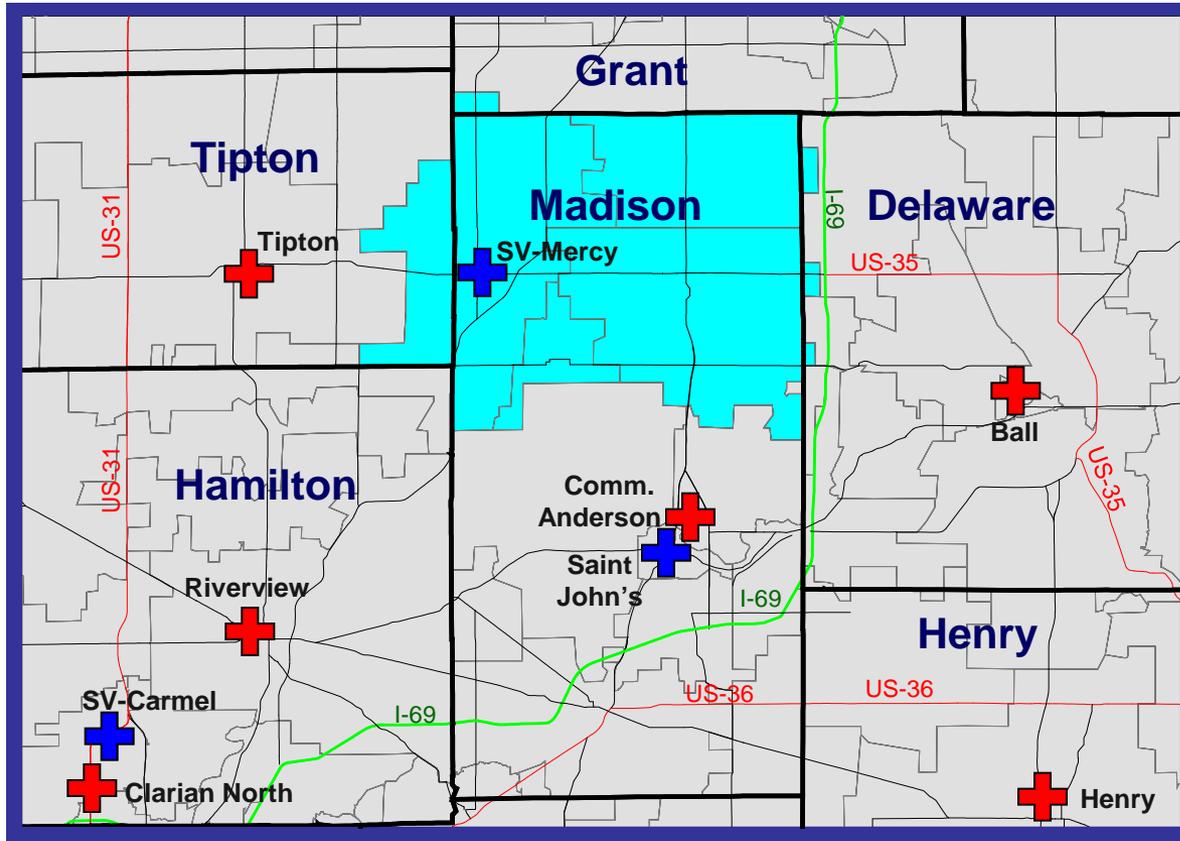
- Services for under- and uninsured
- Affordable dental care
- Teen pregnancy

Hospital Mission Statement

Our Mission

Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually centered, holistic care, which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words.

St. Vincent Mercy Primary Service Area



Allowances and Write-Offs Policy

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POLICY

In accordance with the Core Value of Integrity and Wisdom, this policy establishes the administrative level of approval required to write-off certain account balances that have been determined through routine assessment procedures to be uncollectible and therefore should be accounted for as either a Charity, Administrative write-off or Bad Debt.

Individual departmental procedures in accordance with the Patient Financial Services Department have set forth the guidelines for determining an account's eligibility to be considered for a write-off action.

DEPARTMENTS AFFECTED

1. Patient Financial Services
2. Administration
3. Clinical/charge areas

PROCEDURE

I. Charity Allowances

A. Once it has been determined that a guarantor lacks the resources to either pay for the costs of treatment or to have such costs paid by a bona-fide third party, a charity allowance of part or all of the account balance may be considered. Charity consideration is based on Department of Health and Human Services poverty level guidelines established annually. An explanation of the guarantor's financial circumstances should be documented on the Account Record. Appropriate administrative level approval(s) should then be obtained.

B. Approved (or rejected) charity accounts should be returned to PFS departmental management for processing. It is the responsibility of PFS departmental management to: a.) direct the execution and recording of the charity allowance transaction; and b.) notify the guarantor, by letter, indicating the Hospital's decision to forgive the debt as charity.

Allowances and Write-Offs Policy

Page 2 of 3

- **II. Administrative and Convenience Allowances:**

A. Management in the PFS Department may, with proper justification and documentation, direct the submission of credit adjustments which are deemed necessary for the convenience of the Hospital or as a courtesy to patients when appropriate.

B. Management in other departments of the Hospital or at Satellite locations may, with proper justification and documentation (as approved by the Management in the PFS Department) submit credit adjustments to PFS which are deemed necessary to fulfill the Mission of the Hospital as a convenience or administrative write-off when appropriate.

C. Appropriate administrative level approval(s) should then be obtained by the PFS department manager or supervisor who is responsible for such account management.

D. After administrative approval is obtained, the PFS department is responsible for completing the transaction correctly and for notifying the patient in writing, when appropriate of the special adjustment.

III. Bad Debt Write-offs

A. The PFS Department is responsible for reviewing patient accounts which by virtue of their "account age" or other conditions are deemed to be presently uncollectible.

B. The PFS Department is responsible for summarizing the guarantor's financial circumstances and any other pertinent data on the Account Record or separate memo when necessary and submitting such records along with a recommendation to the appropriate level for approval.

C. The PFS Department is responsible for ensuring submission of proper transactions to record approved write-offs.

Allowances and Write-offs Policy

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- **IV. Bankruptcy Write-offs**

A. The accounts for those patients who have filed a verified Petition in Bankruptcy may be approved for Bad Debt write-off based on Administrative approval limits.

- **V. Small Balance Write-offs**

A. Accounts with a patient balance due of \$9.99 or less will be automatically written off .

B. Accounts with a primary insurance balance due of \$50.00 or less from a contracted payer after the primary insurance payment is posted will be written off as a contractual amount. These balances will be reconciled and recovery attempted with the respective payers on a periodic basis on a batch basis.

- **VI. Administrative Approval Limits**

These limits apply to Charity, Bad Debt and the category of Administrative Allowance write-offs. Contractual write-offs related to contracted payer adjustments do not require approval for adjustment.

Allowance/Adjustment/Writeoff Amount

\$0 - \$250 Biller/Rep

\$251 - \$10,000 Team Leader

\$10,001 - \$25,000 Manager, PFS

\$25,001 - \$50,000 Director, PFS

\$50,001 - \$99,999 Executive Director of Finance

\$100,000+ Chief Financial Officer, President and Board of Directors

Care of the Poor & Community Benefit Policy

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- **POLICY**

It is the policy of St. Vincent Health that each Health Ministry, guided by the Mission, Vision, Values, and Philosophy of the System, will plan for care of persons who are poor and for community benefit and will report annually on this plan.

PRINCIPLES

1. The principle of the common good obliges government, church and civic communities to address the needs and advocate for those who lack resources for a reasonable quality of life. St. Vincent Health desires to strengthen its commitment to this principle through a unified system of accountability.
2. Health Ministries will collaborate in assessing the needs and resources of individuals and communities they serve and will establish substantive goals directed toward those needs in the context of their strategic and financial planning.
3. Health Ministries will account annually to appropriate constituencies for progress toward achievement of these goals.
4. Annually St. Vincent Health will produce an aggregate report.

DEPARTMENTS AFFECTED

All Ministries

Care of the Poor & Community Benefit Policy

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PROCEDURE

Subject

This procedure sets forth the requirement that each health ministry have an effective policy, and establishes a process to develop an annual Care of the Poor/Community Benefit goals and to report progress towards those goals. All activities related to the poor will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with poor and vulnerable persons, and our commitment to distributive justice and stewardship.

Rationale

Care of the Poor/Community Benefit planning and goals are incorporated into the existing Integrated Strategic and Financial Planning (ISFP) process. Progress towards established goals will be reported annually. This procedure provides guidelines to assist Health Ministries:

- a. Establish care of the poor/community benefit goals within the framework of the ISFP process and report progress toward those goals.
- b. Report costs for Categories I through V associated with allowable care of the poor/community benefit programs and services.

Charity Care Minimum Standards (Also see policy on Allowances and Write Offs and Uninsured & Underinsured Patient Management Program)

1. Patients with income less than or equal to 200% of the Federal Poverty Limits ("FPL"), which may be adjusted for inflation utilizing local wage index vs. national wage index by the hospital, will be eligible for 100% charity care write off of the services that have been provided to them in accordance with Ascension Health Policy 9.
2. Patients with incomes above 200% of the FPL but not exceeding 300% of the FPL, subject to inflationary adjustments as described in will receive a discount on the services provided to them based on a sliding scale. The sliding scale will subject to a Means Test to be determined by each hospital and /or Health Ministry in accordance with guidelines established in Policy 9.
3. Eligibility for charity care may be determined at any point in the revenue cycle.

Care of the Poor & Community Benefit Policy

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Financial Assistance Minimum Standards (Also see policy on Allowances and Write Offs and Uninsured & Underinsured Patient Management Program)

These minimum standards are designed to ensure each health ministry designs a methodology to determine qualifying incomes and/or assets available to satisfy the patient's obligation to the hospital.

1. All patients and families are advised of the hospital's applicable policies, including the Care of the Poor /Community Benefit policy and the availability of need-based financial assistance in easily understood terms, as well as in language commonly used by patients in the community.
2. The financial assistance policy must address a patient's eligible income and assets.
3. The policy may allow the determination to be made on a case-by-case basis, but in this circumstance, a review panel must be formed to insure a patient has the right to appeal a decision.
4. Requiring a patient to apply for public financial assistance program.

Other Requirements and Exceptions (Also see policy on Allowances and Write Offs and Uninsured & Underinsured Patient Management Program)

1. Health Ministries require the uninsured to work with financial counselor and apply for Medicaid or other public assistance programs to qualify for charity.
2. Other program that allow for "packaging" payment programs are acceptable. For example, many Health Ministries package prenatal care and delivery charges into a "package" price for the uninsured. This is encouraged and will continue.
3. A nominal charge may be charged to patients qualifying for charity. The participation of individuals in the financial obligation of their health care is recommended by those who work with persons who are poor since it respects their dignity as well as their sense of responsibility.

Care of the Poor & Community Benefit Policy

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Planning

1. As part of the annual ISFP process, establish substantial, measurable and meaningful Care of the Poor/Community Benefit goals. These goals should be derived from Ascension Health "Call To Action".
 - a. Healthcare that Works
 - b. Healthcare that is Safe
 - c. Healthcare that leaves no one behindEach healthcare ministry will develop three to five local strategies in response to a community needs assessment and other initiatives.
2. The ISFP budget for Care of the Poor/Community Benefit should include budget dollars for Categories I-IV for upcoming fiscal year.

Definitions

1. Category I - Charity Care (free or reduced fee/sliding scale care for persons who qualify for financial assistance).
2. Category II - Unreimbursed cost of the care provided to patients enrolled in public programs.
3. Category III - Programs and services targeted to persons who are poor.
4. Category IV - Programs and services targeted to the general community.
5. Category V - Bad Debt costs attributable to Charity Care.

Care of the Poor & Community Benefit Policy

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Guidelines

Guidelines for Category I

- a. Charity care dollars should be an estimate of the cost to provide services to patients who qualify for charity care.
- b. Charity care should include the cost of services provided to charity care patients in all settings (acute and non-acute settings such as ambulatory surgery centers, etc.).

