TO: HRSA Information Collection Clearance Officer

Room 14NWH04

5600 Fisher Lane

Rockville, Maryland 20857

FROM: The Primary Care Office National Committee

SUBJECT: Public comments on proposed data collection projects of the Paperwork Reduction Act of 1995

Information Collection Request for Shortage Designation Management System OMB No. 0906-0029 - Extension

The Primary Care Office National Committee, representing Primary Care Offices (PCOs) across the country, respectfully submits input regarding the State Primary Care Offices Response Shortage Designation Public Comment Request Title: Shortage Designation Management System, OMB No. 0906-0029-Extension The PCO National Committee is a nationally representative body of PCOs, comprised of volunteer representatives from each of the ten HHS regions elected by their peers, with the mission of creating a collective voice for PCOs. The following comments were compiled by the PCO National Committee based on input from PCO meetings, survey forms, emails, and individual conversations and reflect a range of perspectives.

Utility and Use of Shortage Designation

The utility and use of Health Professional Shortage Area (HPSA) data from the Shortage Designation Management System (SDMS) is useful, practical, necessary, and the application of the data varies by state. All offices utilize the data for grants, cooperative agreements, and other federal programming. Various states also use the information for additional activities including:

- Policy development including briefs and publications
- State loan repayment, scholarship and stipend opportunities
- State grant opportunities
- New program development in state statute
- Healthcare recruitment
- Rural Health decision making
- Data sharing across governmental departments
- Evaluation of Certificates of Need
- Create or strengthen interagency and community collaborations
- Program development
- Strategic planning
- Tax credits

States with additional funding and support for healthcare workforce programs report creating internal systems to determine shortages. It is recognized that modernization of the shortage designation program to SDMS has improved the determination process, however, continued improvements are necessary to create an efficient system.

Use of Primary Care Needs Assessment (PCNA)

Each state or territory PCO is required to do an extensive PCNA for each 5-year Cooperative Agreement with HRSA. PCOs are given freedom to tailor their assessments to the specific needs of their state or territory. PCNAs have tremendous value in informing local and statewide policy decisions, programs, and legislation. Examples include State Health Improvement Plans (SHIP), post-secondary healthcare education grant funding, public health initiatives, and collation action plans. The project usually starts a year before the due date and is comprised of stakeholder meetings, epidemiological analysis, etc. The results are compiled into a detailed report, and publicly shared.

Data Integrity

Most states use multiple data sources to complete the yearly required provider updates prior to submission of a HPSA designation application. Due to our society's mobility and healthcare's high turnover rates, provider validations, updates, and attestations is a continuous process. Individual manual provider validation takes approximately 2 to 5 minutes, per provider. This planning and development task time burden would be dependent on the number of active providers for the state. Estimated times can range from 165 hours in a low provider state to over 3000 hours in states with a higher number of providers. Mass provider uploads have been reported to take a similar time frame due to the data aggregation and clean up required for successful downloads. PCOs also face challenges with technical difficulties, system stalling and errors messages, creating instances that require reentry of data and contribute to the time burden. PCOs can also face similar difficulties with the SDMS mapping functions during the application process.

The reliability and validity of the data provided within SDMS, specifically the National Plan & Provider Enumeration System (NPPES) data is low. For example, there are no specific policy guidelines for providers regarding how to report their address. This leads to reported addresses inconsistently reflecting practice location, home address or corporate headquarters. Similar issues are experienced to varying degrees with individual state licensure board data. Other data sources used within SDMS, including CDC data, have and may continue to be impacted by changes, leading to missing information in future applications. There is concern that data gaps may need to be filled by states, potentially adding additional time burdens to PCOs. PCOs agree that no currently available data source can be used as a sole source to accurately determine healthcare provider shortages. Obtaining accurate or complete data (in some cases any data) on a clinician represents the highest time burden for many states.

This continues to create the need for states to enact policies and methods to ensure accurate information. PCOs may spend a significant time burden accessing and validating different sources of provider data. Methods including data sharing and purchasing from licensure boards, state Medicaid agencies, all payer claims databases and different state agencies, as well as compiling information sourced at meetings, by email, conference attendance, paper surveys, online surveys, and telephonic surveys.

Burden Hours

There is a consensus among PCOs that the burden hours for the development and HPSA application process has increased in recent years. In addition, burden hours are complicated by the need for frequent new PCO staff training, policy manual review, documentation, and coordinating verifying documentation with project officers. For example, an annual PCO workforce assessment conducted by the Association of State and Territorial Health Officials finds that approximately half of PCO staff have under three years' experience and have not yet completed a full PCO cooperative agreement cycle, demonstrating the need for time spent on staff training and onboarding.

