AUTOMATIC HPSA SCORING PROCESS AND UPDATE OPTIONS

Scoring Process; Data used to Compute Automatic HPSA Scores
The current scoring methodology for primary care includes four factors: Population-to-Primary Care Physician Ratio, Percent of the Population with Incomes below 100% of the Poverty level, Infant Mortality Rate or Low Birth Weight Rate (whichever scores more highly), and Travel Time or Distance to nearest available source of care (whichever scores more highly). There is a transformation scale that allows computation of partial scores for each of these factors (see Criteria for Determining Primary Care HPSAs of Greatest Shortage), and the sum of these partial scores form the total HPSA score, except that the partial score for Population-to-Primary Care Physician Ratio is double-weighted, since HPSA designation is primarily intended to measure the shortage of primary care providers in the HPSA.

The data used to calculate the scores for the automatic HPSAs listed in Automatic Score Facilities List (Excel/.xls) were:

Population-to-Primary Care Physician Ratio
For the FQHC grantees, FQHCLAs and RHCs, these ratios were calculated for the defined Primary Care Service Area (PCSA) which included the location of the facility, as an approximation to the service area of the facility. Resident civilian population data from the census were used, and primary care physician data were taken from the combined AMA/AOA files used by the Shortage Designation Branch.
For the IHS Service Units and the Alaska Native facilities, Native American or Alaska Native population figures from the IHS or the Alaska Native Health System were used, and physician data represent the non-federal providers in the area as reported by the IHS or the Alaska Native Health System.

Infant Mortality Rates/Low Birth Weight Rates: For FQHC grantees, FQHCLAs and RHCs, IMR/LBW rates for the PCSAs including the FQHC or RHC were used.
For IHS and Alaska Native scoring, service unit data for the appropriate populations were used.

Poverty Rates
For FQHC grantees, 2002 UDS-reported data on percent of users with incomes below 100% of poverty were used. For FQHCLAs and RHCs, the 2000 census poverty data for the county of location were used.
For the IHS and Alaska Native areas, the census poverty data for Native American populations within those areas were used.

Travel Time/Distance to Nearest Available Source of Care
For FQHC grantees, FQHCLAs, and RHCs, travel time and distance were calculated from the population-weighted center of the PCSA in which the entity was located to the population-weighted center of the nearest PCSA with a population-to-primary care physician ratio of at least 2000:1, using average road speeds and travel time for each road segment involved.
For IHS and Alaska Natives, data reported by the IHS or the Alaska Native Health System were used.

Multi-Site Entities
FQHCs with multiple sites received a score for the entire entity. This entity score was calculated by averaging the individual site scores computed for each component site.

Please note that inability to geocode some locations, particularly in Alaska, Hawaii, Puerto Rico, and the Pacific Basin, results in the inability to collect appropriate data for the scoring process. As a result, there are some entities that still have no score, or have a very low score due to lack of data on some components.

The process outlined above has been completed only for primary care HPSA scores. Comparable data were used for these score calculations, and comparable substitute data for the dental and mental health criteria can be supplied as well.

Applicability of Automatic HPSA Scores

These scores have been developed for use in the 2005 recruitment cycle of the NHSC, which will begin in the fall of 2004. They represent the best score results that could be obtained at this time with nationally available data. The scores are displayed in Automatic Score Facilities List (Excel/.xls) which contains a separate spreadsheet for each category of entity or population.

Any site that is located in a regularly designated HPSA can continue to use the HPSA score for that area/population group, which is likely to be much higher than the automatic HPSA scores presented here. This also applies to individual sites that are part of a multi-site FQHC Grantee or FQHCLA Entity HPSA; if any individual site is in a geographic or population group HPSA, or has been designated as a Facility HPSA using the regular process, that site may use that HPSA's score for recruitment purposes. However, other sites of the same entity must use the entity automatic score.

Possible Score Appeals

It is important to keep the automatic scoring issue in context and not overemphasize its importance. There are only four programs which use the HPSA score to allocate resources: the NHSC Scholarship and Loan Repayment Programs, the NHSC Ready Responders Program, and the portion of the Federal J1 Visa Waiver program administered by HHS. In the case of the NHSC Loan Repayment Program, which has the largest pool of clinicians in this group of programs, contracts are approved in descending order of the HPSA score of the site involved, but we project that, similar to last year, even applicants from sites with no scores will likely be funded. The other three programs require that certain minimum HPSA score thresholds be exceeded for the site to be considered; however, these programs are very small in terms of the number of clinicians available. Most J1 Visa Waiver physicians are placed not by HHS but through the State Conrad 30 programs, which are not subject to the scoring restrictions. Therefore, the HPSA score should have a limited impact on recruitment opportunities for most entities.