Guidelines for Category II

- a. Medicare losses/shortfalls should not be reported. This is consistent with standards set by the Catholic Health Association community benefit network and used by other Catholic systems.
- b. Losses/shortfalls from all Medicaid sources, including Medicaid managed care products, should be included.
- c. Medicaid disproportionate share (DSH) payments should be considered Medicaid payment/income.
- d. Prior year settlements from Medicaid programs (including Medicaid DSH) should be considered as an offset to the cost of care provided and, accordingly, increase or decrease the shortfall reported.

Guidelines for Category III

- a. The program/service/activity/event must respond to the needs of special populations; for example, the frail elderly, poor persons with disabilities, the chronically mentally ill, persons with AIDS, or those who find it hard to meet basic needs due to on-going poverty.
- b. The program/service/activity/event should be quantifiable in terms of dollars and should not be included in Category I or II.
- c. The program/service/activity/event may be financed by donations, staff/volunteer efforts, endowments, grants, and sponsorships, etc.
- d. The program/service/activity/event should generate a low or negative margin.
- e. The program/service/activity/event would probably be discontinued or not offered if the decision were made on a purely financial basis. The decision to continue is primarily motivated by a mission commitment versus a marketing interest.
- f. The program/service/activity/event would no longer be available, or would be insufficiently available in the community, or would be the responsibility of the government if not provided by the healthcare organization.

Care of the Poor & Community Benefit Policy

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Guidelines for Category IV

- a. The program/service/activity/event should be quantifiable in terms of dollars.
- b. The program/service/activity/event should generate a low or negative margin.
- c. The program/service/activity/event may be financed by donations, staff/volunteer efforts, endowments, grants, and sponsorships, etc.
- d. The program/service/activity/event provides a response to a unique or a particular health problem in the community or is directed to promoting the wellness of the population in a holistic manner.
- e. The program/service/activity/event would probably be discontinued or not offered if the decision were made on a purely financial basis. The decision to continue generally represents a mission commitment versus a business decision.

Guidelines for Category V

Bad debt cost of services can be calculated for certain bad debt write-offs. This acknowledges that there are charity care patients that may not be identified initially as eligible for charity care. Two possible formulae for determining the cost of bad debt for services provided to charity care patients include:

- a. Cost of bad debt excluding the portion related to coinsurance and deductibles. Patients who have a coinsurance payment or deductible are assumed to have insurance.
- b. Identify the zip code average income that constitutes "poor" and count all bad debts from those zip codes, excluding the portion related to coinsurance and deductibles. It is recognized that while this methodology may count patients with the ability to pay who reside in these zip codes, the methodology also excludes patients from other zip codes that may not be able to pay.

Care of the Poor & Community Benefit Policy

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Reporting Category I and II

1. Reporting Cost for category I and II

Finance department in collaboration with each local ministry reports on categories I and II.

Reporting Category III and IV

1. Reporting Cost for Categories III & IV Programs and Services

The following should serve as guidelines for reporting costs for programs, services, activities or events appropriate to be included in Category III - Programs and services targeted to the poor and Category IV - Programs and services targeted to the general community. (See Exhibit A Charity Care Intranet Reporting).

a. Report cost less any reimbursement received.

b. Medical Education programs should be reported as a community benefit.

i. Medicare Graduate Medical Education (GME) payments should offset costs.

ii. Medicare Indirect Medical Education (IME) payments should not be offset against the direct cost of medical education programs.

c. Volunteering may be reported.

i. Include paid associate time for volunteering at hospital supported activities such as:

- Paid associate time to assist in health screenings performed after hours.
- Replacement cost for associates performing management approved volunteer activities.
- Paid associate time as a volunteer for organizational sponsored events.
- Board representation on management approved organizations.

2. With the Care of the Poor/ Community Benefit report, a narrative for each Care of the Poor/ Community Benefit goal must be identified in the ISFP and describe progress towards achievement for each goal, including to the extent possible baseline measures of success being established, outcomes achieved, program impact, etc.

3. Care of the Poor/ Community Benefit goals are part of the ISFP. Therefore, reporting for Goals is due consistent with the ISFP timeline.

Care of the Poor & Community Benefit Policy

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Reporting Category V

1. Reporting Cost for category V

Finance department in collaboration with each local ministry reports on category V.

Additional resources:

Ascension Health HOTLINE: 1-314-733-8138

Ascension Health e-mail address: policy9@ascensionhealth.org

Statement of Public Notice

EMERGENCY PATIENTS – PLEASE READ

If you have a medical emergency or are in labor, it is this hospital's obligation by law to provide services within the capabilities of this hospital's staff and facilities.

YOU HAVE THE RIGHT TO RECEIVE:

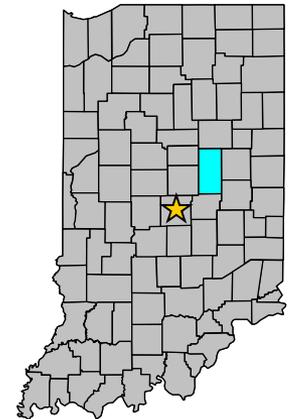
- An appropriate medical SCREENING EXAMINATION.
- Necessary STABILIZING TREATMENT
(including treatment for an unborn child)
- And if necessary,
An appropriate TRANSFER facility

Even if YOU CANNOT PAY OR DO NOT HAVE MEDICAL INSURANCE OR YOU ARE NOT ENTITLED TO MEDICARE OR MEDICAID

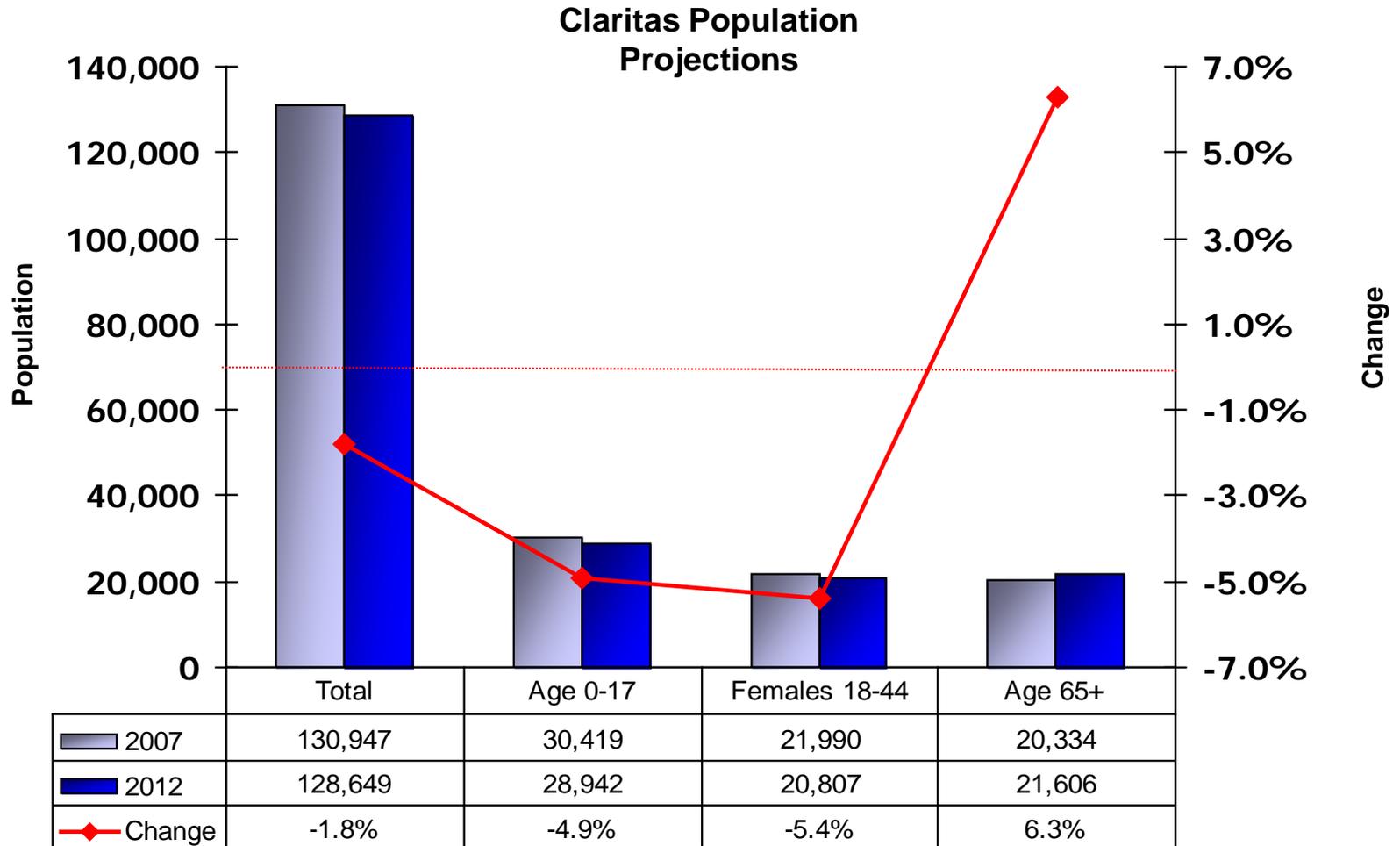
This hospital does participate in the Medicaid Program.



Madison County Assessment August 2008



Population Statistics Madison County

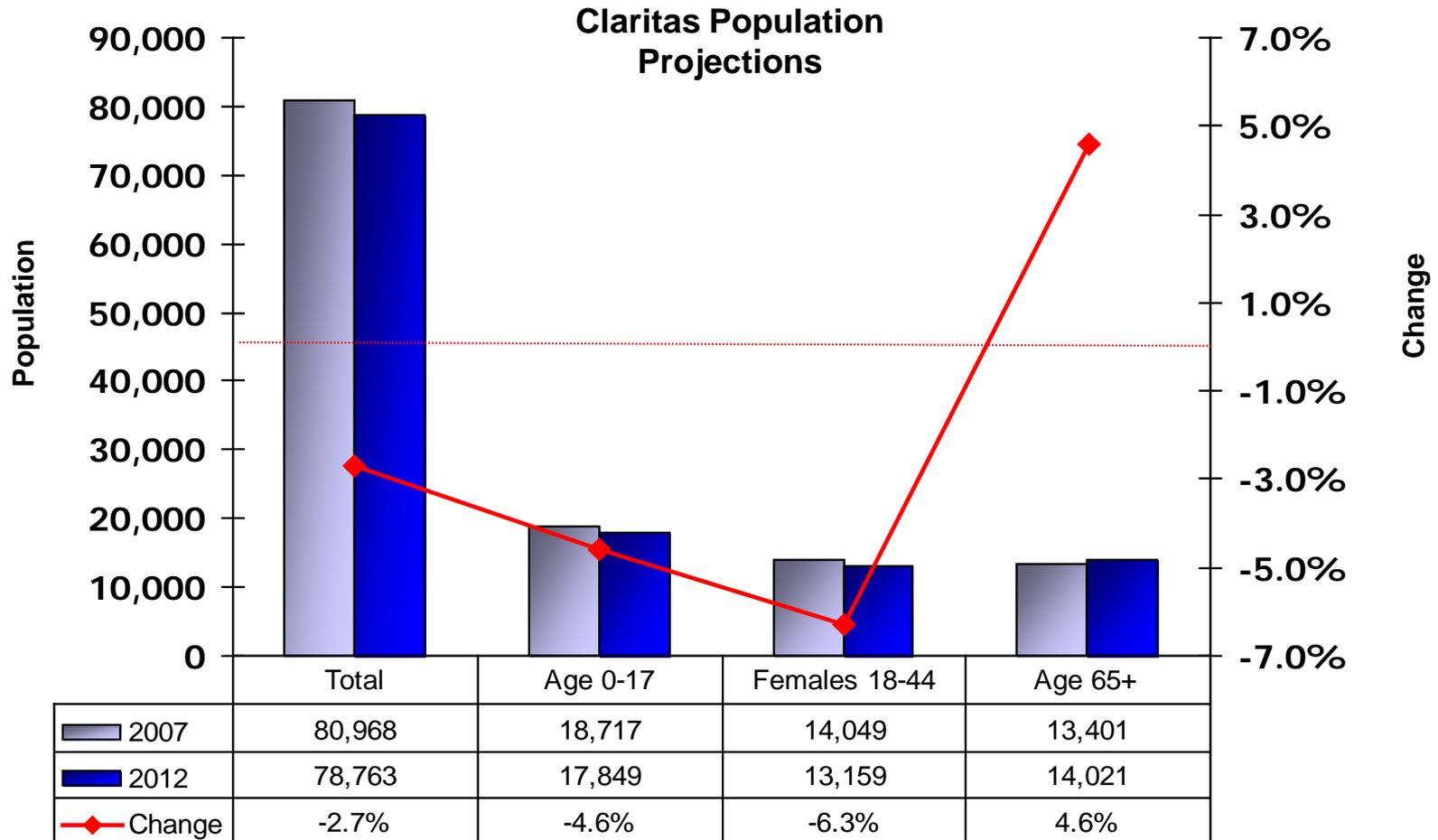


The estimated population of Madison County at 200% of the Federal Poverty Level is 28.2%, or 36,927

