Office of Environmental Health and Engineering (OEHE)
Funding for Healthcare Facilities

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2022 ANNUAL TRIBAL CONSULTATION
APRIL 4, 2022
Outline of Today’s Presentation

- How did we get here?
  - Funding and process to build two YRTC’s
- Where are we going?
  - What is the next healthcare facility we want to build in California?
- How will we get there?
  - New priority system for healthcare facilities construction
  - Demonstration projects
- Next Steps
How Did We Get Here?

THE FUNDING AND PROCESS TO BUILD TWO YRTC’S
IHS Construction Priority List of 1992 (aka the Grandfathered List)

**COMPLETED CONSTRUCTION (FY 1992 - Present)**

<table>
<thead>
<tr>
<th>HOSPITALS</th>
<th>HEALTH CENTERS</th>
<th>QUARTERS</th>
<th>YOUTH REG. TREAT. CTRS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nome, AK 2012</td>
<td>Hays, MT 1997</td>
<td>Zuni, NM 2006</td>
<td></td>
</tr>
<tr>
<td>Barrow, AK 2013</td>
<td>Harlem, MT 1998</td>
<td>Fort Belknap, MT 2007</td>
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<tr>
<td></td>
<td>White Earth, MN 1998</td>
<td>Wagner, SD 2010</td>
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<tr>
<td></td>
<td>Lame Deer, MT 1999</td>
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<tr>
<td></td>
<td>Hopi, AZ 2000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parker, AZ 2001</td>
<td></td>
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</tr>
</tbody>
</table>

**PRIORITY LISTS**

**Health Care Facilities Construction**

**Inpatient:**
- PIMC Health System, AZ,
- PIMC Northeast ACC #
- PIMC Central Hospital, ACC *
- Whiteriver, AZ *
- Gallup, NM *

**Outpatient:**
- Rapid City, SD #
- Dilkon, AZ #
- Alamo Navajo, NM #
- Pueblo Pintado, NM *
- Bodaway Gap, AZ *

**Albuquerque Health System, NM,**
- Albuquerque West *
- Albuquerque Central *
- Sells, AZ *

# Fully Funded * Partially Funded
The YRTC’s took 30+ years to happen

- Initially requested with original HCFC priority system in 1992. (Initial planning meetings were even earlier than this.)
- Started receiving planning funding and evaluating sites in mid-2000’s.
- Southern YRTC Dedication in 2012; Northern YRTC Dedication in 2013
- Sacred Oaks construction complete in 2020, hoping to start accepting residents in 2022.
- This is a generational timeframe – need to lay the foundation now for something that our successors will see built.
- However, the work we do now can PREVENT the next project from taking 30 years
Where Are We Going?

WHAT IS THE NEXT HEALTHCARE FACILITY WE WANT TO BUILD IN CALIFORNIA?
What Should the Next Healthcare Facility Be?

- Regional Surgical and Specialty Care Facilities
  - Inpatient or Outpatient
  - Feasibility study completed in 2013
  - I’ll be talking about this over next several slides

- Young Adult Regional Treatment Center
  - Repurpose existing YRTC for different age group?
  - Plan for new facility construction
  - No feasibility study completed

- Long Term Care Facility?
- Other concept?
Regional Surgical and Specialty Care Centers
Concept of Regional Specialty Centers

A Regional Specialty Center would offer the following services:
- Specialty Healthcare
- Ambulatory Surgery
- Tele-Medicine
- Overnight Stays
- Acute Care/Inpatient
- Short Stay
- Referrals Only

Conversely, a regional site would not offer the following services:
- Primary Care
- Emergency Care
- Deliveries or OB Services
- Walk In Services for Local AI/ANs

Regional Healthcare is designed to support, not replace, services presently offered at Tribal Health Programs across the state.

Regional Healthcare is not designed to compete with existing Tribal Health Programs.

Regional Healthcare is designed to continue such support as need is recognized for the extension of Primary Care assets to future tribal populations – planned for growth.

Regional Care is envisioned to provide services currently not available at existing Tribal Health Programs, ones that would most stretch limited Purchased and Referred Care dollars (thus currently paid for with limited PRC dollars or ones that simply go unmet due to an absence of PRC dollars).
Benefits of a Regional Specialty Center

- Culturally Appropriate Care
- Wraparound Care - Telemedicine Follow-Ups
- 1st Priority = Lower Wait Times
- No Caps on Service
- Saving Money on PRC
How Many Users Are Needed to Justify a Regional Specialty Center?

