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**Healthcare Facilities Construction Priority System
Methodology**

Indian Health Service

Department of Health and Human Services

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Healthcare Facilities Construction Priority System Methodology

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1-00.1 Executive Summary

In language accompanying the FY 2000 appropriations, the Congress directed the Indian Health Service (IHS), in consultation with the Tribes, to review and revise the IHS Healthcare Facilities Construction Priority System (HFCPS). Congress indicated that the review should address specific issues related to projects “funded primarily by Tribes; anomalies such as extremely remote locations; recognition of projects that involve minimal increases in operational costs; and options for alternative funding and modular construction.” In response to this directive, the IHS Director established the Facilities Needs Assessment Workgroup to review the current Priority System and recommend changes to the Facilities Appropriation Advisory Board (FAAB). Two significant recommendations of the Workgroup and the FAAB were that the methodology incorporate five criteria and that Area Services and Facilities Master Plans (Master Plans)

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be completed before PSAs/facilities are evaluated and prioritized. The five criteria and their weighting in the methodology are:

Facility Deficiencies (40%)	The Facility Deficiency Criterion indicates the facility space deficiency by comparing the existing space, adjusted for age and condition, with the space required to house services for a given population. IHS has identified two methods for estimating the space required to house services: the Base Health System Planning Process (HSP) ¹ and the Supportable Space Formula ² . The FAAB believes that a version of HSP the IHS should be used, but also believes that Tribes should have the opportunity to comment on both options. See page 5 for a discussion of these options.
Health Status/Health Resources Indicators (20%)	The Health Status/Health Resources Indicator Criterion increases the ranking for those facilities where there are relatively fewer resources for health programs. IHS has identified three options that could be used as Health Status/Health Resources Indicators: Adjusted Clinical Group Methodology (ACG) ³ , the Federal Health Benefits Plan Disparities Index (FDI) ⁴ , and Status Index comprised of 3 health indicators. The FAAB recommended eliminating the ACGs as an option, but asked IHS to present the other options for Tribal review. See page 6 for a discussion of these options.
Isolation/Barriers-to-Services (15%) 10% for Isolation + 5% for Documented Barriers-to-Services 15% Total	In rural Indian country, access to healthcare is partially dependent on the time it takes to get to a medical facility. The ability to access health care may also be dependent on other factors not related to the physical distance to services. The Isolation/Barriers-to-Services Criterion increases the HFCPS ranking based on both these limitations on

¹ The Base HSP generates space data without manual overrides of assigned threshold values and without manual addition of functions, i.e. additional services, specialty clinics, etc.

² The IHS Supportable Space Formula is used to estimate the space that IHS supports for allocation of Maintenance and Improvement Funds. The formula is: $200m^2 + (user\ population \times .8m^2)$.

³ The ACG is a measurement system, designed by Johns Hopkins University, and widely used in the healthcare industry to aid in identifying differences between patient populations in healthcare resource needs.

⁴ The FDI is an index used to allocate Indian Health Care Improvement funds that includes a health status indicator. The index is based on the relative difference between the federal employee's benefits package and the resources available for treatment of American Indians and Alaska Natives.

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	obtaining medical services.
Facility Size *****(15%)	The Facility Size Criterion increases the total ranking inversely proportional to the size of the facility. The small facilities could receive up to 150 points while the largest facilities receive 0 points.
Innovation (10%)	The Innovation Criterion increases the total ranking where a Tribe has documented innovation in acquiring a facility or delivering health services.

The revised HFCPS methodology does two things: it develops a complete, preliminary ranking of IHS and Tribal healthcare facilities construction need, and it provides a mechanism for prioritizing that need for each of the authorized healthcare facilities construction programs. To accomplish both of these tasks, the HFCPS incorporates two related processes:

- Phase I, the Facilities Needs Assessment process, permits IHS to develop a categorized, preliminary ranking of all healthcare facilities needs using available data in the IHS services and facilities databases; and
- Phase II, the Project Prioritization process, permits IHS to use the categories and preliminary rankings to focus resources on a group of PSAs/facilities projects for more intensive validation, evaluation and possible selection for funding and prioritization under one of the authorized healthcare facilities construction programs.

The revised HFCPS depends on the Master Plans and IHS databases. Each Primary Service Area (PSA) identified in the Master Plan will be reviewed to assure efficient and effective delivery of healthcare services. Tribes, service units, and Area Offices may be asked to provide information in support of some data that is not readily verifiable (e.g., documentation of facility size and condition of Tribal facilities that are not incorporated into the IHS databases).

The Facilities Needs Assessment Process, Phase I, is intended to provide a preliminary ranking score for all Tribal and IHS PSAs/facilities identified in the Master Plans as part of the IHS funded healthcare program. These rankings are reassessed on a five year cycle to update information and review categorization of all PSAs/facilities. Major changes (such as several Tribes pooling resources and forming a larger PSA) would generate a different score and ranking. New PSAs, e.g., newly federally recognized Tribes, may be added and evaluated for Phase I ranking as they are identified and incorporated into Master Plans. This score generated to establish a preliminary ranking is not the facility's priority score, because, although it is based on the best information available, the information has not been validated, and until it is validated, IHS cannot use it as a justification for requesting or allocating construction funding. The purpose of the preliminary ranking and categorization is to identify potential projects for further evaluation and possible prioritization.

The Project Prioritization process, Phase II is intended to provide a consistent means of prioritizing projects as the need arises for each of the specific healthcare facilities construction programs. During Phase II, all of the data for the highest ranking

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PSAs/facilities in Phase I will be validated. A sample twice as large as estimated to be funded will be selected for the Phase II Process. This number will ensure that the Phase II list contains all the top rated PSAs/facilities with the potential to make the final priority list.

When the Project Prioritization process is implemented for a specific construction program, the facilities with the highest preliminary ranking in appropriate categories will be selected for further evaluation and possible prioritization. This evaluation process includes a full validation of all data and information for the selected projects, including the criteria not contained in the IHS databases, e.g., the Barriers-to-Service and Innovation. This validation will be completed by the Healthcare Facilities Validation Committee, a committee appointed by the IHS. After the Phase II score of a PSA/facility has been validated, the PSA/facility will be listed in rank order and by category. The highest ranking PSA/facilities will be advised to proceed, in conjunction with the appropriate Area Offices, with the development of the final healthcare facility planning documents (i.e., Program Justification Documents, Project Summary Documents, Program of Requirements, etc.). The number of facilities selected to prepare planning documents will depend on the funding available or expected to be available.

For the Line Item Priority List, which has a recurring base of funding, the PSA/facility will be placed on the Priority List upon IHS approval of the planning documents, and remain there until funded. PSAs/facilities that do not prepare planning documents within five years will be re-evaluated during the subsequent five-year cycle.

For construction programs without a recurring base of funding, the PSA/facility priority will be used to select projects for a similar approval process. If appropriated funds are not sufficient to fund all prioritized projects, those projects with approved planning documents that are not funded will be held until funding for the same or a similar construction program has been appropriated.

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BEGINNING - Review Options Section -

HOW SHOULD THE HFCPS ESTIMATE REQUIRED SPACE FOR PHASE I

IHS is currently considering two options for estimating required space: the **Supportable Space Formula** and the **Base HSP**. Below is a summary description of each option. Please select the option preferable to you and indicate why you believe it is preferable. If either or neither option below is acceptable, that too is a helpful response; however, if you do not believe either option is acceptable, please provide guidance on how the HFCPS should estimate required space. In your review and comment please consider the resources required to generate an estimated space value. During Phase I of the HFPCS, resources will need to be expended to make this estimate for every Tribal and IHS facility. The IHS and the FAAB believe either of the options below account for efficient and effective use of resources during Phase I. During Phase II of the HFCPS, the full HSP will be used to determine actual space to be constructed.

OPTIONS FOR ESTIMATING REQUIRED SPACE:

OPTION 1 Description: The **Supportable Space Formula** is a method to determine required space utilizing a standardized formula which was developed and used to estimate the space that IHS supports for allocation of Maintenance and Improvement Funds. This formula is based on historical data obtained through a review of approved planning documents. The formula is as follows:

$$\text{Required Space (m}^2\text{)} = 200 + (\text{User Population} \times 0.8)$$

This method for estimating required space does not account for the demographics of the user population; however, it is simple and objective, requires no training or special knowledge.

OPTION 2 Description: The **Base HSP** provides a more detailed measure of the needs of a facility, based upon the demographics of the communities which it serves. It is computed by running the HSP process without overriding any of the threshold values assigned and without adding functions manually such as additional services and specialty clinics. In order to generate space requirement values where space is determined by staffing, values for workload, user population, and floor space automatically produced by the HSP are then run through the Resources Requirements Methodology (RRM) to generate staffing levels. These staffing levels are reintroduced into the HSP, and the resulting new floor space total is used to revise the RRM. This process is repeated until the estimated required space is sufficient to meet the RRM requirement. Usually no more than two iterations are required.