Population Statistics

Anderson

Zip codes 46011, 46012, 46013, 46016, 46017



The estimated population of Anderson at 200% of the Federal Poverty Level could range from 28.2% - 37.4%, representing from 16,215 – 22,319 people

Madison County and Anderson Community Statistics

Category	Indicator	Source	Indiana	Madison County	Anderson
Demographics	White persons, non-Hispanic (2006)	Census (via Solucient)	84.0%	88.3%	Data not available
Demographics	Black or African American persons, non-Hispanic (2006)	Census (via Solucient)	8.7%	7.9%	Data not available
Demographics	Asian persons, non-Hispanic (2006)	Census (via Solucient)	1.2%	0.4%	Data not available
Demographics	Hispanic/Latino origin (2006)	Census (via Solucient)	4.5%	2.0%	Data not available
Demographics	Language other than English spoken at home (2000, 2005 ACS)	Census/ACS	7.3%	3.1%**	3.8%
Demographics	Persons reporting some other race, non-Hispanic (2006)	Census (via Solucient)	1.6%	1.4%	Data not available
Demographics	% people under 18 (2006)	Census (via Solucient)	25.4%	23.5%	Data not available
Community	Licensed child care homes, centers and registered ministries (2008)	IN FSSA		70	45
Community	Median household income (2006)	Census (via Solucient)	\$47,190	\$49,339	Data not available
Community	Median rent (2000; 2006 if ACS)	Census/ACS	\$638	\$595	\$493
Community	Median value of home (2000; 2006 if ACS)	Census/ACS	\$120,700	\$96,900	\$67,900
Community	# nursing facilities (June 2007)	IN FSSA	490	13	Data not available
Community	Renter - occupied housing units (2000; 2006 if ACS)	Census/ACS	27.9%	27.5%	36.2%
Community	Owner - occupied housing units (2000; 2006 if ACS)	Census/ACS	72.1%	72.5%	63.8%
Community	Vacant housing units (2000; 2006 if ACS)	Census/ACS	11.6%	12.3%	8.6%
Family	Single parents (2000)	IN Business Research Ctr	9.1%	9.6%	9.6%
Family	% pop age >15 divorced (2000; 2006 if ACS)	Census/ACS	12.1%	14.8%	14.9%
Family	% births where mother unmarried (2006)	IN Department of Health	41.2%	46.7%	59.0%
Family	Number of abused/neglected children (< age 18) per 1,000. Substantiated cases (2005)	IN Dept of Child Services	12.7	15.9	Data not available
Family	# of religious congregations, all denominations (2000)	American Religious Data Archive	7,491	154	Data not available
Violence	# domestic violence victims served in Emergency Shelter (July 2006 - June 2007)	Indiana Coalition Against Domestic Violence	8,177	212	Data not available
Violence	# juveniles committed to the Dept of Correction (2006)	Indiana Youth Institute		21	Data not available
Education	# of public school student dropouts (2006)	Indiana Youth Institute	9,967	352	
	Anderson Community School Corporation				287
	Frankton-Lapel Community Schools				9
Education	% adults age>25 w/high school diploma or higher (2000; 2006 if ACS)	Census/ACS	85.2%	84.4%	77.4%
Education	% adults age>25 w/bachelor's degree or higher (2000; 2006 if ACS)	Census/ACS	21.7%	16.4%	13.1%
Employment	% of workforce in manufacturing (2006)	IN Business Research Ctr	15.5%	10.9%	10.9%
Employment	Unemployment rate (July 2008)	IN Business Research Ctr	6.1%	7.3%	7.3%

Measures in Red/Yellow based on comparison to State

Green county name indicates 2006 American Community Survey conducted where some census data was updated.

* Indicates that although county census data updated by ACS, this data point is from 2000 census.

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Madison County and Anderson Community Statistics

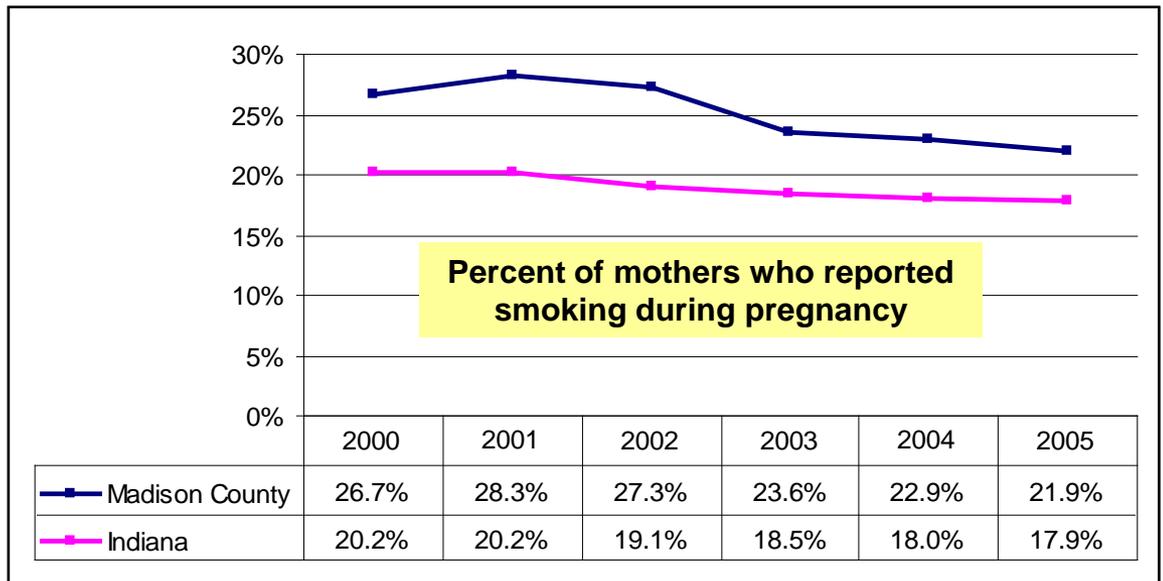
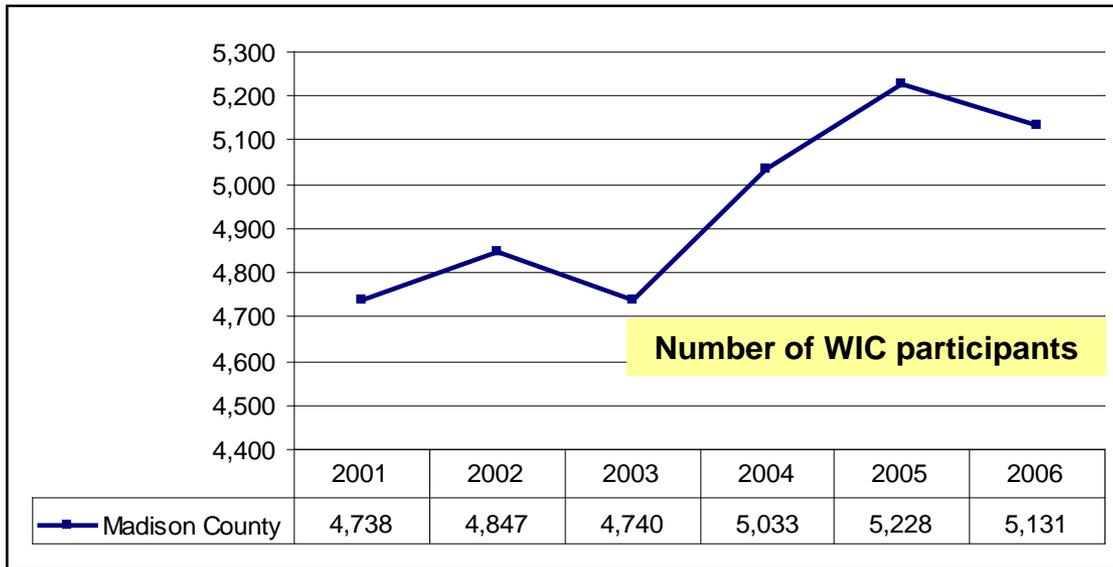
Category	Indicator	Source	Indiana	Madison County	Anderson
Health Status	Cancer as cause of death (per 100K, age adjusted - IN and county; Anderson as percent of all causes) (2006)	IN Department of Health	197.20	196.64	22.9%
Health Status	Heart Disease as cause of death (per 100K, age adj) (2006)	IN Department of Health	285.66	279.52	34.5%
Health Status	Mortality rate - all causes (per 100K, age adjusted) (2006)	IN Department of Health	845.12	879.39	
Health Status	# of Live births (2006)	IN Department of Health	89,404	1,594	827
Health Status	Teen (age 15-19) birth rate (live births per 1,000 women in age grp) (2006)	IN Department of Health	43.8	44.9	Data not available
Health Status	Teen (age 15-19) births (2006)	IN Department of Health	9,611	182	Data not available
Health Status	Infant (< 1 yr) mortality (% of live births) (2006)	IN Department of Health	0.8%	0.6%	Data not available
Health Status	% of mothers who smoked during pregnancy (2006)	IN Department of Health	17.3%	24.5%	29.0%
Health Status	% of low birth weight babies (2006)	IN Department of Health	8.2%	8.8%	8.9%
Health Status	% of mothers who received 1st trimester prenatal care (2006)	IN Department of Health	77.6%	82.5%	76.7%
Health Status	Asthma hospitalization rate (per 10,000) (2005)	IN Department of Health	13.2	18.1	Data not available
Poverty	% children (age 0-17) in poverty (2004)	Indiana Youth Institute		18.2%	Data not available
Poverty	Families whose income in the past 12 months is below poverty level (2006)	American Community Survey (ACS)	9.0%	10.3%	Data not available
Poverty	Single mothers w/children age<5 whose income in the past 12 months is below poverty level (2006)	American Community Survey (ACS)	48.6%	71.1%	Data not available
Poverty	% of pop participating in food stamp program (May 2008)	IN FSSA	9.7%	10.4%	Data not available
Poverty	Medicaid population (2006)	Solucient	13.3%	15.7%	Data not available
Poverty	% students receiving free lunches/textbooks (2006)	Indiana Youth Institute	26.9%	32.4%	
	Anderson Community School Corporation				42.6%
	Frankton-Lapel Community Schools				12.9%
Poverty	% students receiving reduced price lunches (2006)	Indiana Youth Institute	7.7%	7.9%	
	Anderson Community School Corporation				8.4%
	Frankton-Lapel Community Schools				7.1%
Poverty	Seniors (age 65+) whose income in the past 12 months is below poverty level (2006)	American Community Survey (ACS)	7.8%	6.9%	Data not available
Poverty	Uninsured population (2006)	Solucient	13.9%	13.9%	Data not available
Poverty	# of children enrolled in Hoosier Healthwise (2006)	Indiana Youth Institute		13,566	Data not available
Poverty	Monthly avg of persons issued food stamps (2006)	Indiana Youth Institute		15,131	Data not available
Poverty	Monthly avg of families receiving TANF (2006)	Indiana Youth Institute		1,283	Data not available

