

Testimony of Valerie Davidson

Senior Director, Legal & Intergovernmental Affairs
Alaska Native Tribal Health Consortium
Chair, CMS Tribal Technical Advisory Group
Member, Medicaid Commission

and

Rick Boyce

Director, Health Facility Support
Alaska Native Tribal Health Consortium
Alternate Alaska Representative, Facilities Appropriations Advisory Board

State of Indian Health Facilities

U.S. Senate Committee on Indian Affairs
March 6, 2008

**Testimony of Valerie Davidson and Rick Boyce regarding the State of Indian Health Facilities
before the Senate Committee on Indian Affairs**

Good morning, Chairman Dorgan, Vice-Chair Murkowski and Members of the Committee. Quyaná (thank you) for the opportunity to testify today about the state of Indian health facilities.

I was privileged to work for seven years for the Yukon-Kuskokwim Health Corporation, the tribal health program that serves 58 federally-recognized tribes in a region roughly the size of Oregon, of which Bethel is the hub. I am now honored to work for over 2 years for the Alaska Native Tribal Health Consortium, a statewide tribal health program that serves all 229 tribes in Alaska, co-manages with Southcentral Foundation the Alaska Native Medical Center (ANMC), the tertiary care hospital for all American Indians and Alaska Natives (AI/ANs) in Alaska, and carries out all non-residual Area Office functions of the IHS that were not already being carried out by Tribal health programs as of 1997. With me today is Rick Boyce, Director of Health Facility Support, for the Alaska Native Tribal Health Consortium. Mr. Boyce also serves as the Alternate Alaska Representative to the Facilities Appropriations Advisory Board.

The deplorable health status of AI/ANs is clearly understood by this Committee as evidenced by your commitment to modernizing the Indian Health System through your recent efforts to advance the Indian Health Care Improvement Act (IHCIA). We thank the Committee for your efforts in highlighting the unmet needs in Indian Country and congratulate you on your successful passage of the bill in the Senate and its transmittal to the House.

We look forward to the day when we can take advantage of these modern advances. In the meantime, we know that in order to make headway on health disparities, we need to put adequate resources toward improving access to care. In addition to providing resources for direct care, we also need to focus our efforts and resources on building facilities where they do not exist, and improving facilities that are in disrepair because the maintenance and improvement needs have not been sufficiently funded.

For those of you who have not visited Indian country or seen a tribal health facility first hand, I will try to paint a picture. It will be incomplete. It is impossible to understand the diversity and challenges faced by Tribes without visiting a number of them. However, not everyone can visit. So today, I hope to help you understand why adequate health facilities are so important to the Indian health system.

The stories I will tell you come from my experience in Alaska, and from the experience of other tribes across the country, where tribal members experience the same difficulties accessing health care, and tribal governments and clinics experience the same pain of having to deny health care to people in need because there just isn't enough money to pay for it, and because there are just not enough resources to provide adequate facilities.

We specifically recommend that Congress adequately fund the full range of facility construction and operational needs, including primary health care needs, Long-Term Care Skilled Nursing and assisted living facilities, residential alcohol and substance abuse facilities, and our huge unmet sanitation facilities needs.

I. The Indian Health Service System

The federal government has a duty – acknowledged in treaties, statutes, court decisions and Executive Orders – to provide for the health and welfare of Indian Tribes and their members.¹ In order to fulfill this legal obligation to Tribes, it has long been the policy of the United States to provide health care to American Indians and Alaska Natives through a network made up of the Indian Health Service programs, tribal health programs and urban clinics.

The Indian Health Service (IHS), directly and through tribal health programs carrying out IHS programs under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended (ISDEAA), provides health services to more than 1.9 million American Indians and Alaska Natives. We are members of 562 federally-recognized tribes in the United States, located in 35 different states. According to the IHS, these services are offered from the following facilities:²

	IHS Directly Operated	Tribally Operated
Hospitals	33	15
Health centers	54	229
Health stations	38	116
Alaska Community Health Aide (CHA) clinics	0	162

There are also 34 urban Indian health programs funded by IHS under Title V of the IHCA that provide care to approximately 600,000 AI/ANs.³ When health care cannot be provided through these facilities, IHS and tribal programs use funding to purchase “Contract Health Services” from providers outside of the IHS system.

The number of facilities does not really tell the story though. The Indian health system is a real system of care. It is reflected in the IHCA, which addresses health provider workforce

¹ See Federal Basis for Health Services, January 2007 (info.ihs.gov/Files/BasisForServices-Jan2007.doc).

² Indian Health Service Fact Sheet, IHS/OD/PAS January 2007 (info.ihs.gov/Files/IHSFacts-Jan2007.doc).

³ Indian Health Service Year 2007 Profile, January 2007 (info.ihs.gov/Files/ProfileSheet-Jan2007.doc).

**Testimony of Valerie Davidson and Rick Boyce regarding the State of Indian Health Facilities
before the Senate Committee on Indian Affairs**

issues, and a full range of health care services from preventive health care services to critical inpatient care, from prenatal care and deliveries to services needed at the end of one's life.

The IHCA also encompasses services that have been woefully inadequate or simply unavailable like nursing home services and behavioral health, including a continuum of mental health and substance abuse services. In addition, the IHCA addresses those critical infrastructure issues that are so easily overlooked when a suffering patient and her family require immediate attention – the facilities that are needed to provide this vast array of services and basic public health services like safe water and sanitation.

There is a desperate need for additional resources even with reliance on supplemental funding through Medicaid, Medicare and SCHIP. The system simply cannot remain viable without adequate facilities.

II. State of Indian Health Facilities

The unmet need for health facilities for the IHS and tribal health system is \$6.5 billion. This includes only the highest priority need for inpatient hospitals, health centers, staff quarters, and youth regional treatment centers. It does not include adult treatment centers, residential long-term care facilities, nor sanitation facilities, which are sorely needed.

Currently, the average age of an IHS facility is 32 years. Even more startling is that there are 17 installations throughout the IHS where the facility age is between 40 and 66 years.

The state of individual health facilities in Indian Country varies greatly. They range from a few “newer” health facilities to the more common old, poorly maintained facilities that are in desperate need of repair. Even more striking is that entire IHS Areas do not have certain kinds of health facilities at all.

An example of a newer inpatient hospital facility is the Alaska Native Medical Center (ANMC), jointly operated by Southcentral Foundation and ANTHC. Although it was constructed over ten years ago, it is considered a very new facility in the Indian Health System. The planning documents for this facility were completed 10 years before the facility was constructed. In the meantime, it languished on a very long “facilities list” along with other crucial but unfunded projects. The ANMC facility is a significant improvement over the previous hospital that was constructed in 1953, but it is clear that the facility is not large enough to keep up with population growth. This is a common occurrence when limited construction funds are available to meet the need for facilities that have been sitting for years on the IHS facility list.

The more typical IHS inpatient hospital is old and dilapidated. For example, the Nome hospital was constructed in 1948 with an addition in the 1970s. A replacement facility has been on the IHS priority list since 1991. Another Alaskan facility, the Samuel Simmonds Memorial Hospital in Barrow was constructed with wood frame construction in 1964. Although wood framed buildings are short-lived, the Barrow hospital has been on the IHS priority list since 1991.

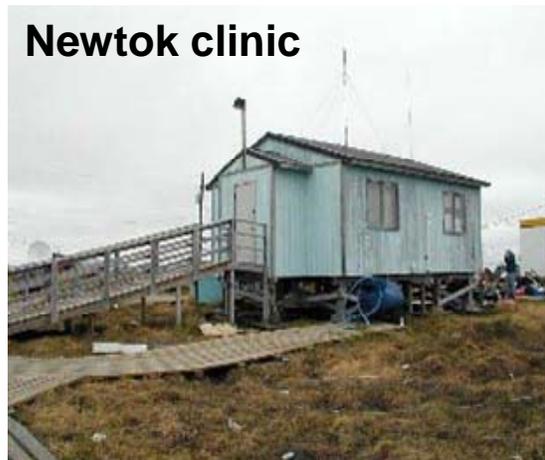
**Testimony of Valerie Davidson and Rick Boyce regarding the State of Indian Health Facilities
before the Senate Committee on Indian Affairs**



This hospital in Barrow, Alaska has been on the IHS facility list since 1991 and is in desperate need of replacement.

Some areas, like the Portland Area (representing Washington, Oregon, and Idaho) and the California Area, have no inpatient hospital facilities at all. Because there is no hospital for AI/AN patients in their respective IHS Area, these facilities depend on Contract Health Services (CHS) funds. In fact, despite the population shifts to the west and east coasts of the United States, there are very few IHS inpatient hospitals in the western United States. Likewise, there are very few IHS inpatient hospitals located on the east coast. There is clearly a need for additional inpatient hospitals.

Like inpatient hospitals, health centers are also in various stages. For example, health clinics in the Portland Area are an average of 40 – 50 years old. One clinic on the Colville Indian Reservation is over 70 years old. Other clinics in the Portland Area make do with mobile homes.⁴



Newtok clinic

This clinic in Newtok, Alaska has no running water

⁴ Testimony of Linda Holt, Chairperson, Northwest Portland Area Indian Health Board, before the Senate Finance Committee, March 22, 2007.

**Testimony of Valerie Davidson and Rick Boyce regarding the State of Indian Health Facilities
before the Senate Committee on Indian Affairs**

The continuing “pause” on facility construction has delayed attempts to address the aging health care facilities within the IHS system. We strongly recommend that Congress appropriate more resources for the construction of desperately needed health facilities and to take advantage of other opportunities for innovation. At a minimum, we recommend that the 2010 budget restore funding to \$93.6 million, allowing the IHS to replace its high priority healthcare facilities with modern facilities, and to significantly expand capacity at its most overcrowded sites.

