



## Introduction

### Background

The Tribes of Montana and Wyoming, in partnership with The Billings Area Office of the Indian Health Service, and The Urban Programs contained within the geographical boundaries of the Billings Area Office, have engaged in a comprehensive planning process to define the Health Care needs of their populations, and their capacity to provide for that care. This plan will examine the scope of staff, facilities and contract health dollars needed across the Area to 2015. The plan will be built up from the community based needs level, and will clearly delineate the services and resources necessary at four levels of consideration, the Primary Service Area, Service Unit, Tertiary Referral Partnerships, and the Area as a whole. The determination of these levels of care came from Tribal Representatives and IHS Staff who worked on the Workgroup, and many other participants who attended and participated in meetings held during the multiple site visits to the Service Areas and Service Units from November of 2002 through August of 2003.

At the First Workgroup kick-Off meeting held in Billings, Montana on Oct 30, 2002, the Workgroup identified the Project Problem:

There is a need to:

- Define and establish primary care, specialty service and support service needs and resources throughout the Billings IHS office area.
- Define existing shortcomings in resources within the area
- Create a comprehensive definition of new and expanded services and facilities for each community served in the Billings IHS office area
- Create and define each community's relationship to the larger service network

This problem was originally set against a backdrop of a 19.96% growth rate, an increase of 14,126 users from a base of 70,779 in 1997 to a predicted 84,905 in the year 2012. The Area Analysis reflects this first understanding and as such is a document representing a "point in time" perspective during the master planning process. This was later updated after further analysis and a projection year change to 2015. This update reflects a revised 16.31% growth rate, an increase of 12,625 users from a base of 77,444 in 2001 to a predicted 92,380 in the year 2015. These figures include Rocky Boy's, a service unit not studied as part of the process. Without Rocky Boy's the 2001 user population is 73,107 while the projected 2015 number is 86,613.

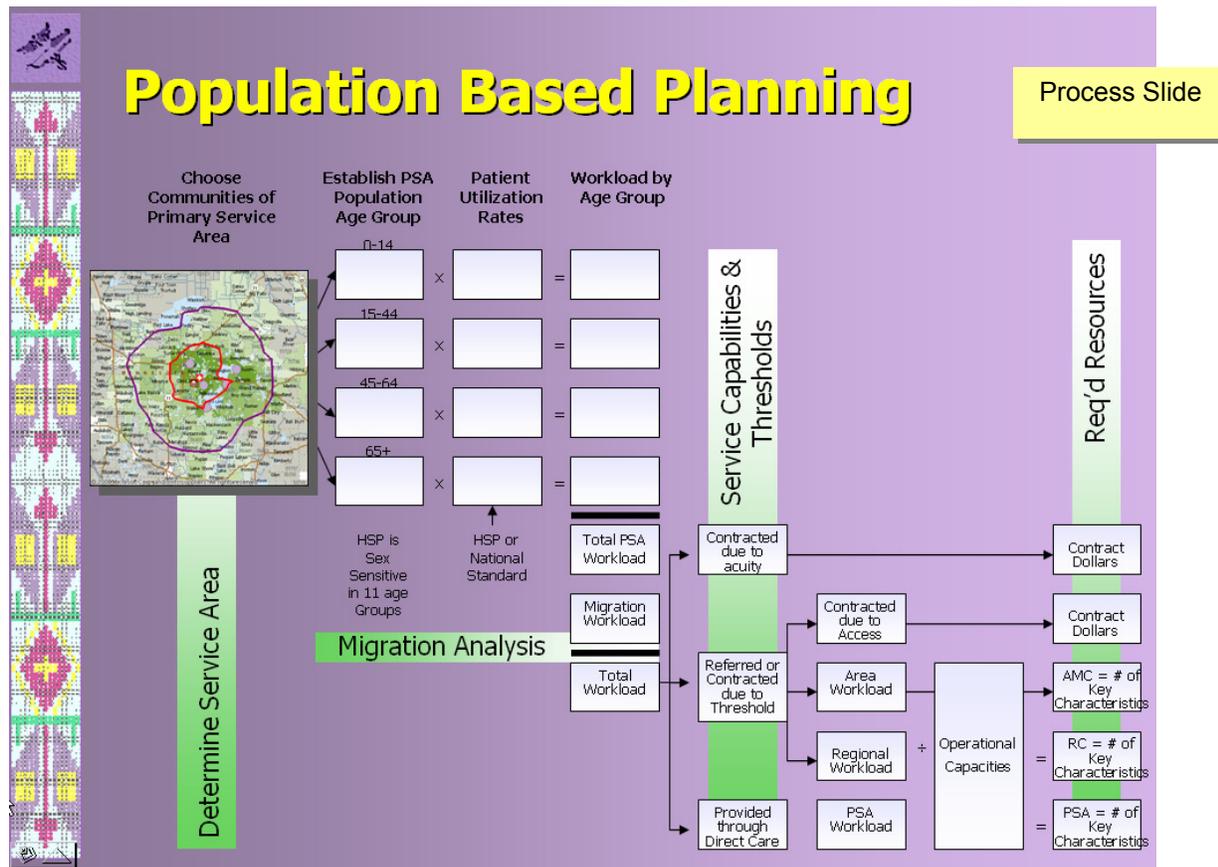
Further, the Workgroup established the following goals for the Master Plan:

