

Community Guide for Health Professional Shortage Area (HPSA) Designation Applications

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**Colorado Department
of Public Health
and Environment**

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Public Use Statement

This guide was written and developed by Stephen Holloway, Director, Colorado Primary Care Office, and based upon the US Health Resources and Services Administration “HPSA and MUA/P Designation Training 2007” program materials. This document is available for public use where attributed to the Colorado Primary Care Office and Stephen Holloway.

Introduction

The uneven geographic distribution of health system resources has long been a problem in the United States. As a result, many individuals do not have adequate access to health services in their community. State and federal policy makers have attempted to ameliorate this problem by developing programs intended to reduce the barriers to healthcare access.

The Health Professional Shortage Area (HPSA) program is among the tools available to increase the supply, capacity, and distribution of health professionals in areas that have a verifiable shortage of providers. There are currently more than 30 federal programs, two state programs, and two private programs, which use shortage designation to determine eligibility. A HPSA designation may help your community attract new primary care, mental health, and dental health workers and it may increase Medicare and Medicaid reimbursement to the professionals already providing care in your community.

Designation Benefits for Select Federal Programs

Shortage Designation Option	National Health Service Corps	Federally Qualified Health Center Program	CMS Medicare Incentive Payment	CMS Rural Health Clinic Program	J-1 Visa Waiver Physician Program
Primary Care HPSA	✓		✓	✓	✓
Dental Health HPSA	✓				
Mental Health HPSA	✓		✓		✓
Geographic HPSA	✓		✓	✓	✓
Population HPSA	✓			✓	✓
Facility HPSA	✓				✓
Exception Medically Underserved Population		✓			✓
Medically Underserved Area		✓		✓	✓
Medically Underserved Population		✓			✓
Governor's Certified Shortage Area				✓	

The federal Department of Health and Human Services, Health Resources and Services Administration (HRSA) has developed criteria to determine whether an area should receive a federal shortage designation. The steps outlined in this community guide will aid you in developing a successful HPSA application. Any individual or organization may submit an application for their community, special population, or healthcare facility. Approval is not competitive and is simply based upon whether your application describes a shortage of **sufficient** magnitude to meet or exceed the federal HPSA guidelines. Should you have any additional questions about the process after reviewing this guide, please contact the Primary Care Office (PCO) for further assistance at 303-692-2298.

Applying for a Health Professional Shortage Area

To receive a federal shortage designation of any kind, an application describing how an area or facility meets federal shortage criteria is required. A shortage application is typically prepared at the local level, in consultation with the state Primary Care Office, and then submitted to the federal Shortage Designation Branch for approval. The complete application and approval process typically takes from three to nine months. Because of the length of time required to complete a designation, communities are well advised to begin the application process as soon as a health provider shortage is recognized.

There are several types of HPSA designations. If it is not readily apparent for which designation your community is likely to qualify, plan to collect enough data so that the assessment requirements of each type are satisfied. This may save you a great deal of time should your course change during the process. In addition, take detailed notes about your strategy, rationale, and key determinations throughout application development and retain them in your files when you are done. A HPSA designation must be renewed approximately every three years and your successor (or you) will find these notes invaluable to expediting the renewal application when it comes due.

The federal Shortage Designation Branch at the Health Resources and Services Administration will make the final determination of shortage designation. Your application should, however, first be submitted to the state Primary Care Office. This step assures that the application is free of errors and makes the best possible case for your designation request. Once the Primary Care Office has reviewed your application and made any recommendations for improvement, a letter of support will be drafted and forwarded along with your application to the Shortage Designation Branch.

Ways in Which a HPSA Designation can be Applied

One may create a HPSA application for primary care, mental health or dental health disciplines in one of three categories. These categories are as follows:

- ***Geographic Area*** – This designation indicates that **all** individuals, who are not living in a group quarter, in the area of designation have insufficient access to primary care, mental health, or dental health services. This is the broadest and simplest designation to request. One should evaluate the possibility of a geographic area designation before considering either of the next two designation categories.
- ***Population Group*** – This designation indicates that a **subpopulation** of individuals living in the area of designation has insufficient access to primary care, mental health, or dental health services. A population group might be defined as an elevated prevalence of residents who are below 200% of federal poverty level, are on Medicaid, are migrant farm workers, or are homeless, among others. One should evaluate the possibility of a population group designation before considering a facility designation.

- **Facility** – This designation indicates that individuals served by a **specific health facility** have insufficient access to primary care, mental health, or dental health professionals. The types of facilities that can be designated include federal and state correctional institutions, public and nonprofit healthcare facilities, and state and county mental hospitals. This designation should not be pursued until all options for a geographic or population designation are exhausted.

HPSA Application Elements

There are four required elements of a complete HPSA application, which must be completed for an application to be successful. These elements are as follows:

- **Rational Service Area** – A description and rationale for the boundaries of the proposed designation
- **Population to Provider Ratio** – A set of calculations, which describes the capacity of existing providers to provide care to the population in the rational service area
- **Contiguous Area Analysis** – A description of why provider capacity in adjacent areas is not reasonably available to the population of the rational service area
- **Nearest Source of Undesignated Care** – A calculation, which indicates the time needed to travel to the nearest source of care that is not in a HPSA of the same discipline, from the population center of the rational service area, regardless of distance or utilization

Generally, a well developed application needs no more than a few pages of narrative, a provider survey data table, and a few attached maps. Longer applications tend to obscure key facts of the proposed designation, rather than emphasizing them, which slows the approval process. An application outline is provided in this guide in Appendix 1A.

Rational Service Area

The first determination one must make when developing a HPSA application is where the boundaries of the HPSA will be. The boundaries must be “rational” in that they describe a distinctive area or population, which meets or exceeds shortage criteria.

Select Boundaries

Identify the boundaries or Rational Service Area (RSA) of the proposed designation. A Rational Service Area may be:

- ***A Whole County*** – except when the total population exceeds 250,000 people. In this instance, two or more service areas, each with its own application, may need to be devised.
- ***Multiple Counties*** – if the counties are contiguous and the largest population center of each county is nearer to one another than 30 minutes travel time for primary care designations and 40 minutes travel time for mental health and dental health designations. Travel minutes must be determined by a specific formula found in Appendix 1B.
- ***Sub-County*** – is rational if the borders of the service area are definable as a town, city, minor civil division (MCD), census county division (CCD), or township **and** the service area is not smaller than a census tract.
- ***Parts of Adjacent Counties*** – are acceptable service areas if the populations are linked together by predominant travel patterns and/or shared population characteristics such as demographics, health status or socioeconomic status.
- ***Mental Health Catchment Area*** – for mental health HPSA applications only.

One may need to try several different service area configurations to achieve the best outcome for the application. For instance, a county as a whole may not qualify under the designation guidelines but a set of census tracts in the county may. The type of population you are serving may also affect how you define your service area. It is important to note that all parts of a service area **must** be contiguous to one another, the service area **cannot** overlap with an existing HPSA designation for the same professional discipline, **or** have interior portions carved out.

Describe Rationale for Determination

Describe in a narrative, why the service area is rational. If one has selected a whole county service area, then simply state such and move on. All other service area configurations require additional justification. The justification is strongest, when **multiple** reasons can be cited for why the service area is rational. Acceptable justifications may include one or more of the following:

1. It is a whole county.
2. It is an area whose population has similar demographic, health status and/or socioeconomic characteristics and is **distinctive** from contiguous areas by the same criteria used to describe the population.
3. It is isolated from health resources because of poverty, racial or ethnic composition, and/or language.
4. There are **significant** physical barriers to travel to contiguous areas such as bodies of water, mountain ranges, large military bases, national parks, large industrial areas, or rail yards.
5. It is a strongly cohesive, homogenous, and interdependent neighborhood like those formed by a shared language, culture, and/or national origin. The populations of neighborhood service areas should be shown to have limited interaction outside of the neighborhood. These areas will generally have a population of greater than 20,000 to be considered and **are distinctive** from contiguous areas by the same criteria used to describe the neighborhood.

Data available from the U.S. Census Bureau should be used in making determinations about the characteristics of the service area population (Appendix 1C). It may be useful to enter this data in a table by census tract on your application to describe the population to state and federal reviewers.

Example: Census Level Description of a Rational Service Area within a County

Census Tract	Population	Population Over 65	White	African American	American Indian	Hispanic	Asian/Pacific Islander	<100% Federal Poverty Level	<200% Federal Poverty Level	Part of Service Area
0001.00	1678	5.5%	90.1	2.1%	0%	3.8%	4.0%	5.4%	11.4%	No
0002.00	2929	29.6%	76.5%	0.6%	0%	21.2%	1.7%	8.7%	32.5%	Yes
0003.01	1162	34.3%	90.1%	3.3%	0%	4.2%	2.4%	12.5%	33.9%	Yes
0003.02	1303	31.3%	23.5%	1.0%	1.8%	71.2%	2.5%	21.9%	32.8%	Yes
0004.00	3647	29.1%	11.5%	17.4%	9.1%	61.3%	0.7%	24.7%	34.3%	Yes

demographic characteristics, which may make a good justification for a Rational Service Area

Population to Provider Ratio

Once one has determined and justified a Rational Service Area, one must next establish how many providers are available to the population of the service area. The population to provider ratio **must** meet or exceed the following to be eligible for a designation. Provider ratios for facilities are found in the facility designation section.

Primary Care Provider Ratios

Geographic Area $\geq 3500:1$

Geographic Area with High Needs $\geq 3000:1$

- a) More than 20% of the population has incomes at or below 100% of the Federal Poverty Level; or
- b) More than 100 births per year per 1,000 women ages 15-44; or
- c) More than 20 infant deaths per 1,000 live births; or
- d) Meets insufficient capacity criteria (Appendix 1D)

Population Group $\geq 3000:1$

Mental Health Provider Ratios

Geographic Area

- $\geq 1:30,000$ psychiatrists, or
- $\geq 1:9,000$ core mental health professionals (Appendix 1E), or
- $\geq 1:20,000$ psychiatrists **and** $\geq 1:6,000$ core mental health professionals

Geographic Area with High Needs

- $\geq 1:20,000$ psychiatrists, or
 - $\geq 1:6,000$ core mental health professionals, or
 - $\geq 1:15,000$ psychiatrists **and** $\geq 1:4,500$ core mental health professionals
- a) More than 20% of the population has incomes at or below 100% of the Federal Poverty Level; or
 - b) A youth ratio of greater than 0.6 (children <18 to adults ages 18-64), or
 - c) An elderly ratio of greater than 0.25 (elderly >65 to adults ages 18-64), or
 - d) Alcohol or substance abuse prevalence data in the area is in the worst quartile of the nation, state, or region

Population Group

- $\geq 1:20,000$ psychiatrists, or
- $\geq 1:6,000$ core mental health professionals, or
- $\geq 1:15,000$ psychiatrists **and** $\geq 1:4,500$ core mental health professionals

Dental Health Provider Ratios

Geographic Area \geq 1:5000

Geographic Area with High Needs \geq 1:4000

- a) More than 20% of the population has incomes at or below 100% of the Federal Poverty Level; or
- b) More than 50% of the population has no fluoridated water; or
- c) Meets insufficient capacity criteria (Appendix 1D)

Population Group \geq 1:4000

Calculating the Population Side of the Ratio

Though these ratios are not hard to interpret, determining the population to provider ratio is not as simple as counting the population and dividing by the number of providers. There are three reasons for this. First, not everyone in the population is presumed to be without access to care; second, not every provider provides care for exactly 40 hours per week and, third, not every provider provides care to the entire population. The type of designation you choose will determine which method you use to formulate your population to provider ratio.