III. Innovations in Facility Development

We have seen the benefit of pursuing and leveraging additional resources in the construction of sanitation facilities. Between 1986 and 1990 project contributions from other sources to IHS sanitation facilities construction projects averaged \$55.7 million annually. After the Sanitation Deficiency System (SDS) was established, annual average contributions for the five years following (1991 - 1995) averaged \$105.6 million.⁵ This resulted in a \$50 million annual increase in contributions from other sources. Thus, contributions almost doubled as a result of SDS.

We anticipate that these same opportunities can be replicated in making additional resources available to address the unmet need for health facilities by increasing appropriations for two successful programs and providing additional resources to implement the FAAB recommendations. Because of the limited amount of funds available for health facility construction, tribes worked with Congress to develop two innovative programs, the Joint Venture Program (JV) and the Small Ambulatory Program (SAP), to leverage other funds to get projects completed. Another opportunity yet to be realized is the FAAB’s recommendation for the Area Distribution Program.

Tribes have built approximately three times more health care space than the IHS has been able to with limited funds through the Joint Venture Program and the Small Ambulatory Program.

The **Joint Venture** program was developed to help assist tribes with their unmet facilities needs. This competitive program provides the medical equipment funds and the complete staffing package for a selected facility that is constructed with tribal resources so long as it meets IHS planning requirements.⁶

The **Small Ambulatory Program** (SAP) also assists tribes with their unmet facilities needs. This competitive program provides the construction funds, facility maintenance costs, and medical equipment costs, while the tribe provides the staffing package.⁷

⁵ The Indian Sanitation Facilities Act, P.L. 86-121, authorizes the IHS to provide essential sanitation facilities, such as safe drinking water and adequate sewerage systems, to Indian homes and communities.

⁶ The Joint Venture program was enacted as an amendment to the IHCA under Section 818 and authorizes Congress to appropriate recurring funds for increased staffing, operation and equipment for new or replacement facilities constructed with non-IHS funding acquired by tribes.

⁷ The Small Ambulatory Program is only available to tribes who contract or compact to operate a facility under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638.

**Testimony of Valerie Davidson and Rick Boyce regarding the State of Indian Health Facilities
before the Senate Committee on Indian Affairs**

One recommendation from the FAAB is the creation of an **Area Distribution Program** (ADP). The ADP is intended to provide funds to each IHS area to fund projects on the national priority list that are high priorities for the Area but don't rank high enough to receive direct Congressional funding in the near future. Thus, it provides a methodology for allocating funds to Area Offices to address the highest priority projects within the Area. These funds can be used to match other local, state, and federal funds to complete a project that would take many more years to complete if they were limited to using IHS funds.

The ADP would be initiated only when Congress appropriates funds for this purpose, the fund would be another line item in the facilities appropriation just as Joint Venture, Small Ambulatory Clinic, Dental, and Priority List Construction are separate line items now.

The ADP proposal would require these funds to be distributed to the highest priority Area Office facilities where the Area and Tribes agree that only limited new staffing is required. Upon completion of ADP projects, the facility will be allocated only about 40% of the additional staffing and operational funds usually allocated to new facilities. As proposed by the FAAB, the ADP funds would be allocated as follows:

- In a given year, the Area Offices may not participate in the ADP if the line-item amount in the Facilities Appropriation exceeds 20% of the total appropriations for facilities construction.
- Those Areas that receive 20% or less of the annual line-item facilities appropriation are allocated a portion of the Area Distribution Program funds using a formula based on Area user population and location cost adjustments.

The benefit of this process is every IHS Area is able to participate. Other matching funds can be used to build, renovate, and expand a facility; and some staffing is provided. Each Area can complete a high area priority project, and M&I funds can now be used for code and infrastructure type projects like boilers, chillers, pumps, air handlers and life-safety code issues. More projects addressing the overall unmet needs are completed more quickly and at a lower costs since non-IHS partners like private foundations and other granting agencies contribute funding for some of the staffing and/or construction costs.

Some Areas have expressed concern about projects identified back in 1991 that are now on the national priority list. They question whether the Area Distribution Funds may dilute the facilities appropriation and further delay funding for their projects. However, the Joint Venture and SAP funding lines are already in place on the facilities appropriation and Congress has continued to provide funding to these programs along with funding individual projects on the priority list. We ask that Congress continue this practice with the Area Distribution Program so that it provides another option for Congress to allow more tribes to participate in what has been a closed priority system since 1991.

There have been 7 Joint Venture projects and 27 Small Ambulatory Program projects awarded since 1998. The JV program and the SAP are examples of the best available opportunities to leverage funds to get desperately needed facilities constructed in Indian Country, but the funds available have been very limited. We recommend that Congress increase Joint

Venture funding and Small Ambulatory Program funding and add new appropriations for the Area Distribution Program to accelerate the completion of needed facilities.

IV. Facility Operational Needs

When addressing facility needs, it is important to look beyond new construction. In order for existing facilities to remain functional and provide maximum use, it is also important to adequately fund Medical Equipment Replacement, Facility and Environmental Support Funding, Maintenance & Improvement and the Village Built Clinic Lease Program. Adequate funding for these programs will ensure that the facilities we build today will be available for continued use into the future. Thus, we recommend adequate funding for these needs as more specifically described below.

A. Medical Equipment Replacement

In order to assure patient safety, medical equipment should be replaced on an average of every 6 years. Unfortunately, current funding levels cover only one-third of the level of need. Thus, equipment that should have been replaced after 6 years may continue to be used for 18 years or longer. Medical equipment maintenance and replacement presents obvious patient safety issues, and some tribes may divert funds from direct patient care to make up this gap.

The annual medical equipment funding is \$21.3 million, when the annual need is actually \$64 million. We urge Congress to increase IHS appropriations to this line item to ensure that neither patient safety nor direct patient care is compromised.

B. Facility and Environmental Support Funding

Facility and Environmental Support (FES) funding provides for the maintenance staff and basic operations of health facilities, including utilities. These funds also pay for Area office programs, like core staffing for health facilities, environmental health, and sanitation construction.

The level of funding has stayed relatively flat or received small increases (less than 2%). With the rising cost of salaries and double digit annual increases in energy costs, this funding line is not keeping pace. In fact, the FY 09 President's budget proposes no change from FY 08 even though it allocates \$25 million out of the base funding for staffing and operational costs for new facilities opening in FY 09. Historically, new funds were made available to meet these additional FES costs for new facilities in addition to any necessary nationwide programmatic increases. However, the effect of the President's FY 09 budget recommendation is that new facility needs are being funded at the expense of existing programs.

We recommend that Congress increase this appropriation by \$4.2 million annually to meet the current national need. We also recommend that Congress appropriate an additional \$25 million recurring need for new staffing requirements associated with new facilities opening in FY 09.

C. Maintenance & Improvement

Maintenance & Improvement (M&I) funds are used to maintain facilities so they can continue to be used in the future. Unfortunately, the level of M&I funding is substantially lower than what is needed. It is estimated that the base M&I funding needed to just sustain the facilities in their current condition should be funded at \$80 million annually. Because funds have not kept pace with the need, there is a tremendous backlog of maintenance needs. The IHS estimates \$371 million is needed just to get caught up. The FY 08 M&I funding level of \$52.9 million is grossly insufficient to sustain the facilities. It fell far short of the estimated \$120 million needed to address the backlog.

Failing to maintain existing facilities will only hasten the need for new construction. Health programs with existing facilities have tremendous and growing maintenance and improvement needs especially those with older facilities. We recommend that the Maintenance and Improvement appropriation be substantially increased to sustain existing facilities and to address the \$371 million backlog of maintenance and improvement issues.

D. Village Built Clinic Lease Program

The Village Built Clinic (VBC) Lease Program funds rent, utilities, insurance, janitorial, and maintenance costs of healthcare facilities in rural Alaska communities.⁸ Despite an increase in the number and size of clinics throughout Alaska as well as the rapidly increasing fuel costs, funding for the VBC Lease Program has barely increased since 1996. Village clinics have also incurred more costs in recent years due to increases in the scope and level of medical services provided, expanded village healthcare programming, new technology, and accreditation standards. Current lease funding covers only approximately 55% of the current operating costs and those costs are expected to continue to increase sharply as energy costs continue to skyrocket in rural Alaska.

Without additional funding for the VBC Lease Program, Alaska villages are forced to subsidize the day-to-day operating costs of their clinics and defer long term maintenance and improvement projects. Therefore, without an increase in funding to the VBC Lease Program, village clinics will be increasingly forced to reduce clinic operations, and these clinics will continue to fall into disrepair. This situation reduces the health care available locally to village residents and threatens the almost 200-million-dollar investment in these facilities by the federal government, Alaska villages, and the regional tribal health organizations in the Alaska Native health care system.

Thus, we recommend an increase of \$5.8 million in funding for the VBC Lease Program to the current program base of the VBC Lease Program. These funds are required immediately to sustain the program, covering the expected operating costs in FY 09 as well as establishing funding for long-term maintenance and improvement. Without this funding, many of Alaska's

⁸ Reprinted from The Village Built Clinic Programs: Village Clinics in Crisis, Alaska Native Health Board, May 2007.

villages will not be able to continue supporting local clinics, eventually leading to serious consequences for the health and safety of Alaska Native people.

V. Impact of the Lack of Funding for Facilities & Facility Operational Needs

The biggest impact of inadequate facilities is decreased access to care, which in turn exacerbates health disparities. While we have provided a snapshot of the unmet primary health care needs, we would be remiss if we did not highlight for the Committee the lack of other types of facilities like Long-Term Care, Skilled Nursing and assisted living facilities, residential alcohol and substance abuse facilities, and our huge unmet sanitation facilities needs.

