



Priorities

Intentionally Blank



Priorities

Overview

Resources for capital and operational expenditures are consistently limited. Clear priorities are necessary for the development of a reasonable, supportable and attainable master plan. Clear priorities are arrived at through the consistent application of mutually agreed upon criteria reflecting the concerns and support of all interested parties whom the master plan will impact. For the Tucson Area, these priorities will have to be developed based on the Health Services Master Plan Work Group's developed objective criteria.

Kickoff Meeting – December 16, 2003 & Supplemental Kickoff Meeting – January 9, 2004

In order to put the project in its present context, the Work Group was asked to identify the strengths and weaknesses of the Tucson Area as it exists today. The following items were identified.

Strengths

- Provides broad range of health screenings
- Most Specialties
- (Global) Wide range of Services
- Health Care Disciplines
- Relative Small size of system & components
- Has accessible path between Service Unit and Area
- Health priorities identified by Tribes
- Area responsive to Tribal request
- Tribal commitment for a long-term solution
- Groups willing to talk to each other – IHS, TON, PYT, ITC
- Service Unit willingness to improve health facilities
- High Quality Medical Care
- Scheduled clinic visits and notification of appointments
- Cheerful greetings from the lab staff
- Good relation with my Primary Doctor
- Proximity to Tucson
- Close to area hospitals
- Access to acute care
- Location of facilities (access to care)
- Access to most healthcare services
- Location of facilities (health care)
- Prevention (improving)
- Training is accessible
- Access to gaming revenues
- Technical assistance for infrastructure development
- Positive resource in community planning/development
- Technical IM expertise
- Dedication of employees
- Dedicated Staff
- Specialize Medical Care (referral to Tucson)
- Development of diverse health Care Services
- (Mobil) Eye Program
- Improvements in Optometry
- Pre-natal
- Eye Programs
- Pharmacy
- In-patient Care
- Dietary Changes made to fit diabetics
- Quality Health Professionals
- Health Care Providers that are dedicated
- Dedication of Staff
- Good Area Relationships
- Tribal Partnerships that facilitate delivery of care
- Tribal & IHS work well together
- Tribe to share same database with IHS
- Health Information System (RPMS)
- Location
- Distance (closer to some)
- Health Care providers willing to relocate and come to the Nation
- Have local health facilities
- We have our own area
- Emergency Service
- Attempts to accomplish mission with resources & infrastructure available
- Commitment to serve the target population
- Transport Services to off Nation Health Care Providers



Weaknesses

- Staff have too many hats – so, some are dropped
- Lack of nursing leadership at area level
- Lack of case management staff for chronic dx
- Fragment, inadequate funding of system
- Too few \$\$ for needs
- Lack of funding for capital improve
- Lack of building space, funds
- Poor pursuit and use of alternate fund sources
- Lack of funding
- Hours of clinics vs. hours @ hospital (barrier to health care after duty day)
- Lack of alternative medicine
- Size of service area (stretch of infrastructure for huge area)
- Old, decrepit facilities
- Old IHS facilities
- Age of facilities
- Condition of facilities & building equipment
- Not sufficient “space”
- Waiting Room for Adults and Children
- Size of facility (no privacy in consultation and ER)
- Health Program space is not adequate
- Parking and Staff Quarters (# and quality)
- Lack of facility on Reservation
- Podiatry’s office small and crowded. The office is also used for some other services.
- Patient waiting area in clinic is always crowded.
- Waiting to get your lab work done is crowded.
- Primary Doc is sometimes hurried.
- Staffing – Planning
- Limited Staff (funding and qualified staff for remote location)
- Lack of ancillary support staff
- Lack of space and staffing
- Appearance of unequal facility planning
“Why not us? They...”
- Recreation for remote staff
- Communication problems at most levels of the system
- Public perception that IHS/Tribes provide all needed services
- Lack of dental services
- Availability and accessibility of services (e.g. transportation)
- Communication = Tribal/IHS “Us/”Them”
- Lack of strategy & development w/ & between IHS and the Nation
- Human Resources (personnel) does not help hiring process detriment to recruitment
- H.R. Support – creates barriers to addressing personnel issues.
- Health Care system does NOT address entire continuity of care “cradle to grave” (Prevention and Follow-up – CM)
- Need Home Health Nursing program
- Case Management
- No Psychiatric In-Patient Care
- Clinic Visit Wait time too long
- Pharmacy Wait time
- Health Education and Resources
- Prevention Service & Funding
- Lack of Staff due to lack of funding
- Funding – less every year
- Confidentiality
- Lack of privacy
- Quality of Service (i.e. Technology, Delivery, Specialty Areas)
- Appointment System
- Need Staff Housing
- Need Subsidized commuter transportation for employees
- Infrastructure (land, water, etc.)
- Staffing Morale issues
- M & M AHCCCS Updates (even when AHCCCS is obviously NA)
- Inadequate service delivery providers
- Too many clients needing health services
- Availability of Nursing
- Lack of O’odham health care professionals
- Lack of Behavioral Health Services Nursing shortage
- Geographic location
- Remoteness and Access to healthcare
- Distances – affect Transportation, staffing, services, \$, etc.
- Distance = Transportation
- Distance to Hospital or services
- Distance to different clinical sites
- Facilities/funding for addressing diseases of lifestyle
- Inadequate space for services offered
- Facilities outdated and antiquated
- Facilities and layout
- Parking lot needs improvement not enough space
- Lack of space for more services & providers
- Outgrown space
- Need new Hospital



In addition to collecting the Work Group response at the Kickoff Meeting, each Service Area was asked to identify the strengths and weaknesses of their own Service Area. The following responses were collected directly from the questionnaires:

2. What are your strengths in terms of serving your community (service area)?

<p>Pascua Yaqui Health Center</p>	<ul style="list-style-type: none"> • Preventive health, dedicated staff from the community, understand living conditions for tribal members, good council support.
<p>Santa Rosa Health Clinic</p>	<ul style="list-style-type: none"> • Our strengths revolve around our providers. They are some of the most dedicated, caring group of people. There seems to be little turnover and Administration works at keeping them happy. Flexible schedules, bonuses and money for training are good incentives. When the doctors are treated in a professional manner, they tend to take on extra duties.
<p>San Xavier Health Center</p>	<ul style="list-style-type: none"> • Locality and proximity to major urban medical health care facilities. • Culturally sensitive and dedicated staff. • Primary care ambulatory expertise. • Primary, secondary and tertiary diabetes management. • A wide range of ambulatory care services (medical, pharmacy, dental, x-ray, lab, etc.) in one location. • Some TON tribal health care programs in the SXHC. • A health care delivery system that is excellent and utilizes managed care concepts, optimizes alternate resources, is both federally and collection based funded. • Participation with the Tohono O’odham Nation Health Services and San Xavier community based health education activities. • Public Transportation. • <i>Dialysis @ hospital in Sells is contracted.</i> • <i>Public transportation is Rural Transit (a minivan that connects to City Bus Lines). There is tribal transport as well. TIC cooperates in this.</i>
<p>Sells Hospital</p>	<ul style="list-style-type: none"> • Taking San Xavier out of the equation, we are the only other diagnostic radiology department in the entire reservation. • We have low provider staff turn over. • We work well with the Tribal Council and meet with them at least several times a year. We serve on Tribal committees when requested, such as IRB, bioterrorism and new facilities (I.E. nursing home). • We have improved our billing practices and nearly half of all the staff are paid out of collections. • We have some ability for same day appointments and walk in visits at all sites. • One of the Internal Medicine Physicians has an MOA with the Tribe to coordinate with the activities of the Tribal Diabetes Program. He spends about 10-12 hours per week working with the Tribal Health Department. Another staff member works with him in his endeavors of increased diabetes education and diet improvement. • The school health program has three nurse practitioners that are well accepted by the community. These women each cover several schools and we can demonstrate changes in health status due to their efforts. For instance, the teen pregnancy rate has decreased since the program started. Parents are asked permission for the practitioners to work with their children and these slips are kept on file. The records are a part of the regular clinic record for that child. Some major medical problems have been prevented by the early treatment and constant presence of these providers. • Some of the inmates in the jail are there for long periods of time. We work closely with the Tribal TB office to monitor all patients with this diagnosis to be sure they are treated properly and promptly. Service Unit staff goes into the jail to test for these and other infectious diseases. Immunizations are taken into the jail for such disease as flu. Regular jail clinics are held two mornings a week by a physician and nurse. Medications are provided for these prisoners and chronic diseases are monitored and better controlled. • Cardiology clinics are held at two of the outpatient facilities through a contract with the Indian Health Service Cardiology Program at the University of Arizona. • The patient management and follow-up is coordinated by one of the Internal Medicine Physicians on Sells Service Unit staff. She reviews the charts and helps the specialists when they come in for the clinics. A similar arrangement is set up through the University of Arizona for the “arthritis” clinic. Again we have a staff physician working with the contract specialists to help with referrals and follow-up. • Another physician is assigned to surgery clinic to work with Phoenix Indian Medical Center Surgeons who come twice a month to evaluate patients for surgery and do what minor procedures that can be