Geographic Designations

This ratio is calculated by determining the resident civilian population to the number of full time equivalent (FTE) providers in direct patient care.

resident civilian population : provider FTE in direct care

The resident civilian population is a number that describes the population that is dependent upon providers in the community rather than providers in institutions. The resident civilian population is determined by subtracting the “group quarters” population (available on the US Census Bureau web site; see Appendix 1C) from the total population. The resident civilian population is the:

- Full time resident, non-institutionalized population, and
- Tourists, and
- Seasonal workers, and
- Part time residents

The count for the last three bullets **must** be adjusted by the proportion of the year the population resides in the service area. For example, if 1340 seasonal workers reside in the service area for 7 months each year, then the adjusted count will be calculated as:

$$1340 \times (7/12) = 782$$

The method used to derive the count and proportion of annual residence in the service area must be fully described in the narrative. The resident civilian population **cannot** include:

- Prison inmates
- Long term care facility residents
- Group-home residents
- College students living in dormitories
- Residents of American Indian reservations
- Residents of military bases

It is acceptable to use data sources other than that available from the US Census Bureau, especially when such data strengthens your case for designation. If one elects to use other data sources, the narrative must describe the quality of the source and the methodology used to collect the data. Be aware that the preceding rules for inclusion or exclusion of certain populations still apply to data from other sources and some data sources may be deemed unusable by the Shortage Designation Branch.

Population Designations

This ratio is calculated by determining the population to be designated to the number of full time equivalent (FTE) providers in direct patient care **to** that population.

population to be designated : provider FTE in direct care to the population

Populations that can be designated include low income, Medicaid eligible, homeless, migrant farm worker, and Native American. Low income and Medicaid eligible designations can **only** be made if 30% or more of the population of the service area is below 200% of the Federal Poverty Level. Migrant farm worker population counts **must** be adjusted by the proportion of the year the population resides in the service area. For example, if 1150 farm workers reside in the service area for 5 months each season, then the adjusted population will be calculated as:

$$1150 \times (5/12) = 479$$

For more information on where to find data related to populations, refer to Appendix 1C.

Calculating the Provider Side of the Ratio for Primary Care

Step 1

Identify all primary care physicians (MD or DO) providing direct patient care in the service area. The Primary Care Office will be able to provide physician data to you (also see Appendix 1C). For the purposes of shortage designation, primary care is defined as general practice, family practice, general internal medicine, general obstetrics and gynecology, and pediatrics. Exclude from your application all primary care physicians who are:

- Providing care solely as a hospitalist or emergency physician
- Engaged solely in administration, research, or training
- Locum tenens who have served less than one year
- Suspended by the Medicaid/Medicare Antifraud and Abuse Act for more than 18 months

You may need to survey all physicians in your service area before you can determine if they should be excluded from your application.

Step 2

Survey each primary care physician who works in direct patient care in the service area using the provider survey tool found in Appendix 1F. Before distributing your survey, review the section on “Contiguous Area Analysis.” You may determine that collecting additional physician data outside of the service area is necessary for your application to be successful.

All primary care physicians, except those excluded by the above criteria, must be included in your application report even if some are not actively providing primary care services. Additionally, FTE estimates of physicians who do not respond to your survey must be included in your results table. This is accomplished by assigning the average FTE, or average low income FTE, of the responders to the non-responders. Estimated FTE calculations must be noted on your table.

Generally, it is disadvantageous to apply averages to non-responders because it often makes it appear that there is more primary care capacity available than what actually exists. It is therefore in your interest to attempt a 100% response rate. An application must attain at least a 67% survey response rate to be considered by the Shortage Designation Branch.

Step 3

Calculate the full time equivalent of physician services for inpatient and outpatient primary care. Decide which physicians to include in the final calculation by using the following table.

Designation Category	Primary Care Providers to Count
Geographic and Geographic with High Needs	All primary care physicians in the service area
Population: Low Income	All primary care physicians in the service area who accept Medicaid and/or use a sliding fee scale for assessing payment
Population: Medicaid Eligible	All primary care physicians in the service area who accept Medicaid
Population: Homeless	All primary care physicians in the service area who serve homeless persons
Population: Migrant Farm Worker	All primary care physicians in the service area who serve migrant farm workers
Population: Native American	All primary care physicians in the service area who serve Native Americans

Regardless of the hours reported in your survey results, you should reduce to zero the FTE of physicians who are:

- Under contract with the National Health Service Corps
- Federal providers with the Indian Health Service, US Public Health Service, or Bureau of Prisons
- Foreign medical graduates, are **not** US permanent resident's, and are working on a J-1 Visa Waver, National Interest Waiver, or H-1B Visa

Partially reduce the FTE of physicians who are:

- Reporting more than 40 hours per week in direct patient care to 1.0 FTE
- Foreign medical graduates **and** are US permanent residents but practicing on a restricted license to 1/2 FTE of the total hours worked
- Medical residents and interns in training to 0.1 FTE

Do not modify the FTE of physicians who are:

- Under contract with a state or local loan repayment program
- Serving at an Indian health clinic or federal prison but who are not federal employees
- Working part time
- Planning to retire but continue to see patients

If hospital inpatient hours are not included in the survey data returned to you, then adjust the FTE of those physicians according to the following ratios. The resulting ratio adjusted total **cannot** exceed 1.0 FTE.

- Family Practice: $1.4 \times \text{total outpatient hours} = \text{Total FTE}$
- General Practice: $1.4 \times \text{total outpatient hours} = \text{Total FTE}$
- Internal Medicine: $1.8 \times \text{total outpatient hours} = \text{Total FTE}$
- Obstetrics and Gynecology: $1.9 \times \text{total outpatient hours} = \text{Total FTE}$
- Pediatrics: $1.4 \times \text{total outpatient hours} = \text{Total FTE}$
- If primary care specialty is unknown: $1.6 \times \text{total outpatient hours} = \text{Total FTE}$

In your application, provide a table containing the survey data as outlined in the examples on the next pages. What you report and how you calculate FTE will vary based on whether you are seeking a geographic or population designation.

Example: Physician FTE Reporting Table for a Geographic Designation

Name, Degree	Specialty	Practice Location and Census Tract	Hospital Hours Included	National Health Service Corps Provider	Working on a J-1 waiver NIW, or H-1B Visa	US Resident F. M. G. on Restricted License	Intern/Resident	Primary Care Hours, Full Time Equivalent
John Smith, MD	General Practice	Crossroads Primary Care 208 W North Street Cortez, CO 81321 – CT 1.00	Yes	No	No	No	No	45/40 = 1.0 FTE
Laura McMillon, MD	Family Medicine	Southwest Primary Care 33 N Elm Street Cortez, CO 81321 – CT 1.00	Yes	No	No	No	No	31/40 = 0.775 FTE
Megan Feltes, DO	Pediatrics	SW Mental Health Center 281 Sawyer Drive, Suite 100 Cortez, CO 81321 – CT 3.01	No	No	No	No	No	(20 x 1.4)/40 = 0.7 FTE
Jose Flores, MD	Obstetrics and Gynecology	Cortez Family Practice Associates 1413 N Mildred Road Cortez, CO 81321 – CT 2.00	Yes	No	No	Yes	No	(40 x .5)/40 = 0.5 FTE
Lennart Mueller, MD	Family Medicine	Cortez Family Practice Associates 1413 N Mildred Road Cortez, CO 81321 – CT 2.00	Yes	No	Yes	No	No	36/40 = 0.9 FTE
Rolland Mills, MD	Internal Medicine	Southwest Internal Medicine 111 N Park Street Cortez, CO 81321 – CT 2.00	Yes	No	No	No	Yes	48/40 = 1.2 FTE

do not list more than 1 FTE even if more than 40 hours are reported

adjust for unreported inpatient hours

reduce by half permanent resident foreign medical grads on a restricted license

reduce to zero non-resident foreign medical graduates

reduce intern or resident in training to 0.1 FTE

$1.0 + 0.775 + 0.7 + 0.5 + 0.0 + 0.1 = 3.1$ Total FTE

round to the nearest tenth

Example: Physician FTE Reporting Table for a Low Income Population Designation

Name, Degree	Specialty	Practice Location and Census Tract	Hospital Hours Included	National Health Service Corps Provider	Working on a J-1 waiver NIW, or H-1B Visa	US Resident F. M. G. on Restricted License	Intern/Resident	Percent of Practice on Medicaid	Percent of Practice Who Pay Sliding Fee	Primary Care Hours, Full Time Equivalent
John Smith, MD	General Practice	Crossroads Primary Care 208 W North Street Cortez, CO 81321 – CT 1.00	Yes	No	No	No	No	10%	13%	45/40 = 1.0 Total FTE (.10 + .13) x 1.0 = 0.23 Pop. FTE
Laura McMillon, MD	Family Medicine	Southwest Primary Care 33 N Elm Street Cortez, CO 81321 – CT 1.00	Yes	No	No	No	No	23%	0%	31/40 = 0.775 Total FTE (.23 + 0) x 0.775 = 0.178 Pop. FTE
Megan Feltes, DO	Pediatrics	SW Mental Health Center 281 Sawyer Drive, Suite 100 Cortez, CO 81321 – CT 3.01	No	No	No	No	No	21%	28%	(20 x 1.4)/40 = 0.7 Total FTE (.21 + .28) x 0.7=0.49 Pop. FTE
Jose Flores, MD	Obstetrics and Gynecology	Cortez Family Practice Associates 1413 N Mildred Road Cortez, CO 81321 – CT 2.00	Yes	No	No	Yes	No	10%	7%	(40 x .5)/40 = 0.5 Total FTE (.10 + .07) x 0.5=0.085 Pop. FTE
Lennart Mueller, MD	Family Medicine	Cortez Family Practice Associate 1413 N Mildred Road Cortez, CO 81321 – CT 2.00	Yes	No	Yes	No	No	30%	15%	36/40 =0.9 Total FTE (.30 + .15) x 0.9 = 0.405 Pop. FTE
Rolland Mills, MD	Internal Medicine	Southwest Internal Medicine 111 N Park Street Cortez, CO 81321 – CT 2.00	Yes	No	No	No	Yes	0%	0%	40/40 = 0.1 Total FTE (0 + 0) x 0.1 = 0.0 Pop. FTE

$.23 + .178 + .49 + .085 + 0.0 + 0.0 = 1.0$ Low Income Population FTE

Calculating the Provider Side of the Ratio for Mental Health

Step 1

Depending on which ratio you have elected to use (page 7), identify either all psychiatrists (MD or DO) or all core mental health professionals and psychiatrists (Appendix 1E) providing direct patient care, consultation or supervision in the service area. The Primary Care Office will be able to provide provider data to you (also see Appendix 1C). Exclude from your application all mental health providers who are:

- Providing care solely to inpatients or providing care in emergency departments
- Engaged solely in administration, research or training
- On the full-time staff of correctional institutions, youth detention facilities, residential treatment centers for emotionally disturbed or mentally retarded children, or inpatient units of state or county mental hospitals
- Suspended by the Medicaid/Medicare Antifraud and Abuse Act for more than 18 months

You may need to survey all mental health providers in your service area before you can determine if they should be excluded from your application.

