



A Severe Shortfall

California American Indian/Alaska Natives experience a severe shortfall in secondary care, most often provided through referrals to the private sector for inpatient and specialty care. This is a hardship to an already challenged population.

California IHS presents this study supporting two Regional Ambulatory Surgical & Specialty Centers for American Indian/Alaska Natives as a strategy for improving access to documented and needed secondary care, closing the Level of Need Funding (LNF) shortfall by as much as 39.8 percentage basis points, and providing a path for IHS to demonstrate its ability to build and operate culturally appropriate healthcare facilities.

A Regional Solution

This study suggests that two Regional Ambulatory Surgical & Specialty Centers, owned/operated by IHS, providing culturally-appropriate care, are the best solution, potentially increasing California Area's LNF from 54% to 93.8%:

- One facility centrally located for the central/northern region, such as Sacramento, to serve the referral needs of central and northern California tribal governments (300,715 square feet with 774 employees). *(See Concept of Operation page 93)*
- One facility centrally located in agreement with southern California tribal governments, such as Temecula, to serve the referral needs of the federally recognized tribes in southern California (119,369 building gross square feet with 269 FTE). *(See Concept of Operation page 93)*

Each would provide an enhanced level of secondary healthcare for American Indian/Alaska Natives residing in California, including Medical & Surgical Specialty, Surgery, advanced Diagnostic Imaging, and Acute care, to name a few. Total project cost for both locations is estimated at \$253.5m. The annual operating cost for both locations is estimated at \$134.6m.

An Enhanced Level of Healthcare

These two Regional Ambulatory Surgical & Specialty Centers would enhance the level of healthcare for American Indian/Alaska Natives residing in California in at least five important ways.

1. ***First, these facilities would provide statewide access to needed healthcare.*** Appropriate locations for regional care in the north/central and southern parts of California would provide reasonable travel time to access consistent secondary care. The alternative, creating agreements with local hospitals, would result in inconsistent access and care for many tribal healthcare programs. *(See Concept of Operation page 90)*
2. ***Second, secondary services currently not accessible, but sponsored by IHS in other IHS areas, would be available.*** Other IHS areas have access to the levels of regional care identified in this study (examples include Phoenix Indian Medical Center in the Phoenix Area, Gallup Indian



Medical Center in the Navajo Area, and Alaska Native Medical Center in the Alaska Area). Such facilities in California would not only help eliminate current gaps in the continuum of care for American Indian/Alaska Natives residing in California, but increase the level of access and presence of direct care services to what is currently available in other IHS areas.

3. **Third, healthcare in a culturally-appropriate environment would be rendered.** The provision of secondary care through contracts with local hospitals fails to address the need for cultural awareness. Providing needed services in a culturally appropriate environment will help raise the health of California American Indian/Alaska Natives to the highest possible level.
4. **Fourth, they would make limited Contract Health Services funding more available for higher levels of acute care.** Providing direct secondary care at regional centers allows local health programs to spend limited Contract Health Services dollars on other care that must be secured from the private sector, stretching those dollars while increasing access to higher level care.
5. **Fifth, these facilities could close the disparity gap in Level of Need Funded.** The 2010 national Level of Need Funding (LNF) benchmark is \$3,510 per-user. California's present LNF is \$1,895 per user, or 54% of the benchmark. The projected value of secondary care satisfied by these regional centers would significantly reduce the existing gap in LNF from 46% to 6.2%, a reduction of 39.8 percentage basis points. This represents an increase in LNF from \$1,895 per-user to \$3,294 per-user for American Indian/Alaska Natives residing in California, an additional \$1,399 per-user for a projected 2025 area-wide user population of 102,745.

This LNF impact is calculated by relating total anticipated operational costs (operations plus depreciation) to the projected California Area user population to produce a per-user dollar value. This value reflects the LNF investment IHS is being asked to make in healthcare delivery for American Indian/Alaska Natives residing in California. This value also approximates the market cost of all referred healthcare demand projected to be satisfied at two Regional Ambulatory Surgical & Specialty Centers. (See *Concept of Operation* page 83)

A Forward Path

This study provides the concept, requirements, and guiding assumptions to begin the process of bringing Regional Care from recommendation to reality in improving health outcomes of American Indian/Alaska Natives residing in California to the highest possible level. Implementation requires active IHS/Tribal involvement and the following steps:

- Tribal and IHS adoption of this report
- IHS support in review and consideration of additional planning documentation
 - Comprehensive financial/revenue analysis
 - Competitor and risk analysis
 - Potential site availability and costs
- Support from the California tribal governments for the development of planning and project approval documentation, design, construction, and staffing.