Most AI/ANs do not have access to Long-Term Care services, including skilled nursing and assisted living services. For example, in the Alaska Tribal Health System which has a relatively comprehensive range of services, there are currently no assisted living facilities and only one long term care skilled nursing facility. Public health measures, such as childhood vaccinations and improved sanitation in rural Alaska, have increased the life expectancy of Alaska Natives and we are now living longer than we ever have. From 1950 to 1997, Alaska Native life expectancy rose from 46 years of age to 68 years of age.⁹ As our population is aging, there are no facilities to provide desperately needed community-based health care. For instance, if I were an elder living in Bethel, Alaska, and my family could not provide the medical care I needed at home, I would have to be sent to a nursing home in Anchorage, hundreds of miles and hundreds of dollars away from my family, community, and culture in order to get the care I need. Our elders make the daily choice to forego this care because such a separation is unconscionable in our communities. Unfortunately this situation occurs throughout the Indian health system because there are only a handful of long term care facilities to meet this need.

Many AI/ANs still do not have access to behavioral health services despite the clear need. An integrated health system requires availability of qualified and trained behavioral health providers in every community. Prevention and treatment approaches to behavioral health must be provided in a seamless integrated fashion, use best and promising practices; and they must start at the community level. The full implementation of this vision is only possible with resources that ensure services are available in the right place and the right time to prevent escalation of the need for more intensive and costly services.

Specifically, there is an overwhelming shortage of residential alcohol and substance abuse facilities for AI/AN throughout the country. Without sufficient facilities to meet this need people continue to be turned away at the door of existing residential treatment programs or wait listed for extended periods of time at the crucial moment in their addiction where they acknowledge they have a problem and are seeking help. Unfortunately, the current reality is that AI/ANs who need residential alcohol and substance abuse services, can expect to wait 6 months to a year for services. For many, treatment is simply not available. The consequences are profound. Again, to use Alaska as an example, 1 in 11 Alaska Native deaths is alcohol-induced;¹⁰ Alcohol contributed to 85% of reported domestic violence cases and 80% of reported

⁹ Status of Alaska Natives Report, Institute of Social and Economic Research, 2004.

¹⁰ Alaska Bureau of Vital Statistics.

**Testimony of Valerie Davidson and Rick Boyce regarding the State of Indian Health Facilities
before the Senate Committee on Indian Affairs**

sexual assault cases between 2000-2003;¹¹ and, Suicide among Alaska Natives remained steadily at 2 times the non-Native rate from 1992-2000.¹² Many AI/ANs still do not have access to behavioral health services facilities despite the overwhelming need. An integrated and modern health system requires not only the services but the facilities in which to provide those services.

Inadequate sanitation continues to plague much of Indian Country and is especially problematic in Alaska where 26% of Alaska Native homes lack adequate water and wastewater facilities. It is 2008 and, despite the fact that we know that people live longer, healthier lives in communities with water and sewage systems, there are over 6,000 homes in rural Alaska without safe drinking water and about 14,000 homes that require upgrades or improvements to their water, sewer, or solid waste systems to meet minimum sanitation standards. Increased sanitation facilities will improve these statistics and the health of these communities, as well as contribute to increasing the Alaska Native life expectancy, as discussed previously.

Funding for these services have been sorely lacking even though we know that improvements in these areas can result in significant improvements in health status. For example, infants in communities without adequate sanitation facilities are 11 times more likely to be hospitalized for respiratory infections and 5 times more likely to be hospitalized for skin infections when compared to all U.S. infants.¹³

In addition, the lack of facilities also increases costs to other IHS budget line items. For example, tribes who are served in an IHS area in which there is no hospital to refer patients to are become dependent on Contract Health Services (CHS) resources and pay private facilities premium rates for care that is too often culturally insensitive. The CHS line item is already substantially under-funded without adding facilities inadequacies into the equation. In order to provide necessary patient care, IHS and Tribal providers are forced into “robbing Peter to pay Paul” in life and death situations. We also know that when facility needs are not adequately funded, these funds necessarily come out of direct patient care dollars especially when life-safety issues are involved, like the replacement of medical equipment. Chronic under-funding of the IHS facilities line items contributes to the lack of adequate facilities, the overburdening of the other budget line items, and rationed health care on a systemic level.

VI. Efforts to Update the Healthcare Facilities Construction Priority System

In FY 2000, Congress recognized the significant and growing unmet facility needs, and directed the IHS to consult with Tribes and the Administration to revise the Healthcare Facilities Construction Priority System (HFCPS). Congress highlighted the need “to reexamine the current system for construction of health facilities” and to develop “a more flexible and responsive program...that will more readily accommodate the wide variances in tribal needs and capabilities.”¹⁴

¹¹ Status of Alaska Natives Report, Institute of Social and Economic Research, 2004.

¹² Alaska Bureau of Vital Statistics.

¹³ Impacts of Water and Sewer Service on the Health of Infants, American Journal of Public Health, In Press, May, 2008.

¹⁴ Conference Report, HR 2466, FY00 Interior Appropriations, Congressional Record – October 20, 1999.

**Testimony of Valerie Davidson and Rick Boyce regarding the State of Indian Health Facilities
before the Senate Committee on Indian Affairs**

Over the course of 8 years, the IHS, working with tribal leaders, undertook a major overhaul of the facilities priority system. Although the resulting proposal is a vast improvement over the current process, it has not yet been implemented by the IHS. We describe the planning process and resulting system below. We recommend that Congress direct the IHS to implement this new system and that Congress provide additional appropriations to ensure the new system is fully effective.

In early 2001, the Facility Appropriations Advisory Board (FAAB)¹⁵ established an IHS Facility Needs Assessment and Priority Criteria Workgroup (Workgroup) to develop specific recommendations to improve the IHS construction priority system. The Workgroup, comprised of 19 tribal leaders, health directors, planners, urban health directors and regional tribal associations, worked on specific recommendations regarding:

- Criteria to be used for establishing and annually reviewing the need for facilities construction need in Indian Country;
- Criteria (and their relative weight) to prioritize competing projects of the same type; and
- Strategies for prioritizing needs of different construction programs (inpatient facilities; outpatient facilities; dental units program; Joint Venture Program; Small Ambulatory Program; the proposed Loan Guarantee Program; etc.).

The Workgroup's recommendations, IHS Facility Needs Assessment and Priority Criteria Recommendations, were forwarded to the FAAB and to the IHS in February, 2002 and became the foundation for the final recommendation for the new priority system.¹⁶

The FAAB spent the next two and a half years refining the Workgroup's recommendations. Extensive tribal consultation began in June 2004 when the IHS sent out a "Dear Tribal Leader" letter in June 2004 with a draft copy of the FAAB priority system proposal. The IHS received 80 responses from 11 IHS Areas containing over 1200 total comments. The FAAB spent the next two years incorporating comments and working with IHS and tribal leaders on the final recommendation. The final recommendation was forwarded to the U.S. Department of Health & Human Services in November, 2007.

VII. The New Healthcare Facilities Construction Priority System

The new Healthcare Facilities Construction Priority System (HFCPS) is more robust than the current system in that it is very orderly and uses reliable data. It is also based on the master plan concept which ensures that service needs of the local population are used for facility planning. It also provides for a tremendous amount of tribal involvement throughout all phases of the process. Among the highlights are the development of a Master Planning process that recognizes the needs of smaller communities, and an Area Distribution Program.

¹⁵ The 14 member FAAB is comprised of a tribal representative of each of the 12 IHS Areas plus 2 IHS members.

¹⁶ IHS Facilities Needs Assessment and Prioritization Criteria Workgroup Report on Findings and Recommendations, February, 2002.

A. Area Health Services and Facilities Master Plan (Area Master Plan)

The Master Planning process is central to the new priority system. Using the IHS “Health System Planning” (HSP) software/model, the services and facilities required in individual service areas are determined nation-wide. Based upon these community-specific or service area specific HSP analyses, a community specific Master Plan would be generated to quantify the costs associated with the potential construction of expanded, replaced or new facilities.

From there, these data can then be integrated at the Area level to produce a State-wide Health Services and Facilities Master Plan. A Master Plan will help establish relative priority within an Area for construction and development of new services and support decision-making consistent with the Area-wide service delivery system, which in turn, will provide the basis for an integrated Area-wide Master Plan.

The key to this approach to master planning is facility planning and construction decisions will be based on accurate factual information about the system-wide health service needs in each Service Unit and Area. As the area wide service delivery plan is developed decisions will be made about where and how each service will be provided. Then, the discussion will move on to deciding what the facility need is and how best to meet the need. Effectively, tribes engage in an analysis of whether renovation and expansion of an existing facility or whether construction of a new facility is warranted and what will best serve their population’s needs.

B. HFCPS Ranking Methodology

Once the facility requirements of each area have been identified in the Area Master Plans, these projects will then be scored according to the HFCPS. The HFCPS ranking is implemented in two phases. Phase I is designed to assess all of the facility needs through the creation of the Comprehensive National Listing of Facility Need (Unmet Needs List). Phase II is designed to further refine the application and allow innovative solutions to be applied to the scoring criteria. This two-phased process allows the IHS and the Tribes to use limited resources to both identify all of the facility needs (phase I), and to allocate the necessary time and resources for concentrating analysis on those facilities that have the opportunity to move forward to receive full funding within 5 years.