Step 2

Survey each mental health provider who works in direct patient care in the service area using the provider survey tool found in Appendix 1G. Before distributing your survey, review the section on “Contiguous Area Analysis.” You may determine that collecting additional provider data outside of your service area is necessary for your application to be successful.

All mental health providers, except those excluded by the above criteria, must be included in your application report even if some are not actively providing mental health services. Additionally, FTE estimates of providers who do not respond to your survey must be included in your results table. This is accomplished by assigning the average FTE, or average low income FTE, of the responders to the non-responders. Estimated FTE calculations must be noted on your table.

Generally, it is disadvantageous to apply averages to non-responders because it often makes it appear that there is more mental health care capacity available than what actually exists. It is therefore in your interest to attempt a 100% response rate. An application must attain at least a 67% survey response rate to be considered by the Shortage Designation Branch.

Step 3

Calculate the full time equivalent of provider services for inpatient and outpatient mental health care. Decide which providers to include in the final calculation by using the following table.

Designation Category	Providers to Count
Geographic and Geographic with High Needs	All mental health providers in the service area
Population: Low Income	All mental health providers in the service area who accept Medicaid and/or use a sliding fee scale for assessing payment
Population: Medicaid Eligible	All mental health providers in the service area who accept Medicaid
Population: Homeless	All mental health providers in the service area who serve homeless persons
Population: Migrant Farm Worker	All mental health providers in the service area who serve migrant farm workers
Population: Native American	All mental health providers in the service area who serve Native Americans

Regardless of the hours reported in your survey results, you should reduce to zero the FTE of providers who are:

- Under contract with the National Health Service Corps
- Federal providers with the Indian Health Service, US Public Health Service, or Bureau of Prisons
- Foreign medical graduates, are **not** US permanent resident's, and are working on a J-1 Visa Waiver, National Interest Waiver, or H-1B Visa

Partially reduce the FTE of providers who are:

- Reporting more than 40 hours per week in direct patient care to 1.0 FTE
- Foreign medical graduates **and** are US permanent residents but practicing on a restricted license to 1/2 FTE of the total hours worked (physicians only)
- Medical residents and interns who are in training to 1/2 FTE of the total hours worked
- In facilities or institutions that provide both inpatient and outpatient services. Only calculate the number of hours of care in outpatient units or short-term care units.

Do not modify the FTE of providers who are:

- Providing an unknown number of hospital hours (there is no adjustment factor as in the primary care provider guidelines)
- Under contract with a state or local loan repayment program
- Serving at an Indian health clinic or federal prison but who are not federal employees
- Working part time
- Planning to retire but continue to see patients

In your application, provide a table containing the survey data as outlined in the examples on the next pages. What you report and how you calculate FTE will vary based on whether you are seeking a geographic or population designation.

Example: Provider FTE Reporting Table for a Geographic Designation

Name, Degree	Specialty	Practice Location and Census Tract	National Health Service Corps Provider	Working on a J-1 waiver NIW, or H-1B Visa	US Resident F. M. G. on Restricted License	Intern/Resident	Mental Health Hours, Full Time Equivalent
Elizabeth Miles, MSW	Clinical Social Work	SW Mental Health Center 281 Sawyer Drive, Suite 100 Cortez, CO 81321 – CT 3.01	Yes	No	No	No	31/40 = 0.0 FTE
Martha Leonard, MD	Psychiatry	Southwest Primary Care 33 N Elm Street Cortez, CO 81321 – CT 1.00	No	Yes	No	No	45/40 = 0.0 FTE
Ralph Roosevelt, Ph.D.	Clinical Psychology	SW Mental Health Center 281 Sawyer Drive, Suite 100 Cortez, CO 81321 – CT 3.01	No	No	No	No	46/40 = 1.0 FTE
Jose Otan, MD	Psychiatry	Cortez Family Practice Associates 1413 N Mildred Road Cortez, CO 81321 – CT 2.00	No	No	Yes	No	(40 x .5)/40 = 0.5 FTE
Mary Callahan, RN, BSN	Psychiatric Nurse	Cortez Family Practice Associates 1413 N Mildred Road Cortez, CO 81321 – CT 2.00	No	No	No	No	35/40 = 0.875 FTE
Mich Rolland, MS	Marriage and Family Counseling	Southwest Primary Care 33 N Elm Street Cortez, CO 81321 – CT 1.00	No	No	No	Yes	40/40 = 0.5 FTE

reduce to zero National Health Service Corps providers

reduce to zero non-resident foreign medical graduates

do not list more than 1 FTE even if more than 40 hours are reported

reduce by half permanent resident foreign medical grads on a restricted license

reduce intern or resident in training to 1/2 FTE

$0.0 + 0.0 + 1.0 + 0.5 + 0.875 + 0.5 = 2.9$ Total FTE

round to the nearest tenth

Example: Provider FTE Reporting Table for a Low Income Population Designation

Name, Degree	Specialty	Practice Location and Census Tract	National Health Service Corps Provider	Working on a J-1 waiver NIW, or H-1B Visa	US Resident F. M. G. on Restricted License	Intern/Resident	Percent of Practice on Medicaid	Percent of Practice Who Pay Sliding Fee	Mental Health Hours, Full Time Equivalent
Elizabeth Miles, MSW	Clinical Social Work	SW Mental Health Center 281 Sawyer Drive, Suite 100 Cortez, CO 81321 – CT 3.01	Yes	No	No	No	45%	23%	$31/40 = 0.0$ Total FTE $(.45 + .23) \times 0.0 = 0.0$ Pop. FTE
Martha Leonard, MD	Psychiatry	Southwest Primary Care 33 N Elm Street Cortez, CO 81321 – CT 1.00	No	Yes	No	No	25%	20%	$45/40 = 0.0$ Total FTE $(.25 + .20) \times 0.0 = 0.0$ Pop. FTE
Ralph Roosevelt, Ph.D.	Clinical Psychology	SW Mental Health Center 281 Sawyer Drive, Suite 100 Cortez, CO 81321 – CT 3.01	No	No	No	No	23%	5%	$46/40 = 1.0$ Total FTE $(.23 + .05) \times 1.0 = 0.28$ Pop. FTE
Jose Otan, MD	Psychiatry	Cortez Family Practice Associates 1413 N Mildred Road Cortez, CO 81321 – CT 2.00	No	No	Yes	No	7%	5%	$(40 \times .5)/40 = 0.5$ Total FTE $(.07 + .05) \times 0.5 = 0.06$ Pop. FTE
Mary Callahan, RN, BSN	Psychiatric Nurse	Cortez Family Practice Associates 1413 N Mildred Road Cortez, CO 81321 – CT 2.00	No	No	No	No	7%	0%	$35/40 = 0.875$ Total FTE $(.07 + 0) \times 0.875 = 0.06$ Pop. FTE
Mich Rolland, MS	Marriage and Family Counseling	Southwest Primary Care 33 N Elm Street Cortez, CO 81321 – CT 1.00	No	No	No	Yes	0%	0%	$40/40 = 0.5$ Total FTE $(0 + 0) \times 0.5 = 0.0$ Pop. FTE

$0.0 + 0.0 + 0.28 + 0.06 + 0.06 + 0.0 = 0.4$ Low Income Population FTE

Calculating the Provider Side of the Ratio for Dental Health

Step 1

Identify all dentists (DDS or DMD) providing direct patient care in the service area. The Primary Care Office will be able to provide provider data to you (also see Appendix 1C). For the purposes of shortage designation, general dentistry, and pediatric dentistry are considered for designation. Exclude from your application all dentists who are:

- Practicing in specialty dentistry exclusively
- Engaged solely in administration, research, or training
- Locum tenens who have served less than one year
- Suspended by the Medicaid/Medicare Antifraud and Abuse Act for more than 18 months

You may need to survey all dentists in your service area before you can determine if they should be excluded from your application.

Step 2

Survey each dentist who works in direct patient care in the service area using the provider survey tool found in Appendix 1H. Before distributing your survey, review the section on “Contiguous Area Analysis.” You may determine that collecting additional provider data outside of your service area is necessary for your application to be successful.

All dentists, except those excluded by the above criteria, must be included in your application report even if some are not actively providing general dental services. Additionally, FTE estimates of dentists who do not respond to your survey must be included in your results table. This is accomplished by assigning the average FTE, or average low income FTE, of the responders to the non-responders. Estimated FTE calculations must be noted on your table.

Generally, it is disadvantageous to apply averages to non-responders because it often makes it appear that there is more dental care capacity available than what actually exists. It is therefore in your interest to attempt a 100% response rate. An application must attain at least a 67% survey response rate to be considered by the Shortage Designation Branch.

Step 3

Calculate the full time equivalent of dentists in the service area. Decide which dentists to include in the final calculation by using the following table.

Designation Category	Dental Providers to Count
Geographic and Geographic with High Needs	All dentists in the service area
Population: Low Income	All dentists in the service area who accept Medicaid and/or use a sliding fee scale for assessing payment
Population: Medicaid Eligible	All dentists in the service area who accept Medicaid
Population: Homeless	All dentists in the service area who serve homeless persons
Population: Migrant Farm Worker	All dentists in the service area who serve migrant farm workers
Population: Native American	All dentists in the service area who serve Native Americans

For dental designations, the contribution of auxiliary providers (hygienists and dental assistants) is a component of the formula, which determines provider capacity. The contribution of auxiliaries is determined by applying a factor to the number of hours worked by the dentist in direct patient care, the age of the dentist, and the number of auxiliaries.

Number of Auxiliaries	Age of the Dentist				
	<55	55-59	60-64	65≤	Unknown
0	0.8	0.7	0.6	0.5	0.8
1	1.0	0.9	0.8	0.7	1.0
2	1.2	1.0	1.0	0.8	1.2
3	1.4	1.2	1.0	1.0	1.4
≥4	1.5	1.5	1.3	1.2	1.5
Unknown	1.2	0.9	0.8	0.6	1.2

For example, if the dentist is 61 years old, provides patient care for 32 hours per week and employs one auxiliary, then the formula to calculate the FTE will be:

$$(32/40) \times 0.8 = 0.6 \text{ FTE}$$

If an auxiliary works less than full time, round to nearest whole number ($\leq .49 = 0$ and $\geq .50 = 1.0$). If more than one auxiliary works less than full time, add the total hours of each auxiliary, divide by 40, then round to the nearest whole number ($.40 + .60 + .80 = 2.0$).

