

Date: October 2015

Subject: Primary Medical Care Facility Health Professional Shortage Designation Eligibility and Process

The Public Health Service Act, as amended, instructs the Secretary of the U.S. Department of Health and Human Services (DHHS) to use data from national, state, and local sources and regulations based upon established criteria, to annually prepare listings of currently designated Health Professional(s) Shortage Areas (HPSA). The DHHS may designate a HPSA for an urban or rural area that is a rational service area (i.e., geographic area); a population group; or a facility.

To be eligible for a primary medical care facility HPSA designation, an entity must i) be a public or non-profit medical facility, ii) provide primary medical care services to an area or population group designated as having a shortage and iii) have insufficient capacity to meet the needs of the area or population group.

To prove provision of primary medical care services, one of the following criteria must be met:

- The facility must be within 30 minutes of a HPSA and the facility is accessible to residents of the HPSA (i.e., no socioeconomic difference).
- More than 50% of the facility's health care services are provided to residents of a HPSA.

To demonstrate insufficient capacity, two of the following criteria must be met:

- Facility has more than 8,000 outpatient visits per year per FTE of primary care physicians.
- Excessive use (greater than 35%) of emergency room facilities for routine primary care.
- Waiting time for appointments in facility is more than 7 days for established patients or more than 14 days for new patients for routine health services.
- Facility waiting time is greater than 1 hour for patients with appointments or 2 hours for walk-in patients.

The Office of Primary Care and Rural Health is responsible for the evaluation and submission of HPSA designations for the state of Kansas. The first step of the evaluation and submission process is to compile the required provider- and site-specific information. To expedite this process, a standardized survey collection tool has been designed for entities to complete and submit to the Office. Once fully completed, please email this survey as well as the required supporting documentation to the Office at primarycare@kdheks.gov.

Once received, the Office will review the information for completeness and analyze the information to determine if the facility meets the requirements listed below. If the above requirements are met, the Office will then proceed with submitting the facility HPSA designation request to the Bureau of Health Workforce, DHHS – Health Resources and Services Administration through their Shortage Designation Management System (SDMS) for approval and scoring.

This form is intended for entities seeking a Primary Medical Care Facility Health Professional Shortage Area designation who are not a federally qualified health center or a rural health clinic. The information requested in this form will be used by the Kansas Office of Primary Care and Rural Health to submit the shortage designation request through the Federal Shortage Designation Management System (SDSM). The completed form can be returned to the Office through mail or email.

Mail --_Attn: Shortage Designation Request to Office of Primary Care and Rural Health, Bureau of Community Health Systems 1000 SW Jackson St, Suite 340, Topeka, KS 66612-1365

Email --_Subject: Shortage Designation Request to primarycare@kdheks.gov

GENERAL FACILITY INFORMATION

Facility Name: _____

Facility Physical Street Address: _____

City: _____ ZIP Code: _____ County: _____

Primary Contact Name: _____

Primary Contact Title: _____

Phone: _____ Email: _____

Is the entity public or non-profit? Yes No

1. Select the statement that the best describes the facility service area.
 - The facility is within 30 minutes of a geographic or population HPSA and the facility is accessible to residents of the HPSA (i.e. no socioeconomic differences.)
 - More than 50% of the facility's health care services are provided to residents of a geographic or population HPSA
 - None of the above

2. What is the total number of outpatient visits completed by the entity during the past 12 months?
 - 2.A Timeframe (e.g., January 1, 2014 to December 31, 2014): _____
 - 2.B Number of outpatient visits for this timeframe: _____

Supporting documentation is required. Label file as "SupportDocument1_Evidence_Outpatient_Visits"

3. What is the mean (average) wait time for scheduling patient appointments?
 - 3.A Length of time, in days, for established patients: _____
 - 3.B Length of time, in days, for new patients for routine health services: _____

Supporting documentation is required. Label document as "SupportDocument2_Evidence_Appointment_Wait_Time"

4. What is the mean (average) wait time for patients to be seen by a provider when arriving at the facility?
 - 3.A Length of time, in hours, for patients with appointments: _____
 - 3.B Length of time, in hours, for walk-in patients: _____

Supporting documentation is required. Label file as "SupportDocument3_Evidence_Provider_Visit_Wait_Time"

5. Does the entity experience an excessive use (greater than 35%) of the emergency room facilities for routine primary care? Yes No

If question is answered "Yes" supporting documentation is required. Label this document as "SupportDocument4_Evidence_of_Emergency_Room_Usage"

PRIMARY CARE PROVIDER INFORMATION

6. Indicate the total number of primary care providers rendering professional services at this facility:

Primary care (MD/DO) _____ No primary care physicians providing services at this facility.