	<p>done without anesthesia.</p> <ul style="list-style-type: none"> • We have our own providers doing flex sig, colposcopy and other clinics, per their training. • Prenatal specialists come in once a month but are on call for us 24/7 and deliver most of our patients. The prenatal clinics are covered by our own physician the rest of the time. • We have our own service unit emergency services team with two ambulances in the field most of the time. We have an arrangement with another ambulance service to fill in when we can not cover the vast space of the reservation. Our EMS staff has one of the hospitals in Tucson as the “base hospital” and thus contact 24/7 with an emergency medicine specialist. This assures good field directions regardless of where the patient eventually is sent. This also keeps us in the regional network for coordination of transportation and hospital services. We have been a part of all the recent emergency training for an unforeseen event such as terrorism. • Other innovative means of delivering good care at less cost are constantly being discussed and considered in the monthly med-staff meetings and via e-mail.
<p>Tucson Indian Center (Tucson Urban)</p>	<ul style="list-style-type: none"> • The organization has over forty years of experience and knowledge in serving the NA community. The services offered are consistent with a strategic plan and community needs assessments. The foundation of the strengths is qualified and competent staff (educated Native Professionals) that possess the knowledge, skills, abilities, and passion to elevate the health status of our community. We have established a good collaboration with I/T/U and conducted effective outreach in a relatively short period of time. We are open to implementing new best practices.
<p>Pisinimo Clinic (West Side)</p>	<ul style="list-style-type: none"> • Our strengths revolve around our providers. They are some of the most dedicated, caring group of people. There seems to be little turnover and Administration works at keeping them happy. They are providing flexible schedules, bonuses and money for training.

All service areas cite their providers as a major strength. More than one suggests this dedication and low turnover is due to Administrative efforts and incentives. Doctors are also commended for cultural sensitivity. In addition to, and perhaps building on this strength, at least one facility prides itself on a quality health delivery system with primary care expertise. Diversity of care is identified as a strength in two service areas with a wide range of ambulatory care services as well as doctors performing specialized services “in house” as per their training.



3. What are your weaknesses in terms of serving your community (service area)?

<p>Pascua Yaqui Health Center</p>	<ul style="list-style-type: none"> • Don't have a comprehensive health center at Reservation for public health data (and in general as well)
<p>Santa Rosa Health Clinic</p>	<ul style="list-style-type: none"> • We do not plan care around our patients. Our care is not patient driven as evidenced by poor case management. Providers do not realize the barriers that distance and poor transportation services have on patient compliance. • The communication between tribe and I.H.S. is not good. There is little collaboration in regards to services. It is an "us and them" philosophy. The interesting thing is that people at the top will say that we have a good relationship. One of the Nation's biggest health concerns is substance abuse and ETOH abuse. Yet, as a service unit, we do not address this. In part because I.H.S. will say, "well the tribe is getting the funds to handle this." So, our weakness is that we do not provide the services related to substance and ETOH abuse. We need to have detox within the hospital. We also need treatment centers (inpatient) for youth. Present assignments for dentists versus doctors are presently unfair and need to be addressed.
<p>San Xavier Health Center</p>	<ul style="list-style-type: none"> • Space. • New staff training and orientation. • Limited staffing and resources in terms of getting out in the community to do more flu shots, immunizations, health education, preventative and wellness activities. • Confusing, (sometimes) conflicting federal regulations that are hard to interpret by staff and patients. Examples are CHS, human resources, acquisition management (FAR), property & supply, Finance, regulations. • Information Technology resources. Inefficient data collection and statistical extrapolation including accessing different systems. • IT staff to train and support staff. • Limited access to services- SXHC has part-time services in nutrition, podiatry, public health nursing, health education, optometry, ophthalmology, dental, etc. • <i>Regarding #D: examples include eligibility issues in direct vs. contract care... Medicaid application process is lengthy and convoluted, Pascua Yaqui access issues.</i> • <i>They have practical problems with GI doc over ACHHS payment. Many don't understand that IHS is a payor of last resort.</i>
<p>Sells Hospital</p>	<ul style="list-style-type: none"> • We are outdated. We are experiencing a nursing shortage that shows little signs of abating. In-patient census has decreased the past few years from an average of about twenty patients in house to eight or less. This is in part due to utilization review improvements. However, much of it is due to an inability to take care of the patient's acuity, either due to nursing training or actual shortage of nursing staff. The physicians are often not comfortable keeping some of the patients since many are on dialysis and the new Medicaid rules do not allow for these patients to be inpatient with outpatient dialysis. This could be worked out, but the contractor for Dialysis is uncomfortable with the arrangements that would be needed. As improvements occur in medicine, patients are living longer with more chronic problems. This requires a different type of service than a rural hospital used to deliver. We do not have the diagnostic testing equipment that has become the standard of care, such as CAT scan, MRI and Ultrasound. • Transportation to appointments has been a real problem due to the vastness of the reservation and the poverty of the people. The "no show" rate in clinics and for referred appointments is very high. Other than transportation, this is propagated by the number of patients who do not have telephones and do not receive daily mail. Lack of services such as in house plumbing also leads to many patients not being well prepared for GI exams. Such situations cause another set of problems with the specialists to which we refer. We also are paying less than some other payers which has decreased the more scarce specialists that will take our patients. We have to serve undocumented aliens, due to legal mandates and cannot collect charges for these services. This costs the service unit resources both financially and emotionally. The staff has very mixed emotions when people need care we can not provide and we are unable to refer them for this care. The scenarios of some of the ways undocumented aliens are brought in for care can be very tragic.