Regardless of the hours reported in your survey results, you should reduce to zero the FTE of dentists who are:

- Under contract with the National Health Service Corps
- Federal providers with the Indian Health Service, US Public Health Service, or Bureau of Prisons

Partially reduce the FTE of dentists who:

- Report more than 40 hours per week in direct patient care, before the auxiliary support factor is applied, to 1.0 FTE

Do not modify the FTE of dentists who:

- After adjusting for the auxiliary support ratio, exceed 1.0 FTE per week in direct patient care
- Are dental residents who are in training and providing direct patient care
- Are under contract with a state or local loan repayment program
- Serve at an Indian health clinic or federal prison but who are not federal employees
- Working part time
- Are planning to retire but continue to see patients

In your application, provide a table containing the survey data as outlined in the examples on the next pages. What you report and how you calculate FTE will vary based on whether you are seeking a geographic or population designation.

Example: Dentist FTE Reporting Table for a Geographic Designation

Number of Auxiliaries	Age of the Dentist				
	<55	55-59	60-64	65≤	Unknown
0	0.8	0.7	0.6	0.5	0.8
1	1.0	0.9	0.8	0.7	1.0
2	1.2	1.0	1.0	0.8	1.2
3	1.4	1.2	1.0	1.0	1.4
≥4	1.5	1.5	1.3	1.2	1.5
Unknown	1.2	0.9	0.8	0.6	1.2

Name, Degree and Age	Practice Location and Census Tract	National Health Service Corps Provider	Federal Provider	Hours of DDS Patient Direct Care	Number of Auxiliaries	Dental Hours, Full Time Equivalent
Kevin Richards, DDS Age: 58	313 West 3 rd Street La Junta, CO 81050 – CT 1.00	No	No	45	1	$(40/40) \times 0.9 = 0.9$ FTE
Samuel Eisen, DDS Age: 60	317 West 3 rd Street, #101 La Junta, CO 81050 – CT 1.00	No	No	32	1	$(32/40) \times 0.8 = 0.64$ FTE
Marty Johnson, DDS Age: 39	13 East 4 th Street La Junta, CO 81050 – CT 1.00	No	No	38	3	$(38/40) \times 1.4 = 1.33$ FTE
Wilma Jones, DDS Age: 30	13 East 4 th Street La Junta, CO 81050 – CT 1.00	Yes	No	40	2	$(40/40) \times 1.2 = 0.0$ FTE

$0.9 + 0.64 + 1.33 + 0.0 = 2.9$ Total FTE

round to the nearest tenth

reduce to zero all National Health Service Corps Providers

Example: Dentist FTE Reporting Table for a Low Income Population Designation

Name, Degree Age	Practice Location and Census Tract	National Health Service Corps Provider	Federal Provider	Hours of DDS Patient Direct Care	Number of Auxiliaries	Percent of Practice on Medicaid	Percent of Practice who Pay on a Sliding Fee Scale	Dental Hours, Full Time Equivalent
Kevin Richards, DDS Age: 59	313 West 3 rd Street La Junta, CO 81050 – CT 1.00	No	No	45	2	10%	3%	$(40/40) \times 0.9 = 0.9$ Total FTE $(.10+.03) \times 0.9 = 0.117$ Pop. FTE
Samuel Eisen, DDS Age: 60	317 West 3 rd Street, #101 La Junta, CO 81050 – CT 1.00	No	No	32	1	0%	5%	$(32/40) \times 0.8 = 0.64$ Total FTE $(0+.05) \times 0.64 = 0.032$ Pop. FTE
Marty Johnson, DDS Age: 39	13 East 4 th Street La Junta, CO 81050 – CT 1.00	No	No	38	3	21%	28%	$(38/40) \times 1.4 = 1.33$ Total FTE $(.21+.28) \times 1.33 = 0.652$ Pop. FTE
Wilma Jones, DDS Age: 30	13 East 4 th Street La Junta, CO 81050 – CT 1.00	Yes	No	40	2	40%	27%	$(40/40) \times 1.2 = 0.0$ Total FTE $(.40+.27) \times 0.0 = 0.0$ Pop. FTE

$0.117 + 0.032 + 0.652 + 0.0 = \mathbf{0.8}$ Low Income Population FTE

Contiguous Area Analysis

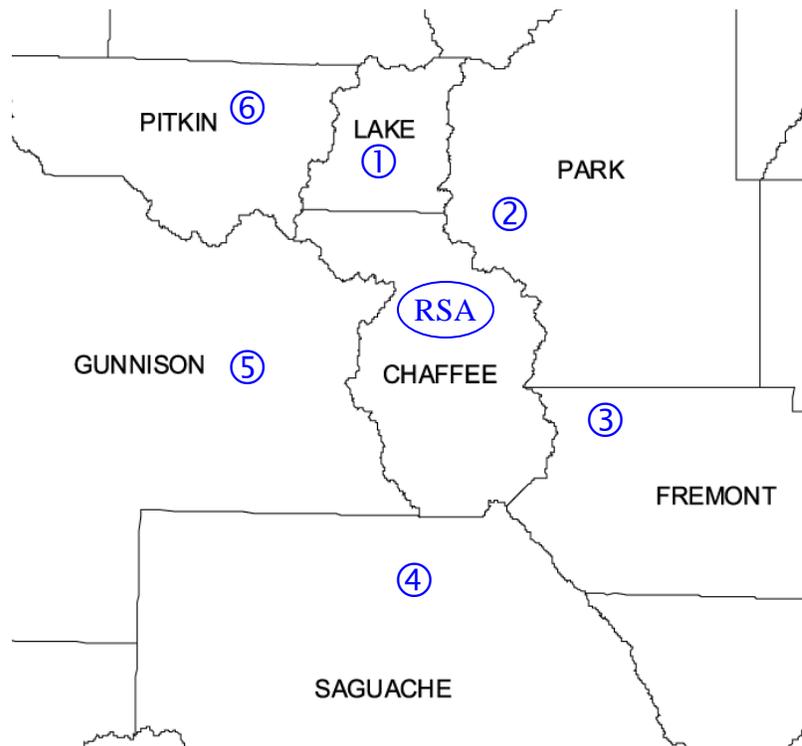
Once you have established the service area and population to provider ratio, it must be demonstrated that the health resources in the areas surrounding the service area of your application are not reasonably available to the population in the service area. This is accomplished by ascertaining if care in the contiguous areas is excessively distant, over utilized, and/or otherwise inaccessible to the population of the service area.

Determine the Contiguous Areas and Their Respective Boundaries

The boundaries of the contiguous areas are generally based upon the same units that the service area is based upon. For example, a whole county service area will have contiguous areas that are counties and a census tract or cluster of tracts will have contiguous areas that are census tracts or clusters of census tracts. A contiguous area can also be based upon an existing HPSA designation, municipalities, geographic barriers, or differing socioeconomic characteristics, which distinguish the service area from the contiguous area.

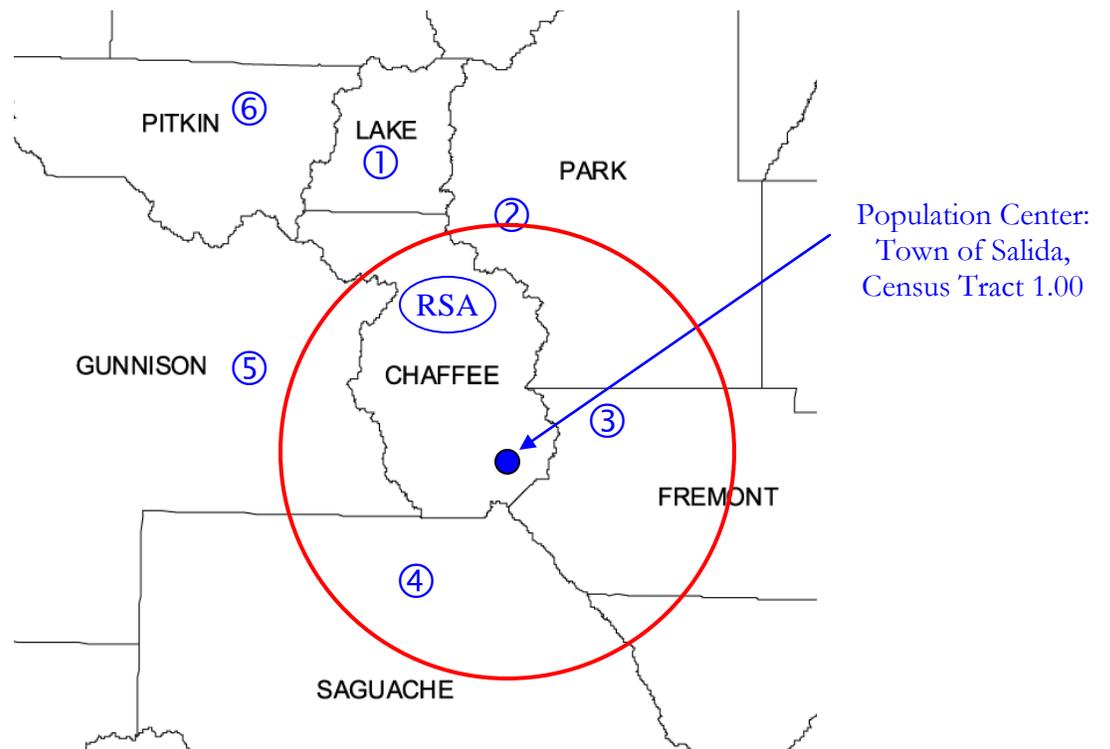
On a map of your Rational Service Area, identify **all** areas that share a border with your service area. Label each contiguous area in a clockwise direction, starting from the most northern area. Use these labels when referring to the contiguous area in your narrative.

Example: Contiguous Area Map of a Hypothetical Designation of Chaffee County



Next, identify the largest population center of your service area (largest population census tract or largest municipality). Label the population center and draw a circle, which circumscribes a 30 minute travel radius for primary care designations or a 40 minute travel radius for dental and mental health designations (Appendix 1B). If it is too difficult to determine the circle radius based on travel time, you may draw a radius that is 20 miles for primary care designations and 25 miles for dental and mental health designations. The contiguous areas that must be further analyzed fall within the boundaries of your circle. Those that are beyond your circle are automatically ruled out for being excessively distant.

Example: Contiguous Area Map with the Travel Radius from the Population Center



(radius not to scale, for demonstration of concept only)

Analyze Contiguous Areas for Availability of Care

The next step is to analyze each contiguous area to determine the availability of care to the population of the Rational Service Area in the contiguous area. Consider each of the following questions to rule out the contiguous area as a source of care.

1. Is the area excessively distant as described by the travel radius added to the contiguous area map?

In an application that seeks designation for a whole county, where all contiguous areas are beyond the travel limitation from the population center, all contiguous areas can be ruled out as excessively distant. If part or all of the contiguous area is inside of the travel radius, any provider with an office location inside the radius must be considered as a potential source of care.

For inner city designations of low income populations, where more than 20% of the population is below 100% federal poverty level (FPL) **and** 30% of the population is dependent on public transportation, a bus route may be substituted for a car route (Appendix 1B).

2. Are there major geographic or seasonal weather barriers between the service area and the contiguous area?

Significant physical barriers to travel such as bodies of water, mountain ranges, large military bases, national parks, large industrial areas, or rail yards may be considered. Also, roads that are closed or impassable for several months each year between the contiguous area and the service area may rule out a contiguous area as a source of care.