There are many FQHCs and RHCs in geographic or population group HPSAs with scores that exceed the thresholds for these programs; and there are already more requests to fill vacancies from qualifying entities than there are NHSC Scholars or J1 Visa Waiver physicians or Ready Responders available. Adding more high scoring HPSAs through attempting to adjust upward the automatic HPSA score will only result in increasing competition among safety net providers for increasingly scarcer resources. Much more can be gained through focusing on loan repayment and cultivating other recruitment resources, such as linking to training programs, or the use of nurse practitioners, physician assistants, and nurse midwives, for whom the role of HPSA scores is less significant. It is unlikely that major changes to the automatic scores shown in Automatic Score Facilities List (Excel/.xls) (Excel/.xls) can be made without significant effort, and the payoff is not likely to be significant.

However, there may be some instances where use of local data can improve the HPSA score. Requests for revision of an entity's HPSA score must be reviewed by the Shortage Designation Branch. To avoid overwhelming the designation process, appeals for reconsideration should be pursued only in critical cases where the resulting score improvement will make a very significant difference in eligibility for resources

The scoring criteria in Criteria for Determining Primary Care HPSAs of Greatest Shortage should be used for reference if appeals are being considered, to see what if any difference new data might make in the score.

AUTO HPSA SCORING UPDATES

If an entity wishes to submit alternative data for use in the scoring process, the following guidelines are provided: (see sample template on last page)

Population Data and Poverty Data: US Census data on these variables should be used for any service area considered: data on these variables may be calculated for the actual service area rather than the whole county or PCSA of the entity's location, if a more accurate definition of the actual service area is available. If FQHC grantees have updated UDS poverty data that are significantly different from that of 2002, they may be helpful. (Please note that the majority of the FQHC grantee sites already get the maximum points allowed for the poverty variable, based on UDS user poverty rates greater than 50 %.) If FQHC Look-Alikes or RHCs have data on the poverty rates of their users comparable to UDS data for FQHC grantees, such data may be submitted and will be considered.

Infant Mortality Rate/Low Birth Weight: in most cases, county-level data are the only data available for these portions of the county; in order to use such sub-county data, there must be at least 4000 births in the area ove consideration has a significantly higher population of one racial or ethnic group than the county as a whole. (Pl score, and it is unlikely that any facility will get more than 1 or 2 points maximum with new data.)

Provider data: all non-federal providers without NHSC obligations or J1 visa waiver obligations must be counted under the current designation and HPSA scoring method. No FTE adjustments were made in the national data used in automatic scoring, and no effort was made to "back out" physicians in the NHSC or on J-1 waivers, so there may be some data available locally that could affect the total provider count for scoring purposes

If the FQHC is located in a geographic or population HPSA, the ratio for that HPSA can be substituted in the scoring for the auto HPSA; the match was not done at the first scoring but can be done upon request or submission of the information.

Travel Time/Distance: these estimates were based on use of PCSA data and GIS road classification data. In some cases, they may not accurately reflect the actual time/distance to nearest source of care for the population being reviewed. Local data could be submitted in accordance with the existing HPSA regulations.

We encourage entities interested in improving their scores to work with the Primary Care Offices (PCOs); they have extensive knowledge and experience with the HPSA process and can help assess the likelihood of significant improvements in scores based on use of any of the various options listed above. Many Primary Care Associations (PCAs) also have experience and expertise with designations and can assist in this scoring process. A coordinated approach within a State, using a consistent methodology for any proposed rescoring of multiple sites, is urged in order to reduce the number of appeal requests that will not significantly change the outcome and minimize the time required for processing successful appeals.

Criteria for Determining Primary Care HPSAs of Greatest Shortage
(Note: GE is defined as greater than or equal to)

1. Score for population-to-full-time-equivalent primary care physician (PCP) ratio

Ratio > 10,000:1, or No PCPs and Population GE 2500	5 points
10,000:1 > Ratio GE 5,000:1, or No PCPs and Population GE 2000	4 points
5,000:1 > Ratio GE 4,000:1, or No PCPs and Population GE 1500	3 points
4,000:1 > Ratio GE 3,500:1, or No PCPs and Population GE 1000	2 points
3,500:1 > Ratio GE 3,000:1, or No PCPs and Population GE 500	1 point

These points are doubled in calculating the final score.