Measures in Red/Yellow based on comparison to State

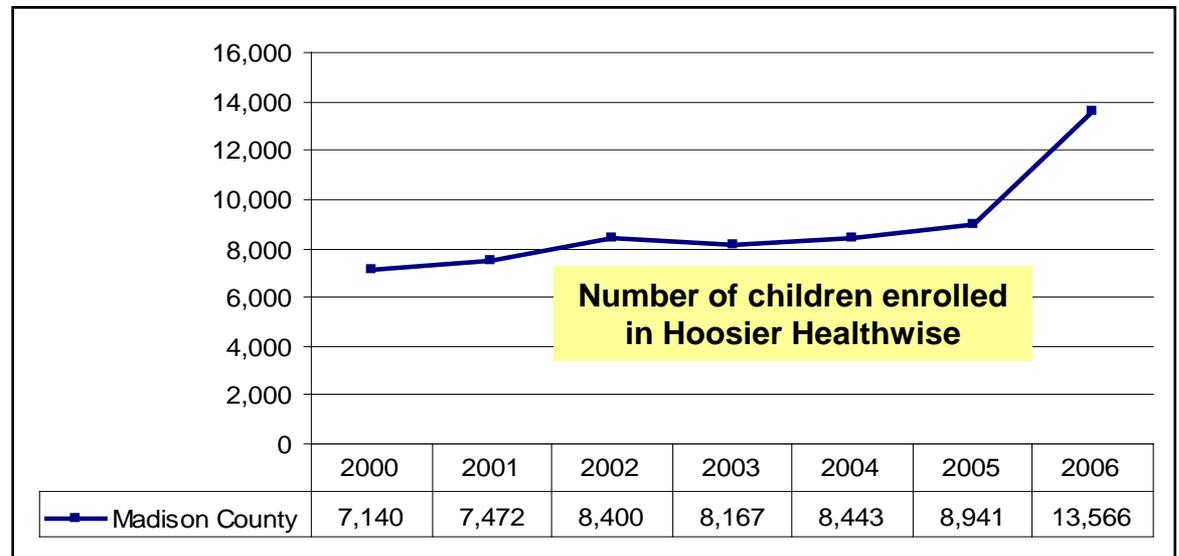
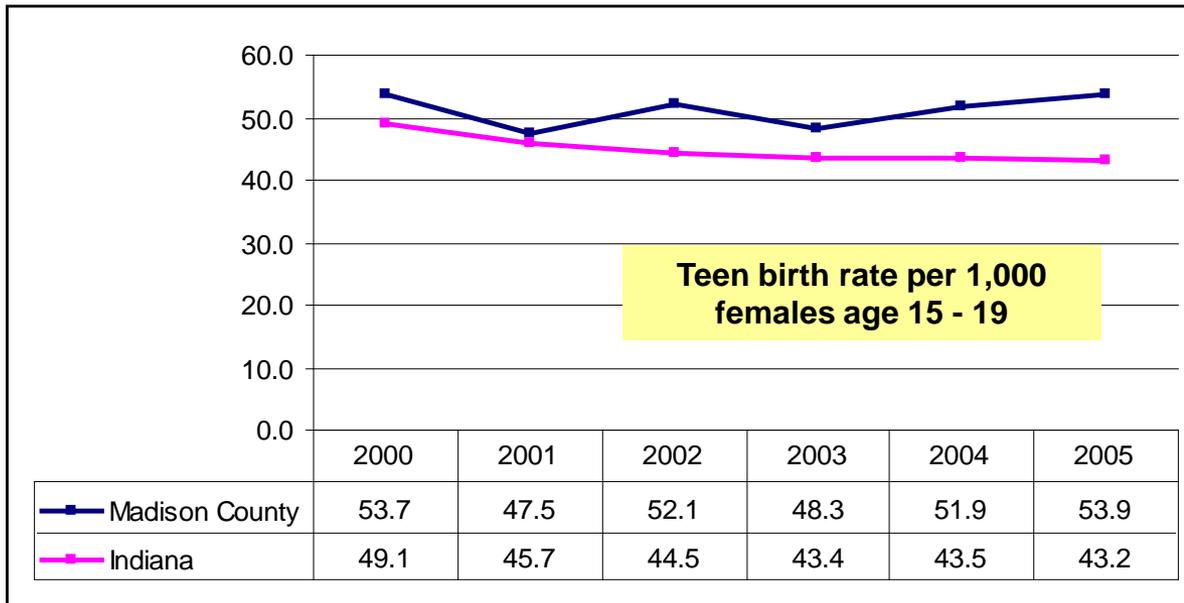
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Trends for Select Community Statistics Madison County



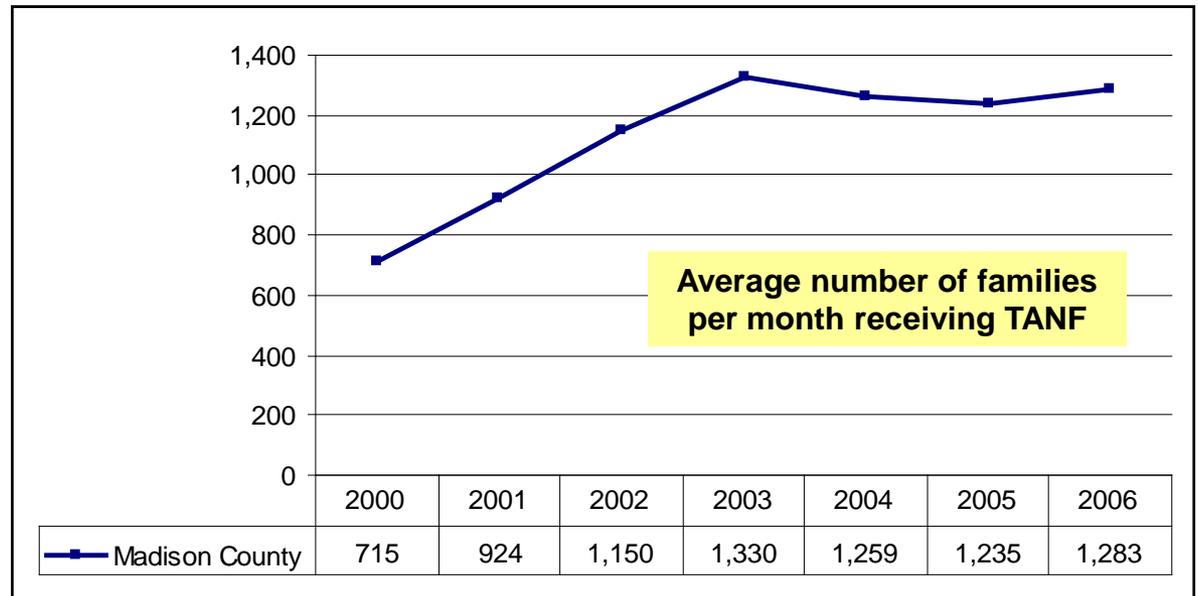
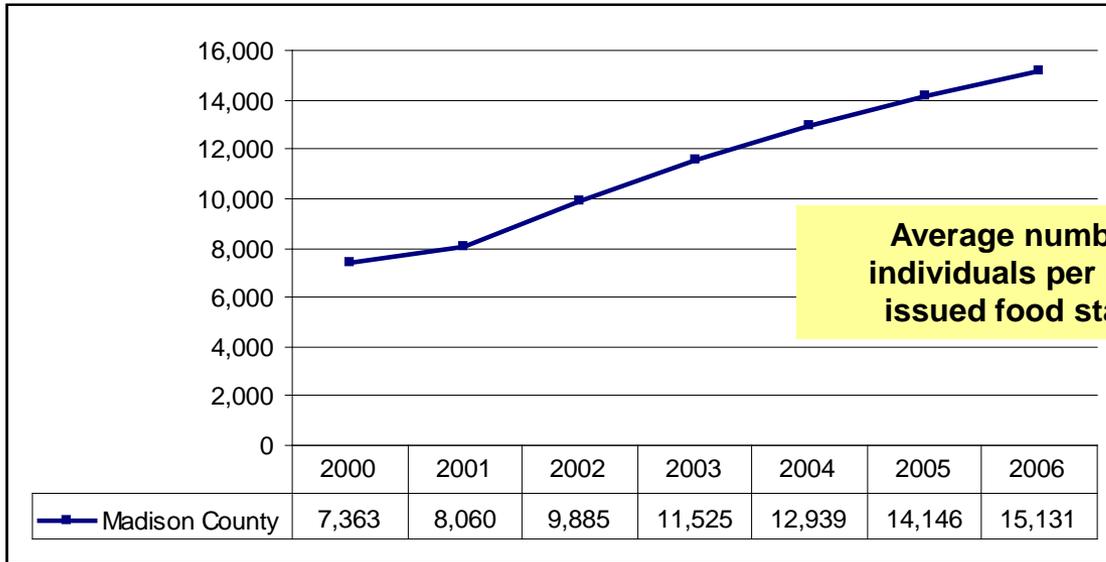
Trends for Select Community Statistics Madison County



Participation in TANF and Food Stamps Madison County, May 2008

Review of Select FSSA Programs			
Indiana FSSA			
May 2008			
	Indiana	Madison County	% of County Pop
Temporary Assistance for Needy Families (TANF)			
Number of families receiving TANF grants	36,153	743	
Total number of grant recipients	95,488	1,749	1.3%
Adult recipients	28,832	497	0.4%
Child recipients	66,656	1,252	1.0%
Total payments	\$7,474,454	\$157,618	
Avg payment per case	\$206.75	\$212.14	
Avg payment per person	\$78.28	\$90.12	
Food Stamps			
Total stamps issued	\$62,748,307	\$1,435,243	
Number of households receiving stamps	263,188	6,218	
Number of recipients	611,239	13,648	10.4%
Avg stamps per household	\$238.42	\$230.82	
Avg stamps per recipient	\$102.66	\$105.16	
2007 population (Claritas)	6,330,596	130,947	

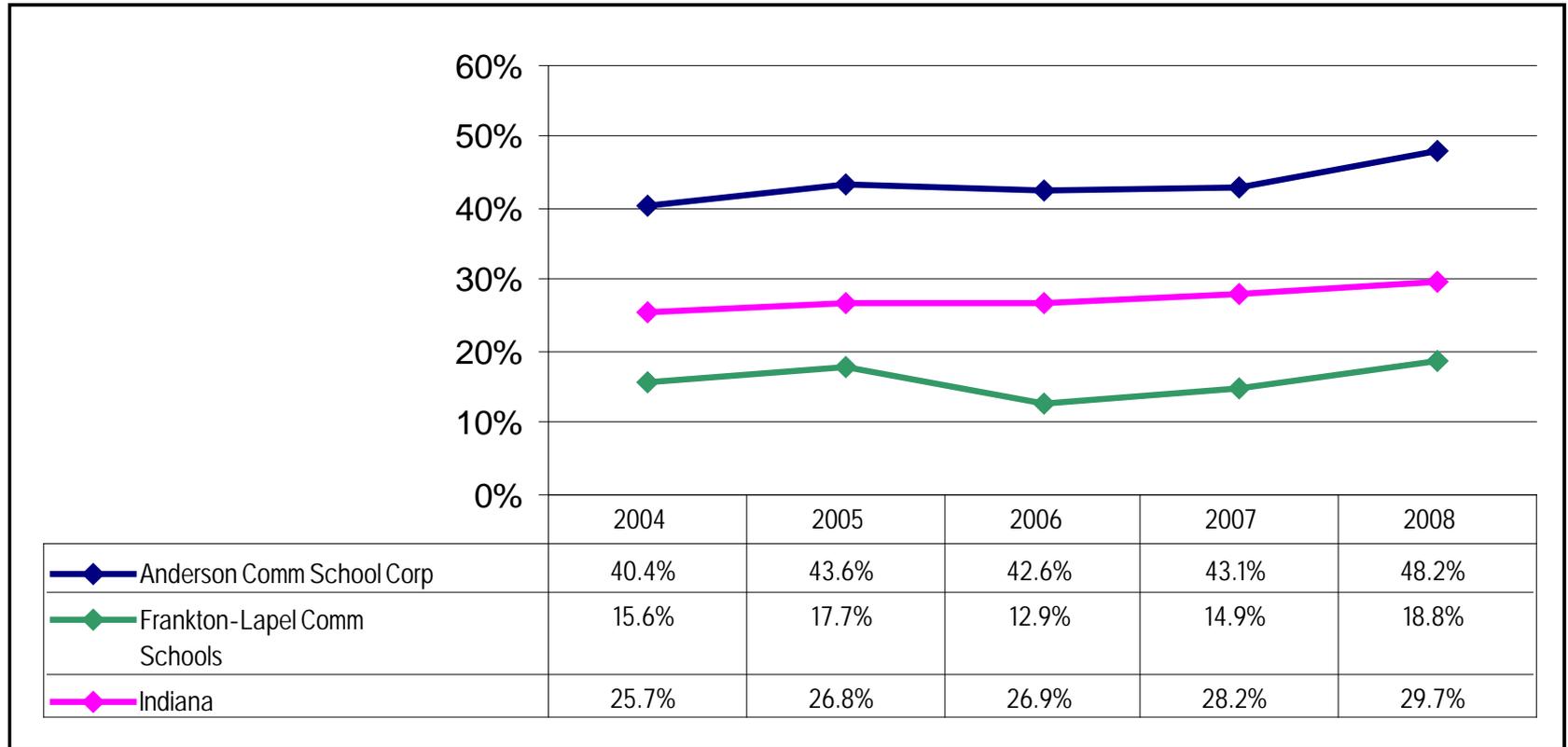
Historical Participation in TANF and Food Stamps Madison County



