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

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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)

HOSPITALS	HEALTH CENTERS		QUARTERS	YOUTH REG. TREAT. CTRS.
Pine Ridge, SD 1993	Sallisaw, OK 1992	Pawnee, OK 2004	Dulce, NM 1993	Alaska - Fairbanks, AK 1993
Shiprock, NM 1995	Puyallup, WA 1993	Pinon, AZ 2005	Barrow, AK 1993	Alaska – Mt. Edgecumbe, AK 1994
Crow Agency, MT 1995	Taos, NM 1993	St. Paul, AK 2005	Rosebud, SD 1993	Phoenix – Sacaton, AZ 1994
Kotzebue, AK 1995	Wagner, SD 1993	Metlakatla, AK 2006	Pine Ridge, SD 1993	Portland – Spokane, WA 1996
Anchorage, AK 1997	Belcourt, ND 1994	Red Mesa, AZ 2006	Kotzebue, AK 1993	Aberdeen – Chief Gall, SD 1996
Talihina, OK 1999	Tohatchi, NM 1995	Clinton, OK 2007	Belcourt, ND 1997	Phoenix – Wadsworth, NV 2007
Ft. Defiance, AZ 2004	Stilwell, OK 1995	Sisseton, SD 2007	Hopi, AZ (Polacca) 2001	California – Hemet, CA 2016
Winnebago, NE 2004	Ft. Belknap, MT	PIMC Southwest, AZ 2008	Bethel, AK 2005	California – Davis, CA 2019
Nome, AK 2012	Hays, MT 1997	New Town, ND 2011	Zuni, NM 2006	
Barrow, AK 2013	Harlem, MT 1998	Eagle Butte, SD 2011	Fort Belknap, MT 2007	
	White Earth, MN 1998	San Carlos, AZ 2015	Wagner, SD 2010	
	Lame Deer, MT 1999	Kayenta, AZ 2015		
	Hopi, AZ 2000	PIMC Southeast, AZ 2017		
	Parker, AZ 2001	Ft. Yuma, AZ 2018		

PRIORITY LISTS

Health Care Facilities Construction

Inpatient:

PIMC Health System, AZ,
PIMC Northeast ACC #
PIMC Central Hospital, ACC *
Whiteriver, AZ *
Gallup, NM *
Rapid City, SD #
Dilkon, AZ #
Alamo Navajo, NM #
Pueblo Pintado, NM *
Bodaway Gap, AZ *

Outpatient:

Albuquerque Heath 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
- Desert Sage construction complete in 2016, started accepting residents in 2017.
- 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?

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

120,000 users

Still No…

NICU, Open Heart, Neurosurgery, Psych Nursing

- *ANMC (140,000 – 152 beds) GIMC (110,000 – 78 beds), PIMC (110,000 – 127 beds)*

60,000 users

Plus…

Cardiology, Neurology, Urology, MRI, Speech Therapy

- *Still No Invasive Cardiology*

We can offer more services at this level

30,000 users

Plus… General Surgery, Orthopedics, Ophthalmology, Otolaryngology, Dermatology, Ob/Gyn, CT, Labor & Delivery Ped/Med/Surg & ICU Beds

True Regional Services start to happen here

15,000 users

Plus…

Specialized Primary Care, Mammo, Ultrasound, Occupational Therapy, Ambulatory Procedures, Medical Short Stay Beds,

7,500 users

Plus…

Lab, Radiography, Physical Therapy, Podiatry, Audiology, & Psychiatry

3,750 users

Full-time Services…

Primary Care, Dental, Optometry, Pharmacy, PHN, Mental Health & Substance Abuse

Options Considered in 2013 Feasibility Study

	One Inpatient Facility Anchoring Additional Outpatient Facilities			Multiple Inpatient Facilities		
	IP + OP			ALL IP		
Scenario	1	2	3	4	5	6
Redding	OP	OP		IP	IP	
Sacramento	IP	IP	IP	IP	IP	IP
Fresno	OP			IP		
Temecula	OP	OP	OP	IP	IP	IP
# of Centers	4	3	2	4	3	2
OP or IP	3 OP/1 IP	2 OP/1 IP	1 OP/1 IP	4 IP	3 IP	2 IP