<p>Tucson Indian Center (Tucson Urban)</p>	<ul style="list-style-type: none"> • We are a new program that is still establishing credibility, visibility, and identity. Our current services are somewhat limited in scope and we offer no clinical services at this time.
<p>Pisinimo Clinic (West Side)</p>	<ul style="list-style-type: none"> • We do not plan care around our patients. Care is not patient driven. As evidenced by poor case management, providers do not realize the barriers that distance and poor transportation services have on patient compliance. • Assignments for dentists and doctors are unfair presently. • The communication between tribe and I.H.S. is not good. There is little collaboration in regards to services. It is an “us and “them” philosophy. The interesting thing is that people at the top will say that we have a good relationship. • One of the Nation’s biggest health concerns is substance abuse and ETOH abuse. Yet as a service unit we don’t address this. In part because I.H.S. will say “well the tribe is getting the funds to handle this”. So, our weakness is that we don’t provide the services related to substance abuse and ETOH use. We need to have detox within the hospital. We need treatment centers (inpatient) for youth. There need to be more wellness centers in the communities, so the people learn to care for themselves and do not wait until they have a crisis situation or health complication. They need to learn self-responsibility for their health and how to address depression, drug abuse and family patterns of abuse. Many believe the doctor can heal any condition with “miracle” drugs.

The Tucson Area identified a major weakness related to remoteness and access. Two service areas commented on the challenges faced when delivering care over such a large geographical area, specifically related to case management and transportation difficulties. This is further accentuated by poverty across the reservation.

The Tucson Area also identified Communication & Regulation issues as a major weakness. Service areas revealed their frustration with this weakness in a variety of ways, but much of the concerns clustered around an inability to have IHS and the services areas coordinate information and resources for the benefit of the population in facing pressing healthcare concerns. Confusing federal regulations (i.e.: CHSDA/CHS eligibility), a lack of centralized accessible data (both public health and IT), weaknesses in consistently training new staff, and the treatment of ETOH and Substance Abuse were all related to a breakdown in IHS/Tribal communication. Some further feel that IHS denies this as a weakness.



In order to understand the concerns of the group and to understand what the group thought was important, the group was asked to respond to the following question:

Prioritizing or improving what services will have the greatest impact on the health of your population?

The left hand column represents their responses and the right hand column indicates the relative importance of each characteristic based on the group's voting. This voting occurred after discussion of each item.

Services	Score
• Prevention	10
• Primary Care	6
• Diabetes Education & Prevention	6
• Residential Treatment for Adolescents & Adults	5
• Health Education	5
• Comprehensive Substance Abuse Programs	4
• Urgent Care	2
• Behavioral Health	1
• Home Health Nursing	1
• Infrastructure	1
• Inpatient Detox Unit and Mental Health Stabilization Unit	1
• Increased Site Based Clinics (Mobile Programs)	1
• Alternative Medicine	
• Halfway House	
• Nutrition Education	
• Contract Health	
• Translators	
• Health Profession Career Facilitation	
• Community Based – Directed to Cultural/Traditional Means	
• Dietetics, Case Management	
• Pharmacy Services	
• Transportation	
• Specialty Care Access	



In order to gain consensus on what is important, and to pursue that goal united, master plan task force members were asked to work together in defining how priorities should be established. They were asked to develop such priorities with an “area wide leadership hat” on, so the needs/concerns of all would be represented. In order to understand the concerns of the group and to understand what the group thought was important, the group was asked to respond to the following question:

What characteristics of a Service Area / Facility / Patient Population should give that Service Area priority in future planning and investment?

After the development of responses, the responses were categorized to determine common themes. The following list reflects the discussion and categorization by the work group:

Physical / Infrastructure Needs - 17

- Age/Space of current facility compared to users
- Condition/size of existing facilities
- Capacity/Space
- Space need
- Old Building

Health Status - 14

- Health Risk factors
- Poorest Health status
- Need as indicated by health status indicators
- Pop. Acuity
- Health status associated with available resources
- Alcohol & Substance Health Status

Lack of Access - 9

- Access (distance) to service
- Remoteness
- Access to available resources (urban vs. remote)
- Distance for service (ER, Hospital, OP)
- Distance from existing services
- Areas that are more rural
- Limited access to care – greater than 80 miles (remote areas)
- TO members that live on the reservation – that have to access services of remote clinics – (decrease travel time to access specialty services)

Population Growth - 8

- Population serviced
- Increase in patient growth (data driven) All billable/non billable
- We need to determine how many O’odham are seen here at SX versus Urban
- Largest Population
- User Population

What the Tohono O’odham Nation wants (priorities) for their Tribal members bases on their community survey and strategic planning – 5

Lack of Continuity of Care - 3

- Home Health Nursing for Follow-up & Teaching

Youth Health Prevention in later years - 2

- Area of TO members, # of youth 0-18.

Lack of Primary Care Capacity – 2

- Develop more “well” Clinics (rural)

Diabetics – 1

Lack of other available services – 1

Prioritize all health indicators (focus \$ & resources to top 3 or 4 issues)

Expanding Existing infrastructure

Community/ies initiating infrastructure

Low economic/Income levels

Ability to staff

Full Service (ER, Hospital, OP)

Reservation Residence

- Those with most limited income lower employment
- Employment off reservation

Need & Gaps in Service



Second Meeting – March 12, 2004

In our Second Tucson Meeting, March 12, 2004, the characteristics identified in December were grouped into four criteria with the task presented to the Work Group to select the critical factors for each criteria that should determine a PSA's priority. The characteristics identified were grouped as follows. The criteria is the column's heading.

Infrastructure	Population	Health	Access
Age of Structure	Population Growth (actual increase in users)	Obesity (Diabetes – Cardiovascular)	Travel Time to Primary Care (FP, Ped, OB/Gyn, IM)
% of Existing Space to Future Need	At-Risk Population: Younger Population plus Older Population	Behavior Issues (FACS, Domestic Violence)	Travel Time to Inpatient Care
Facility Condition (FCI)	Underserved Population (Service Area Expected Visits vs. Historical Workload)	Immunization Rate – Public Health Measurements	Travel Time to Specialty Care
		Prenatal Care Visit Rate (Visits/expectant mothers)	Travel Time to Emergency Care

The Master Plan Workgroup broke into two groups twice in order to develop the Criteria's measurable factors. The Criteria and its measurable factors are used to complete a criteria-ranking equation for each Service Area. The ranking equation will allow the Workgroup to identify a priority Service Area within the Tucson Area.

Criteria factors are specific measurable indicators, which will allow each PSA to be evaluated/scored for each criterion. In order to narrow the effort at the March meeting each group developing the Criteria's measurable factors were given the following rules:

- There would be multiple measurable factors for each criteria
- The factors would allow each Criteria to be isolated – “all else being equal”, that Service Area's “Health” is a priority because _____.
- It would be measurable by objective means, by passing through the following tests:
 - Is it attainable? (Pass = yes)
 - Is it a reliable comparison? Can you trust its result? (Pass = yes)
 - Can it be gamed? (Pass = no)

The factor rules, as developed above, resulted in the factors and scoring mechanisms for each of the four Criterion developed (shown on the following pages).