While this process produces a value that takes into account the demographics of a population, it is a somewhat complex process that requires a trained user to operate.

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WHAT SHOULD THE HFCPS USE AS A HEALTH STATUS/HEALTH RESOURCES INDICATOR?

During the process of developing the HFCPS, the IHS identified options that might be used to represent health status. The FAAB recommended that two of these be presented as options for Tribal review. A description of those options is presented below. In your comments, please indicate the option preferable to you and indicate why you believe it is preferable. If either or neither option below is acceptable, that too is a helpful response; however, if you do not believe either option is acceptable, please provide guidance on what could be used as a health status/health resources indicator.

Please note that in the original recommendation to IHS the Facilities Needs Assessment Workgroup recommended that IHS use a “Health Status” indicator. Option 1 below incorporates more measures than just health status and is more accurately identified as a Health Resources Indicator. As a result in this draft HFCPS, all references to this factor identify it as “Health Status/Health Resources Indicator.” If Option 1 is selected for inclusion in the final document, that identifier will be changed throughout the document to “Health Resources Indicator.” If Option 2 is selected, the reference will be changed to “Health Status Indicator.”

OPTION 1 Description: One rough indicator of health status/health resources is the Federal Health Benefits Plan Disparities Index (FDI). The FDI index is currently being used by IHS to allocate Indian Health Care Improvement Funds and is designed to identify those locations with the greatest resource deficiencies. Although it contains health status indicators among the factors used to develop it, the FDI also contains other factors related more to the resources available to provide services at a location and so is more a “Health Resources Index” than a “Health Status Indicator.” The FDI also differentiates down to the operating units in the IHS funded healthcare system; i.e., almost every PSA will have an individual score.

OPTION 2 Description: Another way to indicate health status/health resources is to use three easily obtained indicators to develop an independent health status index. The IHS selected the following as fair gauges of health status that might indicate a need for a facility: 1) Percent of the population over 55 years old, 2) Composite Poverty Index and 3) Poor Health Status Index. While the proposed criterion utilizes actual IHS health data, the Poor Health Status Index, is available only as an Area wide value, so that all PSAs in an Area will have the same Index. However, the population age statistics are available for each community and the Composite Poverty Index from the FDI differentiates down to the operating level.

- Review Options Section - END

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Introduction

A. Scope of This Document

This document describes the revised Indian Health Service (IHS) Healthcare Facilities Construction Priority System (HFCPS) methodology and the process to be used in its implementation. All PSAs/facilities identified in the Area Health Services and Facilities Master Plans will receive a Phase I score. The aggregate of the Facilities Deficiency Criteria would also contain the information needed to develop the total unmet facilities need.

B. Scope of the HFCPS Methodology

The objective of the HFCPS is to identify and prioritize those locations requiring space in order to house the programs to provide health and related services. The HFCPS is not intended to identify or prioritize the need for staffing and other resources, although these resources are often added to the IHS recurring base funding when a facility is constructed under some construction programs.

The revised HFCPS methodology does two things: it identifies the total need for construction of IHS and Tribal healthcare facilities⁵, and it provides a process for prioritizing that need for each of the authorized facilities construction programs. To accomplish both of these tasks, the HFCPS Methodology incorporates two related processes that

- First, permit IHS to develop a ranked, categorized listing of all healthcare facilities needs using limited resources; and
- Second, permit IHS to use the categories and rankings to focus resources on identifying specific facilities construction projects for more intensive evaluation and possible selection for funding and prioritization under one of the authorized healthcare facilities construction programs.

C. Background

Section 301 of the Indian Health Care Improvement Act (IHCIA), Public Law (P.L.) 94-437 directs IHS to provide to Congress a list of the 10 highest priority inpatient and the 10 highest priority outpatient facilities construction projects. In order to comply with this directive, IHS established the HFCPS in 1991.

In language accompanying the FY 2000 appropriations, the Congress directed IHS, in consultation with the Tribes, to review and revise the existing HFCPS. Congress indicated that the review should address specific issues related to projects “funded primarily by Tribes; anomalies such as extremely remote locations; recognition of projects that involve minimal increases in operational costs; and options for alternative funding and modular construction.” In carrying out this directive, IHS decided to broaden its scope to consider language in proposed amendments to the IHCIA that would require IHS to report to Congress

⁵ Construction includes replacing, expanding and/or modernizing existing facilities and acquisition of new facilities.

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annually on the total need for healthcare facilities construction in Indian Country, including the facilities requirements for IHS Urban Programs.

The IHS established the Facilities Needs Assessment Workgroup and directed it to report to the IHS Facilities Appropriation Advisory Board (FAAB). Following extensive discussion of the existing system and how it might be changed, the Workgroup sent a report (See Exhibit A, “Needs Assessment and Priority Criteria Recommendations, Executive Summary”⁶) to the FAAB in February 2002; the FAAB reviewed the report and recommended that IHS use it, with some changes, as a basis for developing a revised HFCPS.

In general, the Workgroup Report provided recommendations on criteria to be used in revising the existing Healthcare Construction Priority System, including their relative weighting in the formula. It also recommended that Master Plans be completed and that facilities not participating in the master planning process not be considered for prioritization under the HFCPS. In order to include Tribes that choose not to develop a formal Master Plan for their PSA, the OEHE Directors have developed minimum requirements for these Tribes to include them in the Area Master Plans and the HFCPS. In addition, because the proposed IHCIA language would require IHS to report the need for facilities to house the IHS Urban Health Programs, the report recommended that the review of facilities need include the need for facilities for IHS Urban Programs, but that Urban Program facility requirements not be prioritized in the revised HFCPS. It is expected that the IHS Urban Program would prioritize and seek funding for facilities to house Indian urban healthcare programs.

D. Terms and Definitions

Alternative Rural Hospital – A rural IHS hospital with a small number (4 – 16) of beds and that may have a low risk birthing unit, but does not have general surgery or full service OB/GYN.

Base HSP - The Base HSP generates space data without manual overrides of assigned threshold values and without manual addition of functions, i.e. additional services, specialty clinics. (See HSP.)

Facility Needs Assessment Workgroup – (Referred to in this document as “the Workgroup”) A workgroup established by the Director of IHS to review the HFCPS and make recommendations for revising it to the FAAB.

FAAB – Facilities Appropriation Advisory Board. A board, composed of twelve Tribal and two IHS members, established by the Indian Health Service in consultation with the National Indian Health Board, to provide advice and recommendations related to policies and procedures of the Facilities Appropriation funded programs and to address other facilities issues.

⁶ Exhibit A contains the Executive Summary of Facilities Needs Assessment and Prioritization Workgroup Report. The full workgroup report is available on the Internet at <http://www.oehe.ihs.gov/faab/workgroup/workgroupfr.pdf>.

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FEDS – Facilities Engineering Deficiency System. One segment of the Healthcare Facilities Data System (See HFDS) that defines facilities deficiency categories requiring repair or renovation and provides cost estimates .

FDI – Federal Health Benefits Plan Disparities Index. An index used to allocate Indian Health Care Improvement funds that includes a health status indicator. The index is based on the relative difference between the federal employee’s benefits package and the resources available for treatment of American Indians and Alaska Natives.

HFDS – Healthcare Facilities Data System. A database that contains real property and repair backlog information on all IHS and some Tribal facilities.

HSP – Health Systems Planning process. A software package designed to provide the documents necessary for the government or its representative to plan and acquire approval for a medical program and collate and communicate the necessary information to an Architect/Engineer for the design of a facility.

IHS Area - One of the 12 regional administration units within the United States organized by the Indian Health Service to administer the various healthcare programs of in partnership with the Tribes.

IHS Supportable Space Formula – A formula used to estimate the space that IHS supports for allocation of Maintenance and Improvement Funds. The formula is: $200m^2 + (\text{user population} \times .8m^2)$.

NPIRS - National Patient Information Reporting System – The medical information system used by IHS to collect, store and disseminate all related medical data.

PSA - Primary Service Area. A geographical area where residents of Indian communities receive medical care at a healthcare facility staffed by primary care providers. Outpatient facilities are located within reasonable travel distance from the communities.

Required Space – The space necessary to house healthcare services for a given population. In order to plan the actual required space of a facility during the planning process, the IHS uses the HSP.

Option 1 Wording to be included in the final document: However, during Phase I of the HFCPS, which includes ranking of all Tribal and IHS PSA/facilities, required space is calculated using the IHS **Supportable Space Formula**. During Phase II, the full HSP will be used to determine the actual space requirements for the facility.

Option 2 Wording to be included in the final Document: During Phase I of the HFCPS, which includes ranking of all Tribal and IHS PSA/facilities, required space is calculated using the Base Health Systems Planning (HSP) process. During Phase II, the full HSP will be used to determine the actual space requirements for the facility.