Complete the following information for each health care physician that provides direct patient care services at the facility. Add as many pages as necessary to list all providers.

Health Care Provider Name: _____

NPI No.: _____

License No.: _____

Number of hours per week spent providing direct patient care at this facility: _____

Has the provider worked at another practice site prior to working at this facility?

No

Yes, indicate practice site address, below.

Street: _____ City: _____ State: _____

County and state of the provider's home (personal) residence:

County: _____ State: _____

County and state of the provider's previous home (personal) residence (if applicable):

County: _____ State: _____

Health Care Provider Name: _____

NPI No.: _____

License No.: _____

Number of hours per week spent providing direct patient care at this facility: _____

Has the provider worked at another practice site prior to working at this facility?

No

Yes, indicate practice site address, below.

Street: _____ City: _____ State: _____

County and state of the provider's home (personal) residence:

County: _____ State: _____

County and state of the provider's previous home (personal) residence (if applicable):

County: _____ State: _____

Health Care Provider Name: _____

NPI No.: _____

License No.: _____

Number of hours per week spent providing direct patient care at this facility: _____

Has the provider worked at another practice site prior to working at this facility?

No

Yes, indicate practice site address, below.

Street: _____ City: _____ State: _____

County and state of the provider's home (personal) residence:

County: _____ State: _____

County and state of the provider's previous home (personal) residence (if applicable):

County: _____ State: _____

Health Care Provider Name: _____

NPI No.: _____

License No.: _____

Number of hours per week spent providing direct patient care at this facility: _____

Has the provider worked at another practice site prior to working at this facility?

No

Yes, indicate practice site address, below.

Street: _____ City: _____ State: _____

County and state of the provider's home (personal) residence:

County: _____ State: _____

County and state of the provider's previous home (personal) residence (if applicable):

County: _____ State: _____

I certify the information provided is true and correct to the best of my knowledge.

Printed Name and Title

Date

Signature

Date: October 2015

Subject: Mental Health Facility Health Professional Shortage Designation Eligibility and Process

The Public Health Service Act, as amended, instructs the Secretary of the U.S. Department of Health and Human Services (DHHS) to use data from national, state, and local sources and regulations based upon established criteria, to annually prepare listings of currently designated Health Professional(s) Shortage Areas (HPSA). The DHHS may designate a HPSA for an urban or rural area that is a rational service area (i.e., geographic area); a population group; or a facility.

To be eligible for a mental health facility HPSA designation, an entity must i) be a public or non-profit medical facility, or a community mental health center, ii) provide mental health services to an area or population group designated as having a shortage and iii) have insufficient capacity to meet the needs of the area or population group.

To prove provision of mental health services, one of the following criteria must be met:

- The facility must be within 40 minutes of a HPSA and the facility is accessible to residents of the HPSA (i.e., no socioeconomic difference).
- More than 50% of the facility's mental health care services are provided to residents of a HPSA.
- The facility will be considered to be providing services to a designated area or population group if the facility, by Federal or State statute, administrative action, or contractual agreement, has been given responsibility for providing and/or coordinating mental health services for the area or population group consistent with applicable state plans.

To demonstrate insufficient capacity, one of the following criteria must be met:

- Facility has more than 3,000 outpatient visits per year per full time equivalent psychiatrist.
- No psychiatrists are on staff at facility and facility is the only providing mental health services to the designated area or population.

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Once received, the Office will review the information for completeness and analyze the information to determine if the facility meets the requirements listed below. If the above requirements are met, the Office will then proceed with submitting the facility HPSA designation request to the Bureau of Health Workforce, DHHS – Health Resources and Services Administration through their Shortage Designation Management System (SDMS) for approval and scoring.

This form is intended for entities seeking a Mental Health Facility Health Professional Shortage Area designation who are not a federally qualified health center or a Medicare-certified rural health clinic, or a mental hospital. The information requested in this form will be used by the Kansas Office of Primary Care and Rural Health to submit the shortage designation request through the Federal Shortage Designation Management System (SDSM). The completed form can be returned to the Office through mail or email.