3. Is the area currently a designated HPSA of the same discipline? If so, then consider each of the following questions to establish whether the contiguous area can be ruled out as the result of an existing designation.

If the proposed service area is...	then the contiguous area is inaccessible if it is...
a geographic area without high needs,	a Geographic HPSA.
a geographic area with high needs and >20% of the population is below 100% of the federal poverty level,	a Geographic, Low-Income, or high Medicaid Eligible HPSA.
a low-income area,	a Geographic, Low-Income, or high Medicaid Eligible HPSA.
a high Medicaid eligible area,	a Geographic, Low-Income, or high Medicaid Eligible HPSA.
a migrant seasonal farm worker (MSFW), homeless, or migrant farm worker (MFW) population area,	a Geographic, Low-Income, or high Medicaid Eligible HPSA.

4. Are there **significant** demographic differences or disparities between populations in the service area and the contiguous area, which result in the limitation of, or isolation from, care?

What is considered a significant difference is measured in one of two ways based upon the magnitude of the variable. If the indicator you have selected is below 15% in the contiguous area, then a rate that is at least 15% higher in the service area would be considered significant. If the indicator you have selected is above 15% in the contiguous area, then a rate that is at least twice as high in the service area would be considered significant.

5. Is the area over utilized?

Over utilization is defined by the following ratios, which are established by the same methodology as the provider ratio of the service area discussed previously.

- Primary Care $\geq 2,000:1$
- Mental Health Care $\geq 20,000:1$ (psychiatrists)
- Dental Care $\geq 3,000:1$

If you do not know the exact full time equivalent (FTE) of each provider within the travel radius, use 1.0 to complete a rough calculation. If the resulting population to provider ratio is greater than or equal to the over utilization ratio of the discipline you are trying to designate, then the area is over utilized and you do not need to survey the contiguous area providers. If your rough calculation does not show over utilization, then survey the providers to determine if the ratio can be modified because of less than 1.0 FTE practicing providers. Because making the over utilization determination may involve additional provider surveying, it is best to attempt to rule out contiguous areas by the four previous methods first.

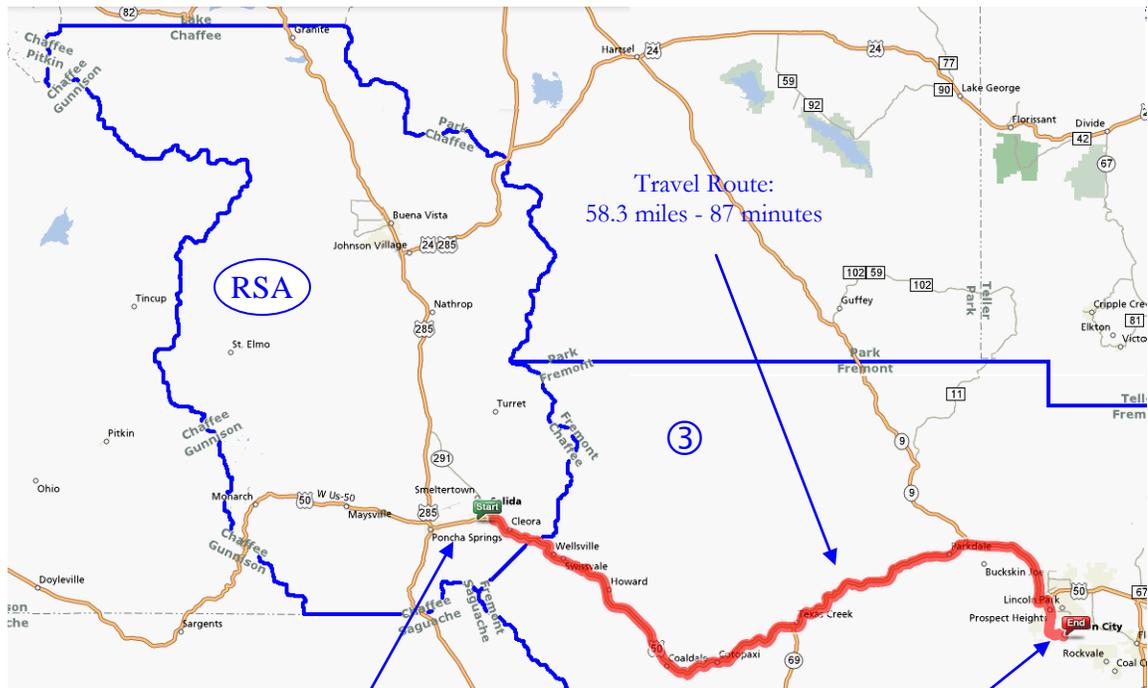
The rationale for excluding each contiguous area as a source of care must be fully described in the narrative of your application. If you are unable to rule out **all** contiguous areas by one or more of the above five methods, you cannot designate the service area as proposed. You may be able to reconfigure the service area or chose a different designation category to achieve the desired designation outcome.

Nearest Source of Undesignated Care

The final section of your application should report the distance and travel time to the nearest source of undesignated, accessible care for the population of the service area. The start point should be the census tract in the service area with the **largest** population or the municipality with the largest population. The end point should be the provider that is closest by road travel to that point **and** is not in an existing HPSA of the same discipline **and** is not inaccessible due to physical or socioeconomic barriers. For the purposes of this section, the nearest source of care **can** be excessively distant and/or over-utilized as determined in the contiguous area analysis. When describing the nearest source of care in your narrative, include all of the following:

1. The census tract or municipality used as the population center (start point).
2. The name and address of the provider who is the nearest source of undesignated care (end point).
3. The miles and minutes (Appendix 1B) necessary to travel from the population center to the nearest source of undesignated care by the shortest, all season route.
4. A road map, which indicates and labels the Rational Service Area, the contiguous area with the nearest source of undesignated care, the designation status of the contiguous areas, the population center, the address of the nearest source of undesignated care, and the shortest route to the nearest source of undesignated care from the population center.

Example: Nearest Source of Care Route Map



Population Center:
Town of Salida,
Census Tract 1.00

Nearest Source of Undesignated Care
(Contiguous Area 3):
Mary Holland, MD
1001 Elm Ave
Canon City, CO 81212

5. For inner city designations of low income populations, where more than 20% of the population is below 100% federal poverty level (FPL) **and** 30% of the population is dependent on public transportation, a bus route may be substituted for a car route (Appendix 1B).

If you have ruled out a provider as the nearest source of undesignated care because of socioeconomic barriers, describe in some detail the demographic disparities, which inhibit access (e.g. racial and ethnic composition, income, or language). If you are applying for a low income designation, the nearest source of care should be the closest provider who accepts Medicaid or offers sliding fee scale services. If the shortest route is not passable in all seasons and you have chosen another route as a result, be sure to clearly note such in your narrative. In every instance where you have ruled out a provider as the nearest source of care, whether it is obvious or not, cite the reason and provide supporting data with its source. It may be useful to enter candidates for a nearest source of care into a table with key information about each exclusion.

Example: Nearest Source of Care Determination Chart

Nearest Source of Care Candidate	Miles and Minutes	Determination
Dr. John Stephens 233 Howard Street Pritchett, CO	16.1 miles 24 minutes	Does not accept Medicaid
Dr. Allan Berg 101 Elm Street Campo, CO	22.1 miles 33 minutes	Provider is over utilized
Dr. Daniel Wright 411 E. Willow Street Walsh, CO	20.6 miles 31 minutes	Practicing in a currently designated Low Income HPSA
Dr. June Adams 23 5 th Street Two Buttes, CO	22 miles 33 minutes	Determined to be the nearest source of undesignated care

Designating a Facility as a Health Professional Shortage Area

If a facility serves a medically underserved population and has insufficient provider capacity to meet the needs of its patients, a facility HPSA **may** be an option. Facility designation applications are not difficult to develop, however, they are the most challenging to justify. The characteristics of a facility that is eligible are as follows:

- ***Federal and State Correctional Institutions and Youth Detention Facilities***
 - ▶ Must be medium to maximum level security
 - ▶ Must have ≥ 250 inmates
 - ▶ Must meet the internee-to-provider ratio
 - ▶ City, county and private correctional facilities are **not** eligible for designation
- ***Public or Nonprofit Facilities***
 - ▶ Must serve a geographic or population HPSA, but does not necessarily have to be physically located within the borders of a HPSA
 - ▶ Must be reasonably accessible and not excessively distant from a geographic or population HPSA
 - ▶ Must demonstrate insufficient provider capacity
 - ▶ For profit healthcare facilities are **not** eligible for designation
- ***State and County Mental Hospitals***
 - ▶ Must have ≥ 100 average daily inpatient census
 - ▶ Must meet workload unit criteria
 - ▶ Private mental health hospitals are **not** eligible for designation
- ***Federally Qualified Health Centers*** receive an automatic facility HPSA designation. Also, any public or nonprofit certified **Rural Health Clinic** may apply for automatic HPSA designation.

A facility designation is made upon a **single physical address**. Patient loads at multiple addresses cannot be aggregated for the purposes of an application. If a provider organization has more than one clinical facility location, then a separate designation application must be completed for each clinic address. Each facility application requires elements that are different from geographic or population designations.

Correctional Facility

The narrative for a correctional facility designation must include: the physical address, county, type of facility (state or federal), level of security, internees, and the existing providers' names, specialty, and hours of service delivery at the facility. If a correctional facility has more than one security level for the full population, minimum security level populations must be

excluded from the calculation of total internees. To be eligible for designation, a correctional facility must exceed the following internee provider ratios.

- Primary Care $\geq 1000:1$
- Mental Health Care $\geq 2000:1$ (psychiatrists)
- Dental Care $\geq 1500:1$

This ratio is calculated by determining the internees to the number of full time equivalent (FTE) providers in direct patient care.

$$\text{internees} : \text{provider FTE in direct patient care}$$

If the average length of stay in the facility is equal to or **greater** than 365 days and exams are routinely preformed upon intake, then use the following formulas to calculate the number of internees.

Primary Care

$$\text{average number of inmates} + (\text{new inmates per year} * 0.3) = \text{internees}$$

Mental and Dental Health Care

$$\text{average number of inmates} + \text{new inmates per year} = \text{internees}$$

If the average length of stay in the facility is **less** than 365 days and exams are routinely preformed upon intake, then use the following formulas to calculate the number of internees.

Primary Care

$$\text{average number of inmates} + (0.2 * \text{new inmates per year} * (1 + (\text{average number of days of stay} / 365 / 2))) = \text{internees}$$

Mental and Dental Health Care

$$\text{average number of inmates} + (0.33 * \text{new inmates per year} * (1 + ((\text{average number of days of stay} / 365) * 2))) = \text{internees}$$

If the average length of stay, frequency of intake exams, and/or average number of new inmates is **unknown**, then use the following formula to calculate the number of internees. Use this formula only as a last option because it results in the least favorable ratio.

$$\text{average number of inmates} = \text{internees}$$

The narrative of your application should describe in some detail, which formula was used to determine the number of internees, the data source on new inmates, the average length of stay and the provision of intake exams. Also, the narrative should describe the number of providers, the total hours of service provided at the facility, and the total full time equivalent (FTE) spent in direct patient care by all providers. Dental applications additionally require the age of each dentist and the number of auxiliaries used in care delivery.