Medicaid Statistics Madison County

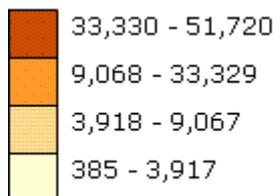
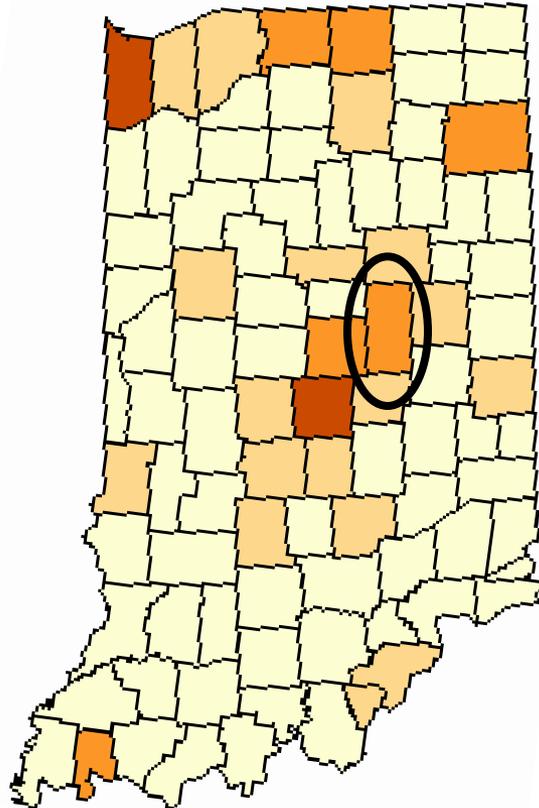
Medicaid Statistics Highlights		
Indiana FSSA		
December 2007		
	Madison County	% of County Pop
Enrollment by service delivery and total expenditure		
Total Medicaid enrollment	20,525	15.7%
Risk-based Managed Care (RBMC) enrollment	13,856	10.6%
Traditional Medicaid enrollment	5,868	4.5%
<i>Medicaid Select</i> enrollment	3	0.00%
Total Medicaid expenditure	\$7,840,147	
Enrollment by aid category grouping		
Aged (including Partials)	1,586	1.2%
Blind & Disabled (incl dual/non-dual and Partials)	3,231	2.5%
Adult	2,784	2.1%
Child	10,853	8.3%
CHIP	1,590	1.2%
Pregnant Women	481	0.4%
HoosierRx information		
HoosierRx participants for December 2007	48	0.04%
2007 population (Claritas)	130,947	

Percent of Students Receiving Free Lunches/Textbooks Anderson, by School District

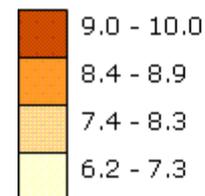
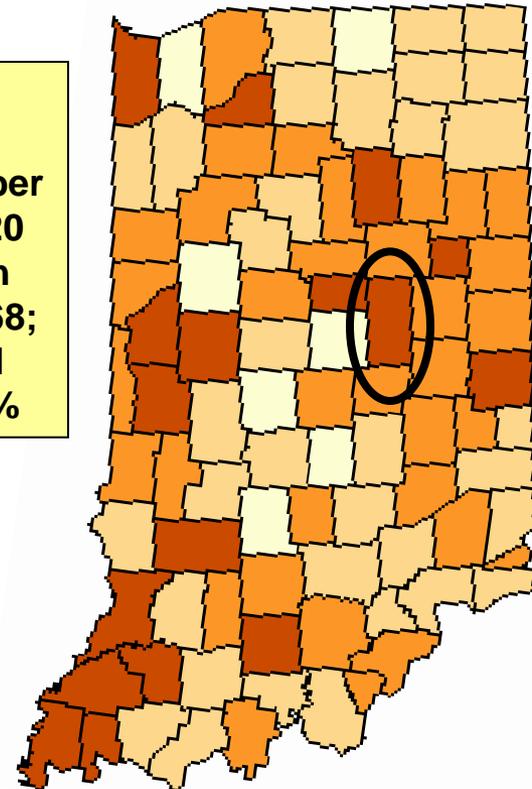


Adults age ≥ 20 with Diabetes Indiana, 2005

Number of adults age ≥ 20
with Diabetes



Percent of adults age ≥ 20
with Diabetes



**In Madison
County, the
estimated number
of adults age 20
and older with
diabetes is 9,068;
the estimated
percent is 9.4%**

Projected Directional Change in Jobs, 2008

By IU Faculty through Kelley School of Business Outlook Panel Program

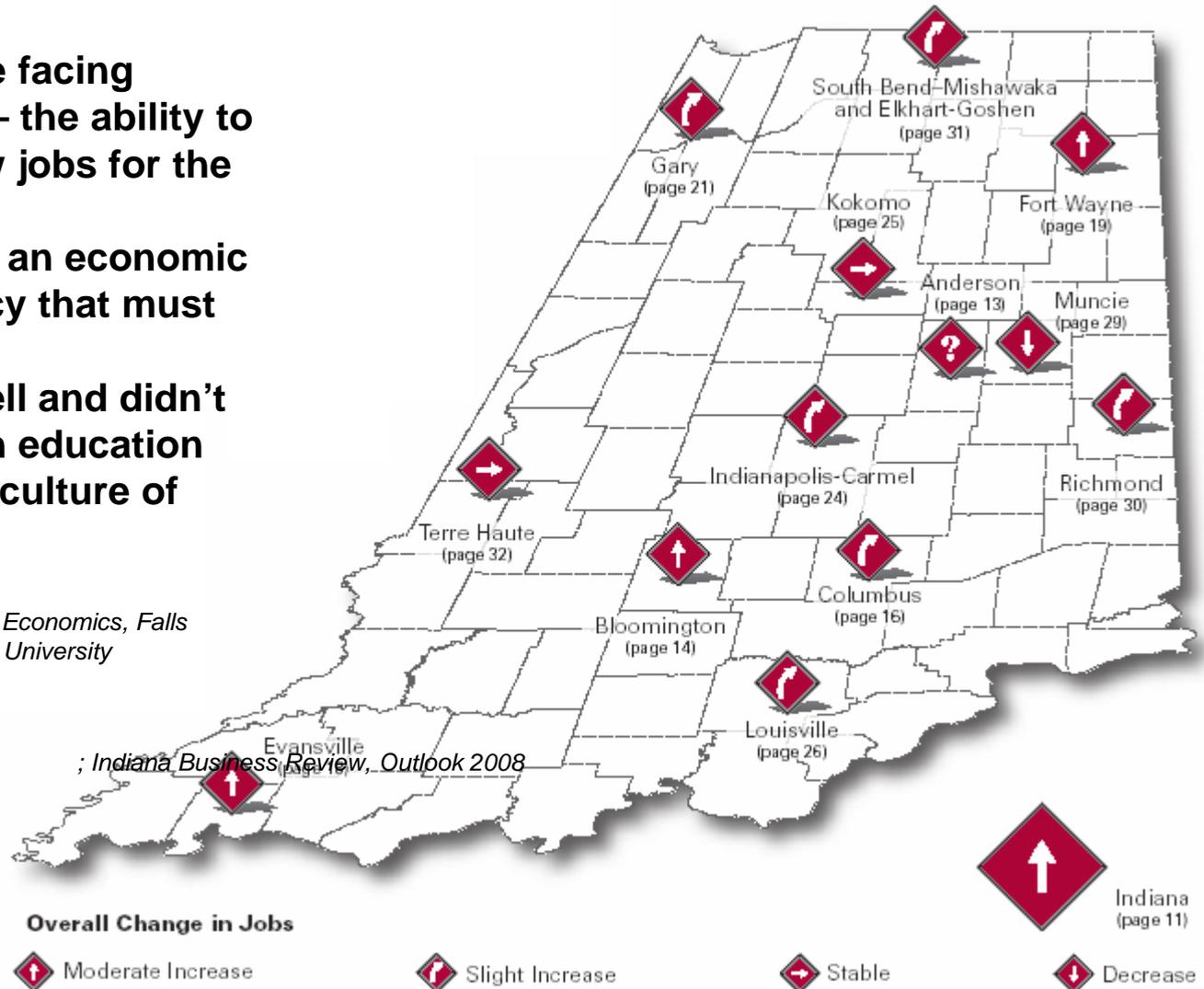
- Automotive manufacturing employment has been the county's economic base. Due primarily to decline in auto industry, employment has been falling
 - ❖ 10 years ago, there were 47,488 jobs in the county; 12,246 of those in manufacturing
 - ❖ In 2006, there were 41,225 jobs in the county; 5,901 in manufacturing
 - ❖ Represents a 13% decrease in overall employment and 52% decrease in manufacturing employment
 - ❖ No employment categories show significant gains over the past 4 years, so unemployment is running far above normal
- Employment decline has led to declines in other areas that measure the economic condition of the community:
 - ❖ Income levels lag behind the rest of Indiana
 - ❖ Average earnings for 2006 are only 88% of average earnings for the state
 - ❖ Industrial tax base has been falling, causing residential property taxes to rise
 - ❖ Population projections indicate a declining population for the county

Projected Directional Change in Jobs, 2008

By IU Faculty through Kelley School of Business Outlook Panel Program

- **Biggest challenge facing Madison County – the ability to attract/create new jobs for the community**
- **Auto industry left an economic and cultural legacy that must change**
 - ❖ **Jobs paid well and didn't require much education**
 - ❖ **Must build a culture of education**

Barry C. Ritchey, Professor of Economics, Falls School of Business, Anderson University