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Email -- Subject: Shortage Designation Request to primarycare@kdheks.gov

GENERAL FACILITY INFORMATION

Facility Name: _____

Facility Physical Street Address: _____

City: _____ ZIP Code: _____ County: _____

Primary Contact Name: _____

Primary Contact Title: _____

Phone: _____ Email: _____

Is the entity public or non-profit? Yes No

1. Select the statement that best describes the facility service area.

- The facility is within 40 minutes of a geographic or population HPSA and the facility is accessible to residents of the HPSA (i.e. no socioeconomic differences.)
- More than 50% of the facility's mental care services are provided to residents of a geographic or population HPSA
- The facility has been given the responsibility by the State (through statute, administrative or contractual agreement) for providing and/or coordinating mental health services for an area or population group, consistent with applicable State plans.
- None of the above

2. What is the total number of outpatient visits completed by the entity during the past 12 months?

2.A Timeframe (e.g., January 1, 2014 to December 31, 2014): _____

2.B Number of outpatient visits: _____

Supporting documentation is required. Label file as "SupportDocument1_Evidence_Outpatient Visits"

3. Is the entity the only facility providing mental health services in the designated area or population?

Yes No

If question is answered "Yes" supporting documentation is required for submission.

Label this document as "SupportDocument2_Evidence_Sole_Mental_Health_Provider"

PROVIDER INFORMATION

4. Indicate the total number of psychiatrists rendering professional services at this facility:

Psychiatrists (MD/DO) _____ No psychiatrists providing services at this facility.

Complete the following information for each psychiatrist that provides direct patient care services at the facility. Add as many pages as necessary to list all providers.

Health Care Provider Name: _____

NPI No.: _____ License No.: _____

Number of hours per week spent providing direct patient care at this facility: _____

Has the provider worked at another practice site prior to working at this facility?

- No
- Yes, indicate practice site address, below.

Street: _____ City: _____ State: _____

County and state of the provider's home (personal) residence:

County: _____ State: _____

County and state of the provider's previous home (personal) residence (if applicable):

County: _____ State: _____

Health Care Provider Name: _____

NPI No.: _____ License No.: _____

Number of hours per week spent providing direct patient care at this facility: _____

Has the provider worked at another practice site prior to working at this facility?

- No
- Yes, indicate practice site address, below.

Street: _____ City: _____ State: _____

County and state of the provider's home (personal) residence:

County: _____ State: _____

County and state of the provider's previous home (personal) residence (if applicable):

County: _____ State: _____

Health Care Provider Name: _____

NPI No.: _____ License No.: _____

Number of hours per week spent providing direct patient care at this facility: _____

Has the provider worked at another practice site prior to working at this facility?

No

Yes, indicate practice site address, below.

Street: _____ City: _____ State: _____

County and state of the provider's home (personal) residence:

County: _____ State: _____

County and state of the provider's previous home (personal) residence (if applicable):

County: _____ State: _____

Health Care Provider Name: _____

NPI No.: _____ License No.: _____

Number of hours per week spent providing direct patient care at this facility: _____

Has the provider worked at another practice site prior to working at this facility?

No

Yes, indicate practice site address, below.

Street: _____ City: _____ State: _____

County and state of the provider's home (personal) residence:

County: _____ State: _____

County and state of the provider's previous home (personal) residence (if applicable):

County: _____ State: _____

I certify the information provided is true and correct to the best of my knowledge.

Printed Name and Title

Date

Signature

Date: October 2015

Subject: Dental Facility Health Professional Shortage Designation Eligibility and Process

The Public Health Service Act, as amended, instructs the Secretary of the U.S. Department of Health and Human Services (DHHS) to use data from national, state, and local sources and regulations based upon established criteria, to annually prepare listings of currently designated Health Professional(s) Shortage Areas (HPSA). The DHHS may designate a HPSA for an urban or rural area that is a rational service area (i.e., geographic area); a population group; or a facility.

To be eligible for a dental facility HPSA designation, an entity must i) be a public or non-profit medical facility, ii) provide general dental care services to an area or population group designated as having a shortage and iii) have insufficient capacity to meet the needs of the area or population group.

To prove provision of general dental care services, one of the following criteria must be met:

- The facility must be within 40 minutes of a HPSA and the facility is accessible to residents of the HPSA (i.e., no socioeconomic difference).
- More than 50% of the facility's dental care services are provided to residents of a HPSA.

To demonstrate insufficient capacity, one of the following criteria must be met:

- Facility has more than 5,000 outpatient visits per year per FTE of dentist.
- Waiting time for appointments at facility is greater than 6 weeks for routine dental services.

The Office of Primary Care and Rural Health is responsible for the evaluation and submission of HPSA designations for the state of Kansas. The first step of the evaluation and submission process is to compile the required provider- and site-specific information. To expedite this process, a standardized survey collection tool has been designed for entities to complete and submit to the Office. Once fully completed, please email this survey as well as the required supporting documentation to the Office at primarycare@kdheks.gov.