Public or Nonprofit Clinic Facility

For a public or nonprofit facility to be designated, the area the facility is located in **must** be demonstrated to be ineligible for a geographic or population HPSA. If after analysis, a facility application is the only option, then the facility must meet at least **one** of the following criteria:

1. More than 50% of the facility's primary care, dental, and/or mental health services are provided to residents of a geographic or population HPSA of the same discipline as the application.

This is established by reviewing patient records for a one month (large practice) to six month period (small practice) to determine patient places of residence. If more than 50% come from an existing HPSA of the same discipline, then the facility is eligible for a facility designation. The methodology used to make this determination must be described in the application narrative.

2. The facility is accessible to residents of a geographic or population HPSA of the same discipline as the application and is within 30 travel minutes for primary health care, and 40 travel minutes for dental or mental health care.

This is established by creating a map similar to that described in the "Nearest Source of Undesignated Care" section. Using Appendix 1B, determine the travel time from the population center (largest census tract) of the existing HPSA to the applicant facility.

3. For mental health facility designations, the facility can also be eligible if it has been given formal responsibility by a governmental authority to provide or coordinate mental health services for an area or a population.

This is established by providing documentation of the care responsibility granted to the facility by a governmental authority.

After eligibility is established by one of the three previous methods, one must demonstrate that the facility has insufficient capacity to meet the needs of the existing patient load.

Insufficient Primary Care Capacity

A primary care facility must meet at least **two** of the following criteria:

1. There is in excess of 8,000 outpatient visits per year per full time equivalent physician.
2. The waiting time for routine appointments is more than seven days for established patients or more than 14 days for new patients.
3. The waiting time at the facility is more than one hour for patients with appointments or more than two hours for walk-in patients.
4. For facilities with emergency departments, more than 35% of emergency room visits are made to acquire primary care services.

Insufficient Mental Health Care Capacity

A mental health facility must meet **one** of the following criteria:

1. There is in excess of 1,000 patient visits per year per full time equivalent core mental health professional (Appendix 1E).
2. There is in excess of 3,000 patient visits per year per full time equivalent psychiatrist.
3. There are no psychiatrists providing care at the facility and the facility is the only organization providing mental health services to a geographic or population mental health HPSA.

Insufficient Dental Care Capacity

A dental facility must meet **one** of the following criteria:

1. There is in excess of 5,000 outpatient visits per year per full time equivalent dentist.
2. The waiting time for a routine appointment is more than six weeks.

The narrative for a public or nonprofit facility must describe how a geographic or population HPSA was not possible for the facility location. It must also include: the physical address, county, type of facility (public or nonprofit), the HPSA(s) from which patients are drawn, documentation of how the facility is eligible to apply and documentation of how the facility has insufficient capacity. The application must list existing providers' names, specialty, and hours of service delivery at the facility. Dental applications additionally require the age of each dentist and the number of auxiliaries used in care delivery.

State or County Mental Hospital

For a state or county mental hospital facility to be designated, the facility must meet **both** of the following criteria:

1. The daily inpatient census must exceed 100.
2. The Workload Units (WLUs) per full time equivalent psychiatrists must be greater than 300:1. The Workload Unit is calculated by the following formula:

$$\text{average daily inpatient census} + (2 * \text{inpatient admissions per year}) + (0.5 * \text{outpatient admissions for day care services per year}) = \text{WLU}$$

The narrative for a state or county mental hospital should include: the physical address, county, type of facility (state or county), the average daily census and the Workload Unit to provider ratio. The application must also list all existing providers' names, specialty, and hours of service delivery at the facility with summary full time equivalent calculations.

Appendix 1: Application Development Tools

A: Application Outline

Introduction

- Application contact (name, organization, address, phone, email)
- Designation request statement including:
 - Application iteration (new or renewal). If renewal, list the current federal identification number and last designation date.
 - Service area type (geographic, population, or facility)
 - Professional discipline (primary care, dental, or mental health)
 - Service area name (i.e. Montezuma County or Adams County West)

Rational Service Area

- Describe the service area and its resident civilian population (list counties served if larger than a county and/or list census tracts included if smaller than a county). If renewal, describe any changes to the composition of the service area.
- Population center and its resident civilian population (either the largest population census tract or the largest incorporated municipality)
- Population Summary:
 - Explain why the service area is rational based on the population and geographic size of the service area, the socioeconomic conditions, and the physical barriers to accessing care
 - Source and collection date of the population data (state demographer, Claritas or US Census Bureau)
 - High needs indicators and data source, if any

Provider Data and Analysis

- Source, collection method, and collection date of the provider data used (Primary Care Office and/or local phonebook)
- Total number of providers
- Total FTE available to the population being designated
- The provider FTE to population ratio

Contiguous Area Analysis

- Detailed description and rationale for each contiguous area boundary and why it is unavailable as a source of care to the population of the service area
- For contiguous areas not excluded with current designations and with excessively distant providers include travel time to closest provider from population center of service area, miles, route, and type of road
- For contiguous areas not excluded with current designations that have access barriers, describe any significant physical barriers or demographic disparities, compared to the proposed service area population
- For contiguous areas not excluded with current designations that are over utilized, provide the population to provider ratios and a description of how the information was obtained

Nearest Source of Undesignated Care

- A description of the nearest source of undesignated care including provider name, address, distance in miles, and travel time in minutes.

Attachments

- Service area map showing boundaries, census tracts where applicable, and population center*
- Service area road map showing boundaries and population center*
- Provider survey data table
- Contiguous area map showing travel radius from population center*
- Contiguous area provider survey table (if necessary)
- Nearest source of care road map with starting and ending addresses*

**Maps may be combined if the component features are clear and easily understood*

B: Travel Time Formula

Private Car Transportation: The travel time for designation purposes is calculated by the following formulas. In an effort to assure consistency across all shortage applications, only Rand McNally Road Atlas, Rand McNally online (www.randmcnally.com) or MapQuest (www.mapquest.com) may be used to determine travel routes and distances. When multiple routes are possible, the shortest all season travel time option must be used.

Interstate Roads (highways)

1 mile = 1.2 minutes (Primary Care) <i>example: 42 miles × 1.2 = 50.4 minutes</i>	1 mile = 1.33 minutes (Mental Health & Dental) <i>example: 21 miles × 1.33 = 27.9 minutes</i>
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Primary Roads (paved city streets and thoroughfares)

1 mile = 1.5 minutes (Primary Care) <i>example: 3 miles × 1.5 = 4.5 minutes</i>	1 mile = 1.6 minutes (Mental Health & Dental) <i>example: 13 miles × 1.6 = 20.8 minutes</i>
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Secondary Roads (mountainous terrain or unpaved roads)

1 mile = 2.0 minutes (Primary Care) <i>example: 69 miles × 2.0 = 138 minutes</i>	1 mile = 2.0 minutes (Mental Health & Dental) <i>example: 7 miles × 2.0 = 14 minutes</i>
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There is no stated rationale for why travel formulas are different based on the professional discipline designation in the federal rules governing shortage designation. Even though the online mapping services provide travel times, **only** the results of these formulas may be used to report travel time for application purposes.

Public Transportation: For inner city designations of low income populations, where more than 20% of the population is below 100% federal poverty level (FPL) **and** 30% of the population is dependent on public transportation, a bus route may be substituted for a car route. Include a bus route map and schedule with the miles and minutes necessary to travel from the population center to the nearest source of undesignated care. Walking time to and from the first and last bus stop cannot be included in the travel time but walking/waiting time for in-transit connections can and should be included.

Example: RTD Online Trip Planner Results

From: E 38TH AVE & PONTIAC ST DENVER To: DENVER HEALTH MEDICAL CENTER - 777 BANNOCK ST Arriving At: 900A
Best Itinerary
Go To: 38th Ave & Olive St (NW Corner of Intersection), DENVER Get On: #38 / 38 Downing Stn 38 Applewood at 8:14AM (Next Bus At 8:44AM) Get Off: California St & 17th St (N Corner of Intersection), DENVER at 8:44AM
Go To: 17th St & California St [Z Stop] (S Corner of Intersection), DENVER Get On: #0 / 0 Broadway Stn at 8:49AM (Next Bus At 8:54AM) Get Off: Broadway & 7th Ave (NW Corner of Intersection), DENVER at 8:58AM
Travel Time : 44 minutes

C: *Data Available on the Web*

American Fact Finder (factfinder.census.gov)

select “Datasets” to find these tables

Data Set	Location	Table
Total population	Summary File 1 – Detailed Table	Table P1
Group quarters	Summary File 1 – Detailed Table	Table P37
Population over age 65	Summary File 1 – Detailed Table	Table P12
Population by race	Summary File 1 – Detailed Table	Table P3
Second homeowners	Summary File 1 – Detailed Table	Table H5
Poverty data	Summary File 3 – Detailed Table	Table P88
Speaks English well	Summary File 3 – Quick Table	QT-P17
Journey to work	Summary File 3 – Quick Table	QT-P23
Dependency on public transportation	Summary File 3 – Quick Table	QT-P23

Health Resources and Service Administration

Data Set	Location
HPSA	http://hpsafind.hrsa.gov
MUA/MUP	http://muafind.hrsa.gov
HRSA data warehouse including customizable health service area maps	http://datawarehouse.hrsa.gov

Provider Data

Data Set	Location
Primary care and mental health providers	http://www.medicalquest.com https://www.doradls.state.co.us/lic_database_req.php http://www.dexknows.com
Dental providers	http://www.cdaonline.org https://www.doradls.state.co.us/lic_database_req.php http://www.dexknows.com

D: Insufficient Capacity Criteria

Primary Care

An area's existing primary care providers will be considered to have insufficient capacity if at least two of the following criteria are met:

1. More than 8,000 outpatient visits per year, per FTE primary care physician serving the area
2. Wait time for appointments for routine medical services for established patients is greater than seven days
3. Wait time for appointments for routine medical services for new patients is greater than 14 days
4. Wait time in the office for patients with appointments is greater than one hour
5. Wait time in the office for patients without appointments is greater than two hours
6. Emergency department data, which indicates that greater than 35% of emergency room visits are for routine primary care services
7. Greater than 65% of the service area's physicians do not accept new patients
8. Low primary care utilization characterized by less than an average of two primary care visits per year, per person

Mental Health

Insufficient capacity criteria are not applicable.