- Service Delivery Improvement
- Focus on the Problem
- System Integrated Services- Area Wide
- Development of a Shared Vision/Direction
- Identify What's Important/Priorities
- Expand Direct Care Services through Partnerships
- Identify Shortcomings- Now vs. Needed
- Quantification of Contract Health Dollars
- Stakeholder Coordination



## Methodology

This report represents the final step of a four-step process in the quantification of your comprehensive health care system and involves the final shaping of the Direct Care System at the Primary, Tertiary Referral Partnership, and Area-wide level with regard to accessing care and service distribution.



The project was initiated at a meeting, October 30, 2002. The process was reviewed, the site visit schedule finalized, the questionnaire content overviewed and initial conversations regarding priorities conducted. Site visits were held in November and December for the purpose of questionnaire completion, data review, and to allow The Innova Group to experience and understand each Service Area, Service Unit and Urban Program.

The January 23, 2002 meeting, or first step, ensured we understood:

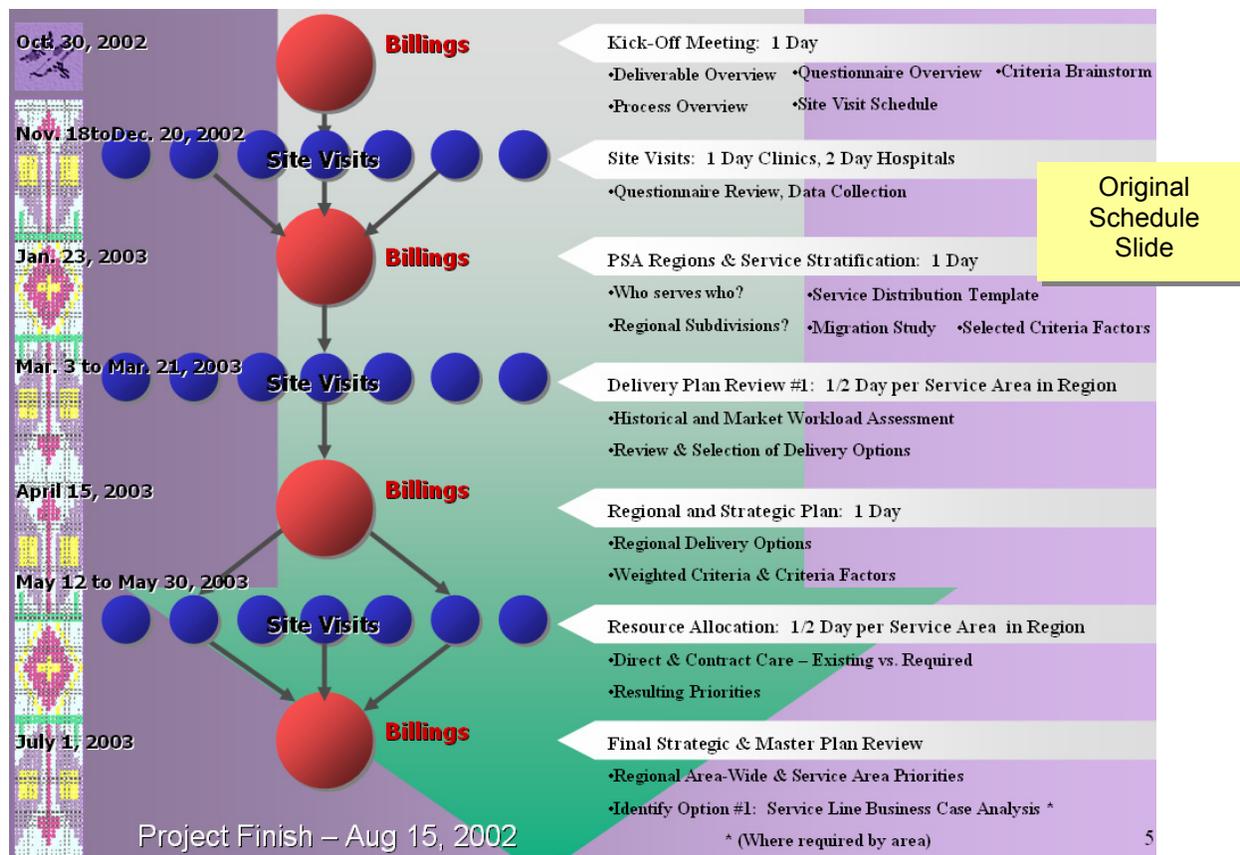
- Which communities are located in what Primary Service Area (PSA)
- What migration or crossover rates between Service Areas are appropriate for planning
- What are possible Regional Service Areas
- What are appropriate access standards for each service
- What criteria factors should be used to initiate prioritization