Infrastructure

Criteria Factor	Explanation	Scoring Application
Age	Facility Age in years, weighted by square foot in case of multiple structures.	1 – Newest 1/3
		2 – Middle 1/3
		3 – Oldest 1/3
% Existing Space to Future Need	Total square meters divided by projected total square meters needed resulting in % of existing space to required space.	1 – Highest 1/3
		2 – Middle 1/3
		3 – Lowest 1/3
Condition	Utilization of Facility Condition Index (FCI) from IHS 2003 Facility Assessment Study. FCI is the overall indicator of the overall condition of each building.	1 – Lowest 1/3
		2 – Middle 1/3
		3 – Highest 1/3

Population

Criteria Factor	Explanation	Scoring Application
Population Growth	Projected net growth in number of users for a Primary Service Area (PSA)	1 – Lowest 1/3
		2 – Middle 1/3
		3 – Highest 1/3
At Risk Population	Combines the two at-risk populations within a PSA to create a total at-risk population. The higher the number the higher the criterion score the PSA receives.	1 – Lowest 1/3
		2 – Middle 1/3
		3 – Highest 1/3
Underserved Population	A ratio created by comparing historical visits experienced to HSP expected visits. A lower ratio indicates larger underserved population and receives a higher score	1 – Highest 1/3
		2 – Middle 1/3
		3 – Lowest 1/3



Health

Criteria Factor	Explanation	Scoring Application
Obesity	Total number of unique users with an obesity, diabetes or cardiovascular ICD-9 code divided by the User Pop.	1 – Lowest 1/3
		2 – Middle 1/3
		3 – Highest 1/3
Behavior Issues	Total number of unique users with an alcohol & substance abuse ICD-9 code divided by the User Pop.	1 – Lowest 1/3
		2 – Middle 1/3
		3 – Highest 1/3
Immunization Rate	Total number of unique users with Immunization ICD-9 code divided by the User Pop.	1 – Highest 1/3
		2 – Middle 1/3
		3 – Lowest 1/3
Prenatal Care Visit Rate	Average visits per expectant mothers by ICD-9 code per pregnancy.	1 – Highest 1/3
		2 – Middle 1/3
		3 – Lowest 1/3

Access

Criteria Factor	Explanation	Scoring Application
Primary Care Access	The travel time from the PSA to complete Primary Care (Family Practice, Pediatrics, Internal Medicine, OB/Gyn)	1 – Lowest 1/3
		2 – Middle 1/3
		3 – Highest 1/3
Specialty Care Access	The travel time from the PSA to Specialty Care.	1 – Lowest 1/3
		2 – Middle 1/3
		3 – Highest 1/3
ER Access	The travel time from the PSA to Emergency Room Care.	1 – Lowest 1/3
		2 – Middle 1/3
		3 – Highest 1/3
Inpatient Care Access	The travel time from the PSA to Inpatient Care.	1 – Lowest 1/3
		2 – Middle 1/3
		3 – Highest 1/3



While all Service Areas have needs, this priority exercise identified which Service Area according to the Workgroup's criteria should be addressed first. The use of this equation will remove the politicizing of priorities from the process. Based on the earlier conversations, the four characteristics or criteria are Infrastructure, Population, Health and Access. The ranking equation is:

$$(I*IW) + (P*Pw) + (H*Hw) + (A*Aw) = \text{Rank}$$

Where;

- I = Infrastructure
- P = Population
- H = Health
- A = Access
- w = Weighted Priority (assigned to each criteria as follows)

A criteria's score will be dependent upon the measurable factors determined by the group, while the criteria's weighting is determined by the group's overall perception as to the importance of that criteria as a priority. That importance is determined by assigning a percentage (out of 100%) to each criterion.

The criteria's score works in a similar way. For example, if two factors affect "Access", individual Workgroup team members would be able to assign a percentage importance to each factor. These individual understandings are then averaged to create a weighting of each measurable factor affecting the Criteria's score. Workgroup members' assignment of importance to the two factors may differ greatly. However, the input of all Workgroup members through such a vehicle facilitates a fair way to score each criterion's importance, ensuring every Workgroup member has equal and discreet input.

Third Meeting – April 30, 2004

In the third area workgroup meeting, the second meeting refined criteria were presented in ballot form for participants to weight. The goal of this meeting was to have the group weight both the factors and the criteria. This results in task force members being able to assign weighting by ballot according to the following formula.

$$\text{Rank} = (((Iw) * (((IF1*IF1w) + (IF2*IF2w) + (IF3*IF3w))/3)) + ((Pw) * (((PF1*PF1w) + (PF2*PF2w) + (PF3*PF3w))/3)) + ((Hw) * (((HF1*HF1w) + (HF2*HF2w) + (HF3*HF3w) + (HF4*HF4w))/4)) + ((Aw) * ((AF1*AF1w) + (AF2*AF2w) + (AF3*AF3w) + (AF4*AF4w))/4))/3$$

The ballots were gathered both at that meeting and during the weeks following from appropriate tribal, facility POCs, and IHS representatives. After tallying the results the following percentages were determined and applied to the comprehensive weighting formula:

Where;

- IFw = Infrastructure.....(28.46% out of 100%)
- PFw = Population(21.54% out of 100%)
- HFw = Health(26.15% out of 100%)
- AFw = Access.....(23.85% out of 100%)

- w = Weighted Priority (assigned to each criteria as follows)
- 1, 2, 3 = Criteria factor

This results in task force members being able to assign weighting by ballot according to the following expanded formula.



The Primary Service Area's Priority Score equals the following:

Infrastructure Criteria - the weighted percentage importance of the following Health criteria factors:

Age -----	(26.92% out of 100%)
Space: % Existing to Future Need -----	(44.62% out of 100%)
Condition -----	(28.46% out of 100%)

Plus (+)

Population Criteria - the weighted percentage importance of the following Access criteria factors:

Population Growth -----	(42.78% out of 100%)
At Risk Population -----	(31.11% out of 100%)
Underserved Population -----	(26.12% out of 100%)

Plus (+)

Health Criteria - the weighted percentage importance of the following Resources criteria factors:

Obesity -----	(32.69% out of 100%)
Behavior Issues -----	(28.46% out of 100%)
Immunization Rate -----	(18.46% out of 100%)
Prenatal Care Visit Rate -----	(20.38% out of 100%)

Plus (+)

Access Criteria - the weighted percentage importance of the following Patient Profile criteria factors:

Primary Care Access -----	(43.46% out of 100%)
Specialty Care Access -----	(15.38% out of 100%)
ER Access -----	(24.62% out of 100%)
Inpatient Care Access -----	(16.54% out of 100%)

The final ranking formula with the weighting factors as determined is as follows:

$$\text{Rank} = (((.2846) * (((\text{Facility Weighted Age} * .2692) + (\% \text{ Existing Space to Future Need} * .4462) + (\text{Facility Condition} * .2846))/3)) + ((.2154) * (((\text{User Population Growth} * .4278) + (\text{At-Risk Population} * .3111) + (\text{Underserved Population} * .2612))/3)) + ((.2615) * (((\text{Obesity Rate} * .3269) + (\text{Behavior Issue Rate} * .2846) + (\text{Immunization Rate} * .1846) + (\text{Prenatal Care Visit Rate} * .2038))/4)) + ((.2385) * ((\text{Primary Care Access} * .4346) + (\text{Specialty Care Access} * .1538) + (\text{Emergency Room Access} * .2462) + (\text{Inpatient Care Access} * .1654)/4))/3)$$

Each Primary Service Area was then scored with a 1, 2 or 3 based on each of the criteria listed, with the higher number indicated greater need and therefore higher priority. The following is the narrative detailing the data for scoring each criterion.