<table>
<thead>
<tr>
<th>User Population</th>
<th>Specialty Services</th>
</tr>
</thead>
</table>
| **120,000 users** | NICU, Open Heart, Neurosurgery, Psych Nursing  
ANMC (140,000 – 152 beds) GIMC (110,000 – 78 beds)  
PIMC (110,000 – 127 beds) |
| **60,000 users** | Cardiology, Neurology, Urology, MRI, Speech Therapy  
Still No Invasive Cardiology |
| **30,000 users** | General Surgery, Orthopedics, Ophthalmology, Otolaryngology, Dermatology, Ob/Gyn, CT, Labor & Delivery Ped/Med/Surg & ICU Beds |
| **15,000 users** | Specialized Primary Care, Mammo, Ultrasound, Occupational Therapy, Ambulatory Procedures, Medical Short Stay Beds |
| **7,500 users** | Lab, Radiography, Physical Therapy, Podiatry, Audiology, & Psychiatry |
| **3,750 users** | Primary Care, Dental, Optometry, Pharmacy, PHN, Mental Health & Substance Abuse |

Not sustainable or not enough increase in services to justify regional center if user population is less than 30,000.

More specialty services are available with a user base of 60,000.

We can offer more services at this level.
## Options Considered in 2013 Feasibility Study

### One Inpatient Facility
- Anchoring Additional Outpatient Facilities

<table>
<thead>
<tr>
<th>Scenario</th>
<th>IP + OP</th>
<th>ALL IP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redding</td>
<td>OP</td>
<td>IP</td>
</tr>
<tr>
<td>Sacramento</td>
<td>IP</td>
<td>IP</td>
</tr>
<tr>
<td>Fresno</td>
<td>OP</td>
<td>IP</td>
</tr>
<tr>
<td>Temecula</td>
<td>OP</td>
<td>IP</td>
</tr>
</tbody>
</table>

### Multiple Inpatient Facilities

<table>
<thead>
<tr>
<th># of Centers</th>
<th>OP or IP</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3 OP/1 IP</td>
</tr>
<tr>
<td>3</td>
<td>2 OP/1 IP</td>
</tr>
<tr>
<td>2</td>
<td>1 OP/1 IP</td>
</tr>
</tbody>
</table>

| 4            | 4 IP     |
| 3            | 3 IP     |
| 2            | 2 IP     |
Four Center Option

Redding: 20,088 users
  • 12,805 greater than 3 hours drive
Sacramento: 31,865 users
  • 1,199 greater than 3 hours drive
Fresno: 10,480 users
  • 2,790 greater than 3 hours drive
Temecula: 24,813 users
  • 988 greater than 3 hours drive
Three Center Option

Redding: 20,088 users
  • 12,805 greater than 3 hours drive
Sacramento: 41,973 users
  • 6,565 greater than 3 hours drive
Temecula: 25,185 users
  • 988 greater than 3 hours drive
Two Center Option

Sacramento: 61,981 users
- 22,964 greater than 3 hours drive
- This gets Sacramento over the 60,000 user threshold that would allow us to provide additional services, such as cardiology, neurology, urology, etc.

Temecula: 25,185 users
- 988 greater than 3 hours drive

THIS IS THE RECOMMENDED SOLUTION FROM THE FEASIBILITY STUDY AND MOST LIKELY TO BE FUNDED THROUGH IHS PRIORITY SYSTEM
Services Included in Two Center Option

- Audiology
- Dental Specialty Care
- Medical Specialty Care*
- Surgical Specialty Care*
- Outpatient Endoscopy*
- Outpatient Surgery
- Short Stay/Observation
- Lab

- Diagnostic Imaging
  - Radiography
  - Fluoroscopy
  - Ultrasound
  - CT
  - MRI*
  - Radiologist

- Pharmacy

- Inpatient
  - Pediatrics
  - Adult Medical
  - Adult Surgical
  - ICU

- Physical Rehab
  - Occupational
  - Speech

- Psychiatry
- Case Management
- Pain Management

*Services in blue text would be offered at Sacramento location, but not at (or only limited services at) Temecula location
Medical and Surgical Specialties Proposed

Medical Specialties:
- Cardiologist
- Dermatologist
- Neurologist
- Endocrinologist
- Gastroenterologist
- Gerontologist
- Rheumatologist
- Others

Surgical Specialties:
- General Surgeon
- Ophthalmologist
- Orthopedist
- Otolaryngologist
- Urologist
- Thoracic Surgeon
- Plastic Surgeon
- Others
Cost Estimates – Two Center Option

2013 Construction Cost Estimate for both facilities - $254.5 million

2013 Annual Operating Cost Estimate for both facilities - $134.6 million

These costs are likely double (or more) in 2022.
FAQ’s

Q: Why aren’t these Regional Centers closer to my reservation / rancheria?
A: They need to be in reasonably large cities with amenities nearby to attract qualified specialists.