The conclusions from this meeting can be found in the Area Analysis portion of this deliverable. These are also included in the first report, already in your possession, as is the data collected in our site visits and questionnaires that were used in our analysis. As already mentioned, this part of the overall document is a snapshot in time understanding and as such is not revised. It was the Innova Group's first



understanding of general needs within the Billings Area. Necessary revisions occur in the Master Plan Summary and all pursuant roll-ups representing full PSA delivery planning decisions.

We learned at this meeting that there was great concern regarding regions and regional delivery of care, so we shifted our emphasis from regional delivery to creating Tertiary Referral Partnerships, where combined Service Units utilizing the same providers for Secondary and Tertiary Care could possibly take advantage of the market value of a greater number of covered lives to gain leverage on providers to the benefit of the Native American population, both in terms of finances as well as culturally appropriate and more culturally sensitive care and service.



In March and April of 2003, we conducted more site visits, the second step of our process. On these site visits we went over historical workloads and Market assessments and then reviewed and determined Delivery Plans for the Service Areas, Service Units, and Urban Programs. These meetings involved initial population based market projections by product line. Through this projection, the resources required to meet this projection; the availability of alternative care, and discussions with leadership at the Tribes and Service Units, a specific service delivery plan was evolved. This view of the health care system was from the community level.

On April 30, 2003, we met again in Billings as the workgroup, the third step, and went through the final determination of criteria and assigned weight to each component of the criteria (factors) selected to be used for prioritization; identified and agreed on Tertiary Referral Partnerships; and in a conceptual basis identified services to be studied for possibly sharing resources for both these partnerships as well as the Area as a whole. Visiting Professional partnerships were a large component of these discussions.

Another round of site visits were held in May and June to go over resource allocation options with Service Area, Service Unit, and Urban Program leadership, both Tribal and IHS. At these meetings, a



comparison of required resources to existing resources was identified at the PSA level and the PSA's own resource priorities were revisited and established. This comparison coupled with the prioritization criteria and the issues identified by the local Service area Leadership during the multiple site visits provides a solid picture of needs for consideration and prioritization over the ten year plan.

The final meeting was held in Billings September 17, 2003. The area work group discussed all summarized material, area-wide priorities and implementation. The master plan pre-final detailed services to provided at each PSA as well as providing an area-wide snapshot of services, new and existing, for each service area. Area wide prioritization results were also analyzed and interpreted. The group voiced feelings, understandings and concerns with the pre-final master plan findings. With the workgroups final comments, the document is now completed for publication and distribution.

## Master Plan Final Revisions

### *Projection Year*

Following the pre-final meeting, and at the request of the Billings Area Office, The Innova Group extended the master plan projection year from 2012 to 2015. All service area plans were updated to reflect the additional 3 years and resultant understandings. Changes resulting from those additional years were rolled up into the Master Plan Summary findings.