- **Infrastructure**

- **Weighted Average Age of Facility** has been calculated using the facility information acquired and recorded during the first site visits cross-referenced to the MI&E Inventory Report and Facility Condition Index Report. Building size and age are recorded in the detail table in Appendix B where age (in years) is multiplied by % utilized size (in square meters) resulting in a weighted age. % utilized is important in cases where the Tucson Area Office may use square footage a clinic may not have access to. In cases where a clinic is nearly completed or under construction, we have used a construction date of 2004, resulting in that building being 0 years old. The 1/3 of service areas with the oldest weighted age will receive a score of 3; the 1/3 of service areas with the median weighted age will receive a score of 2, while the 1/3 of service areas with the youngest weighted age will receive a score of 1.
- **% of Existing Space to Future Need** has been calculated by comparing the projected needed space in 2015 from the Resource Allocation document for each PSA with the total PSA existing space (this space is cross-referenced with the IHS MI&E report and the Facility Condition Index Report). The 1/3



of service areas with the lowest percentage will receive a score of 3; the 1/3 of service areas with the median percentage will receive a score of 2 while the 1/3 of service areas with the highest percentage will receive a score of 1.

- **Condition – Facility Condition Index (FCI)** was based on the Tucson Area's 2003 study of facility condition by contractor Applied Management Engineering. Every facility was considered except Pascua Yaqui Health Complex and the Tucson Urban Program. The index is calculated by dividing the total cost of maintenance and repair, study/audit/feasibility, and handicapped accessibility requirements identified for the next five years by the current replacement value. For example, an index of .26 would mean that repair and upgrade to current code would cost 26% of the cost of complete facility replacement. Total FCI for combined PSA facilities were compared with FCI rates simply for the primary PSA clinic. There was no difference in impact in relationship to score. The higher the number the poorer the facility condition. The 1/3 of service areas with the highest FCI received a score of 3; the 1/3 of service areas with the median FCI received a score of 2 while the 1/3 of service areas with the lowest FCI received a score of 1.

- **Population**

- **Net User Population Growth** was calculated by comparing the Health Systems Planning (HSP) count of 2001 users with the projected count of 2015 users. The difference between the 2015 user population projection and the 2001 user population was recorded as net user population increase. The 1/3 of service areas with the highest net user population increase received a score of 3; the 1/3 of service areas with the median net user population increase received a score of 2 while the 1/3 of service areas with the lowest user population increase received a score of 1.
- **At-Risk Population** was calculated by comparing the Health Systems Planning (HSP) count of two "at-risk" populations: those under age 14 and those over age 55. These counts were combined for the projection year for each PSA. The result was a net "at-risk" population projection for 2015 for each PSA that could be compared. The 1/3 of service areas with the highest projected "at risk" user population received a score of 3; the 1/3 of service areas with the median projected "at risk" user population received a score of 2, while the 1/3 of service areas with the lowest projected "at risk" user population received a score of 1.
- **Underserved Population** was calculated by comparing the Health Systems Planning (HSP) or IHS understanding of expected workload for a given population with the actual historic APC record for 2000, 2001 and 2002. PSA communities were identified and grouped as historical workloads from each PSA were compared with what the HSP would project. The difference (underserved populations shown in terms of missed visits) was expressed as a negative percentage. The 1/3 of service areas with the lowest (greatest negative value) underserved population percentage received a score of 3; the 1/3 of service areas with the median underserved population percentage received a score of 2 while the 1/3 of service areas with the highest underserved population percentage received a score of 1.

- **Health Status**

- **Obesity Rates** counted those unique users accessing the system with an obesity related ICD-9 code in cardiovascular, diabetes or obesity. Only one code was necessary to identify a unique user. Multiple codes recorded for a single user still only produced one unique. The rate is a ratio of unique users with obesity codes to the entire user population. The 1/3 of service areas with the highest obesity rate received a score of 3; the 1/3 of service areas with the median obesity rate received a score of 2 while the 1/3 of service areas with the lowest obesity rate received a score of 1.
- **Behavior Issues Rate** counted those unique users accessing the system with an Alcohol & Substance Abuse related ICD-9 code. Only one code was necessary to identify a unique user. Multiple codes recorded for a single user still only produced one unique. The data set produced a total number of unique users for a three year period (2000, 2001, 2002) which was divided by 3 to



create an average relatable to the 2001 user population. The Behavior Issues rate is a ratio of those unique users to the 2001 PSA user population. The 1/3 of service areas with the highest Behavior Issues rate received a score of 3; the 1/3 of service areas with the median Behavior Issues rate received a score of 2 while the 1/3 of service areas with the lowest Behavior Issues rate received a score of 1.

- **Immunization Rate** counted those unique users (both adult and pediatric) accessing the system receiving one or more immunizations by ICD-9 code. Only one code was necessary to identify a unique user. Multiple codes recorded for a single user still only produced one unique. So the Immunization rate is a ratio of immunized unique users to the entire user population. The 1/3 of service areas with the lowest immunization rate received a score of 3; the 1/3 of service areas with the median immunization rate received a score of 2 while the 1/3 of service areas with the highest immunization rate received a score of 1.
- **Pre-natal Care Visit Rate** was determined by identifying pre-natal related ICD-9 codes to patient visits per expectant mother per pregnancy for the year 2001. This way complete pregnancies were track-able with the existing data set with no pregnancies extending prior to 2000 or after 2002. Pregnancy visits per pregnancy were then averaged by Primary Service area to produce an average visit rate for the entire PSA. The 1/3 of service areas with the lowest average prenatal care visit rate received a score of 3; the 1/3 of service areas with the median average prenatal care visit rate received a score of 2 while the 1/3 of service areas with the highest average prenatal care visit rate received a score of 1.
- **Access to Care**
 - **Primary Care Access** was determined by finding the travel time from the primary point of care at each PSA to the closest complete Primary Care service facility. A complete service set, as determined by the area workgroup, consists of Family Practice, Pediatric, Internal Medicine, and OB/Gyn care (existing either as assets or visiting professionals). The 1/3 of service areas with the greatest travel time to Primary Care received a score of 3; the 1/3 of service areas with the median travel time to Primary Care received a score of 2 while the 1/3 of service areas with the lowest travel time to Primary Care received a score of 1.
 - **Specialty Care Access** was determined by finding the travel time from the primary point of care at each PSA to the closest facility with a resident specialist on staff. The 1/3 of service areas with the greatest travel time to Specialty Care received a score of 3; the 1/3 of service areas with the median travel time to Specialty Care received a score of 2 while the 1/3 of service areas with the lowest travel time to Specialty Care received a score of 1.
 - **Emergency Room Access** was determined by finding the travel time from the primary point of care at each PSA to the closest emergency room. The 1/3 of service areas with the greatest travel time to Emergency Care received a score of 3; the 1/3 of service areas with the median travel time to Emergency Care received a score of 2 while the 1/3 of service areas with the lowest travel time to Emergency Care received a score of 1.
 - **Inpatient Care Access** was determined by finding the travel time from the primary point of care at each PSA to the closest Inpatient Care service facility. The 1/3 of service areas with the greatest travel time to Inpatient Care received a score of 3; the 1/3 of service areas with the median travel time to Inpatient Care received a score of 2 while the 1/3 of service areas with the lowest travel time to Inpatient Care received a score of 1.



Fourth Meeting – September 29, 2004

The area workgroup considered the status of criteria development issues as well as preliminary ranking for all PSAs. Priority Criteria is typically developed with the assumption that they both support the goals of the PSAs and the area as well as provide “the right answer” – meaning that the priority answer provided is one that “makes sense” from all perspectives. The group was informed of the following challenges worthy of consideration prior to final priority ranking.