Q: Why can’t we build more Regional Centers?
A: Two reasons – one, a Regional Center really needs to serve 30,000 users or more to be sustainable and viable (even more services with 60,000 users). Two, the greater the population served, the better it will score when competing for funding.

Q: Why aren’t we planning for a full scale hospital?
A: We don’t have sufficient user population to justify such a hospital. Furthermore, a full hospital would compete with Tribal Health Programs for some services. However, if Tribal leaders want to pursue this option, we can consider it – it would require a new feasibility study – more time and $$.

Q: Why was inpatient recommended over outpatient-only?
A: For the Regional Centers to be viable for a large population who have to travel great distances for service, need to expand the services provided – thus inpatient services also included.
How Will We Get There?

HEALTHCARE FACILITIES CONSTRUCTION PROJECTS
DEMONSTRATION PROJECTS
Health Care Facilities Construction (HCFC) Funding  
Grandfathered List – Approaching the End

- IHS has been operating under the Grandfathered List for 30 years now
- IHS is anticipating completing funding of all remaining health care facilities on the Grandfathered List within the next 5 to 10 years
  - This timeframe is approximate – depends on the appropriations we receive from Congress
  - CONTEXT:
    - FY 21 HCFC Appropriation: $259 million
    - FY 22 HCFC Appropriation: $259 million (higher amount requested in budget)
    - Estimated funding needed to complete grandfathered list is approximately $2 billion
- When those needs on the grandfathered list are all fully funded, IHS will implement a new Health Care Facilities Priority System (HCFPS) – starting approximately in 2030 (estimated)
Goals of the revised priority system methodology

The revised priority system does two things:

- It provides a Comprehensive National Listing of Facility Need by identifying the total need for construction of IHS and Tribal healthcare facilities, and
- Provides a process for prioritizing that need for the authorized facilities construction programs.
  - The revised HFCPS is not intended to identify or prioritize the need for staffing and other resources.
  - The revised HFCPS does not prioritize the need for staff quarters; however, this need is evaluated and addressed prior to requesting construction funding for a facility.
  - The revised HFCPS can only evaluate, identify, and prioritize facilities that are part of an Area Health Services and Facilities Master Plan and that are reporting statistical data to the IHS National Patient Information Reporting System (NPIRS).
Revised Priority System – Scoring by Category

- All health care facilities construction needs should be on the list, including SAP, JV, Urbans*
- Phase I scoring updated every 5 years, Phase II scoring updated every year

* Urban programs not yet eligible for HCFC funding, but reported for budgetary purposes

<table>
<thead>
<tr>
<th>Facilities Categories</th>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Following Phase I scoring, all facilities are placed in an initial category by type of facility. Each facility category is then [describe how] further evaluated during the selection process for Phase II.</td>
<td>Category A</td>
<td>An ambulatory care facility operating a minimum of 40 hours per week, staffed with a basic health team offering services for acute and chronic ambulatory problems and which may act as a referral center to other levels (higher acuity and specialty) of care. A Comprehensive Health Care Center could include an alternative rural hospital for purposes of the IHS construction priority system.</td>
</tr>
<tr>
<td>Comprehensive Health Care Center</td>
<td>Category B</td>
<td>A facility providing inpatient services, ambulatory care, and a range of inpatient and ambulatory specialty care. The facility must meet IHS average daily patient load (ADPL) &gt; 15 policy and usually provides general surgery and full service OB/DYN. Patients for these facilities are routinely referred from Health Centers.</td>
</tr>
<tr>
<td>Comprehensive Inpatient Facility</td>
<td>Category C</td>
<td>An ambulatory care facility designed to serve populations less than 1,200.</td>
</tr>
<tr>
<td>Small Health Care Clinic</td>
<td>Other</td>
<td>Facilities other than those described above, e.g. Youth Regional Treatment Centers, Dental Units, etc.</td>
</tr>
</tbody>
</table>
# Revised Priority System Scoring Criteria