1-00.2 Healthcare Facilities Validation Committee

The Healthcare Facilities Validation Committee or Validation Committee is a standing committee consisting of seven individuals appointed by the Director of

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IHS. Membership may include but not be limited to IHS Headquarters and Area Offices, Tribal, and other health oriented professionals. When formed, members will be asked to serve on the Validation Committee for at least 5 years initially, with no other limit on terms of service. The primary job of the Validation Committee is to validate all the data supporting the score of the highest ranking PSAs/facilities determined in the Phase I HFCPS process.

1-00.3 The HFCPS Methodology

A. Information Required for the HFCPS

The revised HFCPS depends on Area Health Services and Facilities Master Plans (hereafter referred to as Master Plans) and on the Healthcare Facility Data System (HFDS) to provide data and planning information. The Master Plans identify the Primary Service Areas, including the communities that make up the PSAs, describe how clinical and public health services are delivered, discuss how delivery of services might be improved, document deficiencies in the current healthcare delivery system for each Area, and propose solutions to identified health services delivery problems. The HFDS/FEDS provides specific information on facility size and condition.

Tribes, service units, and Area Offices may be asked to provide information in support of some data that are not readily verifiable (e.g., documentation of facility size and condition for Tribal facilities that are not incorporated into the HFDS for Phase I, and documentation supporting the “Innovation” and/or “Isolation- Barriers Services” criteria for Phase II).

1-00.4 Responsibilities for Implementation of the HFCPS

A. Headquarters

Headquarters IHS (HQ) is responsible for

- ° initiating and managing implementation of the HFCPS;
- ° establishing and managing an IHS Healthcare Facilities Validation Committee;
- ° maintaining documentation related to the implementation of the HFCPS;
- ° determining the Phase I results based on PSAs/facilities determined by the Area Master Plans and IHS databases;
- ° selecting PSAs/facilities for detailed analysis based on the Phase I results;
- ° managing the review and validation process for Phase II;
- ° publishing rankings, categories, priority lists and funding plans.

B. IHS Area Office

Each Area Office is responsible for reviewing the data for each Primary Service Area (PSA) and/or facility within its jurisdiction to assure accuracy and consistency with Area Master Plans. Area Offices may also assist Tribes in developing documentation for which the Tribe is responsible. Area Offices will also coordinate with Headquarters to review data when discrepancies arise.

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C. Tribes (638 and Title V)

Each Tribe is responsible for assuring the accuracy of the information provided to IHS during the process. Each Tribe is also responsible for providing appropriate documentation supporting Tribal initiatives or special situations that may affect a facility's ranking and/or prioritization. Tribes should work with the Area Offices to ensure consistency with Area Master Plans.

D. IHS Healthcare Facilities Validation Committee

The IHS Validation Committee is responsible for reviewing, verifying and validating all data used in the Phase II process. Reports of findings shall be made to IHS on every PSA/facility validated and ranked in the Phase II HFCPS. The Validation Committee will also review challenges arising during the HFCPS process and make recommendations on their resolution.

1-00.5 General Concepts

A. Phases and Evaluation Criteria

The revised HFCPS uses five evaluation criteria to rank the need for facilities space in two Phases. Phase I provides a ranking for all the PSAs/facilities identified in the Master Plans. The Phase I rankings are calculated using existing data contained in Area Master plans and IHS databases. Phase II develops validated scores for only the highest ranking Phase I PSAs/Facilities. This allows validation, which is resource intensive, to be performed on those PSAs/Facilities with some expectation of being selected for preparation of planning documents. Upon approval of these planning documents the PSA/facility is placed on a priority list and becomes eligible for funding. The maximum score for each Criteria is weighted in the formula by the value indicated below on Table 1, "The HFCPS Evaluation Criteria and Weighting."

Because "Barriers to Care" (5% or 50 points) and "Innovation" (10% or 100 points) are not used to rank facilities in Phase I, the maximum Phase I score is 850 points. These criteria will be incorporated in the scoring during the Phase II for a total of 1000 maximum points.

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Table 1
The HFCPS Evaluation Criteria and Weighting

Evaluation Criteria	Facility Deficiency	+	Health Resources Indicator	+	Isolation/Barriers to Care	+	Facility Size	+	Innovation	=	Maximum Possible Score
Phase I Criteria Weighting	400	+	200	+	100	+	150	+	0	=	850
Phase II Criteria Weighting	400	+	200	+	150	+	150	+	100	=	1000

A description of each of the evaluation criteria is in Appendix A. The method for obtaining the value for each evaluation criteria and a detailed description of the formula application and sample calculations are in Appendix B.

B. Feasibility for Small Ambulatory Facilities

Every PSA identified in the Master Plans will be evaluated in the HFCPS and receive a ranking score in Phase I. This includes PSAs with a user population of less than 1,300 persons, which, during Phase II, will be required to demonstrate that acquisition and operation of a facility to house health services locally is more effective and efficient than obtaining those services elsewhere.

C. Categories

Each Tribal and IHS facility will be assigned one of the categories listed in Table 2, “Facilities Ranking Categories,” based on a number of factors, including facility workload and the level and type of services to be provided from the facility. Categorization permits IHS to rank each facility’s need relative to other similar facilities.

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Table 2 - Facilities Ranking Categories		
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/Medical Center	Category B	A facility providing inpatient services, ambulatory care, and a range of inpatient and ambulatory specialty care. The facility must meet IHS 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 generating 4400 primary care provider visits or less.
Other	Other	Facilities other than those described above, e.g. Youth Regional Treatment Centers, Dental Units, etc.

D. Ranking

Each Tribal and IHS PSA/facility will be assigned a ranking generated by applying data from the IHS databases to the Phase I HFCPS formula on page 12. The Phase I rankings will be used for selection of the highest ranking PSAs/facilities to be considered for potential prioritization in the Phase II Project Prioritization process.

E. Selection of High Ranking Facilities for Project Prioritization

To focus limited Tribal and IHS resources, only data for the highest ranking PSAs/facilities will be validated in the Phase II process by the Validation Committee. The actual number of Phase I high ranking PSAs/facilities for which data will be selected for Phase II validation will be large enough to cover changes in ranking after validation. A sample twice as large as estimated to be funded by Congress in five years will be selected for the Phase II Process. This number will ensure that the Phase II evaluation process contains the top rated PSAs/facilities with the potential to make the final priority list.

F. Selection for Priority Lists

The PSAs/projects with the highest scores after the completion of the Phase II validation and prioritization process will be eligible to proceed with preparation of planning documents (PJD, PSD, etc.) and will be placed on the Priority List when these planning documents are approved by IHS. Actual placement on the priority list will be determined by the score that results from using information

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generated by the actual planning document. It is envisioned that once a facility is placed on the Priority List, it will remain on that list until funded. The projects selected for full placement on a priority list will be determined by the specific facilities program for which projects are to be prioritized, including but not limited to the following:

- The number of facilities indicated in the specific Construction Program's Congressional authorization;
- The funding available or expected to be available;
- The number of projects already prioritized under previous applications; and
- The historical rate of funding for the specific program.

It is possible that the validation process will change the ranking of a facility such that it will be removed from the Phase II prioritization process. This does not eliminate it from future consideration, if its Phase I rank is high enough to be considered again for Phase II in the future.

1-00.6 The HFCPS - A Two Phase Process

The HFCPS methodology incorporates two related processes: the Facilities Needs Assessment process (Phase I) and the Project Prioritization process, (Phase II).

A. Phase I - Facilities Needs Assessment Process

The Facilities Needs Assessment Process provides a listing of all Tribal and IHS PSAs/facilities that are identified in the Area Health Services and Facilities Master Plans (master plans). During Phase I, all facilities will be reviewed, assigned a new preliminary ranking, and categorized based on information in the Area Health Services and Facilities Master Plans, IHS databases and comparable Tribal data. The Phase I scores rely on the Area Master Plans and the IHS databases for data used in the calculations. The PSAs/facilities are placed in the categories identified in Table 2 with Phase I scores determining rank.

The self-determination and compacted (638 and Title V) Tribes that do not have complete information in the IHS databases will be afforded every effort to submit data that can be equitably incorporated for fair participation in the Phase I process. IHS Area and Headquarters technical staff are available to assist with converting this information into readily useable formats. The Phase I tabulations will be reviewed and published on a five year cycle to update information preliminary rankings, and categorization of all facilities need. Interim updating to the master plans is also welcome because services plans and PSAs may change and because new, federally recognized Tribes may need to be incorporated into the process.

A PSA/facility's Phase I ranking may change as information is verified and validated during Phase II. The purpose of the preliminary ranking and

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categorization is to identify potential projects for further evaluation and possible prioritization.

1. Schedule

On a five-year cycle, the IHS will review all Tribal and IHS health care facilities needs, assigning each PSA/facility to a category and developing a Phase I ranking score using the applicable criteria from HFCPS formula.