1. Process Overview

In Phase I, all health care facilities in IHS Area Healthcare Services and Facilities Master Plans are evaluated and scored by IHS Headquarters using a HFCPS formula. Facilities on this list are categorized according whether they are an inpatient hospital, health center, small clinic, or other health facility, ranked and compiled into the “Comprehensive National Listing of Facility Need.”

Testimony of Valerie Davidson and Rick Boyce regarding the State of Indian Health Facilities before the Senate Committee on Indian Affairs

In Phase II, facilities selected from the Comprehensive National Listing of Facility Need are reviewed by the HFCPS Validation Committee.¹⁷ The IHS will apply the HFCPS Phase II Formula to data about these proposed facilities to develop the Priority List. Facilities are selected from the Comprehensive National Listing of Facility Need. The method for selecting facilities for Phase II review differs based on the requirements of the specific facilities construction funding program.

Six evaluation factors are employed to evaluate and score facility projects over two phases. The evaluation criteria are:

	Phase I	Phase II
• Facility Resources Deficiency	400 points	400 points
• Health Status	200 points	200 points
• Isolation	100 points	100 points
• Barriers to Care		50 points
• Facility Size	150 points	150 points
• Innovation		<u>100 points</u>
Total	<u>850 points</u>	1000 points

2. Implementation of Phase I

Implementation of Phase I should take approximately 6 months. Phase I scores will be recalculated every five years to maintain a relatively up-to-date Comprehensive National Listing of Facility Need. All Area Health Services and Facilities Master Plans will be updated 24 months before Phase I is recalculated.

The data required for completion of Phase I are:

- User population from the IHS National Patient Information Reporting System;
- Existing facility size, age, and condition from the IHS Facility Data System;
- The following indicators from the Federal Disparity Index (FDI):
 - The Birth Disparities Indicator,
 - The FDI Percent of the population over 55 years old,
 - The Composite Poverty Indicator, and
 - The Disease Disparity Indicator
- The distance from the proposed facility to the nearest emergency room.
- The size of the new/expanded facility from the Area Master Plan

Validation of the data used is obtained from existing IHS databases or will be verified by qualified professionals, e.g., certified professional engineers, architects, etc.

¹⁷ The Healthcare Facilities Validation Committee is a standing committee consisting of seven individuals appointed by the Director of IHS. Membership may include but not be limited to IHS Headquarters and Area Offices, Tribal, and other health oriented professionals.

3. Implementation of Phase II

The entire Phase II process should take approximately 1 year to complete. Phase II of the HFCPS will be recalculated every year that funding is available for one or more facilities construction program to assure an up to date list of high priority projects.

The Phase II list will reflect the changes in funding status of each project. The criteria for Phase II will be implemented and applied slightly differently for each of the congressionally authorized facilities construction programs.¹⁸ The basic formula will remain the same, but other factors, identified in law and regulations, will be used to select projects for Phase II review. Data for the scoring is developed from the approved Program Justification Document (PJD).

For Validation purposes, each PJD is approved by the Director, Office of Environmental Health and Engineering. The HFCPS Validation Committee will review the documentation supporting Innovation and Barriers to Service proposals along with any Tribal facilities information that is not included in the Facility Data System (FDS).

The IHS applies the HFCPS formula to the approved and validated data. Finally, facilities under consideration, are prioritized according to their scores and placed on the Priority List in rank order.

Clearly the new process is based on more reliable data and improved needs based planning. It also allows greater tribal involvement throughout all phases of the process. We applaud the FAAB and the IHS on the development of the new model and implore them to implement it expeditiously. It is one more example of the opportunities in innovation that arise when the IHS and tribes work collaboratively in addressing our facilities needs. However, in order for the new system to be successful more resources are necessary. To realize the full potential of the new facilities priority system, and we urge Congress to provide such funding.

Conclusion

For those of you who deal with the size and complexities of a variety of appropriation needs a regular basis, the improvements we seek here may seem inconsequential. That could not be farther from the truth. As American Indians and Alaska Natives, we are a people with painful legacies of forced removal – to boarding schools, to cities, to faraway hospitals – and rampaging epidemics that disrupted families for generations. Despite this, we still have very strong ties to our communities.

We know from experience, that as resources get tighter, individual AI/ANs and the IHS facilities that provide their care will feel the impact more than any other. Why? The highest rates of unemployment are in Indian Country. We have some of the lowest income levels; some

¹⁸ These programs include the line-item program authorized under Section 301 of the Indian Health Care Improvement Act (IHCA), Public Law (P.L) 93-437; the Small Ambulatory Program, authorized under Section 316; the Joint Venture Program authorized under Section 818, etc.; and projects considered under the Area Distribution Program within each Area.

**Testimony of Valerie Davidson and Rick Boyce regarding the State of Indian Health Facilities
before the Senate Committee on Indian Affairs**

of the poorest health status; and we are primarily rural where access to care is a problem. There is a high cost of providing care, and a high cost of living where limited incomes get stretched even more. What this means is that, when our people do finally get the care they need, they have traveled farther with money they simply don't have, are sicker than the average person, and are seen in clinics/hospitals that have fewer resources than most other facilities in the country. Also, because of their rural nature, our facilities have a higher cost of providing care.

As one of the younger members of my Tribe, with the privilege and opportunity to work in our health programs, it is my duty to try to overcome this history and to assure that no AI/AN will have to make the choice to forego medical care due to a lack of facilities or to receive culturally insensitive care because we are buying care from others that we can provide for ourselves. It is my duty to be sure that we protect the health status improvements that have been made and that we accomplish more. We must leave a better health system for our children and grandchildren than we inherited. It is for that reason that I am here today to testify before you.

The strategies we are discussing today will authorize many important steps toward the goal of quality health care in our home communities and in ways that respond to our needs and respect our way of life. I know that we cannot knock down all of these barriers overnight, but these recommendations will make a significant improvement.

In closing, I want to thank the Committee again for all your work and leadership in addressing these critical issues.

**The Indian Health Service
Health Care Facilities Construction Priority System**

Table of Contents

I)	Introduction.....	1
A)	Overview.....	1
B)	Background.....	1
A.	Scope of the HFCPS Methodology.....	2
II)	Definitions.....	3
III)	HFCPS Process	3
A)	Explanation of Phasing.....	3
B)	The HFCPS Criteria.....	4
1)	The Facility Resources Deficiency Criterion	5
2)	Health Status Criterion	6
3)	Isolation Criterion	7
4)	Barriers to Service Criterion	8
5)	Facility Size Criterion	8
6)	Innovation Criterion	9
IV)	Implementation.....	11
A)	The HFCPS Formula.....	11
B)	Phase I.....	11
1.	Time Line	11
2.	Facilities Evaluated in Phase I	11
3.	Data Used	12
4.	Validation	12
5.	Application of Data	12
6.	Scoring	12
7.	Uses of Scoring	13
C)	Phase II.....	13
1.	Time Line	13
2.	Facilities Evaluated in Phase II	13
3.	Data Used	14
4.	Validation:	15
5.	Application of Data	15
6.	Ranking in Phase II	16
D)	Area Distribution Program.....	16

List of Tables

Table 1,	HFCPS Evaluation Criteria and Weighting.....	5
Table 2,	Phase I Required Space Formula.....	6
Table 3,	Calculating the Facility Deficiency Criterion Value,.....	6
Table 4,	Calculating the Health Status Criterion Value.....	7
Table 5,	Calculating Isolation.....	7
Table 6,	Phase II Determining Barriers to Service.....	8
Table 7,	Facility Size Criterion Value Look up Table.....	9
Table 8,	Facility Size Criterion.....	9
Table 9,	Innovation Criterion.....	11
Table 10,	Facilities Categories.....	13
Table 11,	Area Distribution Formula.....	16

List of Appendices

Appendix I.	Glossary.....	I-17
-------------	---------------	------

**The Indian Health Service
Health Care Facilities Construction Priority System**

Appendix II. The Healthcare Facilities Construction Priority System
MethodologyII-20

**The Indian Health Service
Health Care Facilities Construction Priority System**

I) Introduction

A) Overview

The Healthcare Facilities Construction Priority System (HFCPS) is the methodology that the Indian Health Service (IHS) uses to identify and prioritize the need for IHS and Tribal healthcare facilities. It is applied only to those facilities that are part of an IHS Area Health Services and Facilities Master Plan. The methodology determines need based on the size of the American Indian and Alaska Native population requiring access to services, hence the most significant factor in scoring and prioritizing need is a comparison of the size of the existing facility with the size of a facility required for the population. Other factors used to rank and prioritize need include:

- The population's health status,
- The isolation of the population
- the social and economic factors that hinder access to services at existing facilities,
- The size of the required facility (this factor increases the priority for smaller facilities), and
- A tribe's willingness to develop innovations for construction and/or operation of a facility.

This document provides an overview of the HFCPS methodology. The methodology formula is detailed in, Appendix II, "The Healthcare Facilities Construction Priority System Methodology," but will be implemented using an internet database. Following each application of the HFCPS, the formula (including the data, calculations and results for each facility) will be posted on www.dfpc.ihs.gov.

B) Background

In Section 301 of the Indian Health Care Improvement Act (IHCIA), Public Law (P.L) 94-437, the Congress directs IHS to provide a list of the highest priority facilities construction projects. In order to comply with this directive, IHS established the HFCPS in 1991. Other sections of the IHCIA enacted over the years have authorized a variety of other funding programs for healthcare facilities construction, including:

- The Joint Venture Program. Under this program, the IHS is authorized into enter into agreements with Tribes under which the Tribes agree to construct a facility and IHS agrees to provide staffing and operating funds.