<table>
<thead>
<tr>
<th>Evaluation Criteria</th>
<th>Evaluation Criteria Value</th>
<th>Phase I Criteria Weighting</th>
<th>Phase II Criteria Weighting</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Resources Deficiency</td>
<td>Score Between 0 &amp; 1</td>
<td>X</td>
<td>400</td>
<td>400</td>
</tr>
<tr>
<td>Health Status</td>
<td>X</td>
<td></td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>Isolation/Barriers to Service</td>
<td>Isolation X</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Barriers to Service X</td>
<td>Phase II only X</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Facility Size</td>
<td>X</td>
<td>150</td>
<td>150</td>
<td>150</td>
</tr>
<tr>
<td>Innovation</td>
<td>Phase II only X</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Maximum Possible Score</td>
<td>+</td>
<td>850</td>
<td>1000</td>
<td>1000</td>
</tr>
</tbody>
</table>
How Do We Compete for HCFC Funding under the New Priority System?

- NEED A NEW CALIFORNIA AREA MASTER PLAN
- Any Facilities need to be on an Area Master Plan to be considered for HCFC funding under Two-tiered priority system (including SAP and Joint Venture)
  - Most recent full California Area Health Care Facilities Master Plan was completed in 2005
  - Also a Regional Ambulatory Surgical and Specialty Health Services Feasibility Study was completed in 2013
  - Also need to identify funding – Area master plan will be a multi-million $$ effort. IHS Headquarters is tentatively planning for $1.5 million per Area for master plans (this is likely not enough for California).
  - IHS HQ is planning to start master plans in May 2023, have completed by May 2025.
  - Ideally, before we award the contract for our California Area master plan, we will have a concept approved by Tribes for what type(s) of facilities we want, that the master plan can develop.
The Indian Health Care Improvement Act (IHCIA) authorized the IHS to fund “demonstration projects”

- A formal program has not been created yet, but IHS HQ is exploring it now.

One category of projects is “convenient care services,” or any primary health care service, such as urgent care services, nonemergent care services, or prevention services and screenings that is offered—(A) at an alternative setting; or (B) during hours other than regular working hours.”

The other category of projects is “alternative or innovated methods” of health care delivery within a service area. They may include medical, dental, pharmaceutical, nursing, clinical laboratory, contract health services, convenient care services, community health centers, or any other health care services delivery models designed to improve access to, or efficiency or quality of, the health care, health promotion, or disease prevention services and programs under the IHCIA.

IHS is further authorized to use its discretion to provide several new facility types, including Specialty Care Centers. In response to an IHS letter requesting input on the new facility types, Tribal leaders identified Specialty Care Centers as one of their top five priorities for implementation.
Criteria for Demonstration Projects

(1) There is a need for a new facility or program or the reorientation of an existing facility or program.

(2) A significant number of Indians, including those with low health status, will be served by the project.

(3) The project has the potential to deliver services in an efficient and effective manner.

(4) The project is economically viable.

(5) The organization has the administrative and financial capability to administer the project.

(6) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services.
How Do We Submit a Request for a Demonstration Project?

- Portland, Oklahoma, Phoenix and Nashville Areas have already expressed interest in having Demonstration Projects funded.
- The sooner California Area submits a request, the more likely we would be to receive funding.
- Need to have a feasibility study completed already, and it needs to be incorporated into the Area’s master plan.
  - Existing feasibility study may need to be updated (for costs at minimum)
- Need to submit a request approved by Tribal and Area leadership showing support for the demonstration project.
- Funding may be available sooner for this – don’t have to wait until 2030.
Next Steps
Next Steps for Healthcare Facility

1. We need Tribal consensus on what are our priorities for the next California Area healthcare facility
   - Do we want to create an advisory group to evaluate different healthcare facility options (type and location) and propose a priority for Tribal leaders to vote on?
   - Are you ready to vote on an option after this meeting without any further evaluation?