2. Input - Criteria

The information required for completing the needs assessment and preliminary ranking include the following:

- Existing facility size, age and condition (from the FHDS/FEDS)
- Facility required space
 - Population (from Master Plan/NPIRS)
- Health Status/Health Resource Indicator
- Isolation (From Master Plan)

Existing facility size is obtained from the FHDS. Facility required space is calculated using

OPTION 1) the Base HSP

OPTION 2) the IHS Supportable Space Formula ($200m^2 + [.8 X \text{user population}]$).

Isolation is the distance from an existing emergency room to the proposed or actual location of the healthcare facility being scored.

3. Area Review

Each Area Office will review all information to affirm that all necessary information and documentation is available and to assure accuracy and consistency with Master Plans.

4. Phase I Ranking

A score is developed for each PSA/facility using the Phase I HFCPS formula in Table 1, “The HFCPS Evaluation Criteria and Weighting,” on page 12. All PSAs/facilities then ranked. This preliminary ranking will be reviewed and updated on a five-year cycle. The Phase I rankings are used to select PSAs/facilities for more intensive review, during Phase II, the Project Prioritization process.

5. Categorization

Each PSA/facility will be categorized based on the information in the Master Plans. The rankings already assigned will be maintained during categorization. This categorization should be updated every five years.

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B. Phase II - Project Prioritization

The Project Prioritization process (Phase II) is intended to provide a consistent means of prioritizing projects as the need arises for each of the specific healthcare facilities construction programs. The Project Prioritization process may be implemented as needed for specific construction programs to fill out priority lists or to allocate funding under new authorities. When the Project Prioritization process is implemented for a specific construction program, the facilities with the highest Phase I ranking in appropriate categories are selected for further evaluation and possible prioritization. This will be set at twice the number of facilities expected to be funded within five years. This evaluation process includes a full validation of all data and information used for the Phase II ranking score.

For those construction programs with a recurring base funding (i.e., Priority Lists authorized in Section 301 of the IHCIA) the Project Prioritization process will be implemented on a five-year cycle. For other programs (e.g., the Small Ambulatory Program, Joint Venture Program, etc.), the Project Prioritization process will be implemented as funds become available. The number of facilities selected will depend on the funding available or expected to be available, and on the estimated cost of each project.

1. Schedule

Phase II, the Project Prioritization Process, will be initiated as needed to allocate appropriated funds and/or to comply with Congressional directive to provide construction priority lists.

2. Input to Verify Ranking

Phase II will require the same information as is used during the Facilities Needs Assessment process. However, during the Phase II Project Prioritization process, additional documentation supporting the “Barriers-to-Service” and “Innovation” criteria must be provided.

3. Data Validation

During the Phase II Project Prioritization process, the data for the highest ranking facilities in Phase I are verified and validated. Population data are validated against the IHS NPIRS and data projections are cross checked for statistical accuracy. Existing Facility space is verified using the IHS FHDS or Tribal documentation of facility size (as-built drawings). Isolation data are validated using the 2004 *Microsoft Streets & Trips* Software. Barriers-to-Services and Innovation information is validated, using documentation provided by the Tribe, service unit and/or Area Office. The Health Status/Health Resources Indicator is verified against current values in the FDI. Validation of the Phase II data is performed by the Validation Committee, and a report of results is furnished to IHS. The “Barriers-to-Service,” “Innovation,” and, where applicable, the business plans will be validated by the Validation Committee using the same standards for all PSA/facilities.

Healthcare Facilities Construction Priority System Methodology

4. Ranking Reassessment

During Phase II, ranking of PSAs/facilities under consideration is reevaluated twice using the HFCPS:

- First, all PSAs/facilities under consideration for Phase II are ranked using validated data and information to determine those for which planning documents (Program Justification Document, Program Summary Document, etc.) will be developed. The number selected depends on the costs of the projects and the availability of funding. All facilities not scoring high enough to be selected to proceed with preparation of planning documents will be returned to the Phase I and may be considered in future Phase II evaluations.
- Second, following completion of the planning documents, all PSAs/facilities with approved documents will be ranked to determine the priority for funding.

1-00.7 Priority Lists and Planning Documents for Funding

After the Phase II ranking of a PSA/facility has been established following approval of the planning documents, the project is placed on the appropriate priority list. For construction programs with a recurring base for funding (i.e., the Priority Lists authorized in Section 301 of the IHCA, Public Law 94-437), this project priority will be used to request funding. These projects will remain on the Priority List until funded. For construction programs without a recurring base of funding, the project priority list will be used to allocate already appropriated funds. If appropriated funds are not sufficient to fund all prioritized projects, those projects that are not funded will be the first eligible for funding when funds are appropriated for the same or a similar construction program in the future.



Appendix A - Assessment and Prioritization Criteria

The HFCPS uses five ranking criteria to rank the need for facilities space in all identified PSAs. The data used to rank these PSAs is available in the IHS databases (NPIRS, HFDS, FDI, etc.) and should be documented during the Master Planning process.

The Facility Needs Assessment process (Phase I) uses four criteria and does not incorporate the “Access to Services” element of the “Isolation/Access to Services” criterion; as a result the potential high score for Phase I is 850 points. The Phase I process develops a score for every PSA identified in the Area Health Services and Facilities Master Plan (Master Plan). Those PSAs/facilities ranking highest during Phase I are selected for further evaluation during Phase II, the Project Prioritization process.

During Phase II, the highest ranking PSAs/facilities from Phase I that meet the requirements of the specific construction program for which a list of construction projects are required (i.e., Public Law 94-437, section 301 Priority List; Joint Venture; Small Ambulatory Program; etc.) are selected for further evaluation. Those PSAs/facilities being considered in Phase II are reviewed to assure the accuracy and validity of data, including documentation of “Documented Barriers to Care”, which is part of “Access to Care” for a potential addition of 50 points, and “Innovation” for a potential addition of 100 points. In scoring for Phase II, all criteria are used; as a result the potential high score is 1000 points.

During Phase II, ranking of PSAs/facilities under consideration is reevaluated twice using the HFCPS:

- first, all PSAs/facilities under consideration for Phase II are ranked using validated data and information to determine those for which planning documents (Program Justification Document, Program Summary Document, etc.) will be developed; and
- second, following completion of the planning documents, all PSAs/facilities with approved documents will be ranked to determine the priority for funding.

Below is a summary of the Phase I and Phase II ranking formulas:

	Facility Deficiency	+	Health Status/Health Resources	+	Access to Care	+	Facility Size	+	Innovation	Potential Score
Phase I	400	+	200	+	100	+	150		N.A.	850
Phase II	400	+	200	+	150	+	150	+	100	1000

Each of the criteria is described below.

FACILITY DEFICIENCY CRITERION (400)

Healthcare space should be provided where it is required to house healthcare services. The facility deficiency criterion indicates the facility space deficiency by comparing the existing healthcare facility space (IHS or Tribal), adjusted for age and condition, with the space required to house services, including public health services. The facility condition

is estimated by dividing the HFDS/FEDS estimated cost to repair the facility by the average cost to replace the facility based on the IHS Budget Cost Estimating System. The facility age is derived from the HFDS/FEDS information. Facility required space is estimated during Phase I by

Option 1 Wording) using the IHS Supportable Space Formula.

Option 2 Wording) using the Base HSP.⁷

Below is a summary of the formula to derive the Facility Deficiency Criterion:

$$\text{Facility Deficiency Criterion} = (1 - [\text{Adjusted Existing Space} \div \text{Required Space}]) \times 400$$

HEALTH RESOURCES/HEALTH INDICATOR CRITERION⁸ (200)

Healthcare space should be provided where resources are required to house health services that would improve the health of the AI-AN people. This criterion will increase the Priority Score for those facilities in communities that have relatively fewer health resources and/or poorer health indicators to address health care services delivery.

Option 1 Wording) The index value for the **Health Resources Indicator** is the same value as the Federal Health Benefits Plan Disparities Index (FDI) value used to allocate Indian Health Care Improvement Funds to the Tribe or community. Below is a summary of the formula to derive the Health Resources Indicator:

$$\text{Health Resources Indicator} = (1 - \text{FDI}) \times 200$$

Option 2 Wording) The **Health Status Indicator** for a PSA is calculated by using a population statistic and two indicators from the FDI that are related to health. The three factors for this criterion are:

- 1) Percent of the population over 55 years old,
- 2) Composite Poverty Index, and
- 3) Poor Health Status Index. The formula is depicted below:⁹

$$\text{Health Status Indicator} = (1/3 \times (\% > 55 \text{ yr age})) + (1/3 \times (\% \text{ Poverty})) + (1/3 \times \text{Disease Disparity Index}) \times 200$$

ISOLATION/BARRIERS-TO-SERVICE CRITERION (150)

In rural Indian country, access to healthcare is partially dependent on the time it takes to get to a medical facility. The ability to access health care may also be dependent on other factors not related to the time it takes to travel to where services are provided. The Isolation/Barriers-to-Care Criterion attempts to insert both these limitations on obtaining services into the HFCPS, by allocating up to 100 points for physical isolation (minutes of travel required to access services) and 50 points for Barriers-to-Service not related to

⁷ See Page 5 for full discussion of the options.