**The Indian Health Service
Health Care Facilities Construction Priority System**

- The Small Ambulatory Program. Under this program the IHS is authorized to assist Tribes whose outpatient facilities meet certain requirements:
 - The facility must provide access for population of at least 500 users in a service area with more than 2,000 eligible Indians; and
 - The facility may not be part of a hospital campus.
 - Etc.;
- Other programs that have been authorized but not funded.

In addition to prioritizing projects for these authorized facilities construction programs, the HFCPS results may be used to allocate funds for other programs for which Congress may appropriate funds. One program specifically identified during the review of the HFCPS would distribute funds to Area Offices to address high priority projects within the Area.

In fiscal year 2000, the Congress directed IHS, in consultation with the Tribes, to review the HFCPS. Based on this directive, the IHS, with input from various Tribal and IHS workgroups, developed a revision to the HFCPS and presented it for Tribal comment. The discussions and consultation process generated many and diverse comments. While all of these comments could not be incorporated into this document, all were considered.

A. Scope of the HFCPS Methodology

The HFCPS methodology does two things:

- It provides a Comprehensive National Listing of Facility Need by identifying the total need for construction of IHS and Tribal healthcare facilities¹, and
- It provides a process for prioritizing that need for the authorized facilities construction programs.

The HFCPS is not intended to identify or prioritize the need for staffing and other resources, although the Congress usually provides an increase to the IHS recurring funding base when a facility is constructed.

The HFCPS does not identify or prioritize the need for staff quarters; however, this need is evaluated and addressed prior to requesting construction funding for a facility. If staff quarters are needed at a facility and if Congress appropriates

¹ Construction includes replacing, expanding and/or modernizing existing facilities and acquisition of new facilities.

**The Indian Health Service
Health Care Facilities Construction Priority System**

funds for them, they are planned, designed, and constructed at the same time as the facility.

The 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).

II) Definitions

See, Appendix I, "Glossary" for definitions used in this document.

III) HFCPS Process

The HFCPS consists of two phases. In Phase I, all health care facilities documented in IHS Area Healthcare Services and Facilities Master Plans, are evaluated and scored by IHS Headquarters using the HFCPS formula. This scored listing is referred to as the Comprehensive National Listing of Facility Need. Facilities on this list are categorized according Table 10, "Facilities Categories, on page 13. In Phase II, facilities selected from the Comprehensive National Listing of Facility Need are reviewed by the HFCPS Validation Committee. Data from these facilities are applied to the HFCPS Phase II formula by IHS Headquarters to develop the Priority List.

The method for selecting facilities for Phase II review differs based on the requirements of the facilities construction funding program. For example, facilities selected for the Section 301 Priority List will be the highest scoring Phase I facilities on the Comprehensive National Listing of Facility Need; however, those selected for the Joint Venture Program will be the highest scoring facilities on Comprehensive National Listing of Facility Need, where the Tribe(s) is willing to construct a facility in return for operation assistance from IHS. See "Facilities Evaluated in Phase II" on page 13 for details on selection criteria for these and other construction programs.

Following each application of the HFCPS, the formula used (including the data, calculations and results for each facility reviewed) will be posted on www.dfpc.ihs.gov.

A) Explanation of Phasing

Implementing the HFCPS in two phases permits the IHS and the Tribes to use limited resources to review all healthcare facilities needs in Phase I, while concentrating analysis on the few facilities selected for Phase II.

**The Indian Health Service
Health Care Facilities Construction Priority System**

Phase I is less resource-intensive than Phase II because:

- The "Required Space" element of the "Facility Deficiency Factor" is estimated using a simple formula (see Table 2, "Phase I Required Space Formula") in Phase I, while a full application of the IHS Health System Planning Process (HSP) is used in Phase II.
- The "Innovation" Factor, which requires extensive resources to validate, is in Phase II only, and
- The "Barriers to Services" element, which requires extensive resources to validate, is in Phase II only.

In Phase I, the HFCPS methodology is used to rank all facilities based on the adequacy of the space available to provide access to services for the population. The adequacy of the existing space is determined by comparing the space available with the estimated Required Space for the population. The less adequate the space, the higher the Phase I score. Phase I results are reported as the "Comprehensive National List of Facility Need." The scores established in Phase I may not indicate the actual priority of a facility, but are used to identify facilities for a more comprehensive review and prioritization during Phase II.

In Phase II, the HFCPS methodology is applied to determine actual need for the highest scoring facilities selected from Phase I and to establish the priority of those facilities. This is done by comparing the space available with the actual space required for the population. Facilities identified as priority projects in Phase II are incorporated into the IHS 5-Year Planned Construction Budget which is used to request appropriations for construction funding.

B) The HFCPS Criteria

The HFCPS Methodology uses four criteria in Phase I and six criteria in Phase II (See Table 1, "HFCPS Evaluation Criteria and Weighting"). The weighting shown in Table 1 is the maximum that each criterion may add to the score. Weightings indicate the relative influence on the final score.²

² The "Barriers to Service" and "Innovation" factors are not considered in Phase I because these criteria require significant resources to validate. They are included only in Phase II, when a limited number of facilities are evaluated.

**The Indian Health Service
Health Care Facilities Construction Priority System**

Table 1, HFCPS Evaluation Criteria and Weighting

Evaluation Criteria		Evaluation Criteria Value		Phase I Criteria Weighting	or	Phase II Criteria Weighting	=	Score
Facility Resources Deficiency		1	X	400	or	400	=	
Health Status		2	X	200	or	200	=	
Isolation/ Barriers to Service	Isolation	3	X	100	or	100	=	
	Barriers to Service	4 <small>Phase II only</small>	X	0	or	50	=	
Facility Size		5	X	150	or	150	=	
Innovation		6 <small>Phase II only</small>	X	0	or	100	=	
Maximum Possible Score			+	850	or	1000	=	(850 or 1000 Maximum)
Use this table by obtaining a value from the appropriate value from the tables listed below. Place that value on the appropriate row under "Evaluation Criteria Value." Complete the calculations to obtain a score for either Phase I or Phase II.				1. See 2. See Table 4, Calculating the Health Status Criterion Value 3. See Table 5, Calculating Isolation 4. See Table 6, Phase II Determining Barriers to Service 5. See Table 7, Facility Size Criterion Value Look up Table 6. See Table 9, Innovation Criterion.				

1) The Facility Resources Deficiency Criterion

The Facility Resource Deficiency Factor compares the existing size of a facility with the size required to provide access to healthcare services. Four pieces of data are needed to generate the Facilities Deficiency Factor. These are:

- o The existing facility space in square meters (facility size)
- o The facility age.
- o The facility condition expressed in the cost to repair the facility.
- o The cost to replace the existing facility
- o The IHS User Population for the facility's service area.

The existing facility size, age and condition are used to calculate the "Adjusted Existing Space" for a facility. These data are obtained from the IHS Healthcare Facilities Data System (HFDS) data base. Tribes that do not participate in the IHS HFDS data base must provide this data, with documentation verified by a licensed professional (engineer, architect, etc.) For Tribes not participating in the IHS HFDS, size, age and condition data will be used as submitted in Phase I, but will be validated before used in Phase II. If there is a significant difference between data used during Phase I and the data validated during Phase II, a facility could be disqualified from Phase II. It will be re-ranked in Phase I based on the validated data.

**The Indian Health Service
Health Care Facilities Construction Priority System**

The cost to replace a facility is determined using the existing facility size and two factors in the IHS Cost Estimating System³:

- o unit cost based on facility type, and
- o a locality factor.

The value of each of the factors varies from facility to facility. It may also change from year to year based on economic conditions. The value used for each facility in a specific application of the HFCPS will be shown in the formula posted at www.dfpc.ihs.gov.

User population is used to estimate a facility's "Required Space" and is obtained from the IHS National Patient Information Reporting System (NPIRS). Only Tribes participating in NPIRS may participate in the HFCPS. In Phase I, required space is estimated using the formula in Table 2, "Phase I Required Space Formula," on page 6. In Phase II, required space is determined using the IHS HSP.

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 ⁴	= 1 - ($\frac{\text{Adjusted Existing Space}}{\text{Required Space}}$)	=

2) Health Status Criterion

The Health Status Criterion provides an advantage in scoring to those locations with a low health status. The following four indices are incorporated as part of the Health Status Criterion:

³ The IHS Cost Estimating System unit cost is based on facility type and may change from year to year based on economic conditions. The locality factor is obtained from the Federal Budget Estimating System and may also vary from year to year based the economy. Both the unit cost value and the locality factor are determined using the historical record and data from nationally recognized, private sector construction estimating organizations, such as R.S. Means, Marshall and Swift, and the McGraw Hill Engineering News Record.

⁴ See, Appendix II, "The Healthcare Facilities Construction Priority System Methodology" for details on developing the different elements of this formula.

**The Indian Health Service
Health Care Facilities Construction Priority System**

- o Birth Disparities Indicator (BDI),
- o Percent of the population over 55 years old (Pop>55),
- o Composite Poverty Indicator (CPI)
- o Disease Disparity Indicator (DDI).

Table 4, "Calculating the Health Status Criterion Value," illustrates how the Health Status criterion is calculated.

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

3) Isolation Criterion

The Isolation Criterion provides advantage to those facilities where the population is isolated and does not have access to nearby healthcare services of any kind. It refers specifically to the amount of time it takes most people to get to a place where they can receive healthcare services. In the HFCPS, time is estimated using the distance to the nearest Level I, II, or III emergency room (Federal, Tribal or private sector)⁵. Table 5, "Calculating Isolation," illustrates how the Isolation Criterion value is calculated:

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	=	$\frac{\text{Km to Alternatives}}{90 \text{ Kilometers}}$	=	
More than 90 Km an ER	Isolation	=	1	=	1
Not on a road connecting to Federal or state highway	Isolation	=	1	=	1

⁵ 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.