Where Would Regional Care Be Located? What Services Would Be Offered?

One inpatient facility centrally located for the central/northern region, such as Sacramento, to serve the referral needs of central and northern California tribal governments. The facility would be sized at 300,715 building gross square feet and require a staff of 774 FTE. And one inpatient facility centrally located in agreement with southern California tribal governments, such as Temecula, to serve the referral needs of the federally recognized tribes in southern California. The facility would be sized at 119,369 building gross square feet and require a staff of 269 FTE.

The Level of Care would vary at each facility because each would serve a different numbers of users. Sacramento is planned for about 75,000 potential users. Temecula is planned for about 27,000 potential users. Remember, more users

The Key Characteristic, or KC, is the single most important element in delivering a line of care. It is used for planning purposes. Examples include: Providers, Dentists, Imaging Rooms, Inpatient Beds, etc.	2 Regional Centers					
	Temecula		Sacramento			
	# of Key Characteristics	Department Gross Square Feet	# of Key Characteristics	Department Gross Square Feet		
Ambulatory						
Audiology (Audiologist)	1.5	872	3.9	3,148		
Dental Care - Specialty Only ¹ (Chairs)	5.6	8,553	14.5	22,284		
¹ Includes Pediatric, Endodontics, Orthodontics, Prosthodontics, Periodontics, Maxiofacial						
Specialty Care						
Medical Specialties (Providers)						
Cardiologists	0.0	9,052	2.4	27,907		
Dermatologists	0.0		1.8			
Neurologists	0.0		1.2			
Other Medical Specialists ²	4.0		11.3			
² Includes Endocrinologist, Nephrologist, Allergist, Gerontologist, Rheumatologist, Gastroenterologist, Oncologist, Neurosurgeon, Pulmonologist, etc.						
Surgical Specialties (Providers)						
General Surgeons	0.0	9,052	3.1	27,907		
Ophthalmologists	0.0		3.5			
Orthopedists	1.3		3.8			
Otolaryngologists	0.0		1.8			
Urologists	0.0		1.4			
Other Surgical Specialists ³	0.9		2.4			
³ Includes Thoracic, Plastic, Vascular, etc.						
Ancillary						
Outpatient Endoscopy (Suites)	0.0	9,286	2.0	20,502		
Outpatient Surgery Cases (OP ORs)	3.0		7.0			
Short Stay / Observation (Beds)	1.0		1.0			
Laboratory (FTE)	3.0	2,158	16.0	4,187		
Diagnostic Imaging						
Radiography (Rooms)	2.0	6,862	6.0	16,049		
Fluoroscopy (Rooms)	1.0		2.0			
Ultrasound (Rooms)	1.0		3.0			
Mammography (Rooms)	1.0		3.0			
CT (Rooms)	1.0		2.0			
MRI (Rooms)	0.0		1.0			
Radiologist	1.7		5.1			
Pharmacy (Pharmacists)	4.5	2,400	20.8	9,115		
Inpatient Care						
Pediatric (Beds)	2.6	13,627	7.3	43,131		
Adult Medical (Beds)	15.7		41.6			
Adult Surgical (Beds)	7.0		31.2			
ICU (Beds)	4.4	2,357	12.9	6,932		
Physical Rehab Services						
Occupational Therapist	2.0	938	5.4	2,537		
Speech Pathologist	0.5		1.3			
Behavioral Health						
Psychiatry (Psychiatrists)	1.5	681	4.0	1,398		
Other Programs						
Case Management (FTE's)	8.6	1,638	22.9	4,335		
Pain Management (Specialists)	0.6	911	1.5	2,422		
Summary						
Full Time Equivalent Employees	269		774			
Building Gross Square Feet	119,369		300,715			

Cost

Total Project Cost for Regional Ambulatory Center development in two locations is estimated at \$253.5m.