⁸“Health Indicator Criterion” of the Workgroup Report.

⁹ See page 6 for a full discussion of the options.



physical distance. Since the latter factor is highly subjective, it will be validated in Phase II by the Validation Committee.

The physical isolation element in this criterion will be calculated using the distance between the proposed facility and the nearest Level I, II, or III emergency room, whether IHS or other. Distance is used rather than time, because it is easier to establish. During Phase I, only the isolation factor will be used for this criterion. A facility that is more than 90 kilometers (56 miles) from alternative services will receive 100 points for the Isolation Element; a facility that is less than 40 kilometers (25 miles) from alternative services will receive 0 points; all other facilities will calculate the Isolation Element as a proportion of the distance between 40 and 90 km as follows:

IF distance to alternatives is 40 kilometers or more and 90 kilometers or less use the following to determine the Isolation element.

$$\text{Isolation Element} = \text{Kilometers to Alternatives} / 90 \text{ kilometers} \times 100$$

If a Tribe or PSA provides documentation of Barriers-to-Service, 50 points may be added to the “Isolation/Barriers-to-Service Criterion” after validation during Phase II.

Documented Barriers-to-Services may include, but are not limited to, incidents where American Indians and Alaskan Natives are denied, or prevented from accessing, services for social or economic reasons. The documentation must show a significant pattern of such incidents and be validated by the Validation Committee.

The Isolation/Barriers-to-Service Criterion for Phase II is calculated by adding the Isolation Element and the Barriers-to-Services Element as shown below:

Isolation/Barriers-to-Services Criterion	=	Isolation	+	Barriers-to-Services
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FACILITY SIZE CRITERION (150)

There has been an increased effort to place the access to healthcare facilities as close to the community as practicable. This has placed an emphasis on smaller facilities located near or within the community. The Facility Size Criterion addresses this issue by increasing the total priority score inversely proportional to the size of the facility, with the smallest, facilities receiving up to 150 points while some larger facilities might receive 0 points. The Facility Size Criterion is based on the size of the proposed facility as determined by

Option 1 Wording) Required Space Formula, $200 \text{ m}^2 + (\text{user population} \times 0.8 \text{ m}^2)$.

Option 2 Wording) the Base HSP¹⁰

The following rules describe how the Facility Size Criterion is derived:

¹⁰ See Page 5 for full discussion of the options.

<p>If the Required Space is less than 1 200 m², then the Facility Size Criterion = 150</p>
<p>If the Required Space is equal to or greater than 1 200 m² and less than 6 000 m², then the</p> <ul style="list-style-type: none"> • Facility Size Criterion = $(1 - [(\text{Required Space} - 1200 \text{ m}^2) \times 0.00006]) \times 150$
<p>If the Required Space is equal to or greater than 6 000 m² and less than 20 000 m², then the</p> <ul style="list-style-type: none"> • Facility Size Criterion = $(0.7 - [(\text{Required Space} - 6 000 \text{ m}^2) \times 0.0000428]) \times 150$
<p>If Required Space is equal to or greater than 20 000 m², then the</p> <ul style="list-style-type: none"> • Facility Size Criterion = 0.

INNOVATION CRITERION (100)

Innovation in the provision of healthcare or acquiring healthcare facilities should be encouraged. Innovation should significantly increase health promotion/disease prevention, efficiency and/or effectiveness of healthcare services delivery, or reduce federal cost in acquiring, operating and/or maintaining healthcare facilities. The Innovation Criterion addresses this issue by identifying several ‘innovations’ that may be documented to increase the final priority score. Because all innovations have to be validated, this criterion will be applied during the Phase II process. Each innovation identified (up to a total of 5) is worth up to 20 points, for a total possible of 100. Each innovation must be thoroughly documented, demonstrating salient features such as increased efficiency, effectiveness, community involvement, etc. Potential innovation examples are listed below.

1. Planning/Coordination with another Tribe or PSA for sharing major Health Delivery programs with written use agreements.
2. 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.
3. Developing other health delivery innovations that involve major medical departments or programs and partnering with State or Local Health Programs.
4. 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.

5. Reducing the new construction costs by 25% (capital investment) by reusing parts of the existing facility. Proportionally fewer points are assigned for lesser construction savings.
6. Developing, administering, and funding a public health initiative or program.
7. Other innovations can also be proposed for review and validation by the Validation Committee during the Phase II process.

Below is a summary of the formula to derive the Innovation Criterion Score (Phase II only):

$$\text{Innovation Criterion} = \text{Element 1} + \text{Element 2} + \text{Element 3} + \text{Element 4} + \text{Element 5}$$

Appendix B - HFCPS Formulas and Sample Calculations

Introduction:

This document presents an explanation and an example (beginning on page 23) of how the values for the five criteria in the Health Facilities Construction Priority System (HFCPS) are determined and used in the HFCPS. It illustrates how all primary service areas or proposed projects will calculate and arrive at a numerical score for placement on the IHS HFCPS. Each PSA/facility to be evaluated using this formula must be included in and consistent with the Area Health Services and Facilities Master Plan.

Calculation Formulae:

Calculation of the priority score for Phase I is accomplished by adding the values for four criteria (all except “Innovation”), less the “Barriers-to-Service” element of the “Isolation criterion.” There is a total of 850 points possible for Phase I. The priority score for Phase II is accomplished by adding all the five criteria listed to generate a possible high score of 1,000 points.

Facilities Deficiency (400 Points)

This factor is determined by adjusting the existing facility size for its condition and age then comparing this adjusted existing facility size with Required Space, which is determined using population¹¹. Facility age and condition are obtained from the HFDS and FEDS.

For PSAs with multiple buildings, the weighted age of the facility is determined using the weighted age (AW) formula:

$$\text{Weighted Age (AW)} = (\text{Sum [Each Building Age x Building Area]}) \div (\text{Total Building Area})$$

Use the table below to determine the Age Factor.

Weighted Age (AW)	Age Factor
0-10 years	0
11-50 years	0.0125
51 or more years	.5

Next, a Building Condition Factor (CF) is calculated:

- If there is no existing facility, then CF = 0, or
- If the total FEDS cost is greater than 0.75 of the total cost to replace the existing facility, then CF = 1 otherwise:
- Use the following steps to calculate CF:
 1. Add the cost of all the appropriate FEDS deficiency categories (see Table A, Applicable FEDS Codes, below) for a facility,
 2. Divide the sum of the appropriate FEDS deficiency categories by the estimated facility replacement cost (from the IHS Facilities Budget Estimating System), and

¹¹ Options for using population to estimate and/or determine required space are discussed on page 6.

3. Divide the resulting value of steps 1 and 2 by the existing building area to generate CF.

If there is no existing facility space = 0, then CF = 0,

or

If the (total Replacement Cost is * 0.75) is less than the total FEDS cost, then CF = 1

Otherwise:

$$CF = [FEDS Deficiencies \$\$] \div [Replacement Cost per m^2] \div [Existing Building Area]$$

Table A, Applicable FEDS Codes and Categories	
FEDS Code	FEDS Category
2	Life Safety Compliance
3	General Safety
4	Environmental Compliance
7	Handicapped Compliance
8	Energy Conservation
10	Architectural Maintenance and Repair
11	Structural Maintenance and Repair
12	Mechanical Maintenance and Repair
13	Electrical Maintenance and Repair
14	Utilities Maintenance and Repair
17	Roof Maintenance and Repair

Next, the existing building area is adjusted by applying age and condition factors to develop the Adjusted Existing Space (AES) that will be used in determining the total space deficiency.

$$\text{Space Adjustment Factor (SF)} = AF + CF$$

If SF is greater than 1, then SF = 1 (AES will be equal to zero)

$$AES = [Existing Building Area] - (SF \times [Existing Building Area])$$

The Facility Deficiency Criterion is then calculated by multiplying the Facility Deficiency weighting (400) times the percentage of space that the facility is deficient.

$$\text{Facilities Deficiency Criterion} = (1 - ([AES] \div [Required Space]) \times 400$$

Health Status/Health Resources Indicator Criterion (200 Points)

This Criterion

Option I wording is calculated by multiplying (1 - the Federal Health Benefits Plan Disparities Index for the Operating Unit containing the PSA/facility) times the Health Resources Indicator weighting (200).

Option II wording) is calculated by multiplying the Health Resources Indicator weighting (200) times one third of the sum of the Poor Health Status Index from the FDI, the Composite Poverty Index from the FDI, and the % PSA population > 55 years old.¹²

$$\text{Health Status/Health Resources Indicator Criterion} = (\text{Health Status/Health Resources Indicator}) \times 200$$

Isolation/Barriers-to-Services (150 Points)

The Isolation element of the Isolation/Barriers-to-Service Criterion is based on the road distance of the proposed facility from an emergency room or IHS or Tribal health center. This factor will be used in both Phase I and Phase II score calculations.