### *Diabetes Impact*

The Innova Group also finished a Diabetes impact analysis and applied the findings to all PSA delivery plans for the Billings Area. The process and resulting metrics for this study are detailed in Appendix G. This appendix explains the analysis process and identifies which service lines are affected. Relevant workloads are identified for the total Billings Area and the diabetes impact per service line is calculated in the detail sheets that follow. Each impact is stated in terms of a ratio by population growth (ex: "for every 1% in population growth the workload will go up \_ %"). The impacted service lines are identified by red font in each PSA's market assessment pages.

## Wrap-Up

The Master Plan presented on the following pages, starts at the community level and builds. This development of needs has considered Tribal and IHS input, historical and national norms of patient utilization and productive models of health care delivery. The proposed system has been viewed from the community level as well as at the Tertiary Referral Partnership and Area-wide level. It is a plan built on age sensitive projection of population and the user's historical tendency to crossover for care to other centers of greater specialization and market activity. It provides a framework for local organizations and Service Areas and Urban Programs to guide their own resource allocation, showing needs as well as establishing local priorities. It has the potential to create leverage for combined Service Units to go to the Market for Secondary and Tertiary care, commanding greater respect for the Native American patient. It also provides the Master Plan Workgroup with a ranking system which de-politicizes what community needs should be prioritized. This ranking system allows for groupthink, based on the criteria established by the workgroup. One of the goals, met by this exercise, has been to document needs for the Billings Area Office of the Indian Health Service and provide for their resolution.

This project has involved the people on the following pages and has brought together both IHS and Tribal and Urban Program Leaders to establish and share goals and priorities for their communities.



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The table below lists the points of contact for each of the twenty-four Service Areas involved in the development of the Billings Area Health Services Master Plan.

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## Glossary of Terms

The Master Planning process is an extensive multi-month process that employs its own terminology, one not always known to all document users or process participants. The terms below are defined in an attempt to give some help in understanding how these terms are generally used, verbally as well as within the deliverable documents.

Additional Services.....	Medical or Health Care support services offered that are typically not provided for by IHS. These services are usually tribal and hold no IHS supported planning metrics or thresholds.
Alternative Care .....	Alternative rural or urban hospitals within 90 miles of a Primary Service Area. These are profiled in the first phase of the Master Planning process as part of the PSA deliverable.
Area.....	The IHS consists of 12 large geographic and/or tribally organized administrative units responsible for the planning and provision of health care within each of their Service Units.
CHS.....	Contract Health Services. Health Care services that must be purchased from Non-IHS providers, based upon threshold issues or high acuity. These are generally facility and professional services of greater scope and intensity than are available through IHS facilities and providers.
CHSDA.....	Counties defined all or in part as the Contract Health Services Delivery Area. To receive CHS payment for needed services outside of the IHS delivery system, a Native American must reside within this area.
Crossover .....	(See also "Migration"). The natural tendency for some people to crossover/ migrate outside their area for health care. <i>Negative or "Out" crossover/migrate:</i> service areas where more visits from their user population seek care elsewhere, than where other service area user populations seek care at their facility. <i>Positive or "In" crossover/migrate:</i> where more other service area user populations seek care at their facility service areas than where their service area user populations seek care elsewhere.
Deliverable .....	A specific planned report from The Innova Group given to the Master Planning workgroup, Area Office and/or PSA. These are published in a small number of binders as well as on the web for PSA download and printing as needed.
Defining Characteristic.....	The recognized significant component of a discipline's ability to deliver care (e.g.: physician, radiology room).
Discipline .....	A specific medical specialty (e.g.: primary care, dentistry or radiology).
Existing Delivery System.....	A table of medical services presently offered by access distance.



- HSP ..... Health Systems Planning process software. The computer application that manages the IHS tool for the planning, programming and design of health facilities.
- Historical Workload Analysis..... The past workload generated by a PSA’s communities. This workload reflects an average number over a 3 year period by service line. It is not countable for CHS purposes when the payor is a third party. This measure is typically visits but varies by service.
- IHS ..... The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes.
- Justification ..... Used within the context of whether or not workload, criteria and market assessment “justify” the placement of resources or services at an identified location.
- Market Assessment..... A part of the Delivery Plan report wherein a PSA’s historical 3 year workload is compared to the United States National Average (USNA) workload understanding for an identical non-native population number, and the HSP understanding of expected workload for an identical native population number. The largest of these three is typically carried forward to the Delivery Plan as a planning assumption.
- Market Share..... The percentage of the user population from a specific community that is expected to be served at a facility for a specific discipline.
- Migration..... (See also “Crossover”). The natural tendency for some people to crossover/ migrate outside their area for health care. *Negative or “Out” crossover/migrate:* service areas where more visits from their user population seek care elsewhere, than where other service area user populations seek care at their facility. *Positive or “In” crossover/migrate:* where more other service area user populations seek care at their facility service areas than where their service area user populations seek care elsewhere.
- .....
- Patient Utilization Rates ..... The annual health care demand a single patient has for a discipline.
- Payor Profile..... An analysis of the payor mix for a Service Area, typically focusing on Medicare, Medicaid, Veterans and other third party payors that may or may not affect the Service Area’s ability to raise third party billing thereby increasing revenue.
- Primary Care Service Area ..... A group of communities and its population for which, at a minimum, the primary care disciplines are being planned and resourced. Referred to as the PSA.