2. When consensus is reached, develop or update feasibility study for the preferred option(s)
   - We likely have enough funding to update existing study, may need more $$ for a new one
   - Also, make sure preferred option is incorporated into new California Area Master Plan

3. As applicable, submit for Demonstration Project funding (available soon) and / or Health Care Facilities Construction funding under new priority system (likely not available before 2030)

4. Also, once we have consensus, we can start the next step – evaluation of sites.

- Realistically – best case scenario, this process from planning to funding to construction to having a facility providing services, will take 10-15 years. More likely may stretch to 20 years.
- The work we do now to build consensus and get planning started will help reduce that timeline.
Discussion of California Area Healthcare Facilities Priorities
Thanks and take care

Contact me with any questions or follow-up

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Phase I - Facility Resource Deficiency

Criterion with the greatest weight (400 points)

Existing facility size, age and condition are used to determine “Adjusted Existing Space” – based on data in HFDS

Required space is based on user population

See formulas to the left
Phase I - Health Status and Isolation Factors

- Health Status based on metrics of the user population (200 points)
- Isolation – 100 points
- Population over 55 likely to be modified to Average life expectancy
- “The nearness of an emergency room does not mean that this emergency room would be the primary access to services for IHS and Tribal patients. The availability of an emergency room is used as a measure of isolation because it is assumed that any place supporting an emergency room would have healthcare services available.”

Table 4, Calculating the Health Status Criterion Value

<table>
<thead>
<tr>
<th>Health Status Indicators from the FDI</th>
<th>Health Status Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Disparities Index</td>
<td>X .25 =</td>
</tr>
<tr>
<td>Percent of Population over 55</td>
<td>X .25 =</td>
</tr>
<tr>
<td>Composite Poverty Index</td>
<td>X .25 =</td>
</tr>
<tr>
<td>Disease Disparities Index</td>
<td>X .25 =</td>
</tr>
<tr>
<td>Total</td>
<td>Maximum of 1</td>
</tr>
</tbody>
</table>

Table 5, Calculating Isolation

<table>
<thead>
<tr>
<th>If the facility is:</th>
<th>Isolation Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 40 Km from an ER</td>
<td>Isolation = 0</td>
</tr>
<tr>
<td>40 - 90 Km an ER</td>
<td>Isolation = Km to Alternatives + 90 Kilometers</td>
</tr>
<tr>
<td>More than 90 Km an ER</td>
<td>Isolation = 1</td>
</tr>
<tr>
<td>Not on a road connecting to Federal or state highway</td>
<td>Isolation = 1</td>
</tr>
</tbody>
</table>
Phase I - Facility Size Criterion

- Required space is same as calculated in Facility Resource Deficiency, based on user population
- Purpose of this factor is to increase score for smaller facilities (150 points)
- These are the four criteria for the Phase I scoring process – much of the data is available at HQ level, so data requirement is minimal
- However, facilities need to be part of an Area Healthcare Services and Facilities Master Plan to be scored under Phase I
Phase II – Barriers to Service

- The two additional scoring criteria for Phase II require more evaluation and investigation.
- The ability to access health care may be difficult for reasons besides the geographic distance to available services. Some IHS patients may find other hindrances to obtaining services in hospitals and clinics available to them.
- The Barriers-to-Care Criterion attempts to capture these situations by increasing the Priority Score by up to 50 points in Phase II.
- Information required to support Barriers-to-Service is documentation showing that IHS clients have been consistently turned away or not provided services at the available facilities.
- The documentation must show that there is a pattern of IHS clients not receiving services at the same level and with the same consistency as other patients at the available facilities.
- Documentation must be validated by Validation Committee before scoring is applied.
Phase II – Innovation Criterion

- Documented innovative ways to (1) increase health promotion / disease prevention, (2) increase efficiency or effectiveness of health care delivery services, and/or (3) reduce costs in acquiring, operating or maintaining facilities.

- Up to 5 innovations can be considered – 20 points each, up to 100 points total.

- Examples include:
  - Developing a written shared use agreement with private or other non-IHS health delivery organizations involving major diagnostic or treatment departments, e.g. one health program providing diagnostic imaging while the other would establish and maintain a burn unit.
  - Developing other health delivery innovations that involve major medical departments or programs and partnering with State or Local Health Programs.
  - Providing a portion of the cost of construction or operation (at least 15% of the total acquisition cost, or at least 15% of the annual recurring costs for the life of the facility; i.e., operation, maintenance, and staffing. A proportionally fewer number of points are assigned for lesser contributions. Greater contributions do not generate more points.
  - Developing, administering, and funding a public health initiative or program.
  - Other types of innovative approaches

- All innovations will be evaluated and verified by the Validation Committee