- FCI (Facility Condition Index) was not applicable across all PSAs for the simple reason that Pascua Yaqui opted not to participate when the TAO provided the study. As a result Pascua cannot be scored apart from an assigned score by the planner that may or may not be appropriate.
- Health Issues criteria may not be reliable. For example, there is currently an inability to obtain a prenatal care visit rate that rests on reliable primary data findings. Current primary data upon which existing criteria is based shows half the births we would expect to see for the Tucson Area.
- Data for Pascua Yaqui seems incomplete on key Health Criteria factors resulting in questionable results when scoring Alcohol & Substance Abuse (Behavior Issues) as well as Unique Users Immunized.
- It is debatable whether ‘users immunized’ for a given number of years is an appropriate criteria. It might be better to think in terms of users whose charts evidence that immunizations are up to date – data currently not accessible.
- The Access criteria factors are favoring the new/projected PSAs in a manner that may not have been the intent of the area workgroup when developing criteria.
- It is questionable whether or not priority ranking is appropriate for the Tucson Area since there are not a great number of tribes sharing Area attention or requesting help.

The end result was that while a priority ranking score was available it did not convey the level of confidence the area workgroup desired. Two different paths forward were available.

- Refine criteria and obtain additional data to create higher credibility for scoring purposes, or...
- Dismiss priority ranking from an area-wide perspective and utilize the priority table in the master plan summary to address priorities as the TAO deems appropriate while consulting existing developed criteria for direction as required.

The area workgroup chose the latter directing the priorities table to show PSA in an order as ranked by each tribe. Therefore, Sells Service Unit would rank its six service areas as it deems appropriate. Internal PSA specific priorities would continue to be shown as determined by that PSA on the executive summary page of its delivery plan.



Summary Scorecard

Factor Weighting	Factors				Composite Score	Summary Rank
	28.46%	21.54%	26.15%	23.85%		
Service Area	Infrastructure Criteria	Population Criteria	Health Criteria	Access Criteria		
Ajo/Why PSA	0.63	0.75	0.80	1.00	0.79	2
North PSA	0.63	0.51	0.80	0.33	0.58	7
Santa Rosa Health Center	1.00	0.67	0.80	0.95	0.86	1
San Xavier Health Center	0.85	1.00	0.39	0.62	0.71	4
Sells Hospital	0.85	0.83	0.81	0.44	0.74	3
Westside Health Center	0.52	0.33	0.88	1.00	0.69	5
Pascua Yaqui Health Center	0.52	0.91	0.52	0.67	0.64	6
Tucson Indian Center	0.48	0.33	0.33	0.33	0.38	8

Since there were 8 PSAs, the following score application was utilized: the top three PSAs with need were assigned a "3", the middle two PSAs with need were assigned a "2", while the bottom three PSAs with need were assigned a "1".

Tucson Indian Center (TIC) was scored and ranked even though it is an urban program (urban programs are often not ranked in IHS health services master plans). This was done due to the unique status of the Tucson Area and the Area Workgroup's desire to not rely on a numerical scoring methodology for implementation purposes.



Infrastructure Criteria Scorecard

Factor Weighting	Factors						Infrastructure Score	Rank
	26.92%		44.62%		28.46%			
Service Area	Weighted Age	Score	Existing Space to Needed	Score	Condition (FCI)	Score		
Ajo/Why PSA	0.0	1	0.0%	3	0.00	1	0.63	4
North PSA	0.0	1	0.0%	3	0.00	1	0.63	4
Santa Rosa Health Center	45.0	3	15.2%	3	0.66	3	1.00	1
San Xavier Health Center	49.6	3	42.0%	2	0.53	3	0.85	2
Sells Hospital	34.0	3	41.8%	2	0.35	3	0.85	2
Westside Health Center ¹	0.0	2	147.6%	1	0.19	2	0.52	6
Pascua Yaqui Health Center ²	6.4	2	55.7%	1	0.00	2	0.52	6
Tucson Indian Center	0.0	1	41.0%	2	0.00	1	0.48	8

Criteria Development Summary

Infrastructure		
Criteria Factor	Explanation	Scoring Application
Facility Weighted Age	Facility Age in years, weighted by square foot in case of multiple structures.	1 - Newest 1/3
		2 - Middle 1/3
		3 - Oldest 1/3
% Existing Space to Future Need	Total square meters divided by projected total square meters needed resulting in % of existing space to required space.	1 - Highest 1/3
		2 - Middle 1/3
		3 - Lowest 1/3
Condition	Utilization of Facility Condition Index (FCI) from IHS 2003 Facility Assessment Study. FCI is the overall indicator of the overall condition of each building.	1 - Lowest 1/3
		2 - Middle 1/3
		3 - Highest 1/3

¹ Westside is treated as new for purposes of criteria application since construction is underway. As a result, though the FCI condition index is available and shown, it is not applied.

² Pascua Yaqui has been assigned a "2" in the FCI column. While they did not participate in the FCI study, and as a result data is unavailable to score, a "2" was deemed appropriate for two reasons: first, a medium score is typically assigned in the absence of scoring ability; second, Pascua's facility condition would probably align between new/non-existent PSAs and the oldest PSAs (SX & SR).



Infrastructure Detail - Facility Age Weighting

Building	Constructed	Age	%	Size (SM)	Net Size (SM)	Weighted Age
PSA						0
Ajo/Why PSA						
No Building	0	0	0%	0	0	0
Total Square Meters				0	0	0

PSA						0
North PSA						
No Building	0	0	0%	0	0	0
Total Square Meters				0	0	0

PSA						45
Santa Rosa Health Center						
Main Clinic	1959	45	100%	320	320	14,400
Total Square Meters				320	320	14,400

PSA						50
San Xavier Health Center						
00SX1 Health Center	1932	72	100%	2,358	2,358	169,776
00SX2 Purchasing	1937	67	0%	210	0	0
00SX3 office	1932	72	0%	138	0	0
00SX4 CHS/AR	1942	62	0%	125	0	0
00SX5 HR	1942	62	90%	125	113	6,975
00SX6 office	1932	72	0%	208	0	0
00SX7 office	1932	72	0%	50	0	0
00SX9 office	1938	66	0%	57	0	0
0616T office		0	0%	167	0	0
0617T Dental	1978	26	100%	167	167	4,342
0618T Env. Health	1977	27	0%	167	0	0
0619T Property & Supply	1979	25	90%	167	150	3,758
0621T service	1977	27	0%	134	0	0
0622T Finance	1973	31	75%	134	101	3,116
0623T office	1974	30	0%	134	0	0
0624T office		0	0%	67	0	0
0625T office	1973	31	0%	67	0	0
0626T office		0	0%	67	0	0
0627T office	1977	27	0%	33	0	0
0628T storage		0	0%	67	0	0
0642T Warehouse	2001	3	90%	217	195	586
0643T Future Dental Mods	2004	0	100%	718	718	0
0SX10 Facilities	1938	66	0%	130	0	0
0SX11 service	1960	44	0%	78	0	0
Total Square Meters				5,785	3,802	188,552