Physician Presence Madison County

Total physician FTEs and Medicaid panel sizes

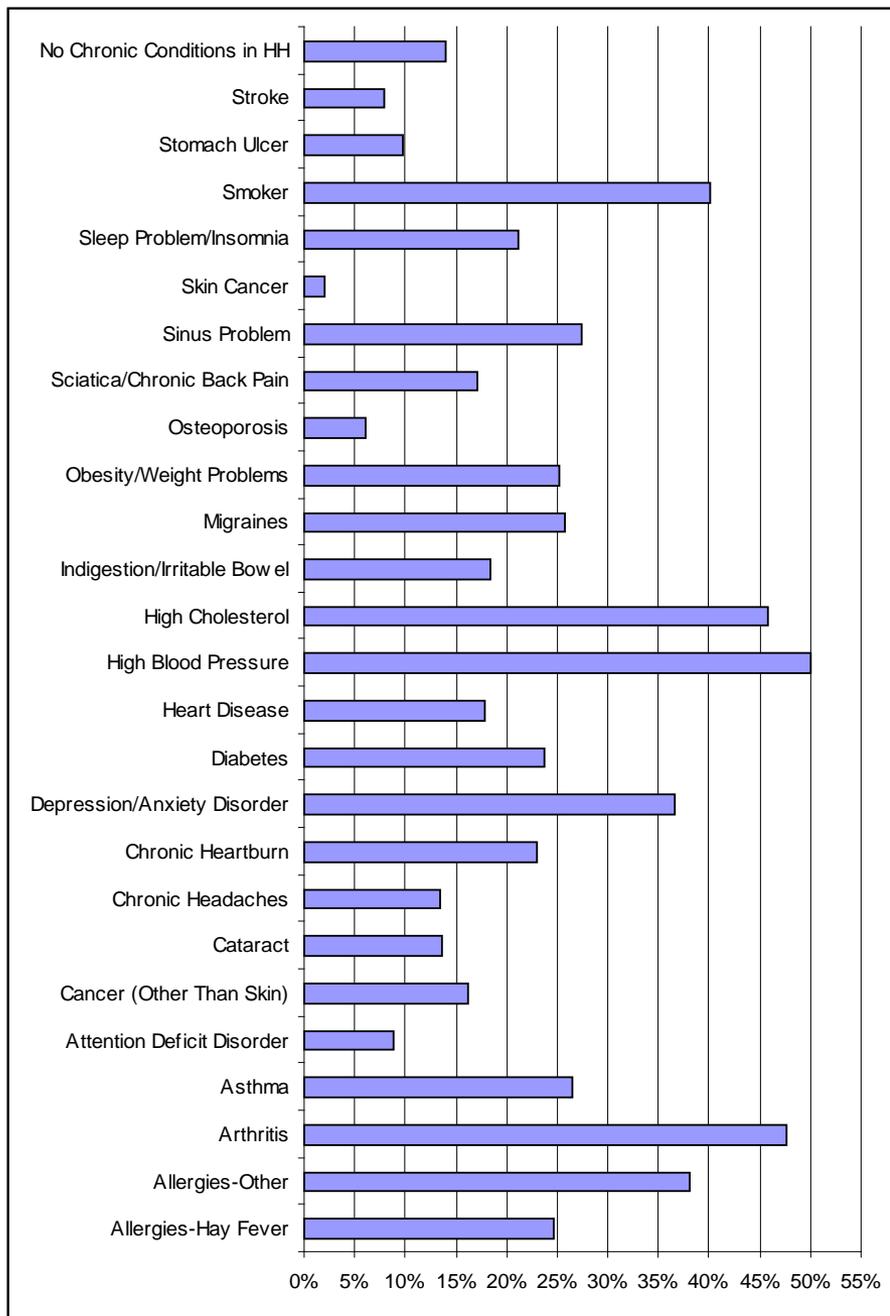
Madison County

St. Vincent Health Planning & Business Development physician database, July 2008

FSSA Indiana Medicaid data on total panel size for billing and rendering physicians, August 2008

	Physician FTEs	Panel Size
Family, General Practice	56.49	Expect OMMP data near end of August for last 2 months
Internal Medicine	8.50	
OB/GYN	13.00	
Pediatrician	8.00	
Emergency Medicine	33.33	
Psychiatry	14.83	
All other specialty	112.82	
Total	246.97	

Medicaid panel size represents the total number of Medicaid patients a physician **can** see at his/her office, not the **actual** number of Medicaid patients seen. Panel information represents both billing and rendering physicians – those that directly bill Medicaid and those rendering service for a group that bills Medicaid. Only Hoosier Healthwise and CareSelect PMPs have panels.



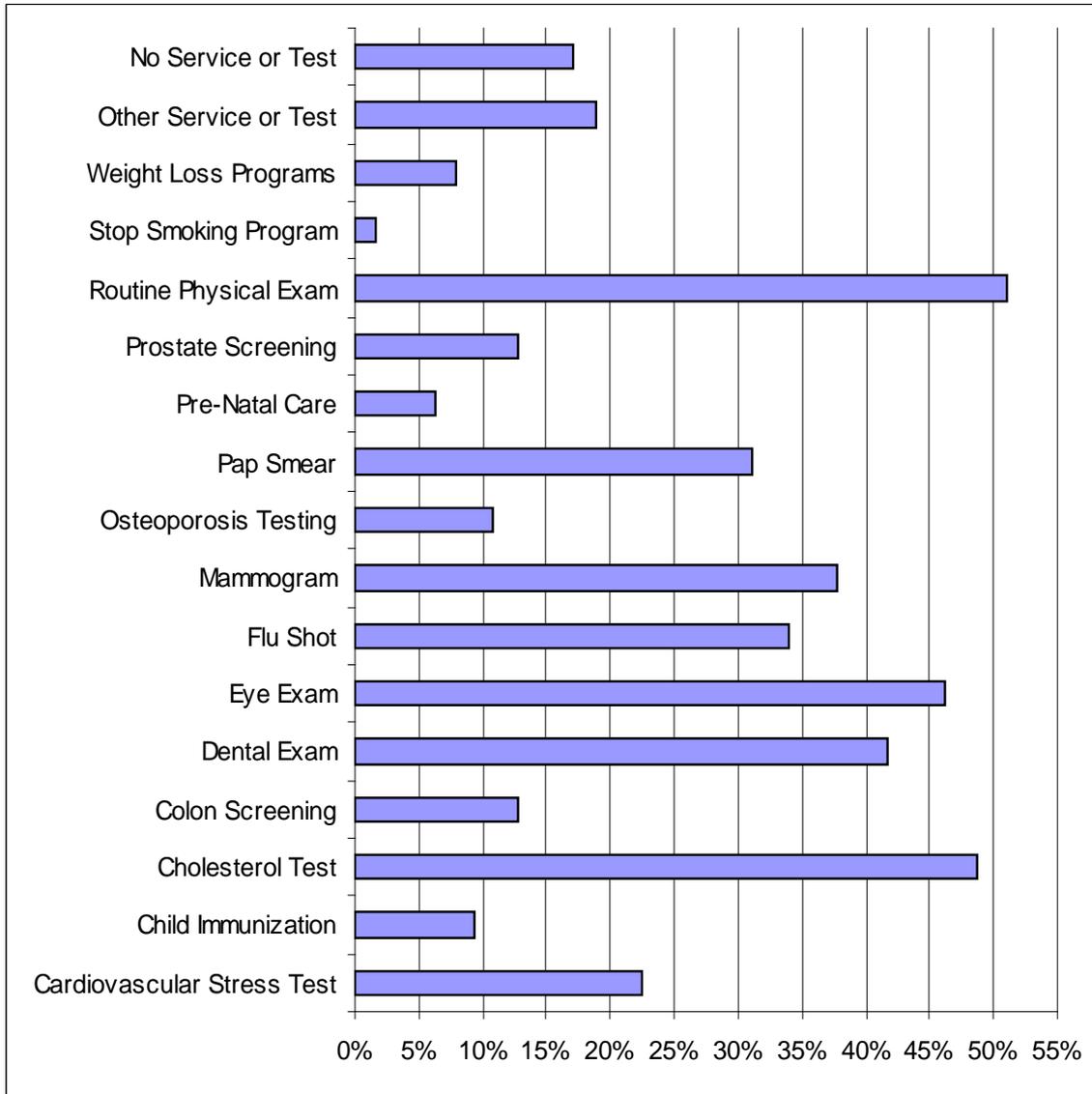
Percent of Madison County respondents who report that at least one of their HH members have been diagnosed with a particular health problem

NRC Results

*Survey Question: Has ANY HOUSEHOLD MEMBER been **diagnosed** as having any of the following health problems? (Select as many as apply) 2007: n = 114 At 95% confidence level, sampling error = +/- 9.18% Study conducted via the Internet*

Percent of Madison County respondents who report that at least one HH member used or had a particular health care service or test

NRC Results



Survey Question: Has any household member used or had any of the following health care services or tests in the last 12 months? (Select as many as apply)

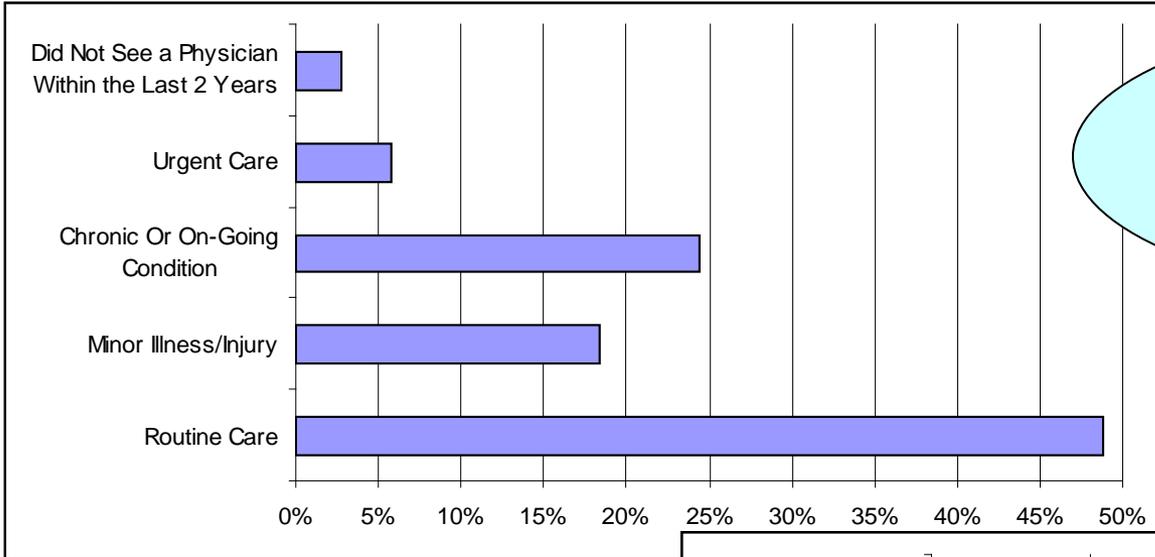
2007: n = 114 At 95% confidence level, sampling error = +/- 9.18% Study conducted via the Internet

Physician Access

Madison County

NRC Results

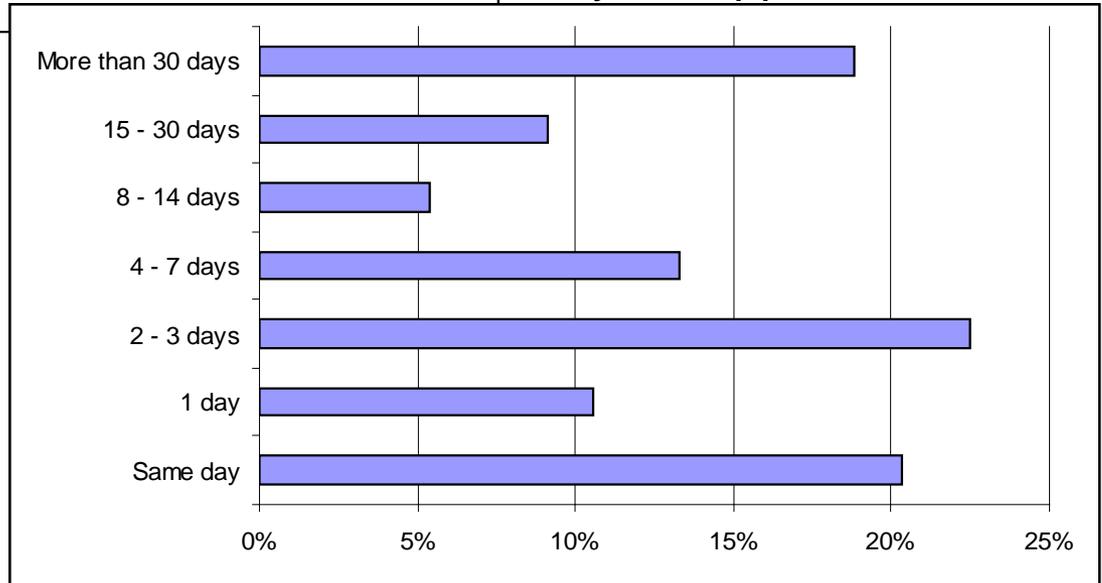
Purpose of last physician visit



18.9% of Madison County respondents report there were more than 30 days between the day their appointment was made and the day they saw the doctor

16.3% of Indianapolis MSA respondents also report more than 30 days between appt date and visit date

Days to appointment access



Survey Questions:

Thinking of your HOUSEHOLD'S last physician visit, what was the purpose of this most recent visit?