The Annual Operating Cost for Regional Ambulatory Center development in two locations is estimated at \$134.6m.

Impact...

The Level of Need Funded (LNF) could improve from 54% to 93.8%, closing the gap toward the Federal Benchmark by 39.8 % basis points. This represents a projected increase from \$1,895 per-user to \$3,294, or an additional \$1,399 per user toward the Federal Benchmark of \$3,510.

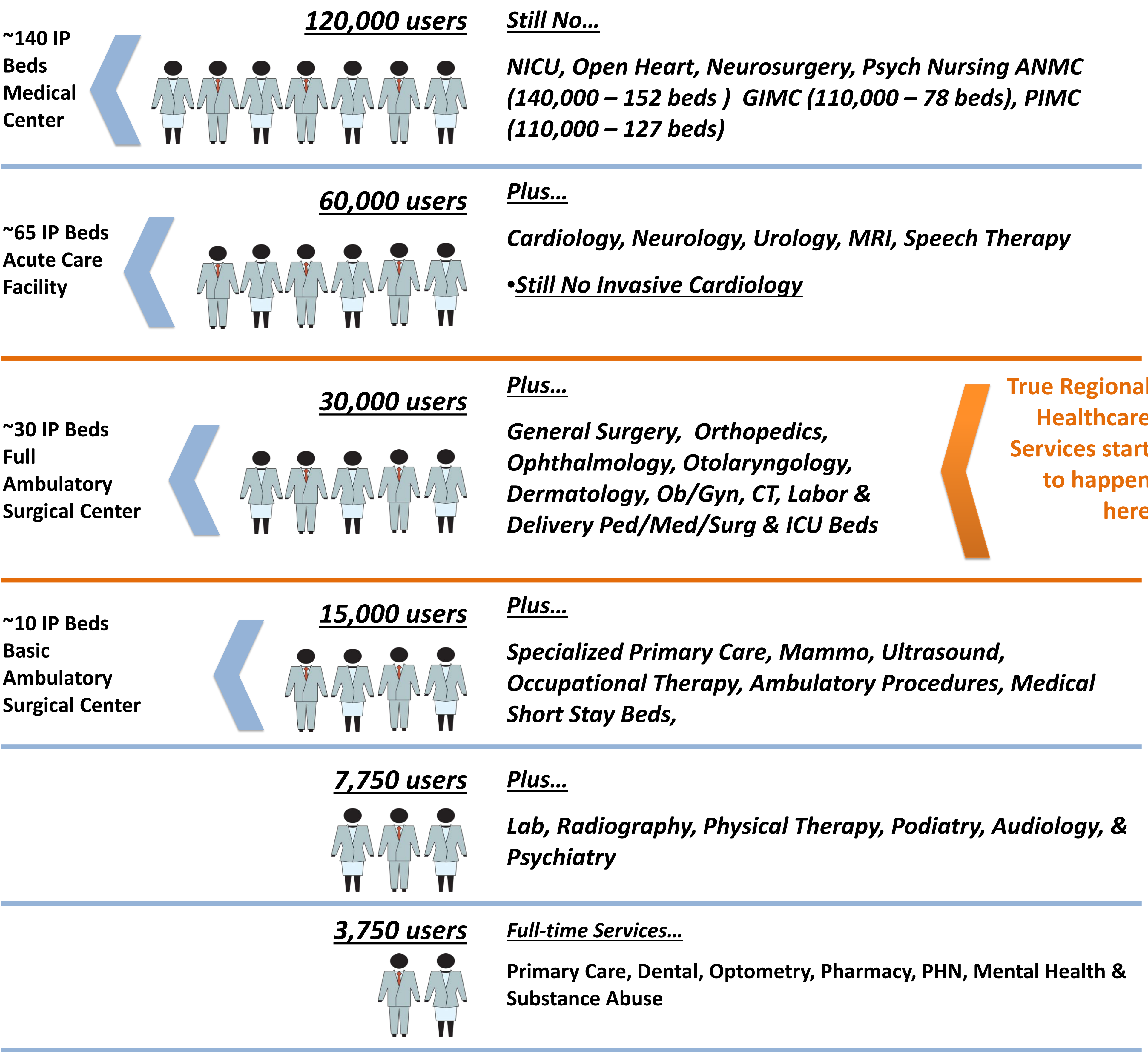
The LNF increase is based on a projected 2025 area-wide user population of 102,745 (or a projected regional user population

Population Matters!