Infrastructure Detail - Facility Age Weighting

Building	Constructed	Age	%	Size (SM)	Net Size (SM)	Weighted Age
PSA Sells Hospital						34
00505 Hospital	1960	44	100%	4,718	4,718	207,575
00506 Hospital Support	1960	44	100%	114	114	5,003
00507 Housekeeping	1960	44	100%	294	294	12,946
00508 Equipment	1960	44	100%	236	236	10,362
00603 Supplies	1977	27		45	0	0
00604 Supplies	1977	27		45	0	0
00635		0		0	0	0
0505A Gen Admin Bld	1972	32	100%	82	82	2,631
0610T Supplies	1976	28		64	0	0
0611T Office	1973	31		33	0	0
0614T Supplies	1980	24	100%	334	334	8,027
0615T Support	1978	26	100%	75	75	1,957
0616T Support	1972	32		58	0	0
0618T General	1969	35		281	0	0
0619T General	1978	26	100%	78	78	2,029
0620T General	1972	32	100%	65	65	2,069
0621T General	1972	32	100%	65	65	2,069
0623T General	1977	27	100%	74	74	1,999
0624T General	1977	27	100%	125	125	3,371
0625T Garage, Gov Veh	1982	22	100%	89	89	1,962
0630T		0		0	0	0
0631T General	1978	26		107	0	0
0633T Hazardous	1988	16		15	0	0
0634T Equipment	2001	3		29	0	0
0638T Dental	1997	7	100%	371	371	2,600
P0637 Medical Gas	1995	9		20	0	0
0001 Office Counseling ASAP	1988	16	100%	540	540	8,640
0002 Office Counseling ASAP	1988	16	100%	263	263	4,208
0003 Office - General	1988	16	100%	267	267	4,272
0004 other institutional - Field Health	1988	16	100%	328	328	5,248
0005 other institutional - Field Health	1988	16	100%	336	336	5,376
0006 Office - General	1988	16	100%	283	283	4,528
Total Square Meters				9,433	8,737	296,873

PSA	Westside Health Center ¹					0
Main Clinic	2004	0		2,608	0	0
Total Square Meters				2,608	0	0

PSA	Pascua Yaqui Health Center ²					6
Health Department / El Rio Clinic	1998	6	100%	3,065	3,065	18,390
Dental	2004	0	100%	489	489	0
Behavioral Health Modularity	2000	4	100%	580	580	2,320
Alternative Care	1970	34	100%	95	95	3,230
VAHCOM House (A&SA Abuse)	1970	34	100%	130	130	4,420
Dialysis Center	1998	6	100%	575	575	3,450
				0	0	0
Total Square Meters				4,934	4,934	31,810

PSA	Tucson Indian Center					0
All Space is Currently Leased		0		0	0	0
Total Square Meters				0	0	0



Population Criteria Scorecard

Factor Weighting	Factors						Population Score	Rank
	42.78%		31.11%		26.12%			
Service Area	Population Growth	Score	At-Risk Population	Score	Under-served Population	Score		
Ajo/Why PSA	180	2	417	2	-30.8%	3	0.75	4
North PSA	32	1	204	1	-31.1%	3	0.51	6
Santa Rosa Health Center	313	2	670	2	-5.9%	2	0.67	5
San Xavier Health Center	1,691	3	3,456	3	-45.2%	3	1.00	1
Sells Hospital	1,138	3	2,684	3	7.4%	1	0.83	3
Westside Health Center	158	1	341	1	-3.5%	1	0.33	7
Pascua Yaqui Health Center	1,120	3	2,511	3	-15.5%	2	0.91	2
Tucson Indian Center*	324	1	703	1	N/A	1	0.33	7

* TIC's population numbers are implied as per Master Plan Summary explanation rather than actual. As a result a score of 1 has been applied to all 3 factors.

Criteria Development Summary

Population		
Criteria Factor	Explanation	Scoring Application
Net User Population Growth	Projected net growth in number of users for a Primary Service Area (PSA)	1 - Lowest 1/3
		2 - Middle 1/3
		3 - Highest 1/3
At-Risk Population (Young + Old)	Combines the two at-risk populations within a PSA to create a total at-risk population. The higher the number the higher the criterion score the PSA receives.	1 - Lowest 1/3
		2 - Middle 1/3
		3 - Highest 1/3
Underserved Population	A ratio created by comparing historical visits experienced to HSP expected visits. A lower ratio indicates underserved population and receives a higher score.	1 - Highest 1/3
		2 - Middle 1/3
		3 - Lowest 1/3



Health Criteria Scorecard

Factor Weighing	Factors				Health Score	Rank
	32.69%	28.46%	18.46%	20.38%		
Service Area	Obesity	Behavior Issues	Immunization Rate	Prenatal Care Visit Rate		
Ajo/Why PSA	2	2	3	3	0.80	4
North PSA	2	2	3	3	0.80	4
Santa Rosa Health Center	3	3	2	1	0.80	3
San Xavier Health Center	1	1	2	1	0.39	7
Sells Hospital	3	3	1	2	0.81	2
Westside Health Center	3	3	1	3	0.88	1
Pascua Yaqui Health Center	1	1	3	2	0.52	6
Tucson Indian Center	1	1	1	1	0.33	8

Criteria Development Summary

Health		
Criteria Factor	Explanation	Scoring Application
Obesity	Number of uniques with either an obesity, diabetes or cardiovascular ICD-9 Code divided by the User Pop.	1 - Lowest 1/3
		2 - Middle 1/3
		3 - Highest 1/3
Behavior Issues	Number of uniques with an Alcohol and Substance Abuse ICD-9 Code divided by the User Pop.	1 - Lowest 1/3
		2 - Middle 1/3
		3 - Highest 1/3
Immunization	Number of Uniques with Immunization ICD-9 Code divided by the User Pop	1 - Highest 1/3
		2 - Middle 1/3
		3 - Lowest 1/3
Prenatal Care Visit Rate	Average visits per expectant mother by ICD-9 Code per pregnancy.	1 - Highest 1/3
		2 - Middle 1/3
		3 - Lowest 1/3



Health Criteria Supporting Detail

Service Unit	2001 User Pop	Obesity			Behavior Issues			Immunization Rate			Prenatal Care Visit Rate			
		3 Yr. Ave. of Unique Users with Obesity, Diabetes, or Cardiovascular related ICD-9 code	Obesity Rate	Score 1-8 Obesity	3 Yr Ave. of Unique Users with Alcohol & Substance Abuse ICD-9 code	Behavior Issue Rate	Score 1-8 Behavior Issues	Unique Users Immunized	Immunization Rate	Score 1-8 Immunization Rate	Pregnancies in 2001 by Dx	Pre-natal Visits by Dx Code	Visit Rate per Pregnancy	Rank 1-8 Pre-natal Visit Rate
Ajo/Why PSA	928	139	15.0%	2	35	3.8%	2	88	9.4%	3	2	15	7.50	3
North PSA	516	73	14.1%	2	24	4.7%	2	48	9.2%	3	3	7	2.33	3
Santa Rosa Health Center	1,450	275	19.0%	3	83	5.7%	3	166	11.4%	2	6	138	23.00	1
San Xavier Health Center	8,366	908	10.8%	1	247	3.0%	1	841	10.1%	2	14	231	16.50	1
Sells Hospital	5,807	977	16.8%	3	353	6.1%	3	733	12.6%	1	28	445	15.89	2
Westside Health Center	817	141	17.2%	3	45	5.5%	3	99	12.1%	1	3	33	11.00	3
Pascua Yaqui Health Cent	5,522	609	11.0%	1	62	1.1%	1	47	0.9%	3	78	1,014	13.00	2
Tucson Indian Center	1,592	0	0.0%	1	0	0.0%	1	0	0.0%	1	0	0		1

RPMS health numbers unavailable for TIC



Access Criteria Scorecard

Factor Weighting	Factors				Access Score	Rank
	43.46%	15.38%	24.62%	16.54%		
Service Area	Primary Care Access	Specialty Care Access	ER Access	Inpatient Care Access		
Ajo/Why PSA	3	3	3	3	1.00	1
North PSA	1	1	1	1	0.33	7
Santa Rosa Health Center	3	2	3	3	0.95	3
San Xavier Health Center	2	1	2	2	0.62	5
Sells Hospital	1	3	1	1	0.44	6
Westside Health Center	3	3	3	3	1.00	1
Pascua Yaqui Health Center	2	2	2	2	0.67	4
Tucson Indian Center	1	1	1	1	0.33	7