Once received, the Office will review the information for completeness and analyze the information to determine if the facility meets the requirements listed below. If the above requirements are met, the Office will then proceed with submitting the facility HPSA designation request to the Bureau of Health Workforce, DHHS – Health Resources and Services Administration through their Shortage Designation Management System (SDMS) for approval and scoring.

This form is intended for entities seeking a Dental Facility Health Professional Shortage Area designation who are not a federally qualified health center or a Medicare-certified rural health clinic. The information requested in this form will be used by the Kansas Office of Primary Care and Rural Health to submit the shortage designation request through the Federal Shortage Designation Management System (SDSM). The completed form can be returned to the Office through mail or email.

Mail -- Attn: Shortage Designation Request to Office of Primary Care and Rural Health, Bureau of Community Health Systems 1000 SW Jackson St, Suite 340, Topeka, KS 66612-1365

Email -- Subject: Shortage Designation Request to primarycare@kdheks.gov

GENERAL FACILITY INFORMATION

Facility Name: _____

Facility Physical Street Address: _____

City: _____ ZIP Code: _____ County: _____

Primary Contact Name: _____

Primary Contact Title: _____

Phone: _____ Email: _____

Is the entity public or non-profit? Yes No

1. Select the statement that best describes the facility service area.

The facility is within 40 minutes of a geographic or population HPSA and the facility is accessible to residents of the HPSA (i.e. no socioeconomic differences.)

More than 50% of the facility's dental care services are provided to residents of a geographic or population HPSA

None of the above

2. What is the total number of outpatient visits completed by the entity during the past 12 months?

2.A Timeframe (e.g., January 1, 2014 to December 31, 2014): _____

2.B Number of outpatient visits: _____

Supporting documentation is required. Label file as "SupportDocument1_Evidence_Outpatient Visits"

3. What is the mean (average) wait time for scheduling routine dental appointments: _____

4. Is the entity the only facility providing dental health care services in the designated area or population?

Yes No

If question is answered "Yes" supporting documentation is required for submission.

Label this document as "SupportDocument2_Evidence_Sole_Dental_Health_Provider"

PROVIDER INFORMATION

5. Indicate the total number of dentists rendering professional services at this facility:

Dentists (DDS/DMD) _____ No dentists providing services at this facility.

Complete the following information for each dentist that provides direct dental services at the facility. Add as many pages as necessary to list all providers.

Health Care Provider Name: _____

NPI No.: _____ License No.: _____

Number of hours per week spent providing patient care at the facility: _____

Number of dental hygienists assisting: _____ Number of dental assistants assisting: _____

Has the provider worked at another practice site prior to working at this facility?

- No
- Yes, indicate practice site address, below.

Street: _____ City: _____ State: _____

County and state of the provider's home (personal) residence:

County: _____ State: _____

County and state of the provider's previous home (personal) residence (if applicable):

County: _____ State: _____

Health Care Provider Name: _____

NPI No.: _____ License No.: _____

Number of hours per week spent providing patient care at the facility: _____

Number of dental hygienists assisting: _____ Number of dental assistants assisting: _____

Has the provider worked at another practice site prior to working at this facility?

- No
- Yes, indicate practice site address, below.

Street: _____ City: _____ State: _____

County and state of the provider's home (personal) residence:

County: _____ State: _____

County and state of the provider's previous home (personal) residence (if applicable):

County: _____ State: _____

Health Care Provider Name: _____

NPI No.: _____

License No.: _____

Number of hours per week spent providing patient care at the facility: _____

Number of dental hygienists assisting: _____ Number of dental assistants assisting: _____

Has the provider worked at another practice site prior to working at this facility?

- No
 Yes, indicate practice site address, below.

Street: _____ City: _____ State: _____

County and state of the provider's home (personal) residence:

County: _____ State: _____

County and state of the provider's previous home (personal) residence (if applicable):

County: _____ State: _____

Health Care Provider Name: _____

NPI No.: _____

License No.: _____

Number of hours per week spent providing patient care at the facility: _____

Number of dental hygienists assisting: _____ Number of dental assistants assisting: _____

Has the provider worked at another practice site prior to working at this facility?

- No
 Yes, indicate practice site address, below.

Street: _____ City: _____ State: _____

County and state of the provider's home (personal) residence:

County: _____ State: _____

County and state of the provider's previous home (personal) residence (if applicable):

County: _____ State: _____

I certify the information provided is true and correct to the best of my knowledge.

Printed Name and Title

Date

Signature