If the road distance is 90 km (56 miles) or more, or if there is no access by road:
Isolation = 100

For road distances between 40 km (25 miles) and 89.9 km (55.9 miles):
Isolation = ([Road Distance to Alternate Care] ÷ 90 km) X 100

For road distances of 39 km (24 miles) or less:
Isolation = 0

The Barriers-to-Service element of this criterion is based on significant documented evidence that there are barriers or hindrances to patients receiving services. This factor will be used only for Phase II calculations and only if supporting information is validated by the Validation Committee. If such evidence is provided and validated, the Barriers-to-Services Factor = 50 points, otherwise the Barriers-to-Service Factor is 0.

The Isolation/Barriers-to-Service Criterion is calculated by adding the Isolation and Barriers-to-Service elements.

$$\text{Isolation/Barriers-to-Services Criterion} = \text{Isolation} + \text{Barriers-to-Services}$$

Facility Size (150 Points)

The Facility Size Criterion is based on Required Space for the proposed healthcare facility. It is calculated using the

Option 1 wording) the supportable space formula [200 m² + (0.8m² x user population)]

Option 2 wording) the Base HSP.¹³

Use the following table to obtain the Facility Size Factor.

Facility size		Formula to apply
From	To	
0 m ²	1 200 m ²	Facility Size Factor = 1.0

¹² See page 6 for a full discussion.

¹³ See Page 5 for full discussion of the options.

Appendix B - HFCPS Formulas and Sample Calculations



1 201 m ²	6 000 m ²	Facility Size Factor = 1 – ((Required Space– 1 200) x 0.00006)
6 001 m ²	20 000 m ²	Facility Size Factor = 0.7 – ((Required Space – 6 000) x 0.0000428)
20 001 m ²	∞	Facility Size Factor = 0

The Facility Size Criterion is calculated by multiplying the Facility Size weighting (150) by the Facility Size Factor.

Facility Size Criterion= Facility Size Factor x 150.

Innovation (100 Points)

This criterion, which is applied only in Phase II, provides twenty points for each identified and documented innovative method to deliver healthcare. A maximum of 5 innovations (100 points) are allowed.

The Innovation Criterion is calculated by multiplying the number of validated innovations (up to a total of 5) X 20 for the Innovation Criterion score. This only applies to the Phase II process.

Innovation Criterion = [Number of Innovations] x 20
 If [number of validated innovations is greater than 5] then Criterion 5 = 100

Health Facilities Construction Priority List Score

The Phase I ranking score and the Phase II priority score is obtained by adding the individual scores of the applicable criteria.

Phase I Ranking	Facility Deficiency	+	Health Status/ Resources ¹⁴	+	Isolation/Barriers ¹⁵	+	Facility Size	+		=	850 Max
Phase II Priority	Facility Deficiency	+	Health Status/ Resources ¹⁶	+	Isolation/Barriers	+	Facility Size	+	Innovation	=	1000 max

¹⁴ See page 6 for a full discussion of options
¹⁵ Phase I does not incorporate the Barriers to Care element.
¹⁶ See page 6 for a full discussion of options

Sample Healthcare Facility Information:

° User Population – 3650; projected 10 yrs	4,280
° Size of Existing Health Facility	1 720 m ²
° Age of Existing Facility 2 buildings	350m ² , age 80 years 1 370m ² , age 24 years
° Replacement Cost From the IHS Budget Cost Estimating System	\$1,800 per m ²
° Qualifying FEDS Items Costs, (Nos. 2, 3, 4, 7, 8, 10, 11, 12, 13, 14, and 17)	\$650,000
° FDI	.53
° Poor Health Status Index (from FDI)	.41
° Composite Poverty Index (from FDI)	.29
° % PSA Population > 55	.15
° Distance to nearest healthcare facility	52km
° Barriers to Care	0
° Facility Required Space ¹⁷	3 624 m ²
° Innovations used in Health Program for Primary Service Area	3
o Inter Tribal Health Delivery Plan;	
o Re-use of 24 year old facility with 25% savings;	
o Regional Health Agreement with County Hospitals for Diagnostic Imaging.	

Sample Phase I PSA/Project Calculations

Facilities Deficiency (400 Points)

1. Calculate the weighted age (AW)

AW= (Sum [Building age x Building Area]) ÷ (Total Building Area)

AW= [350 m² x 80yrs + 1 370 m² x 24yrs] ÷ [1 720 m²]

AW=35.4yrs

2. Second calculate the age factor (AF)

For AW> 10 < 50 years, then AF= [AW – 10] x 0.0125

AF= [35.4 – 10] x 0.0125 =0.32

3. Calculate the building condition factor (CF)

Determine if FEDS deficiencies is less than 0.75 of replacement costs

\$650,000 < 0.75 x \$1 800 per m² x 1 720 m²

\$650,000 < \$2.322 million ;

CF= [FEDS Deficiencies \$\$ ÷ Replacement Costs per m²] ÷ Existing Building Area

CF= [\$650,000 ÷ \$1,800 per m²] ÷ 1 720 m²= 0.21

4. Calc space adjustment factor (SF)

¹⁷ For the purposes of this example, required space was calculated using the supportable space formula. However, when the HFCPS is implemented, the method for estimating required space during Phase I may be different. During Phase II required space will be determined using the HSP. See page 6 for a full discussion of potential options for estimating required space.

$$SF = AF + CF$$

$$SF = 0.31 + 0.21 = 0.53$$

5. Calculate the Adjusted Existing Space (AES)
 - AES = Existing Building Area – [SF x Existing Building Area]
 - AES = 1 720sm – [0.53 x 1 720sm] = 812.8sm

6. Determine the Required Space
(FOR the purposes of this example required space is assumed to be 3 624 M². See page 5 for discussion of Options for estimating required space.)
 Criterion 1 is calculated by dividing the Adjusted Existing Space by the Required Space and Multiplying times the Facility Deficiency weight (400):

$$\text{Facilities Deficiency} = (1 - [\text{AES} \div \text{Required Space}]) \times 400$$

$$\text{Facilities Deficiency 1} = (1 - [812.8 \div 3\,624]) \times 400 = 310.3$$

Health Status/Health Resource Indicator (200 points)

Option I

$$\text{Health Status/Health Resource Indicator} = 1 - [\text{Primary Service Area FDI}] \times 200$$

$$\text{Health Status/Health Resource Indicator} = 1 - [.53] \times 200 = 106$$

Option II

$$\text{Criterion 2} = [(\text{Poor Health Status Index from FDI} + \text{Poverty Index from FDI} + \% \text{Pop.} > 55) \div 3] \times 200$$

$$\text{Criterion 2} = [(.41 + .29 + .15) \div 3] \times 200 = 56.6^{18}$$

Isolation/Barriers-to-Service (150 points)

1. Determine distance to alternative healthcare (Level I, II, III Emergency Room) and calculate the Isolation Factor (IsF)

$$\text{IsF} = [\text{Distance to Alternate Care} \div 90 \text{ km}] \times [2/3 \text{ of weight or } 100 \text{ points}]$$

$$\text{IsF} = [52 \text{ km} \div 90 \text{ km}] \times 100 = 57.8$$

2. Determine the Barriers-to-Service Factor (BtS)
 BtS = 0 There is no documentation for “Barriers-to-Service.” If validated documentation were available, the Phase II score would be augmented by 1/3 of the weight or 50 points.

$$\text{Isolation/Barriers-to-Service} = \text{IsF} + \text{BtS}$$

$$\text{Isolation/Barriers-to-Service} = 57.8 + 0 = 57.8$$

Facility Size (150 points)

Calculate the Facility Size Criterion as follows:

$$\text{Facility Size} = 1 - ((\text{Required Space} - 1\,200) \times 0.00006) \times 150$$

$$\text{Facility Size} = 1 - ((3624 - 1\,200) \times 0.00006) \times 150 = 128.2$$

¹⁸ See page 6 for a full discussion of options

Innovation – (100 points)

Phase II only; the three innovations are validated.