Criteria Development Summary

Access		
Criteria Factor	Explanation	Scoring Application
Primary Care Access	The travel time from the PSA to complete Primary Care (FP, IM, Peds, OB/Gyn).	1 - Lowest 1/3
		2 - Middle 1/3
		3 - Highest 1/3
Specialty Care Access	The travel time from the PSA to Specialty Care.	1 - Lowest 1/3
		2 - Middle 1/3
		3 - Highest 1/3
ER Access	The travel time from the PSA to Emergency Room Care.	1 - Lowest 1/3
		2 - Middle 1/3
		3 - Highest 1/3
Inpatient Care Access	The travel time from the PSA to Inpatient Care.	1 - Lowest 1/3
		2 - Middle 1/3
		3 - Highest 1/3



Access Criteria Worksheet

Service Area	Primary Care (Complete: FP, IM, Peds, Ob/Gyn)					Score
	On Site Svcs	Qualify?	Alternate Facility	Travel Time from PSA ^a	Rank	
Ajo/Why PSA	None	No	Sells Hospital	60	1	3
North PSA	None	No	Casa Grande Reg MC*	10	6	1
Santa Rosa Health Center	FP/IM	No	Sells Hospital	34	3	3
San Xavier Health Center	FP/Peds/Ob-Gyn	No	St. Mary's - Tucson	11	5	2
Sells Hospital	Complete	Yes	-	0	8	1
Westside Health Center	FP	No	Sells Hospital	37	2	3
Pascua Yaqui Health Center	FP/Peds	No	St. Mary's - Tucson	14	4	2
Tucson Indian Center	None	No	University Medical Ctr - Tucson	2	7	1

**Distance is estimate due to imprecise PSA location*

Service Area	Specialty Care					Score
	Specialist On Staff?*	Qualify?	Alternate Facility	Travel Time from PSA ^a	Rank	
Ajo/Why PSA	No	No	St. Mary's - Tucson	118	1	3
North PSA	No	No	Casa Grande Reg MC	10	7	1
Santa Rosa Health Center	No	No	Casa Grande Reg MC	49	4	2
San Xavier Health Center	No	No	St. Mary's - Tucson	11	6	1
Sells Hospital	No	No	St. Mary's - Tucson	63	3	3
Westside Health Center	No	No	Casa Grande Reg MC	73	2	3
Pascua Yaqui Health Center	No	No	St. Mary's - Tucson	14	5	2
Tucson Indian Center	No	No	University Medical Ctr - Tucson	2	8	1

**Means the presence of some specialty care as an asset, not simply a visiting provider.*

Service Area	Emergency Care					Score
	On Site Svcs	Qualify?	Alternate Facility	Travel Time from PSA ^a	Rank	
Ajo/Why PSA	No	No	Sells Hospital	60	1	3
North PSA	No	No	Casa Grande Reg MC*	10	6	1
Santa Rosa Health Center	No	No	Sells Hospital	34	3	3
San Xavier Health Center	No	No	St. Mary's - Tucson	11	5	2
Sells Hospital	Yes	Yes	-	0	8	1
Westside Health Center	No	No	Sells Hospital	37	2	3
Pascua Yaqui Health Center	No	No	St. Mary's - Tucson	14	4	2
Tucson Indian Center	No	No	University Medical Ctr - Tucson	2	7	1

**Distance is estimate due to imprecise PSA location*

Service Area	Inpatient Care					Score
	On Site Svcs	Qualify?	Alternate Facility	Travel Time from PSA ^a	Rank	
Ajo/Why PSA	No	No	Sells Hospital	60	1	3
North PSA	No	No	Casa Grande Reg MC*	10	6	1
Santa Rosa Health Center	No	No	Sells Hospital	34	3	3
San Xavier Health Center	No	No	St. Mary's - Tucson	11	5	2
Sells Hospital	Yes	Yes	-	0	8	1
Westside Health Center	No	No	Sells Hospital	37	2	3
Pascua Yaqui Health Center	No	No	St. Mary's - Tucson	14	4	2
Tucson Indian Center	No	No	University Medical Ctr - Tucson	2	7	1

^a - Travel Time is equated as one mile = one minute due to driving distance calculation within TON



Priority Weighting Ballot Source

Ballot	Ballots														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
I = Infrastructure	35	20	30	40	20	10	30	40	30	25	10	40	40		28.46
Facility Weighted Age	50	20	20	50	5	0	40	20	45	20	20	0	60		26.92
% Existing Space to Future Need	35	50	30	30	70	40	30	50	25	50	60	100	10		44.62
Condition (FCI)	15	30	50	20	25	60	30	30	30	30	20	0	30		28.46
<i>Sum</i>	100	100	100	100	100	100	100	100	100	100	100	100	100	0	100.00
P = Population	20	20	20	30	25	30	20	20	20	15	40	20	0		21.54
Net User Population Growth	40	40	30	30	50	33.3	100	50	30	10	40	60			42.78
At-Risk Population (Young + Old)	25	50	35	20	25	33.3	0	10	45	60	40	30			31.11
Underserved Population	35	10	35	50	25	33.4	0	40	25	30	20	10			26.12
<i>Sum</i>	100	100	100	100	100	100	100	100	100	100	100	100	0	0	100.00
H = Health	30	25	25	20	30	40	20	20	25	35	40	20	10		26.15
Obesity	25	25	45	25	35	40	40	20	30	30	40	30	40		32.69
Behavior Issues	25	25	40	25	20	20	20	50	25	30	40	30	20		28.46
Immunization	25	25	5	25	30	20	20	10	20	20	10	10	20		18.46
Prenatal Care Visit Rate	25	25	10	25	15	20	20	20	25	20	10	30	20		20.38
<i>Sum</i>	100	100	100	100	100	100	100	100	100	100	100	100	100	0	100.00
A = Access	15	35	25	10	25	20	30	20	25	25	10	20	50		23.85
Primary Care Access	40	55	30	40	60	50	25	60	30	50	25	60	40		43.46
Specialty Care Access	15	5	25	20	10	0	25	10	25	10	25	20	10		15.38
ER Access	25	30	30	30	10	50	25	20	20	35	25	10	10		24.62
Inpatient Care Access	20	10	15	10	20	0	25	10	25	5	25	10	40		16.54
<i>Sum</i>	100	100	100	100	100	100	100	100	100	100	100	100	100	0	100.00
Grand Total	100	0													



$$PSA \text{ Score} = (I * Iw) + (P * Pw) + (H * Hw) + (A * Aw)$$

The sum of these criteria must equal 100%

I = Infrastructure	28.46%	Facility Weighted Age	+	26.92%
		% Existing Space to Future Need	+	44.62%
		Condition (FCI)	+	28.46%
		Total =		

The sum must equal 100

+

P = Population	21.54%	Net User Population Growth	+	42.78%
		At-Risk Population (Young + Old)	+	31.11%
		Underserved Population	+	26.12%
Total =			100.00%	

+

H = Health	26.15%	Obesity	+	32.69%
		Behavior Issues	+	28.46%
		Immunization	+	18.46%
		Prenatal Care Visit Rate	+	20.38%
Total =			100.00%	

+

A = Access	23.85%	Primary Care Access	+	43.46%
		Specialty Care Access	+	15.38%
		ER Access	+	24.62%
		Inpatient Care Access	+	16.54%
Total =			100.00%	

Total	100%
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Name	
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