- RRM ..... Resource Requirements Methodology: The IHS staffing methodology.
- Regionalization/Referral Partners ..... The grouping of workload from different PSAs for the purpose of stretching resources and improving access. A region may be as simple as a referral pattern among facilities creating effective leverage to purchase commonly needed services, or it may be a facility where on site resources are justified and can be offered to one or more PSAs thereby stretching CHS dollars.
- RPMS ..... Registered Patient Management System: the IHS standard Patient record system that forms the data basis for the master planning process.
- Resource Allocation ..... Analysis that follows the Delivery Planning phase. This focuses on the capacities exceeded by Delivery planning decisions, documenting shortfall and need. Resource deficiencies identified and documented include providers, rooms, staff, square feet, and CHS dollars.
- Service Area..... The communities and its population intended to be supported by a specific discipline’s resources.
- Service Delivery Plan ..... Analysis that follows the Regional Analysis and Services Stratification Report. This plan is final component of a report that includes the historical workload and market assessment pieces as well. The Delivery Plan assigns a projected workload assumption to a specific delivery option for approximately 120 service lines. Options typically include one of the following: delivery on-site, delivery through a Visiting Professional on-site, purchase care through CHS dollars, referral to the Service Unit for consideration, referral to the Region for consideration, or referral to the Area for consideration.
- Service Access Distribution Template ..... A table of medical services, either desired or planned, detailing services offered by access distance.
- Service Population ..... The IHS understanding of the number of Native Americans living within a county which may or may not be users. Census based and projected into the future. Primarily used for growth projection and market opportunities.
- Service Unit..... An administrative unit overseeing the delivery of health care to a specific geographic area. May consist of one or more facilities, Service Areas, or PSAs.
- Threshold ..... The minimum workload and/or remoteness necessary to justify the provision of a specific discipline.
- Travel Distance ..... The distance a User has to travel from his home to a facility to receive care.
- User ..... A Native American that has received or registered to receive health care in the past three years.
- User Population..... The number of Active Indian Registrants in the health care system from a specified area.



## Small Ambulatory Care Criteria

In order to provide consistent appropriate health care to remote Native American communities, the Indian Health Service relies on a number of standard tools to distribute resources based on a community's population and medical workload. The standard tools, the Resource Requirements Methodology (RRM) and the Health System Planning software (HSP) do not adequately address communities of less than 4,400 primary care provider visits (PCPVs). Typically this is a population of approximately 1320 Active Users.

The Small Ambulatory Care Criteria was developed as a means of understanding and planning for needs in such communities as mentioned above. Most maps in this Master Planning document utilize a population number threshold based upon the Small Ambulatory Care Criteria developed by IHS. The numbers relate directly to typical delivery systems ranging from a Small Health Clinic down to a Health Location. The table below identifies the significance of each number and what facility might be justified for consideration at such a level.

User Population	Facility	Staffing & Service Concept
900-1319	Small Health Clinic	A Physician utilized between 70 – 100%. Two Dentists or a Dentist and Hygienist at all times
588-900	Large Health Station	Minimal facility to allow One full time dentist work with a medical provider 3 days a week.
256-587	Medium Health Station	Minimal facility that allows dentist to work 4 days a week and medical provider 2.5 days/week. One full time Public Health Nurse and Contract Health Clerk.
138-275	Small Health Station	Minimal facility that allows dentist to work 3 days a week and medical provider 2 days/week
0-137	Health Location	Minimal facility with visiting providers less than one day per week.

*Note: Other criteria must be applied to justify consideration for a small ambulatory care facility. Standard planning scenarios would apply to populations greater than represented in the table above.*