2007: n = 114 At 95% confidence level, sampling error = +/- 9.18%

How many days were there between the day your appointment was made and the day you saw the doctor?

2007: n = 111 At 95% confidence level, sampling error = +/- 9.30%

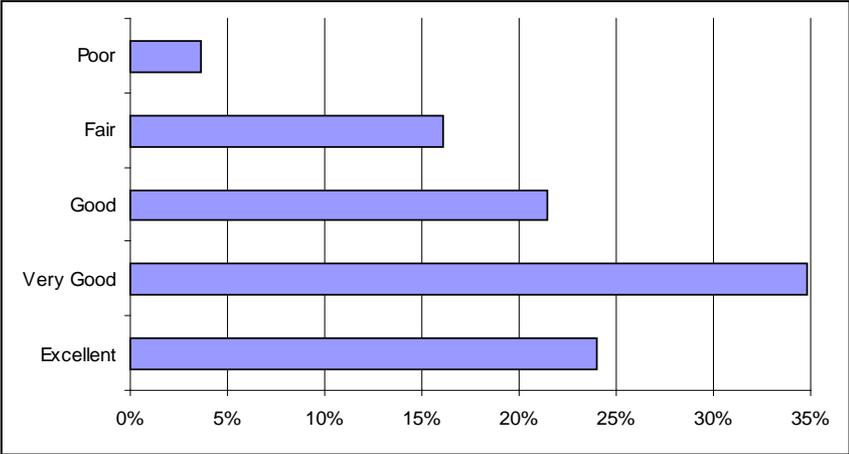
Study conducted via the Internet

Satisfaction with last physician visit

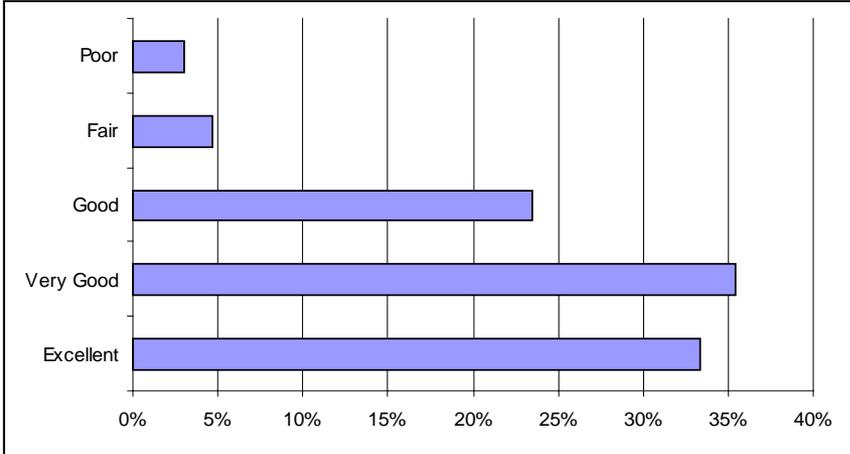
Madison County

NRC Results

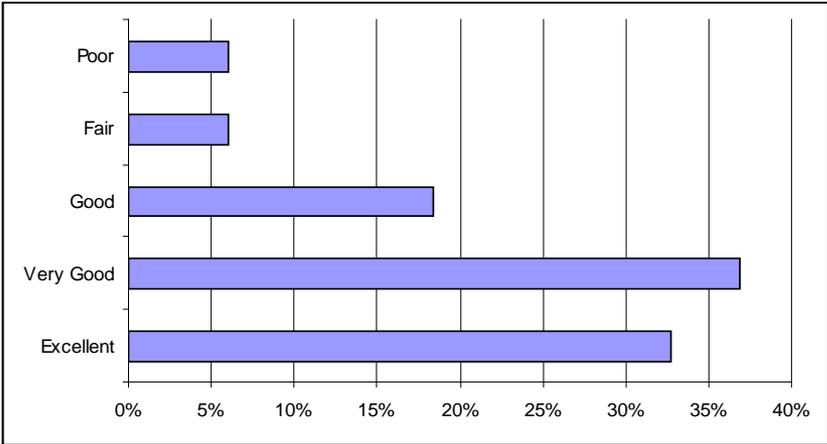
Time with doctor/staff



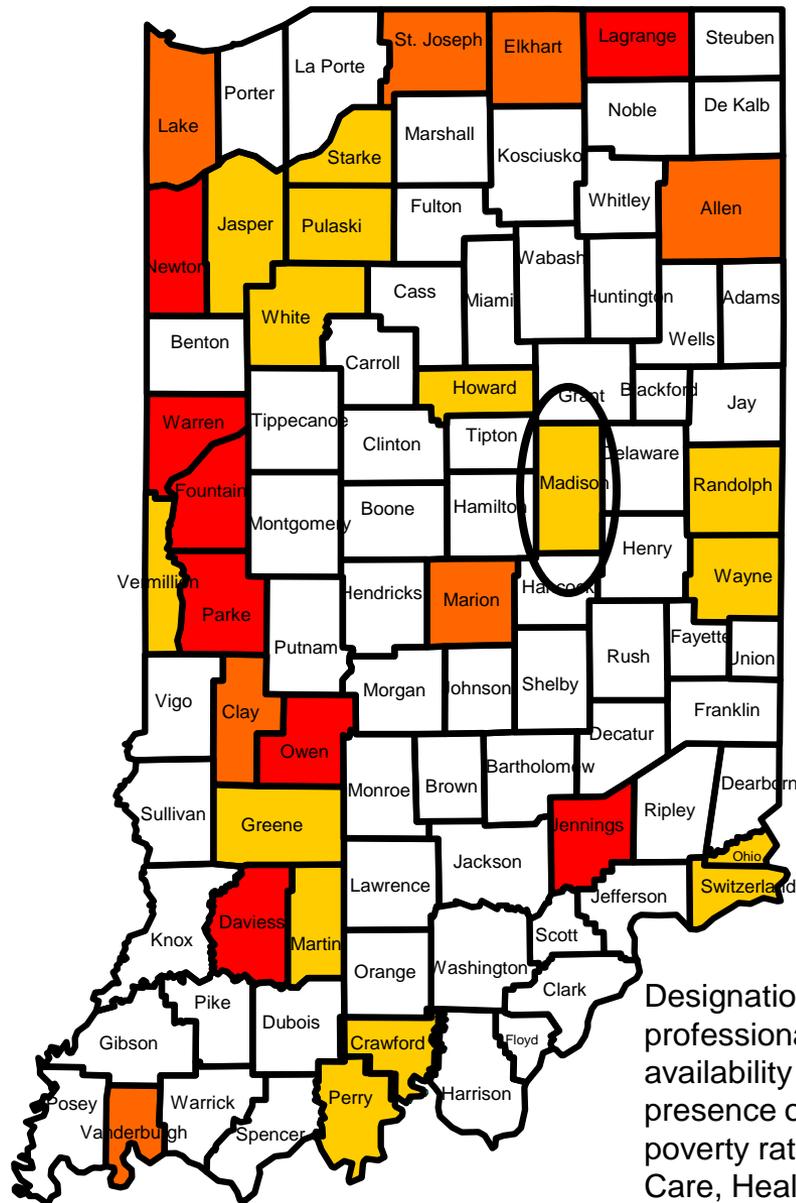
Quality of care



Access to medical care when needed



Survey Questions: Thinking about the last doctor visit, how would you rate: Amount of time you had with the doctor and staff during your visit? Overall quality of the care and services you received? Access to medical care whenever you need it?
2007: n = 111 At 95% confidence level, sampling error = +/- 9.30%. Study conducted via the Internet

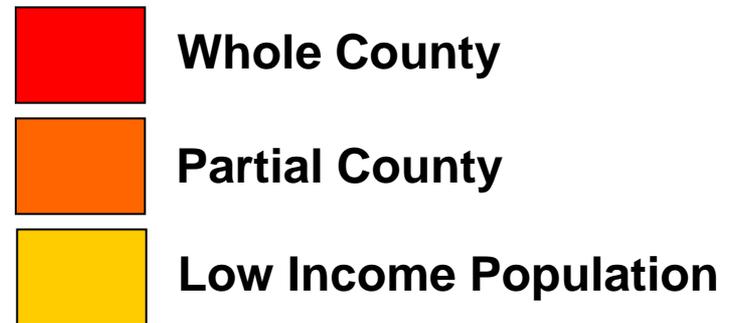


Primary Care Health Professional Shortage Areas (HPSAs)

2008

Data accessed 6/19/08

Source: ISDH



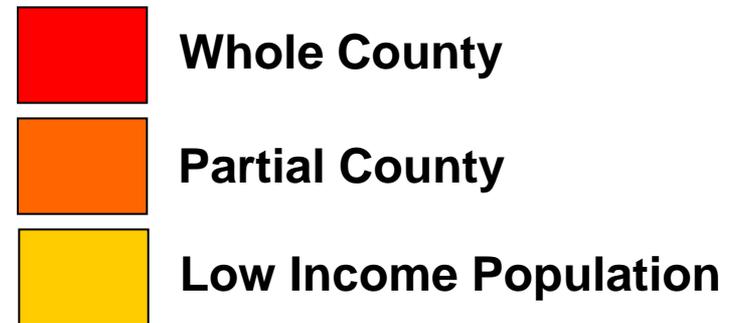
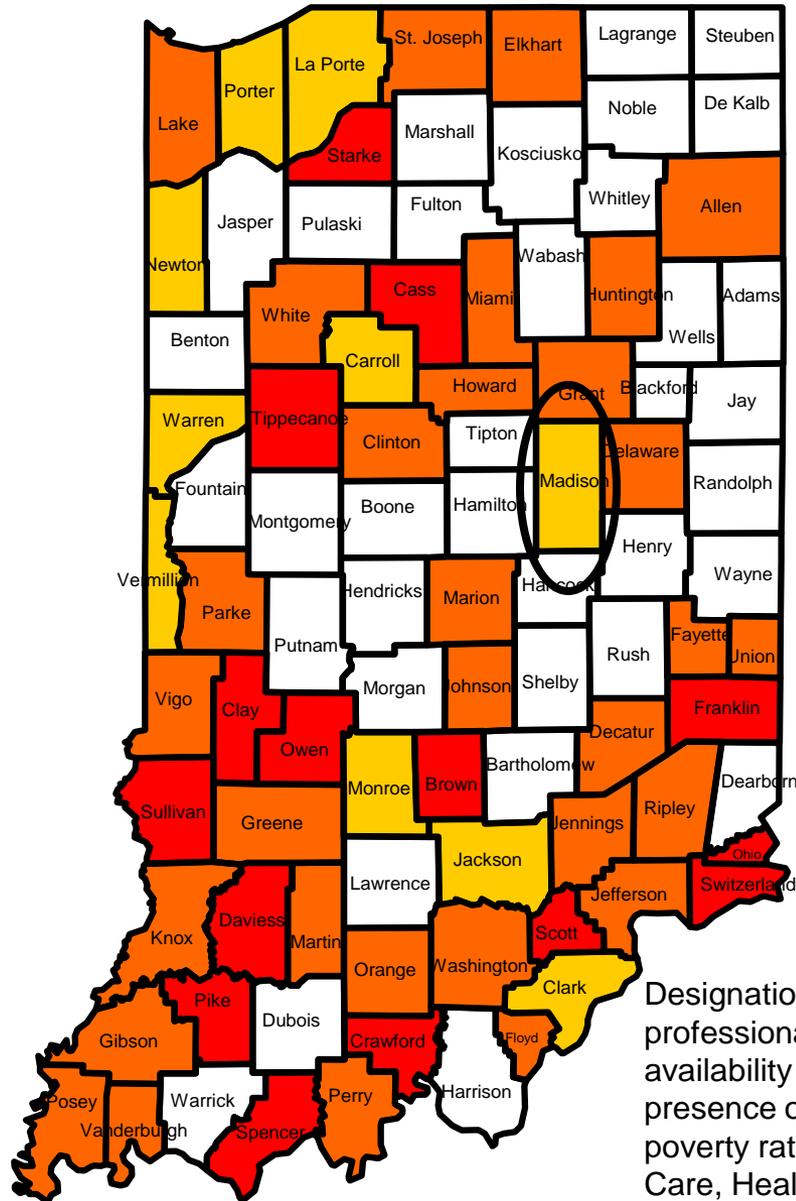
Designation as a HPSA or MUA is based on the availability of health professional resources within a service area. Also considered is the availability of primary care resources in contiguous areas and the presence of unusually high need, such as high infant mortality rate or high poverty rate. The Division of Shortage Designation, Bureau of Primary Care, Health Resources and Services Administration, Dept. of Health and Human Services is responsible for the designation process.