More People = More Regional Services.

Increasing population generates increased services. The graphic illustrates how services grow relative to an increasing user population. The kinds of services most desirable by American Indian/Alaska Natives who reside in California require a user population of 30,000 or more.

It is desirable to place required healthcare as close to the user population as possible. In regional healthcare, this is difficult since 30,000 users represents about one-third of California’s total user population. Further complicating this is the fact that user population is not evenly distributed across the state. Consequently, locating Regional Care requires a balancing act. Distribution of services, while desirable, diminishes the level of healthcare sustainable because fewer populations are clustered or grouped for healthcare. Consolidation of services, while undesirable, increases the level of healthcare sustainable because greater population is clustered or grouped for healthcare. The Study suggests two points of Regional



Who Would Go Where?

Various access times for regional healthcare were evaluated, ranging from two to four hours. Unfortunately, some service areas will always face considerable travel times for regional healthcare (3+ hours). Many currently face similar travel times for secondary healthcare, and still must pay for that care (personal funds or Contract Health Services). Though such travel time is not desirable, covered healthcare at the time of arrival represents an improvement over the present situation.

The table below shows how each Regional Center is supported by a corresponding population grouping. A travel time of 3 hours was assumed. Service Areas within that travel time are shaded green. Service Areas beyond that travel time are shaded rose. Populations shown are "current" - taken from the 2011 Health Systems Planning Software user count.

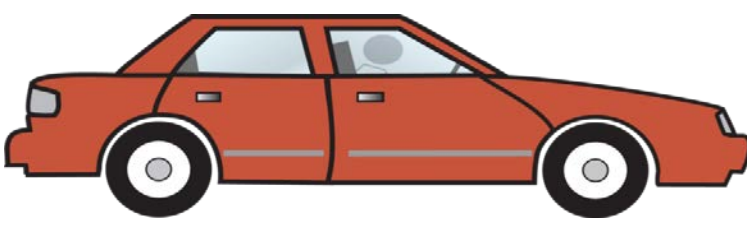
Sacramento?

Service Areas Assumed Would Travel to Sacramento Area (Market Share Would Vary)			
Central Valley	4,737	Hoopa	2,850
Chapa De	6,576	Karuk	1,931
Chicken Ranch	28	Round Valley	1,199
Colusa IHCC	129	Toiyabe	2,790
Consolidated	2,806	Tule River	2,576
Feather River	4,751	United Indian Health Svc	7,898
Lake County	2,090	Warner Mountain	126
MACT	1,915	Greenville Rancheria	1,204
Northern Valley	2,309	Modoc	190
Redding Rancheria	3,609	Pit River	916
Shingle Springs	1,112	Quartz Valley	211
Sonoma County	5,248	Susanville Rancheria	1,073
Table Mountain	5		
Tuolumne Me-Wuk	231		
Service Areas within Travel Time		Service Areas beyond Travel Time	

Temecula?

Service Areas Assumed Would Travel to Temecula Area (Market Share Would Vary)			
Cabazon Band	7	Santa Ynez	988
Indian Health Council	4,691		
Riverside/San Bernardino	13,391		
Southern IHC	2,725		
Sycuan Band	126		
Tejon Tribe	372		
Service Areas within Travel Time		Service Areas beyond Travel Time	

How Far Do You Drive?



And... How Far Would You Travel for Needed Secondary Care in a Culturally Appropriate Setting where Cost is not a Barrier?		
<i>“Over the last four decades the typical American household acquired more vehicles, more drivers, and more workers.”</i>	Vehicles Per Household	1.86
	Miles Travelled Per Household	33,004
	Daily Miles Travelled Per Household	90.24
	Annual Household Miles Travelled for Getting To/From Work & Related	8,334
	Annual Household Miles Travelled for Social and Recreational Activities	9,998
<i>2009 National Household Travel Survey</i>		