**The Indian Health Service
Health Care Facilities Construction Priority System**

4) Barriers to Service Criterion

The ability to access health care may be difficult for reasons besides the 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.

Since determining whether or not barriers exist could be subjective, documentation will be verified and all claims validated by the Validation Committee before it is applied to the formula in Phase II. Table 6, "Determining Barriers to Service," illustrates how the value for the Barriers to Service is determined:

Table 6, Phase II Determining Barriers to Service

If the Validation Committee:	Barriers To Service Value
Does not Verify Barriers to Service	Barriers to Service = 0
Does Verify Barriers to Service	Barriers to Service = 1

5) Facility Size Criterion

The Facility Size Criterion increases the total Priority Score for smaller facilities⁶. Smaller facilities receive up to 150 points, while facilities serving large populations receive proportionally fewer points. The Facility Size Criterion is based on the IHS User Population for the facility Service Area. This information is obtained from the IHS National Patient Information Reporting System (NPIRS). Table 7, "Facility Size Criterion Value Look up Table," provides an approximate Facility size Criterion Value for all facilities up to 25 200 m². The actual value can be calculated using the formula in Table 8, "Facility Size Criterion." This table can also be used to calculate The Facility Size Criterion Value for the three or four IHS and Tribal facilities larger than 25 200m².

⁶ The facility size is the required space. In Phase I required space is based on population for outpatient facilities and on workload for inpatient facilities. In phase II required space is determined using the HSP.

**The Indian Health Service
Health Care Facilities Construction Priority System**

Table 7, Facility Size Criterion Value Look up Table

Facility Required Space In Square Meters (m ²)			Facility Size Value	Facility Required Space In Square Meters (m ²)			Facility Size Value	Facility Required Space In Square Meters (m ²)			Facility Size Value
Up to 1 200			1								
1 201	to	1 600	0.976	9 601	to	10 000	0.541	18 001	to	18 400	0.345
1 601	to	2 000	0.952	10 001	to	10 400	0.524	18 401	to	18 800	0.340
2 001	to	2 400	0.928	10 401	to	10 800	0.507	18 801	to	19 200	0.335
2 401	to	2 800	0.904	10 801	to	11 200	0.489	19 201	to	19 600	0.329
2 801	to	3 200	0.880	11 201	to	11 600	0.472	19 601	to	20 000	0.324
3 201	to	3 600	0.856	11 601	to	12 000	0.455	20 001	to	20 400	0.318
3 601	to	4 000	0.832	12 001	to	12 400	0.438	20 401	to	20 800	0.313
4 001	to	4 400	0.808	12 401	to	12 800	0.421	20 801	to	21 200	0.308
4 401	to	4 800	0.784	12 801	to	13 200	0.416	21 201	to	21 600	0.302
4 801	to	5 200	0.760	13 201	to	13 600	0.410	21 601	to	22 000	0.297
5 201	to	5 600	0.736	13 601	to	14 000	0.405	22 001	to	22 400	0.291
5 601	to	6 000	0.712	14 001	to	14 400	0.399	22 401	to	22 800	0.286
6 001	to	6 400	0.695	14 401	to	14 800	0.394	22 801	to	23 200	0.281
6 401	to	6 800	0.678	14 801	to	15 200	0.389	23 201	to	23 600	0.275
6 801	to	7 200	0.661	15 201	to	15 600	0.383	23 601	to	24 000	0.270
6 801 or more			Calculated using the same formula used for Table 8, 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 m ²) X 0.00006])	
6 000 m ² than 12 800m ²	(.712 - [(Required Space - 6000 m ²) X 0.0000428])	
More than 12 800 m ²	(.416 - [(Required Space - 6000 m ²) X 0.0000135])	

6) Innovation Criterion

The Innovation Criterion increases the Priority score during Phase II for Tribes and Service Units that identify and document innovative ways of providing of healthcare or acquiring healthcare facilities. For an innovation to be validated the Tribe or Service Unite must show that the innovation(s) significantly

- o Increases Health promotion/disease prevention,
- o Efficiency and/or effectiveness of healthcare services delivery, or
- o Reduces federal cost in acquiring, operating and/or maintaining healthcare facilities.

Each innovation identified is worth up to 1/5 (or 20 percent) of the Innovation Criterion value. Documentation supporting each innovation must show that it increases efficiency, effectiveness, community involvement, etc. General examples of innovation that might be used are listed below:

**The Indian Health Service
Health Care Facilities Construction Priority System**

- o Planning/Coordination with another Tribe or PSA for sharing major Health Delivery programs with written use agreements.
- o 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.
- o Developing other health delivery innovations that involve major medical departments or programs and partnering with State or Local Health Programs.
- o 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.
- o 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. Greater savings do not affect scoring.
- o Developing, administering, and funding a public health initiative or program.
- o Etc.

Innovation should not be limited to a pre-conceived definition of what it is. Tribes, Areas, Service Units, consortiums, etc., are encouraged to develop innovative approaches to providing services and/or facilities. These will reviewed by the Validation Committee during the Phase II process. *Table 9, Innovation Criterion*, illustrates how the Innovation Criterion Value is calculated.

**The Indian Health Service
Health Care Facilities Construction Priority System**

Table 9, Innovation Criterion

Innovation Elements (up to 5)	Value per Element (max of 0.2 per Element)
Element 1 Verified by Validation Committee	+
Element 2 Verified by Validation Committee	+
Element 3 Verified by Validation Committee	+
Element 4 Verified by Validation Committee	+
Element 5 Verified by Validation Committee	+
Total	(Maximum of 1)

IV) Implementation

A) The HFCPS Formula

For each facility considered, the HFCPS Formula incorporates the weighting for each factor and sums the factors to obtain the score (see Table 1, "HFCPS Evaluation Criteria and Weighting"). In Phase I only Facility Resource Deficiency, Health Status, Isolation, and Facility Size are summed. In Phase II, these factors as well as Barriers to Service and Innovation are summed. Table 1, "HFCPS Evaluation Criteria and Weighting," on page 5 shows the weightings and how the factors are summed in both Phase I and Phase II.

B) Phase I

1. Time Line

The IHS will run Phase I of the HFCPS every five years to maintain a relatively up-to-date Comprehensive National Listing of Facility Need. During those five years, modifications to Area Master Plans may generate minor changes in the Phase I scores.

Implementation of Phase I should take approximately 6 months, after all Area Health Services and Facilities Master Plans are updated. The IHS will notify all Tribes and Areas to finalize any updates to Master plans at least 24 months prior to implementation of Phase I.

2. Facilities Evaluated in Phase I

During Phase I of the HFCPS, every facility identified on Area Health Services and Facilities Master Plans, including urban program facilities, are reviewed and ranked according to the Phase I evaluation criteria. Urban facilities are ranked on a separate list and are not forwarded to Phase II of any facilities construction program. The listing of Urban Program facilities need is provided to the IHS Urban Program for use in the budget process.

**The Indian Health Service
Health Care Facilities Construction Priority System**

3. Data Used

The data required for completion of Phase I are:

- User population from the IHS National Patient Information Reporting System;
- Existing facility size, age, and condition from the IHS Facility Data System;
- The following indicators from the FDI:
 - The Birth Disparities Indicator,
 - The FDI Percent of the population over 55 years old,
 - The Composite Poverty Indicator, and
 - The Disease Disparity Indicator; and
- The distance from the proposed facility to the nearest emergency room.

4. Validation

Phase I data will not be validated; however, the data used is obtained from existing IHS databases or will be verified by qualified professionals, e.g., certified professional engineers, architects, etc. Data used during Phase I will be included in a database available for public viewing and assessment.

5. Application of Data

For Phase I, the IHS Headquarters Staff uses an internet based database to apply the data to the HFCPS formula shown on page 5 in Table 1, "HFCPS Evaluation Criteria and Weighting," using weighting factors in the column headed "Phase I Criteria Weighting." The "Innovation" and "Access-to-Care" criterion are not evaluated during Phase I.

The way data are applied for each facility will be viewable on the internet data base.

6. Scoring

Every facility reviewed during Phase I is ranked on the Comprehensive National Listing of Facility Need according to the Phase I scoring. They are then categorized (see Table 10, Facilities Categories) according to type of facility as identified in the Area Master Plans. This categorization may be different than the type of facility that is finally planned and constructed, but will serve to assist in making decisions about which facilities are placed in Phase II for specific programs.

**The Indian Health Service
Health Care Facilities Construction Priority System**

Table 10, Facilities Categories

Following Phase I scoring, all facilities are placed in an initial category. This initial placement is used as a part of 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 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.

7. Uses of Scoring

The Phase I scoring will be used by all funded healthcare facilities construction programs to identify facilities for review in Phase II. These programs include the line-item program authorized under Section 301 of the Indian Health Care Improvement Act (IHCIA), Public Law (P.L) 93-437, the Small Ambulatory Program, authorized under Section 316, the Joint Venture Program authorized under Section 818, etc. These will also be used within each Area to identify the projects for the "Area Distribution Program" described on page 16.

C) Phase II

1. Time Line

The IHS anticipates running Phase II of the HFCPS every year to assure a dynamic list of high priority projects for each facilities construction program. However, given the fluctuation in funding for programs, there may not be a need to add projects to the list every year. In a years when appropriated funding is less than anticipated for a program, the IHS may cancel application of Phase II so that a large backlog of unfunded projects do not "clog" the process.

Application of Phase II, which includes development and finalization of a Program Justification Document (PJD) for each project, should take approximately 1 year.