Innovation = Number of innovations x 20

Innovation = 3 x 20 = 60.0

Health Facilities Construction Priority List Score

	Facility Deficiency	+	Health Status/ Resources ¹⁹		+	Isolation/ Barriers		+	Facility Size	+	Innovation	=	HFCPS Score	
			Opt 1	Opt 2		Opt 1	Opt2							
Phase I	310.3		106	56.6		57.8		128.2					<u>602.3</u>	<u>552.9</u>
Phase II	310.3	+	106	56.6	+	57.8	+	128.2	+	60.0	=		<u>662.3</u>	<u>612.9</u>

¹⁹ See page 6 for a full discussion of options

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EXECUTIVE SUMMARY

The Indian Health Service (IHS) Facility Needs Assessment and Priority Criteria Workgroup (“the Workgroup”) was first convened in February, 2001 for the purpose of developing and implementing a one-year work schedule to develop specific recommendations regarding changes to the IHS system. The Workgroup was composed of Tribal leaders, health directors, planners, urban health directors and regional Tribal associations. IHS staff provided technical support. The Workgroup met five times over the course of the next 12 months to develop specific recommendations. The IHS Director and the IHS Facility Appropriation Advisory Board (FAAB) requested that the Workgroup develop recommendations regarding:

- The criteria to be used for establishing and annually reviewing the need for facilities construction in Indian Country;
- The criteria and relative weight of each criterion to be used to prioritize among competing projects; and
- Strategies for dealing with (coordinating and integrating) the prioritization needs of the various health care facilities construction programs (inpatient facilities; outpatient facilities; dental units program; Joint Venture Program; Small Ambulatory Program; the proposed Loan Guarantee Program; etc.).

The following is an executive summary of the Workgroup’s recommendations.

I. Needs Assessment Recommendations

Many of the recommendations proposed by the Workgroup regarding Needs Assessments are based upon the assumption that the Health System Planning (HSP) Process software can be easily applied in a fair, consistent manner across all twelve Areas.

A. Health System Planning

ISSUE: There is currently no routinely administered system for assessing facility needs in the Indian health delivery system serving IHS, Tribal, and urban (I/T/U) programs. Without a consistent method of assessing need, it is difficult if not impossible to define the real need in terms that are reliable and credible. The IHS invested in the development of a software system designed to identify service and facility needs for defined populations. The system has been implemented in only a few areas, but has proven to be a useful and effective tool. The system is not driven by workload data. It factors in local available alternative resources and applies generally accepted utilization rates for service types to best describe needed services and facilities for a population. This latest technology is available to Indian health systems, but should be uniformly applied in order produce a national picture of need.

RECOMMENDATION: The Workgroup recommends that the IHS, in consultation with the I/T/U's, implement the "Health System Planning" (HSP) software/model locally to determine the services and facilities required in individual service areas nation-wide. Based upon these community-specific or service area-specific HSP analyses, a community-specific Master Plan will be generated to quantify the costs associated with the construction of expanded, replaced, or new facilities.

B. Area Master Plans:

ISSUE: Assuming that each community will engage in the HSP method of establishing a definition of services and facilities needs, these data can then be integrated at the Area level to produce a Master Plan. The importance of integrating these data must be emphasized. A Master Plan will better develop the HSP to show multi-Tribal systems, regional levels of care and referral systems. It will also help to establish relative priority within an Area for construction and development of new services. It will prevent IHS construction funds from supporting the construction of facilities that are not rational or warranted within the context of the Area-wide service delivery system.

RECOMMENDATION: The Workgroup recommends that the results of the community-specific HSP services and facilities analyses be integrated into a regional Area-wide Master Plan for each of the 12 IHS Areas, in consultation with I/T/U's, which will describe the services and facilities for the Area, the required expanded, replacement or new construction for needed facilities and estimated costs associated with those projects, roughly estimated based on facility type and size.

C. HSP Adaptability for Smaller Communities:

ISSUE: Currently the HSP makes certain planning assumptions about each community it examines. For example, the HSP may not be formulated to accurately examine the services and facility needs for populations of 100 to 500 residents. American Indian and Alaska Native communities in these rural, remote settings are not served well under the existing IHS system for establishing priority for construction funding. While the HSP is, in the view of the Workgroup, ready to be applied to rational service delivery areas and/or smaller communities, it may need to be adapted to ensure it truly reflects the needs of rural, remote communities. However, the Workgroup felt that making these adaptations for communities of fewer than 100 users may not be productive in light of the overall demand for services and facilities nation-wide.

RECOMMENDATION: The Workgroup recommends the IHS modify the current HSP technology, so that communities of not less than 100 users can be included in the updated HSP analysis.

D. Space Deficiency for Core Services Only:

ISSUE: Currently the HSP model examines core services that are traditionally included in basic health care delivery systems, e.g., outpatient medical care, outpatient dental care, laboratory services, pharmacy services, mental health counseling, inpatient services, etc. The HSP model does not include templates to calculate needed services and facilities for other alternative aspects of health delivery, e.g., wellness centers, long term care, traditional Native healing. While the Workgroup is supportive of the IHS eventually making these alternative services a part of the HSP, the Workgroup recognizes that without agreed upon “standards” for these new services, communities could potentially skew the results of the HSP by adding in extra square footage for alternative or “off-template” services. This would unfairly elevate the relative need of one community over another based upon the inclusion of these off-template services. It is important that this system compare “apples to apples” and “oranges to oranges”. Therefore, until such time as adequate Tribal consultation has occurred to reach national consensus on standards for off-template services, only those existing core services within the HSP should be considered in the national Needs Assessment and Priority Criteria system.

RECOMMENDATION: The Workgroup recommends that calculations for space deficiency, which results from application of the HSP, should be based only upon those “core health services” currently within the template formula of the HSP. IHS cautions against the expansion of these templates until there is consultation and agreement regarding space requirement standards for off-template services.

E. Off-Template Services and Future Planning:

ISSUE: Services considered to be “off-template” within the HSP system are still important to the long term health and wellness of AI/AN populations. For example, as the AI/AN population ages, long term care services will become more and more important. It is important that off-template services be defined and standards developed through a rational consultation process that weighs I/T/U input and demographic data, and is supported or verified through industry standards if they exist. Without ensuring the integrity and reliability of off-template standards, the Workgroup fears that the results of a national Needs Assessment will become suspect and therefore discounted by Congressional decision-makers.

RECOMMENDATION: The Workgroup recommends that the IHS invest in a long term plan to develop a formula for templates for alternative services not currently described in the HSP that could be applied in the future. These alternative services could include, but not be limited to, wellness centers, long term care facilities, traditional medicine, alcohol and substance abuse treatment, preventive services, etc.

F. Unit Price Budgeting:

ISSUE: There are a variety of ways to calculate the total estimated cost of needed facilities. The integrity and reliability of the national Needs Assessment requires that some method of standardizing unit costs that are regionally sensitive be utilized. Using a regionally sensitive standard unit cost will enable quick calculations of construction projects based upon the level of facility space identified through the HSP. Again, the Workgroup believes that a national Needs Assessment should reflect some level of comparable standards applied to health services and facilities needs across Indian Country.

RECOMMENDATION: In accordance with acceptable IHS Standards, the Workgroup recommends that regionally appropriate unit price budget calculations be utilized within each of the Local and Area Master Plans to calculate preliminary estimated costs associated with construction projects.

G. Repair vs. Replacement:

ISSUE: As a part of the national Needs Assessment, it will be important to identify not just new and replacement construction needs, but also repair and renovation needs as well. A means of determining when a project warrants repair and when a project warrants replacement is necessary. Such a mechanism should be applied across the board in a standard formula.

RECOMMENDATION: The Workgroup recommends that industry standards be followed for determining repair or replacement options, such that if repair estimates exceed 75% of replacement estimates, projects may be recommended for replacement.

H. Non-IHS Funding:

ISSUE: This Workgroup found that non-IHS dollars far outpace the investment of IHS dollars in the construction of health care facilities in I/T/U settings across the country. Investment of non-IHS resources should be encouraged and leveraged to provide expanded resources and facilities. It is important to understand the significance of these alternate resources and track these investments over time.

RECOMMENDATION: The Workgroup recommends that each Area Master Plan include a thorough description of the space and dollars for new or replacement construction of Tribal and urban health facilities constructed with non-IHS dollars from 1996 to present.

II. Rating Criteria Recommendations

ISSUE: The accuracy of the Needs Assessment utilizing the HSP model requires comparable data so that proposals can be compared to one another in a fair manner. Assuming that the HSP produces data that can be fairly compared from project to project, the Workgroup developed the following specific recommendations for conducting both Area and National priority ranking. The Workgroup understands that the IHS may need to respond to Congress soon regarding new construction projects on the priority list. The following recommendations should be taken into consideration before any future priority ranking occurs. Also, because only IHS and Tribal projects are considered under the current construction priority system, methods for ranking urban Indian projects under the Urban Indian health authority have also been considered.