Medically Underserved Areas and Populations (MUA/Ps)

2008

Data accessed 6/19/08

Source: ISDH



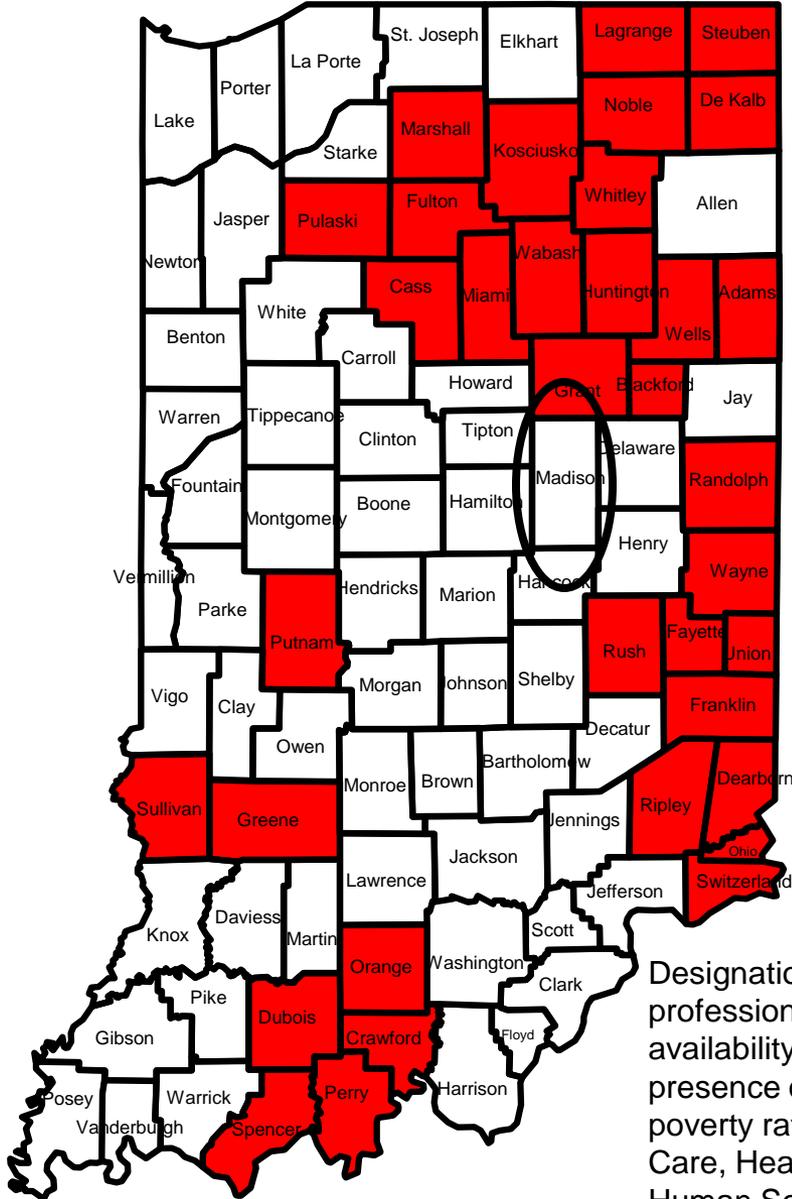
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Mental Health Professional Shortage Areas (HPSAs)

2008

Data accessed 6/19/08

Source: ISDH



 **Shortage Area**

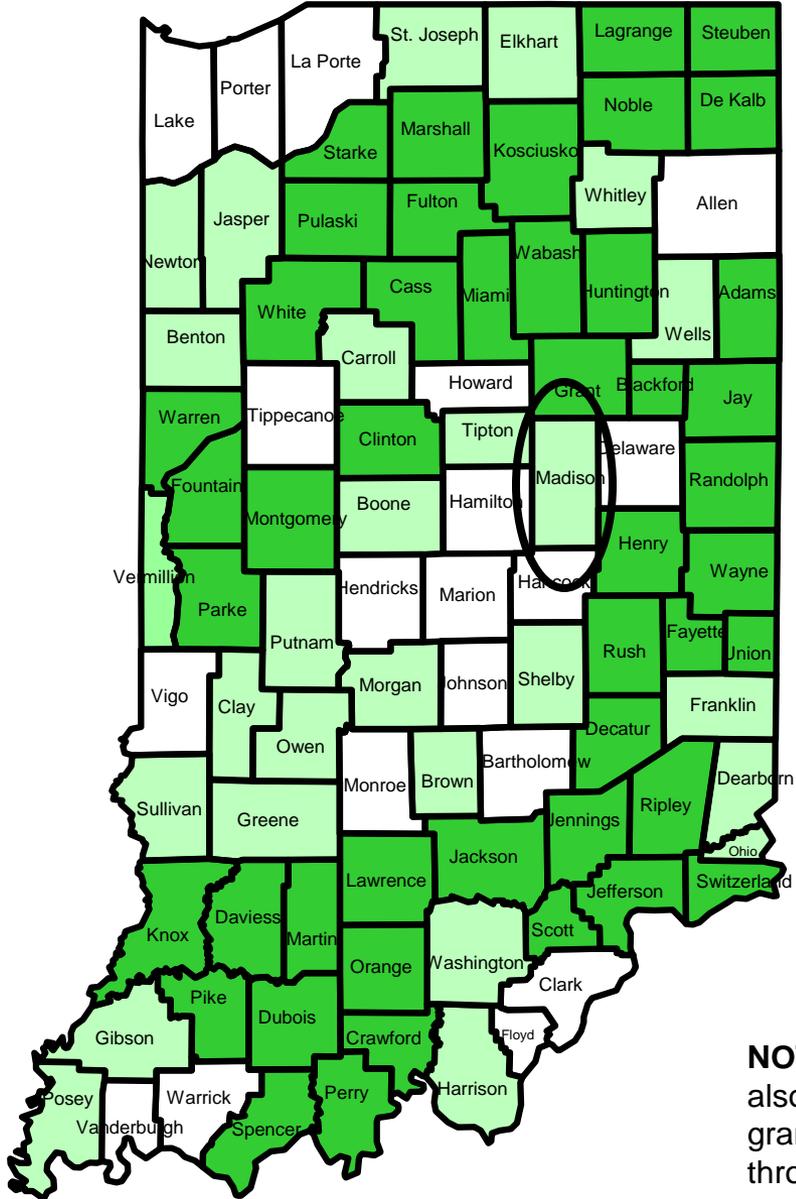
Designation as a HPSA or MUA is based on the availability of health professional resources within a service area. Also considered is the availability of primary care resources in contiguous areas and the presence of unusually high need, such as high infant mortality rate or high poverty rate. The Division of Shortage Designation, Bureau of Primary Care, Health Resources and Services Administration, Dept. of Health and Human Services is responsible for the designation process.

US Office of Rural Health Policy

Designated Rural Counties Eligible for Rural Health Grants

2008 (11/28/07)

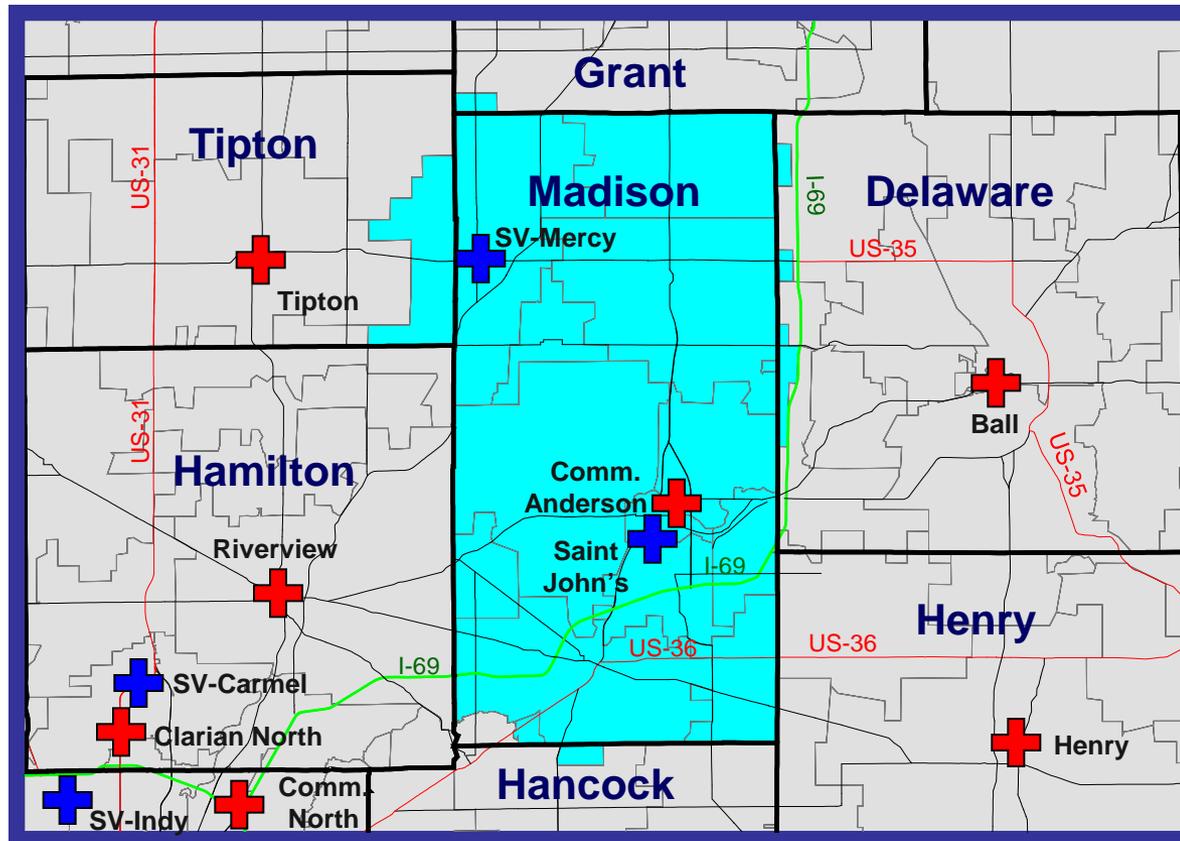
Source: Indiana State Dept. of Rural Health



-  Rural County
-  Metro County with Rural Census Tracts

NOTE: Many Census Tracts within non-rural counties are also designated as rural areas eligible for rural health grants. Information on these Census Tracts are available through www.hrsa.gov.

Madison County Healthcare Providers



Source: Solucient	Inpatient Est. (Discharges)	Total Population	Population Age 0-17	Population Age 65+
2007	18,641	130,947	30,419	20,334
2012	18,781	128,649	28,942	21,606
% Change	0.8%	-1.8%	-4.9%	6.3%

Solucient Inpatient Demand Estimates (Madison County) (2007 to 2012 Projections)