Dental Care

An area's existing dental providers will be considered to have insufficient capacity if at least two of the following criteria are met:

1. More than 5,000 outpatient visits per year, per FTE dentist serving the area
2. Wait time for appointments for routine dental services is greater than six weeks
3. Greater than 65% of the service area's dentists do not accept new patients

E: Core Mental Health Professionals

- I. Psychiatrists
 - a) A doctor of medicine (M.D.) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology.
 - b) A doctor of osteopathy (D.O.) who is certified by the American Osteopathic Board of Neurology and Psychiatry.
 - c) An MD or DO who is not board certified but is “board eligible” (i.e., has successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry); and is licensed to do so.
- II. Clinical Psychologist
 - a) An individual with a doctorate in psychology who is practicing as a clinical or counseling psychologist and is licensed or certified to do so by the state of practice.
 - b) If licensure or certification is not state required, the individual must have a doctorate in psychology and two years of supervised clinical training or counseling experience (excluding school psychologists).
- III. Clinical Social Worker (CSW)
 - a) Is certified as a CSW by the American Board of Examiners in Clinical Social Work
 - b) or is listed on the National Association of Social Workers’ Clinical Register
 - c) has a masters degree in social work and two years of supervised clinical experience; and is licensed to do so by the state.
- IV. Psychiatric Nurse Specialist
 - a) A registered nurse who is certified by the American Nurses Association as a psychiatric and mental health clinical nurse specialist, or
 - b) has a masters degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical training; and is licensed to do so by the state.
- V. Marriage and Family Therapist (MFT)
 - a) An individual with a masters or doctoral degree in marriage and family therapy and at least two years of supervised clinical experience who is practicing as a MFT and is licensed to do so if required by the state of practice; or
 - b) if licensure or certification is not state required, is eligible for clinical membership in the American Association for Marriage and Family Therapy.

13. _____ Physician's last name	If the physician has more than two practice sites, copy this page and complete for additional practices.	
PHYSICIAN'S OUTPATIENT PRACTICE	MAIN PRACTICE	ADDITIONAL PRACTICE, IF ANY
14. List the name and physical location of each outpatient practice then respond to the following questions for each practice location .	NAME: _____ ADDRESS: _____ CITY, ZIP: _____	_____ _____ _____
15. Is the physician practicing as a locum tenens or volunteer physician for less than one year at this site?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
16. How many hours per week does the physician typically provide outpatient primary care to patients at this location? (defined by the specialties listed in question 4) Do not include practice administrative or hospital hours.	_____	_____
17. In a typical week, what is the total number of patients seen by the physician for primary care?	_____	_____
18. a. Does the physician accept Colorado Medicaid ?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. If yes, what percent of patients in the practice are on Medicaid? Include those on Medicaid only (not dual eligible) in this total.	_____	_____
c. If yes, is the physician accepting new patients on Medicaid?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
19. a. Does the physician accept Medicare ?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. If yes, what percent of patients in the practice are on Medicare? Include dual eligible patients in this total.	_____	_____
c. If yes, is the physician accepting new patients on Medicare?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
20. a. Does the physician offer a sliding fee schedule? A sliding fee schedule is a formal, posted , discount policy based on income or ability to pay. Bad debt write-off policies are excluded.	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. If yes, what is the percent of patients in the practice where a sliding fee scale is use to assess payment due? (enter 0 if none)	_____	_____
21. a. Is the physician accepting new patients?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. If yes, what is the typical number of days a new patient waits for a routine appointment? (enter 0 if none)	_____	_____
22. What is the typical number of days an established patient waits for a routine appointment? (enter 0 if none)	_____	_____
23. Can the physician provide care in a language other than English? (may include spoken or through a qualified staff person or interpretation service)	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

HEALTH PROFESSIONAL SHORTAGE AREA: SURVEY OF MENTAL HEALTH PHYSICIANS

1. _____ Form completed by, if different than physician (NAME, PHONE):	____/____/____ DATE COMPLETED
PHYSICIAN'S INFORMATION	
2. _____ Physician's name (LAST, FIRST, MIDDLE, SUFFIX):	____-____-____-____ YEAR OF BIRTH
3. Professional degree:	MD <input type="checkbox"/> DO <input type="checkbox"/>
4. Is the physician board certified as a psychiatrist?	YES <input type="checkbox"/> NO <input type="checkbox"/>
5. Is the physician board certified as a child psychiatrist?	YES <input type="checkbox"/> NO <input type="checkbox"/>
6. Is the physician a permanent US resident or citizen?	YES <input type="checkbox"/> NO <input type="checkbox"/>
7. Is the physician currently in an internship or residency program?	YES <input type="checkbox"/> NO <input type="checkbox"/>
8. Is the physician currently an obligated provider on a National Health Service Corps loan or scholarship commitment?	YES <input type="checkbox"/> NO <input type="checkbox"/>
9. Is the physician currently a Federal Physician (e.g. IHS, PHS)?	YES <input type="checkbox"/> NO <input type="checkbox"/>
10. Approximately how much longer does the physician expect to practice?	<5 YEARS <input type="checkbox"/> 5-10 YEARS <input type="checkbox"/> >10 YEARS <input type="checkbox"/>
11. Is the physician currently practicing on a restricted license?	YES <input type="checkbox"/> NO <input type="checkbox"/>
PHYSICIAN'S PRACTICE	MAIN PRACTICE
	ADDITIONAL PRACTICE, IF ANY
12. List the name and physical location of each practice then respond to the following questions for each practice location . NAME: _____ ADDRESS: _____ CITY, ZIP: _____	
13. Is the physician practicing as a locum tenens or volunteer physician for less than one year at this site?	YES <input type="checkbox"/> NO <input type="checkbox"/>
14. How many hours per week does the physician typically provide outpatient mental health care to patients at this location? Do not include administrative time in the practice.	_____
15. In a typical week, what is the total number of patients seen by the physician for care?	_____
16. a. Does the physician accept Colorado Medicaid ?	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. If yes, what percent of patients in the practice are on Medicaid? Include those on Medicaid only (not dual eligible) in this total.	_____
c. If yes, is the physician accepting new patients on Medicaid?	YES <input type="checkbox"/> NO <input type="checkbox"/>
17. a. Does the physician accept Medicare ?	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. If yes, what percent of patients in the practice are on Medicare? Include dual eligible patients in this total.	_____
c. If yes, is the physician accepting new patients on Medicare?	YES <input type="checkbox"/> NO <input type="checkbox"/>
18. a. Does the physician offer a sliding fee schedule (a sliding fee schedule is a formal, posted , discount policy based on income or ability to pay. Bad debt write-off policies are excluded)?	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. If yes, what is the percent of patients in the practice where a sliding fee scale is use to assess payment due? (enter 0 if none)	_____
19. a. Is the physician accepting new patients?	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. If yes, what is the typical number of days a new patient waits for a routine appointment? (enter 0 if none)	_____
20. What is the typical number of days an established patient waits for a routine appointment? (enter 0 if none)	_____

HEALTH PROFESSIONAL SHORTAGE AREA: SURVEY OF DENTISTS

1. _____ Form completed by, if someone other than dentist (NAME, PHONE):	___/___/___ DATE COMPLETED	
DENTIST'S INFORMATION		
2. _____ Dentist's name (LAST, FIRST, MIDDLE, SUFFIX):	_____ YEAR OF BIRTH	
3. Professional degree:	DDS <input type="checkbox"/> DMD <input type="checkbox"/>	
4. Dental specialty (if neither, answer question 5, then stop, and return the survey):	GENERAL DENTISTRY <input type="checkbox"/> PEDIATRIC DENTISTRY <input type="checkbox"/> NEITHER OF THESE <input type="checkbox"/>	
5. List any other specialty or subspecialty that is not listed in question 4, which is part of the dentist's routine practice (leave blank if none):	OTHER: _____ OTHER: _____	
6. Is the dentist a permanent US resident or citizen?	YES <input type="checkbox"/> NO <input type="checkbox"/>	
7. Is the dentist currently an obligated provider on a National Health Service Corps loan or scholarship commitment?	YES <input type="checkbox"/> NO <input type="checkbox"/>	
8. Is the dentist currently a Federal Employee (e.g. IHS, PHS)?	YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. Approximately how much longer does the dentist expect to practice dentistry?	<5 YEARS <input type="checkbox"/> 5-10 YEARS <input type="checkbox"/> >10 YEARS <input type="checkbox"/>	
10. Is the dentist currently suspended by Medicaid?	YES <input type="checkbox"/> NO <input type="checkbox"/>	
DENTIST'S PRACTICE	MAIN PRACTICE	ADDITIONAL PRACTICE, IF ANY
11. List the name and physical location of each practice then respond to the following questions for each practice location (copy and attach additional pages if more than two practices). NAME: _____ ADDRESS: _____ CITY, ZIP: _____	_____ _____ _____	_____ _____ _____
12. Is the dentist practicing as a locum tenens or volunteer physician for less than one year at this site?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
13. How many hours per week does the dentist typically provide direct general or pediatric dentistry to patients at this location (defined by the specialties listed in question 4 above)? Do not include administrative time in the practice.	_____ _____	_____ _____
14. How many total hours per week do hygienists or dental assistants provide direct patient care under the direct supervision of the dentist? For example, two full time hygienists would be reported as 80 hours (enter zero if none).	_____ _____	_____ _____
15. In a typical week, what is the total number of patients seen by the dentist for general or pediatric dentistry services?	_____ _____	_____ _____
16. a. Does the dentist accept Colorado Medicaid ?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. If yes, what percent of patients in the practice are on Medicaid? (enter 0 if none)	_____ _____	_____ _____
c. If yes, is the dentist accepting new patients on Medicaid?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
17. a. Does the dentist offer a sliding fee schedule (a <i>formal</i> discount policy based on income or ability to pay. Bad debt write-off or professional discount policies are not included)?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. If yes, what is the percent of patients in the practice where a sliding fee scale is use to assess payment due? (enter 0 if none)	_____ _____	_____ _____
18. a. Is the dentist accepting new patients?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. If yes, what is the typical number of days a new patient waits for a routine appointment?	_____ _____	_____ _____
19. What is the typical number of days an established patient waits for a routine appointment?	_____ _____	_____ _____

Appendix 2: Terms, Acronyms and Abbreviations

Bureau of Health Professions (BHP): The federal Bureau of Health Professions helps to assure access to quality healthcare professionals in all geographic areas and to all segments of society. BHP is part of the Health Resources and Services Administration (HRSA), an agency of the Department of Health and Human Services (DHHS).

Bureau of Primary Healthcare (BPHC): The federal Bureau of Primary Healthcare assures that underserved and vulnerable people have access to the healthcare they need. BPHC is part of the Health Resources and Services Administration (HRSA), an agency of the Department of Health and Human Services (DHHS).

Census County Division (CCD): is a subdivision of a county that is a relatively permanent statistical area established by the U.S. Census Bureau and state and local government authorities. CCDs are used for presenting decennial census statistics in those states that do not have well-defined and stable minor civil divisions that serve as local governments.

Census Tract (CT): Census tracts are generally small, relatively permanent statistical subdivisions of a county, delineated as part of the U.S. Census Bureau's Participant Statistical Areas Program. The primary purpose of census tracts is to provide a stable set of geographic units for the presentation of census data.

Centers for Medicare & Medicaid (CMS): The federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).

Colorado Community Health Network (CCHN): The state primary care association (PCA), representing community, migrant, and homeless health centers. CCHN is committed to achieving 100% access to healthcare, and to eliminating health disparities for all Coloradans.

Colorado Department of Public Health and Environment (CDPHE): The state health agency charged with assuring healthy people and places in Colorado. The Primary Care Office is an office of the department.