Four Center Option

Redding: 20,088 users

- 12,805 greater than 3 hours drive

Sacramento: 31,865 users

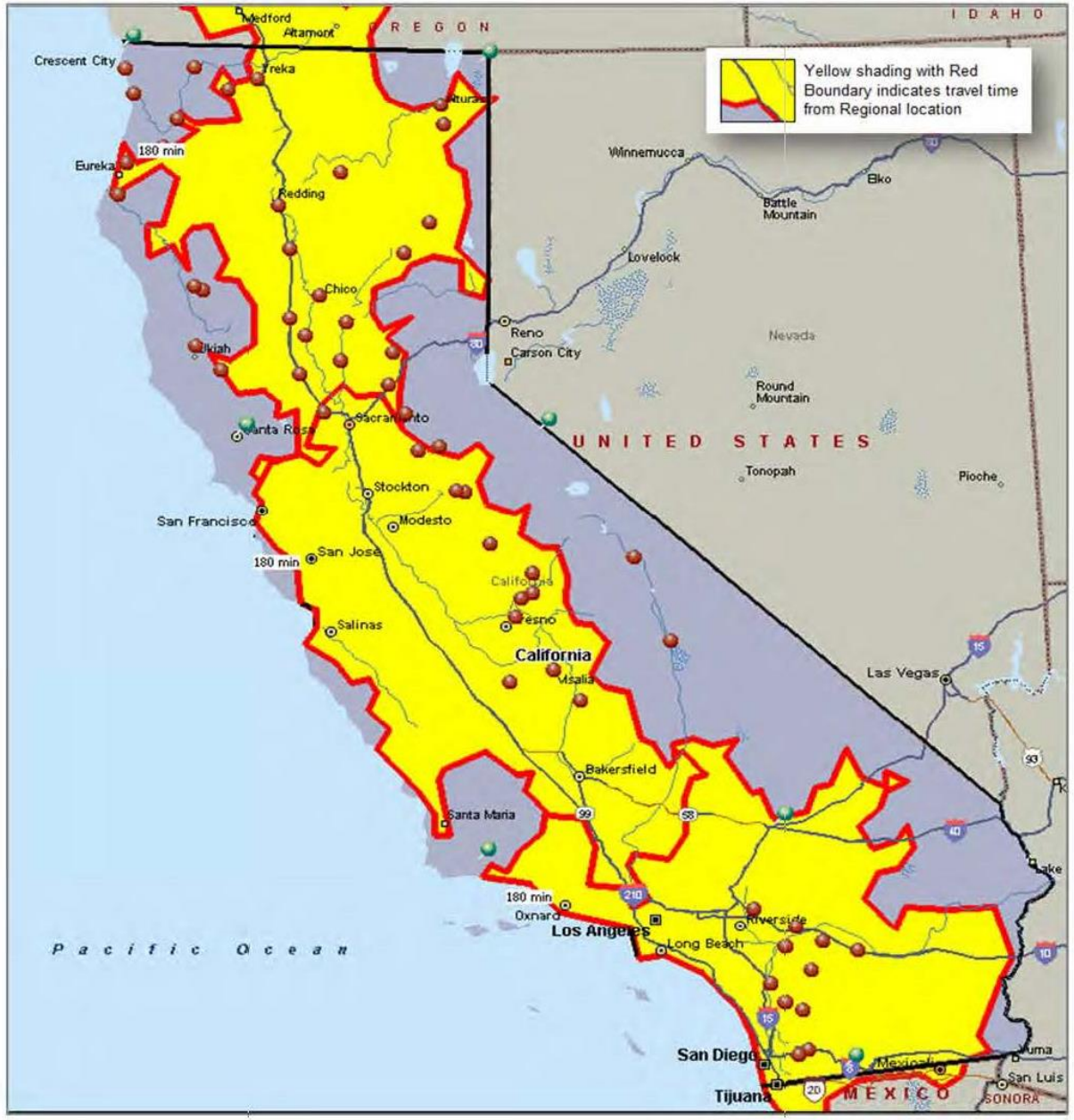
- 1,199 greater than 3 hours drive

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

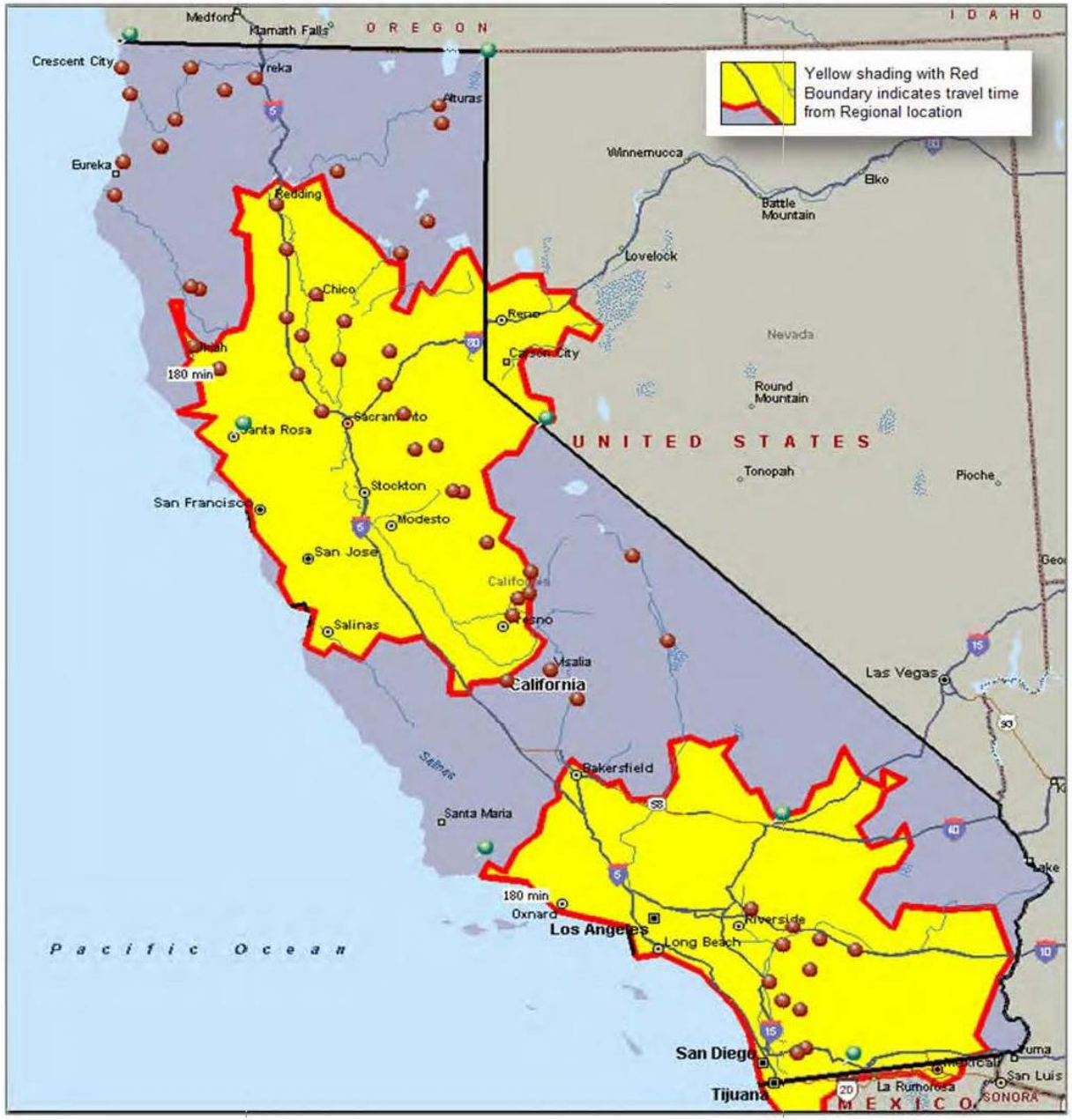
- 12,805 greater than 3 hours drive

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 10, Facilities Categories

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.	Category	Category Abbreviation	Description
	Comprehensive Health Care Center	Category A	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.
	Comprehensive Inpatient Facility	Category B	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))≥ 15 policy and usually provides general surgery and full service OB/GYN. Patients for these facilities are routinely referred from Health Centers.
	Small Health Care Clinic	Category C	An ambulatory care facility designed to serve populations less than 1320.
	Other	Other	Facilities other than those described above, e.g. Youth Regional Treatment Centers, Dental Units, etc.

Revised Priority System Scoring Criteria

Evaluation Criteria		Evaluation Criteria Value		Phase I Criteria Weighting		Phase II Criteria Weighting		Score
Facility Resources Deficiency		Score Between 0 & 1	X	400	or	400	=	
Health Status			X	200	or	200	=	
Isolation/ Barriers to Service	Isolation		X	100	or	100	=	
	Barriers to Service	Phase II only	X		or	50	=	
Facility Size			X	150	or	150	=	
Innovation		Phase II only	X		or	100	=	
Maximum Possible Score			+	850	or	1000	=	

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.

Demonstration Project

- 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