2. Score for percent of population with incomes below poverty level (P)

P GE 50%	5 points
50% > P GE 40%	4 points
40% > P GE 30%	3 points
30% > P GE 20%	2 points
20% > P GE 15%	1 point
P < 15%	0 points

3. Infant Health Index

IMR GE 20 or LBW GE 13	5 points
20>IMR>18 or 13>LBW>11	4 points
18>IMR>15 or 11>LBW>10	3 points
15>IMR>12 or 10>LBW> 9	2 points
12>IMR>10 or 9>LBW> 7	1 point
IMR<10 or LBW< 7	0 points

4. Score for travel distance/time to nearest source of accessible care outside the HPSA
(Nearest Source of Care is defined as the closest location where the residents of the area or population that is designated have access to comprehensive primary care services.)

Time GE 60 minutes or Distance GE 50 miles	5 points
60 min > Time GE 50 min or 50 mi > Dist GE 40 mi	4 points
50 min > Time GE 40 min or 40 mi > Dist GE 30 mi	3 points
40 min > Time GE 30 min or 30 mi > Dist GE 20 mi	2 points
30 min > Time GE 20 min or 20 mi > Dist GE 10 mi	1 point
Time < 20 min or Distance < 10 mi	0 points

Criteria for Determining Dental Care HPSAs of Greatest Shortage
(Note: GE is defined as greater than or equal to)

1. Score for population-to-full-time-equivalent primary care physician (PCP) ratio

Ratio > 10,000:1, or No DDs and Population GE 3000	5 points
10,000:1 > Ratio GE 8,000:1, or No DDs and Population GE 2500	4 points
8,000:1 > Ratio GE 6,000:1, or No DDs and Population GE 2000	3 points
6,000:1 > Ratio GE 5,000:1, or No DDsand Population GE 1500	2 points
5,000:1 > Ratio GE 4,000:1, or No DD and Population GE 1000	1 point

These points are doubled in calculating the final score.

2. Score for percent of population with incomes below poverty level (P)

P GE 50%	5 points
50% > P GE 40%	4 points
40% > P GE 30%	3 points
30% > P GE 20%	2 points
20% > P GE 15%	1 point
P < 15%	0 points

3. Score for travel distance/time to nearest source of accessible care outside the HPSA
(Nearest Source of Care is defined as the closest location where the residents of the area or population that is designated have access to comprehensive primary care services.)

Time GE 90 minutes or Distance GE 60 miles	5 points
90 min > Time GE 75 min or 60 mi > Dist GE 50 mi	4 points
75 min > Time GE 60 min or 50 mi > Dist GE 40 mi	3 points
60 min > Time GE 45 min or 40 mi > Dist GE 30 mi	2 points
45 min > Time GE 30 min or 30 mi > Dist GE 20 mi	1 point
Time < 20 min or Distance < 10 mi	0 points

4. Percent of Population with Access to Fluoridated Water

$\geq$ 50% = 0 points

< 50%=1 point

Questions: **Please phone 301-594-0816** to speak to the appropriate area analyst. Please keep in mind that continuing submissions of HPSA designation requests, and of MUA/P requests related to new starts, are being processed as well.

AUTOMATIC HPSA SCORE REVISIONS

Here is a useful, easy, and clear way to present the information to revise the auto scores

Rational Service Area:

Can be the whole county or a portion of it; suggest that health centers use their service area/target area.

1. Score for population to full-time primary physician ratio: can be the whole population or the low income population (below 200%) of the area, in which case the FTES include Medicaid and Sliding Fee Scale. No 30% minimum requirement.

Data:

Source:

2. Score for Percent of Population with incomes below 100% Poverty Level:

Data:

Source: For CHCs, annual UDS data; for LALs and RHCs, latest census

3. Infant Mortality Rate/Low Birth Rate

Data:

Source: must be 5 year rate; if less than whole county must be at least 4000 births for 5 year period

4. Travel Time/Distance: Nearest source of accessible care for the target population

Data:

Source: i.e. Rand McNally, MapQuest