RECOMMENDATIONS:

- The Workgroup recommends against the application of the existing HFCPS when considering the addition of facilities to the priority lists. Rather, the Workgroup recommends a new system be implemented for any future priority ranking based upon the specific proposals and recommendations contained in this report.
- The Workgroup decided that competing facilities should be ranked according to the following two criteria: (1) Urban Indian facilities will be ranked with other Urban Indian facilities when requesting consideration for Title V funding; and (2) Tribal and IHS facilities will be ranked against each other when requesting consideration for funding under the construction line-item of the IHS budget.
- Proposed Priority Criteria and Criteria Weighting:
 - A. **Master Plan Required:** To be considered for the priority list, a project must be included in its respective Area Master Plan.
 - B. **Relative Criterion Weights:** The Workgroup recommends that the following criteria be used with the corresponding relative weights shown:

<u>Criteria</u>	<u>Proposed Weighting:</u>
a. Facility Deficiency Scores	35
b. Isolation	10
c. Documented Barriers	10
d. Health Indicators	15
e. Innovation	15
f. Type of Facility	<u>15</u>
Total Possible	100

C. Justification and Explanation of Proposed Criteria:

1. **Facility Deficiency Scores:** These scores weigh the greatest in the proposed criteria. The score reflects the gap between existing space and required space as determined through the HSP analysis. Factors such as facility age, condition of facility, and user population are included in this analysis.
2. **Isolation:** This criterion refers to the physical distance of the population to the nearest health center or hospital. To receive full weight for this criterion, a community would need to be 60 miles or more from the nearest hospital and 30 miles to the nearest outpatient facility, or be distant enough from that facility to require travel by air or water. The closer the alternative facilities, the less weight assigned.
3. **Documented Barriers:** This criterion could be calculated in a number of ways, and is included to cover “access barriers other than geographic distance”, such as economic barriers, cultural barriers, transportation barriers, racial discrimination and other socio-economic factors. Developing objective measures that can be documented and consistently applied will be a challenge.
4. **Health Status Indicators:** Health status indicators represent a new and important addition to facility construction ranking criteria. This criterion can also be calculated in a number of ways. For purposes of discussion, we have presented two options, one looking at infant mortality rates as a ratio to national U.S. rates, and “Years of Productive Lives Lost” (YPLL) as a ratio to U.S. rates. There may be other, more appropriate measures, such as those under development at Johns Hopkins University which will incorporate a range of both morbidity and mortality data.
5. **Innovation:** Significant weight is assigned to this “new” criterion proposed by the Workgroup. Additional work is needed to define the types of innovations which might qualify for added weight. For discussion purposes, we have provided examples of innovative steps which could provide incremental points in this area. This could include investments of non-IHS dollars in the project, collaboration with other Tribes or consortia, or regional partnerships.
6. **Type of Facility:** These factors will be consistent with the standards for services and facilities reflected in the HSP. The Workgroup wanted to provide a mechanism to prioritize smaller outpatient facilities over inpatient facilities and support community-based prevention and primary care. This criterion would be applied based upon a grid that assigns values inversely to projects based upon size. The larger the project, the lower the value. The smaller the project the greater the value.

7. **Defining Thresholds and Values for Facility Types**

- A. Medical Center or regional inpatient facilities;
- B. Small Hospital and other local inpatient facilities;
- C. Primary Care Health Center and other comprehensive outpatient settings; and
- D. Health Station and other solo practitioner stations.

III. Integrated System Recommendations

These recommendations are based upon an assumption that Congress will provide recurring construction appropriations, which can be allocated consistent with the proposed recommendations below.

1. **Universal Priority List:**

ISSUE: Rather than develop multiple lists for different types of facilities, e.g. outpatient list, inpatient list, etc., the Workgroup proposes that a universal priority list be developed. Only through a universal priority list can priority ranking occur that shows priority of outpatient services over inpatient services, for example. While Congress may exercise its option to pull from the list those inpatient facilities in a ranked order, it is important to have a universal list that reflects the priorities across Indian Country.

RECOMMENDATION: The Workgroup recommends that priority ranking be conducted for all of the many construction programs proposed in each of the 12 Area Master Plans of the IHS, not just the 10 top outpatient and 10 top inpatient facilities. From this ranking, a universal national priority list will be produced that includes all projects in the Area Master Plans, including inpatient, outpatient, dental, joint venture, small ambulatory clinics, staff quarters, regional youth treatment centers and other proposals in the Master Plan. New services that are currently outside the existing HSP template, such as long term care, wellness centers, etc., will be added to this priority list as developed and accepted under an amended national HSP format.

2. **National Priority List for Congressional Consideration:**

ISSUE: The Workgroup proposes that there be two levels of review and allocation of resources for construction projects. Those projects which include increases in recurring costs (such as increased staffing and increased operation/maintenance) should fall under the review and approval of the U.S. Congress for construction appropriations. Other “one-time” construction projects that do not include increases in recurring costs for the IHS budget should be handled separately, through Area allocations.

RECOMMENDATION: From the Universal List, all projects which have implications for recurring costs (staffing, operations) will be compiled in a National Priority List for consideration for Congressional appropriations. This may include inpatient facilities, outpatient facilities, staff quarters, joint venture projects, etc.

3. **Area Priority List:**

ISSUE: The Workgroup is proposing greater involvement of I/T/U's through the Area Offices of the IHS, planning and implementing their Master Plans through the allocation of construction funds for one-time projects that do not include increases in recurring costs.

RECOMMENDATION: All construction projects that do not involve new or expanded staffing or increased recurring commitments from the IHS will be deferred to the Area Priority List in each of the 12 IHS Areas. These may include regional youth treatment centers, dental clinics, small ambulatory care clinics, or other innovative or alternatively funded projects. Area ranking of these projects will be conducted based upon the proposed criteria.

4. **Area Percentage Allocation:**

ISSUE: The Workgroup is proposing that each of the 12 IHS Areas receive an allocation of the annual construction appropriations for purposes of making allocations to one-time projects that are included in the Area Master Plans. This method for allocating resources to the Areas will expand the importance of the Area Master Plan and the rational allocation of construction dollars for priority projects. The Workgroup expects that such a system will enhance Area planning and regional health delivery coordination.

RECOMMENDATION: The Workgroup recommends that a percentage of annual construction appropriations be allocated to each of the 12 Areas according to a need-based formula. Each Area will determine for itself how best to allocate these Area construction dollars according to the Area Master Plan and Area Priority Lists, including but not limited to, construction costs, debt relief, loan guarantees and other innovative construction strategies.

5. **Amendments to Authorizing Statutes:**

ISSUE: Existing provisions in the Indian Health Care Improvement Act prevent the application of many of our recommendations. For example, the small ambulatory clinic program is restricted to communities with 2,000 or more people. This definition of a "small clinic" is too restrictive and eliminates many truly small American Indian and Alaska Native communities from being eligible for funding. Existing law that requires IHS to provide the 10-top outpatient and 10-top inpatient facilities on the construction priority list is not consistent with the Workgroup proposals that all facilities be rated and presented in total.

RECOMMENDATION: We recommend that IHS seek Congressional amendments to authorizing statutes to eliminate threshold restrictions on categorically authorized and funded facility construction programs, such as small ambulatory clinic restrictions to

communities with 2,000 users or more, to be consistent with existing HSP formula and proposed integration recommendations.

6. Davis/Bacon Waivers

ISSUE: A major drain on limited construction dollars for new and replacement health facilities in AI/AN communities is the federal requirement that the Davis/Bacon Act govern IHS funded construction. In many rural, remote areas where IHS construction dollars are used to build health facilities, the Davis/Bacon requirement means that construction costs are drastically inflated and construction funding is provided to contractors from outside AI/AN communities. Rather, the Workgroup proposes that these requirements be waived for IHS funded construction so that construction revenues can stay within AI/AN communities and costs can be reduced.

RECOMMENDATION: The Workgroup is recommending that Congress provide a waiver of the Davis Bacon Act for all construction funded through the IHS appropriations. This waiver can be achieved through either authorizing statute or through annual stipulations on the Interior Appropriation Acts.

The following table provides a quick comparison of Workgroup recommendations with the current Health Facility Construction Priority System used by IHS:

COMPARISON OF HEALTH FACILITIES PRIORITY SYSTEMS

Criteria	Existing-IHS-HFCPS	Workgroup Recommendations /Weight
FACILITY DEFICIENCY	Space required for workload is adjusted for existing space and condition.	Use HSP space minus existing space adjusted for condition (BEMAR). (35%)
<ul style="list-style-type: none"> • Facility Age 	Age is included in facility space adjustment	Separately age adjusted
<ul style="list-style-type: none"> • Population and Demographics 	User population only included in facility Deficiency	Census (service population) and demographics included in HSP space calculations
ISOLATION	Factor applied by formula for distance to IP, OP and Alternate Facility	Factor applied for distance to nearest health care facility. (10%)
ACCESS BARRIERS (other than isolation)	NONE	Factors are added for access barriers, such as language, culture, economics, discrimination, etc. (10%)
HEALTH INDICATORS	NONE	Factors for infant mortality rates, morbidity rates or Hopkins ACGs are being considered. (15%)
INNOVATION	NONE	Factors such as use of non-IHS dollars, collaboration with other Tribes, new health programs or regional partnerships would score higher for this criterion. (15%)
FACILITY TYPE	NONE	Smaller facilities would score higher for this criterion. (15%)