Table 2, Phase I Required Space Formula

	Base size	Population Increment		Phase I Required Space
Required Space =	200 m^2	+ (.8 m^2 X user population)	=	

Table 3, "Calculating the Facility Deficiency Criterion Value," illustrates how the Facility Deficiency criterion will be calculated.

Table 3, Calculating the Facility Deficiency Criterion Value,

	Calculate the Facilities Resource Deficiency		Facility Resource Deficiency Value
Facility Resource Deficiency[1] =	1 - (Adjusted Existing Space / Required Space)	=	

- 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

Table 4, Calculating the Health Status Criterion Value

Health Status Indicators from the FDI				Health Status Value
Birth Disparities Index	X	.25	=	
Percent of Population over 55	X	.25	=	
Composite Poverty Index	X	.25	=	
Disease Disparities Index	X	.25	=	
			+	
Total				Maximum of 1

Table 5, Calculating Isolation

If the facility is:					Isolation Value
Less than 40 Km from an ER	Isolation	=	0	=	0
40-90 Km an ER	Isolation	=	Km to Alternatives ÷ 90 Kilometers	=	
More than 90 Km an ER	Isolation	=	1	=	1
Not on a road connecting to Federal or state highway	Isolation	=	1	=	1

- 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."

Phase I - Facility Size Criterion

Table 8, Facility Size Criterion

If Required Space is	Use							Facility Size Value
0 to 1 200m^2		1						1
1 201m^2 – 6 000m^2	(1	–	[(Required Space	–	1 200 m2)	X	0.00006])	
6 000 m^2 than 12 800m^2	(.712	-	[(Required Space	–	6000 m2)	X	0.0000428])	
More than 12 800 m^2	(.46	-	[(Required Space	–	6000 m2)	X	0.0000135)	

- 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 facilties.
- 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