2. Facilities Evaluated in Phase II

Each of the congressionally authorize facilities construction programs has different requirements. To ensure that the requirements of each are addressed, Phase II will be implemented and applied slightly differently for each. Although the basic formula will remain the same, other factors, identified in law

**The Indian Health Service
Health Care Facilities Construction Priority System**

and regulations, will be used to select projects for Phase II review.

The number and type of facilities evaluated in Phase II will depend on the program for which Phase II is being applied. For the line-item program authorized in Section 301 of the IHCA, the facilities selected will depend primarily on the scoring in the Phase I "Comprehensive National Listing of Facility Need." However, because some types of facilities are funded more quickly than others, selection may be limited to certain categories of facilities (see Table 10 "Facilities Categories"). The actual number of facilities selected depends on the number of facilities already on the Priority List, on the cost to complete these projects, and on what is expected to be appropriated over the subsequent years.

Below is a summary of some of the Phase II selection criteria for other authorized programs:

- o Before a facility may be considered in Phase II for the Small Ambulatory Program funding, it must meet specific ownership, size, and population criteria and must not be connected to a hospital. It should be noted that in the past, when funds are appropriated, the Congress has specified the amount that can be expended on each project;
- o Before a facility may be considered in Phase II for the Joint Venture Program, a Tribe must show a capability and willingness to enter into an agreement with the IHS. Under the Joint Venture agreement the Tribe will acquire the facility and lease it, at no cost for 20 years, to the IHS; in return, the IHS will equip the facility and provide resources for its staffing and operation.
- o Other authorized programs have never been funded by the Congress, but these, too, have requirements that may restrict selection for Phase II..

3. Data Used

During Phase II, data from the approved PJD will be used. This data should be solidly based on the Phase I data but may be applied differently to reflect more accurately the situation and the expected service population. For example, to estimate the required space in Phase II, the IHS will use Health System Planning Process (HSP) instead of the formula used in Phase I. The HSP provides a more detailed and accurate analysis of a population than the space formula used in Phase I.

In addition, Phase II will incorporate two additional factors that are not part of Phase I:

**The Indian Health Service
Health Care Facilities Construction Priority System**

- o Innovation and
- o Barriers to Service

Tribes or service units with facilities evaluated in Phase II that wish to increase the score based on these two factors, will be asked to submit supporting documentation.

The Joint Venture, Small Ambulatory and some other programs may require Tribes and service units to provide other, additional information during Phase II. These requirements are usually specified in authorizing and/or appropriations Law. In addition, policy, regulation, etc. may require additional information that needs to be considered during Phase II.

4. Validation:

Each PJD must be approved by the Director, Office of Environmental Health and Engineering, to ensure consistency with Master Plans and IHS planning guidelines. The HFCPS Validation Committee will review the documentation supporting Innovation and Barriers to Service proposals. The Validation Committee will also review any Tribal facilities information that is not included in the FDS (i.e., existing space, facility condition, and facility age).

Facilities that do not have approved PJDs when the Validation Committee meets to review projects for Phase II will be removed from Phase II consideration. They remain on the Comprehensive National Listing of Facility Need, and may be selected for subsequent Phase II review. These facilities could be bypassed for subsequent review, if there has not been sufficient progress on developing an approvable PJD. If this occurs, the next facility that has not been reviewed or that has made adequate progress in developing a PJD, will be selected for Phase II review.

Facilities with Phase II scores lower than their Phase I score following validation of the data may be removed from Phase II consideration. These facilities will be re-ranked on the "Comprehensive National Listing of Facility Need" using the validated data. They may be considered for subsequent Phase II applications, based on their Phase I scores.

5. Application of Data

The IHS Headquarters Staff applies approved and validated data to the HFCPS formula shown on page 5 in Table 1, "HFCPS Evaluation Criteria and Weighting."

**The Indian Health Service
Health Care Facilities Construction Priority System**

6. Ranking in Phase II

During Phase II, facilities under consideration, are prioritized according to their scores and placed on the Priority List in rank order immediately following any facility already on the list.

D) Area Distribution Program

The Area Distribution Program provides a methodology for allocating funds to Area Offices to address the highest priority projects within the Area. It is initiated only when the Congress appropriates construction funds for this purpose. These funds must be distributed to the highest priority Area Office facilities where the Area and Tribes agree that only limited new staffing is required. The reason for this is that, upon completion of Area Distribution Program projects, the facility will be allocated only about 40% of the additional staffing and operation funds usually allocated to new facilities. The Area Distribution Program funds are allocated as follows:

In a given year, the Area Offices where the line-item amount in the Facilities Appropriation exceeds 20% of the total appropriations for facilities construction may not participate in the Area Distribution Program. Those Areas that receive 20% or less of the annual line-item facilities appropriation are allocated a portion of the Area Distribution Program funds based on the following Formula:

Table 11, Area Distribution Formula

Area Allocation	=	Total Area Distribution Funds Appropriated	X	$\frac{\text{Area User population} \times \text{Avg. Area locality factor}}{\text{Sum all the Participating Area's (Area User population} \times \text{Avg. Area locality factor)}}$
-----------------	---	--	---	--

Actual Allocation to the Areas will be based on the capability for completing the highest priority projects with the funding available. This means that there may be some adjustment of actual allocation from year-to-year in order to ensure that projects are fully funded.

After a project is funded under the Area Distribution Program, it is re-scored and re-ranked in the Phase I HFCPS based on planned size and condition of the facility after completion of the project.

**The Indian Health Service
Health Care Facilities Construction Priority System**

Appendix I. Glossary

Area Distribution Program - The Area Distribution Program is a subset of the HFCPS that is implemented when Congress appropriates funding to be allocated to Area Offices based on a pro-rata formula. Because appropriations in a given year may not be enough to fully fund a project in each Area, results of this formula may be adjusted to complete fewer projects, with the idea that Areas that do not receive their full allocation one year would be eligible for more funding in a subsequent year. The Areas distributes these funds to address the needs of high priority projects within the Area. The IHS will support requests for partial increase staffing levels at these facilities. Tribes may elect not to participate in this program. Facilities identified for this program are rescored and re-ranked in Phase I of the HFCPS based on changes in the size and condition of the facility following construction.

Categories - Each Tribal and IHS facility will be assigned one of the categories listed on page II-21 in Figure 2, "Facilities 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.

Comprehensive National Listing of Facility Need - A listing of all IHS and Tribal health care facilities in which each facility is scored according to need. Each facility's score is developed during Phase I and is based on estimated space requirements and Master Planning data.

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.

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.

HFCPS (Healthcare Facilities Construction Priority System) - The IHS process for evaluating and scoring the need for healthcare facilities to provide access to health services for American Indians and Alaska Natives. It consists of two phases: phase I assesses facilities need to produce the "Comprehensive National Listing of Facility Need," and Phase II re-assesses and determines the placement of high ranking facilities on the IHS Healthcare Facilities Construction Priority List.

**The Indian Health Service
Health Care Facilities Construction Priority System**

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 in partnership with the Tribes.

PJD (Program Justification Document) - A detailed planning document that describes the program and the general facility plan. It is developed by IHS and Tribal using the HSP as a tool.

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

Priority List - the list used to request funding from Congress or to allocate funds appropriated by Congress. It is a list of projects that have been fully evaluated and planned. Ideally, IHS should have only one priority list from which it funds the projects with the greatest need. However, there are several Congressionally authorized funding programs, and each of these has different requirements. Some of these requirements limit the kinds of facility project that can be funded, and sometimes these limitations mean that facilities with high Phase I scores are bypassed and not placed on a priority list. For example, the Small Ambulatory Program is authorized by Congress to provide outpatient facilities that are not part of a hospital. In addition, these facilities must provide access to a user population of at least 500. Facilities that do not meet these basic congressional requirements will not be considered in Phase II for the Small Ambulatory Program and will not be placed a Priority List for this program, regardless of their Phase I scores.

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.

Scoring - Each Tribal and IHS PSA/facility will be assigned a score generated by applying data from the IHS databases to the Phase I HFCPS formula in Appendix II, "The Healthcare Facilities

**The Indian Health Service
Health Care Facilities Construction Priority System**

Construction Priority System Methodology." The Phase I scores will be used to establish the Comprehensive National Listing of Facility Need.

Required Space - The space necessary to provide access to healthcare services for a given population. In Phase I of the HFCPS, required space is estimated by using a simple formula (see Table 2, "Phase I Required Space Formula"). In Phase II the required space is obtained from the approved Program Justification Document (PJD) for the facility.

Validation Committee (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 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 Indian Health Service
Health Care Facilities Construction Priority System**

Appendix II. The Healthcare Facilities Construction Priority System Methodology

Table of Figures

Figure 1, Calculating the Phase I Score.....	II-21
Figure 2, Facilities Categories.....	II-21
Figure 3, Calculating the Phase II Score.....	II-22
Figure 4, Calculating the Facility Deficiency Criterion Value.....	II-22
Figure 5, Estimating Required Space for Phase I.....	II-23
Figure 6, Calculating Adjusted Existing Space.....	II-23
Figure 7, Look-Up: Age Factor.....	II-23
Figure 8, Calculate Weighted Age for Multi Building Facilities.....	II-24
Figure 9, Calculate Condition Adjustment Factor for Existing Facilities.....	II-24
Figure 10, Calculating the Health Status Criterion Value.....	II-25
Figure 11, Calculating the Isolation Criterion Value.....	II-25
Figure 12, Calculating the Barriers to Service Criterion Value.....	II-25
Figure 13, Facility Size Criterion Value Look up Table.....	II-26
Figure 14, Facility Size Criterion Formula.....	II-27
Figure 15, Innovation Criterion Value.....	II-27
Figure 16, Facility Condition Factor Lookup Table.....	II-28

Overview

This document describes the formula used in the HFCPS methodology. It provides a step by step review of the formula and includes look-up tables as shortcuts some of the calculations. The lookup tables will not always provide the most accurate score. They are developed using calculations from the HFCPS formula, but are not intended to reflect every situation exactly. There are likely to be slight differences between scores generated using the lookup tables and those that use the calculations on which the tables are based. The HFCPS formula will be implemented using an internet database, which will use the formula. Following each application of the HFCPS, the formula (including the data, calculations and results for each facility) will be posted on www.dfpc.ihs.gov.