Colorado Rural Health Center (CRHC): Is a nonprofit organization, which provides information, education, linkages, tools and energy toward addressing rural healthcare issues. Among its many activities, the Center provides or helps arrange for technical assistance to rural communities so they can take full advantage of federal, state, public, and private resources.

Community Health Centers (CHCs): Community Health Centers, also sometimes referred to as Federally Qualified Health Centers, provide comprehensive, quality healthcare to medically underserved populations. Colorado has 118 community, migrant, and homeless health center sites that provide healthcare to approximately 396,000 Coloradans, most of whom are low income and uninsured.

Contiguous Area: The area surrounding a proposed service area that is characterized by its sources of care and its ability to provide accessible services to the population in the proposed service area.

Federal Poverty Level: A statistical estimate conducted by the federal government of the income resources below which an individual or family unit is considered impoverished.

Federally Qualified Health Center: see Community Health Centers.

Full Time Equivalent (FTE): The full time equivalent is the percentage of time worked, based on a 40 hour workweek. For example, someone working 20 hours per week would be .50 FTE. When applying for a HPSA designation, one is asked the proportion of provider time spent on providing direct care services to a given population.

Health Professional Shortage Area (HPSA): A federal designation of a health service area that describes a shortage of health professionals in primary care, mental or oral health based upon standard criteria.

Health Resources and Service Administration (HRSA): HRSA is the nation's access agency, which improves health and saves lives by making sure the right services are available in the right places at the right time. HRSA is an agency of the U.S. Department of Health and Human Services and is the primary Federal agency working to improve access to health care services for people who are uninsured, isolated or medically vulnerable.

Index of Medical Under Service (IMU): The IMU involves four variables - ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. The value of each of these variables for the service area is converted to a weighted value, according to established criteria. The four values are summed to obtain the area's IMU score.

J-1 Visa see Appendix C.

Medicaid: The state health insurance program for significantly impoverished women and children.

Medically Underserved Area (MUA): A federal designation of a health service area that describes the health status of a population according to an Index of Medical Under Service based upon standard criteria. Designation is contingent upon a score on a scale of 0 to 100, where higher scores describe higher need.

Medically Underserved Population (MUP): A federal designation of a health service area that describes the health status of a *subset* of the population according to an Index of Medical Under Service based upon standard criteria. Designation is contingent upon a score on a scale of 0 to 100, where higher scores describe higher need.

Medicare: The federal health insurance program for those 65 and older.

Medicare Incentive Payment: see Appendix C

Minor Civil Division (MCD): Minor civil divisions (MCDs) are the primary governmental or administrative divisions of a county in many states. MCDs are variously designated as American Indian reservations, assessment districts, boroughs, charter townships, election districts, election precincts, gores, grants, locations, magisterial districts, parish governing authority districts, plantations, precincts, purchases, road districts, supervisor's districts, towns, and townships. MCDs aren't recognized in the State of Colorado.

National Health Service Corps: see Appendix C.

Primary Care Association (PCA): The Primary Care Association (PCA) is the state association of community health centers. The Colorado Community Health Network (CCHN) is the PCA for Colorado.

Primary Care Office (PCO): The Colorado Primary Care Office exists to lower the barriers that prevent Coloradans from receiving adequate primary, oral and mental health care.

Rational Service Area (RSA): A geographic area made up of one or more census tracts that is rationally devised based on common health care utilization and population characteristics.

Rural Health Clinic: see Appendix C.

Shortage Designation Branch (SDB): A branch of the Bureau of Health Professions, National Center for Workforce Analysis, which sets regulatory guidelines for shortage designation and approves shortage applications.

Appendix 3: Select Shortage Designation Benefits

A: Physician Incentive Payments

Beginning in 1991, physicians have been entitled to a 10% incentive bonus payment for Medicare services under Part B. Services must be provided in a Geographic Health Professional Shortage Area. The bonus payment is not available for services rendered in a population HPSA. A physician does not necessarily need to have a primary office in a HPSA, nor does the patient have to reside in a HPSA, so long as the location of the services rendered is within the area designated as a geographic HPSA.

The incentive is 10% of the amount actually paid by Medicare to the provider for the previous quarter and is taxable as is other income derived from Medicare. For more information, physicians should contact the Centers for Medicare and Medicaid Services, Denver Regional Office at 303-844-6218.

B: Certified Rural Health Clinics

A Rural Health Clinic (RHC) is a primary health care clinic model that requires a non-urban address and demonstrated service to a designated shortage area. Rural Health Clinics may be public, for-profit, or nonprofit facilities. A RHC has to be certified by the state health department under rules set by Medicare. RHCs are charged with improving access to care in rural, underserved areas in part by increasing utilization of midlevel providers (advanced practice nurses and physician assistants). RHCs receive cost based reimbursement from Medicare and Medicaid upon certification.

How to Apply to be a Rural Health Clinic

- Step 1:** Determine that your community is in a non-urbanized area (www.census.gov).
- Step 2:** Determine that the clinic facility is located in a Health Professional Shortage Area <http://hpsafind.hrsa.gov/> or Medically Underserved Area <http://muafind.hrsa.gov/>. If no, complete an application for a new shortage designation. For additional application guidance, contact the Primary Care Office at 303-692-2298.
- Step 3:** Determine that your clinic can, or does, employ at least one mid-level primary care provider.
- Step 4:** Review the application guidelines posted at: <https://www.colorado.gov/pacific/cdphe/rural-health-clinics>
- Step 5:** Contact the Colorado Rural Health Center at 800-851-6782 for application technical assistance.

C: Federally Qualified Health Centers

Federally Qualified Health Centers (Community Health Centers) are federally designated entities that provide comprehensive primary care services regardless of ability to pay. Community Health Centers (CHCs) also provide access to dental and mental health services. CHCs are public or nonprofit health care providers with a mission to provide comprehensive primary health care to low income families. Funding for Community Health Centers is provided under Section 330 of the Public Health Service Act.

Community Health Centers can apply to receive a grant to start or enhance a clinic facility. In addition, health centers receive cost based reimbursement from both Medicaid and Medicare. Community health centers also receive federal grant funds each year to defray the costs of providing care to the uninsured.

How to Apply to be a Federally Qualified Community Health Center

- Step 1:** Determine that your community is not already served by a FQHC. www.cchn.org/health_centers.php# If yes, your clinic is less likely to qualify for FQHC status. If no, proceed to Step 2.
- Step 2:** Determine that the clinic meets federal criteria. The clinic must be public or nonprofit and serve patients of all ages who are on Medicare, Medicaid, CHP+, and offer services on a sliding fee scale to the uninsured. The clinic may not refuse care to anyone based on ability to pay. The clinic must also provide primary health care services, referrals and other health services needed to facilitate access to care, such as case management, translation, and transportation. If yes, proceed to Step 3.
- Step 3:** Determine that the clinic facility is in a Medically Underserved Area or Medically Underserved Population <http://muafind.hrsa.gov/> If no, complete an application for a new Medically Underserved Area or Population. For additional application guidance, contact the Primary Care Office at 303-692-2298.
- Step 4:** Contact the Colorado Community Health Network at 303-861-5165 for application and technical assistance.

D: Conrad 30 J-1 Visa Waiver and National Interest Waiver Programs

J-1 Visa Waiver

International medical graduates (foreign physicians who attend medical school and receive a medical degree in a foreign country) are permitted to come to the United States for residency training on a J-1 Visa. Upon completion of residency training, these physicians are required to return to their home country for two years before applying for a new U.S. Visa. The two year home return requirement may be waived if the physician is willing to practice medicine, full-time for three years, in an underserved area of the United States. The State Conrad 30 J-1 Visa Waiver Program allows state governments to act as an interested governmental agency in recommending a Visa rule waiver, to the U.S. Department of State, for qualified international medical graduates.

National Interest Waiver (NIW)

The National Interest Waiver Program allows professionals of exceptional ability to request a waiver of the US Immigration labor certification requirements, based on a letter of recommendation from a state health department. The health department provides an official letter to the US Department of State stating that the work of the professional is in the public interest. Physicians applying for a National Interest Waiver are required to work full-time for five years, providing primary care, in a designated underserved area (HPSA or MUA). Time spent in H1-B status to fulfill J-1 Visa Waiver requirements may be counted towards the five year term, but time spent in J-1 status as a resident may not. National Interest Waivers are an effective way for foreign physicians to attain permanent residency status in the U.S.

How to Apply for a J-1 or NIW Physician

- Step 1:** Review the application guidelines posted at:
<https://www.colorado.gov/cdphe/international-medical-graduates>
- Step 2:** Determine that the clinic patient population meets program criteria. To be a J-1 or NIW site, the clinic facility must serve patients who are on Medicare, Medicaid, CHP+, and offer services on a sliding fee scale to the uninsured. The sliding fee scale must be posted in the clinic's waiting room. If yes, proceed to Step 3.
- Step 3:** Determine that the clinic facility is in a designated shortage area
<http://hpsafind.hrsa.gov/>. If no, complete an application for a new Health Professional Shortage Area. A waiver application may be considered if the facility is not in a shortage area, if it can be demonstrated that the facility cannot meet the needs of its medically underserved patients.
- Step 4:** Identify a physician in need of a Visa waiver who meets the qualifications and needs of the practice. Prepare an application on behalf of the physician and submit it to the State Primary Care Office. For additional application guidance, contact the Primary Care Office at 303-692-2298.

E: National Health Service Corps

The National Health Service Corps (NHSC) is committed to improving the health of the Nation's underserved by uniting communities in need with caring health professionals. The Corps supports efforts to build better systems of care for underserved areas. The NHSC provides comprehensive team-based healthcare that bridges geographic, financial, cultural, and language barriers.

NHSC Programs

The NHSC offers a Scholarship Program and Loan Repayment Program. Scholars have their educational expenses paid in exchange for a future commitment to serve upon completion of their training. Loan Repayment providers receive assistance in repayment of student loans in exchange for a similar commitment. Both groups of clinicians are required to practice in a Health Professional Shortage Area.

How to Apply to be a NHSC Designated Site

- Step 1:** Determine that the clinic patient population meets NHSC criteria. To be a NHSC site, the clinic facility must serve patients who are on Medicare, Medicaid, CHP+, and offer services on a sliding fee scale to the uninsured. The sliding fee scale must be posted in the clinic's waiting room. If yes, proceed to Step 2.
- Step 2:** Determine that the facility has a patient non-discrimination policy. If yes, proceed to Step 3.
- Step 3:** Determine that the clinic can employ the prospective NHSC provider for a minimum 40 hours per week. If yes, proceed to Step 4.
- Step 4:** Determine that the clinic facility is in a Health Professional Shortage Area <http://hpsafind.hrsa.gov/>. If no, complete an application for a new Health Professional Shortage Area. If yes, proceed to Step 5.
- Step 5:** Complete a Site Application from the NHSC <http://nhsc.hrsa.gov/sites/index.html>. Applications are accepted only during a designated cycle. Sites located within the highest scoring HPSAs are given highest priority. For additional application guidance, contact the Primary Care Office at 303-692-2466.