Burden hours are program and state dependent. It was noted that Geographic applications with insufficient capacity, correctional, mental health and other facility applications, auto HPSAs, areas with higher numbers of practicing providers, urban, and subcounty HPSAs require additional time to develop a supporting argument and upload into SDMS. It is difficult to estimate the time required for planning and entry due to the fluid nature of the work. Time burdens for both development and entry ranged from 12 hours to 8 weeks. Some special circumstances can require months of work. Additionally, some states require internal or board approval prior to work submission.

The system updates and requirements have created strain for some states that are unable to financially support additional PCO employees. States report the highest time burden of shortage designation related projects consist of:

- Developing and justifying Rational Service Areas (RSA).
- Developing the State Rational Service Area Plan (SRSA).
- Development, production and distribution of the PCNA.

Improvements

States had a variety of suggestions for ways to improve the shortage designation program.

- Prepopulate some data that the PCOs provide including SAMHSA alcohol and substance use prevalence or water fluoridation data.
- Connect UDS reports to SDMS to automatically update provider records and/or the percentages of special populations served by provider addresses if they are working at a FQHC/LAL.

- Ensure more reliable source provider data from CMS.
- Standardize data of homeless populations.
- Ensure more accuracy for Medicaid populations, including ways that Medicaid data could be automatically included within SDMS.
- Utilize American Medical Association location data.
- Reduce instances of provider data pulls that require PCO interventions (geocoding, missing disciplines).
- Allow a single state PCO to update hours and address details when a provider is listed in multiple state locations. Currently, PCOs must collaborate with other states, requiring both states to update a provider, increasing time burden.
- Collaborate with the National Health Service Corps (NHSC) to obtain provider information when sites apply or recertify for NHSC site designation.
- Improve systems within SDMS for planning, such as including provider FTEs or ratios for each type prior to selection of HPSA type.
- Decrease the complexity of SDMS.
- Change NPPES policy to require clinicians to report their clinical address rather than where they can be contacted by mail. Additional enhancements include other contact information such as email or phone to assist in clarifying information.
- Include PCOs in ongoing user testing.
- Update Shortage Designation policy to prevent Geographic and Low-Income dually eligible designations from working against each other in Primary Care and Mental Health disciplines. Communities must decide between retention of physicians (through the bonus program) with lower scoring or Low-Income designations that encourage NHSC participation.
- Reduce system delays, long loading screens, and frequent page time-outs.
- Have HRSA collaborate with CMS on importing data so that accurately verified data obtained by the PCO can be utilized by more agencies.
- Determine ways PCOs can address shortages in low population areas.
- Consider changing methodology to allow service areas to include populations below 500.
- Include all demographic data that can be used to assess HPSA and MUA/MUP designations in the SDMS Informational Mapping Tool.
- Add the ability to pull updated provider lists and service area breakdowns for Auto-HPSA rescores submitted between National Shortage Designation Updates (NSDUs).
- Create an automated PCO alert when a provider moves out of their state.
- Including provider license expiration dates in SDMS.
- Assist the Shortage Designation Branch (SDB) staff workload by reducing the number of review levels required for approval (currently 3 levels are required).
- Consider the removal of the required 30-day public comment wait periods for shortage designation applications and updates.

- Consider mid-level providers with separate scoring for physicians. It should be noted that PCOs could not implement this change with current funding, staffing or processes. The time burden would be estimated to at least triple or more from current workloads.
- If modernization of MUA/MUP methodology is considered, include other health outcomes that influence Primary Care beyond low birth rate calculations.
- Continue maintenance of federal databases used in HPSA determinations.
- Provide additional support targeted to healthcare clinician surveying and data management.
- Complete desk audits with PCO staff in a range of states and designation types to understand the time burdens and challenges faced.

Community Engagement

The PCOs are in a unique position as healthcare workforce experts in their states. PCO staff provide accurate data through the development and maintenance of relationships within state communities. Due to the number of possible designations, PCOs must engage and analyze communities to determine which type will best assist to improve health outcomes in that community. Time estimates vary on the rurality of the community, public health needs, and natural disaster recovery needs. Some encounters can require 20 minutes, while others require multiple meeting times and discussions, leading to hours of input. Those community relationships require soft skills and knowledge that need to exist outside of any technological updates to make lasting impacts.

Technology

States report using a variety of programs including Excel, Access, GIS, Strata, R, program management software, REDCAP, and in-house applications to support shortage designation work. PCOs often collaborate to determine best practices, reduce time burdens and increase efficiency. There is concern that some automated advances will increase the number of inaccurate evaluations of and delay processing. On behalf of the PCO National Committee, we encourage HRSA to include the PCOs in changes and decision-making processes so that together we can continue to work towards improving healthcare access.