HFCPS Methodology Formula

Each facility identified in a Services and Facilities Master Plan is evaluated in Phase I using Figure 1, "Calculating the Phase I Score."

**The Indian Health Service
Health Care Facilities Construction Priority System**

Figure 1, Calculating the Phase I Score

<p>Enter the Facility Deficiency, Health Status, Isolation, and Facility Size criterion values on the appropriate line under the column headed "Evaluation Criteria Value."</p> <p>Complete the calculation for lines A, B, C, and D, as indicated. Enter each result on the appropriate line in the column headed Score.</p> <p>Add the scores for lines A, B, C, D and enter the result in line E under Score.</p>	Line	Evaluation Criteria	Evaluation Criteria Value	Criteria Weighting	Score
	A	Facility Deficiency		x 400	=
	B	Health Status		x 200	=
	C	Isolation		x 100	=
	D	Facility Size		x 150	=
E	Phase I Total Score The Total Score is the sum of the scores on lines A, B, C, and D.				(850Maximum)

The Evaluation Criteria values used on this table can be determined as follows:
 For Line A see Figure 4, "Calculating the Facility Deficiency Criterion Value" Calculating this value is fairly complex and will also require the use of Figure 5, "Estimating Required Space for Phase;" Figure 6, "Calculating Adjusted Existing Space;" Figure 7, "Look-Up: Age Factor;" Figure 8, "Calculate Weighted Age for Multi Building Facilities;" and Figure 9, "Calculate Condition Adjustment Factor for Existing Facilities."
 For Line B see Figure 10, "Calculating the Health Status Criterion Value."
 For Line C see Figure 11, "Calculating the Isolation Criterion Value."
 For Line D see Figure 13, "Facility Size Criterion Value Look up Table."

After scoring each facility in Phase I, they are placed in categories shown in Figure 2, "Facilities Categories."

Figure 2, Facilities Categories

<p>Following Phase I scoring, all facilities are placed in an initial category. This initial placement is used as a part of the selection process for Phase II.</p>	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 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.

The highest scoring facilities identified in Phase I are selected for review for Phase II. Figure 3, "Calculating the Phase II Score," is used during Phase II to prioritize these facilities.

**The Indian Health Service
Health Care Facilities Construction Priority System**

Figure 3, Calculating the Phase II Score

<p>Enter the Facility Deficiency, Health Status, Isolation, Barriers to Service Facility Size and Innovation criterion values in column headed "Evaluation Criteria Value" for lines A, B, C, D, E, and F respectively.</p> <p>Complete the calculation for lines A, B, C, D, E, and F as indicated. Enter each result on the appropriate line in the column headed Score.</p> <p>Add the scores for lines A, B, C, D, E, and F and enter the result in line G under Score.</p>	Line	Evaluation Criteria	Evaluation Criteria Value	Criteria Weighting	Score
	A	Facility Deficiency		x 400	=
	B	Health Status		x 200	=
	C	Isolation		x 100	=
	D	Barriers to Service		x 50	=
	E	Facility Size		x 150	=
	F	Innovation		x 100	=
	G	Phase II Total Score			

The Evaluation Criteria values used on this table can be determined as follows:
 For Line A see Figure 4, "Calculating the Facility Deficiency Criterion Value" Calculating this value is fairly complex and will also require the use of Figure 6, "Calculating Adjusted Existing Space;" Figure 7, "Look-Up: Age Factor;" Figure 8, "Calculate Weighted Age for Multi Building Facilities;" and Figure 9, "Calculate Condition Adjustment Factor for Existing Facilities." In addition, the required space in the approved Program Justification Document will be needed.
 For Line B see Figure 10, "Calculating the Health Status Criterion Value."
 For Line C see Figure 11, "Calculating the Isolation Criterion Value."
 For Line D see Figure 12, "Calculating the Barriers to Service Criterion Value."
 For Line E see Figure 13, "Facility Size Criterion Value Look up Table."
 For line F see Figure 15, "Innovation Criterion Value"

Facility Deficiency Criterion Calculations

Figure 4, Calculating the Facility Deficiency Criterion Value

<p>During Phase I, Required Space is estimated using Figure 5, "Estimating Required Space for Phase I." During Phase II Required Space is estimated using the Health System Planning Process (HSP) with no deviations. During both phases, Figure 6, "Calculating Adjusted Existing Space" is used to obtain values for Adjusted Existing Space.</p>	Facility Deficiency	Facilities Deficiency Formula
		$= 1 - \left(\frac{\text{Adjusted Existing Space}}{\text{Required Space}} \right)$

**The Indian Health Service
Health Care Facilities Construction Priority System**

Figure 5, Estimating Required Space for Phase I

<p>Outpatient: During Phase I the estimated size for any outpatient facility will be at least 200m², with and additional .8m² per user population. The IHS user population for a facility is the IHS User Population obtained from the IHS National Patient Information Reporting System.</p> <ul style="list-style-type: none"> • Enter the IHS user population for the facility on line B. • Multiply Line A (0.8 m2) times Line B and enter the result on line C. • Add line D (200 m2) to line C and enter the result on line E. 	Line			
	A		IHS Average Space per User Population	0.8 m ²
	B	x	User Population	
	C		User Population Space	
	D	+	Base Facility Size	200 m ²
E		Estimated Required Space for an outpatient facility		
<p>Inpatient: During Phase I the estimated size for any inpatient facility will be at least 5 500m², with and additional 3.5m² per annual inpatient bed days (ID). The estimated space for the outpatient component of an inpatient facility has been included as part of the calculations F-J. The IHS ABD for a facility is the ID obtained from the IHS National Patient Information Reporting System.</p> <ul style="list-style-type: none"> • Enter the IHS ID for the facility on line G. • Multiply Line F (3.5 m2) times Line G and enter the result on line H. • Add line I (5 500 m2) to line G and enter the result on line J. 	Line			
	F		IHS Average Space per ID	3.5 m ²
	G	x	ID	
	H		IDL Space	
	I	+	Base Facility Size	5 500 m ²
	J		Estimated Required Space for an inpatient facility	

Figure 6, Calculating Adjusted Existing Space

<p>If there is no existing facility, enter Das the Adjusted Existing Space on Line E. If there is an existing facility:</p> <ul style="list-style-type: none"> • Refer to Figure 7, "Look-Up: Age Factor" and Figure 8, "Calculate Weighted Age for Multi Building Facilities," to obtain the Age Adjustment Factor for Line A, • Refer to Figure 9, "Calculate Condition Adjustment Factor for Existing Facilities" to obtain the Condition Adjustment Factor for line B. • Add lines A and B. If the result is 1 or less, enter the result in line C. If the result is greater than 1, enter 1 on line C. • Enter 1 on line D. • Subtract Line D from Line C and enter the result on line E • Enter the Existing Space on Line F. Existing space is obtained from the IHS FDS data base or, for Tribal facilities, is the documented gross size in square meters. • Multiply line E times Line F and enter the result on line G. 	Line		
	A		Age Adjustment Factor
	B	+	Condition Adjustment Factor
	C	=	Space Adjustment Factor
	D	-	1
	E	=	Space adjustment
	F	*	Existing Space
G	=	Adjusted Existing Space	

Figure 7, Look-Up: Age Factor

<p>If the facility consists of only one building use the age of that building to obtain the Age Factor using the lookup table to the right.</p> <p>If the facility consists of multiple buildings, obtain the Weighted Facility Age from Figure 8, "Calculate Weighted Age for Multi Building Facilities," and use that value in the look up table to determine the Age Factor.</p>	Weighted Facility Age	Age Factor
	0-10 years	0
	11-50 years	0.0125
	51 or more years	.5

**The Indian Health Service
Health Care Facilities Construction Priority System**

Figure 8, Calculate Weighted Age for Multi Building Facilities

<p>The weighted age of a facility consisting of only one building is the age of that building. The weighted age of a facility with multiple buildings is calculated using this table as follows: Calculate the weighted age of each building by dividing its size by the total size of the facility then multiplying that value times the building age. Use a separate sheet for additional buildings.</p> <p>Sum the Weighted Building Age of all the buildings to obtain the Weighted Facility Age.</p> <p>Information for this table may be obtained from the FEDES data base or, for facilities not participating in FEDES, from documentation.</p>	Building Size		Facility Size		Building Age		Weighted Building Age
		÷		x		=	
		÷		x		=	
		÷		x		=	
		÷		x		=	
		÷		x		=	
		÷		x		=	
		÷		x		=	
	Weighted Facility Age = Sum of Weighted Building Age						

Figure 9, Calculate Condition Adjustment Factor for Existing Facilities

<p>To determine the Facility Condition Adjustment Factor:</p> <ul style="list-style-type: none"> Enter the cost to correct each FEDES deficiency listed in columns A through K. For facilities not participating in the FEDES, use the documented cost to repair any deficiencies that meet the definitions of the FEDES Categories listed. Add lines A through K and enter the result in line L. Enter the Existing Facility size (unadjusted) on Line M. Divide line L by line M and enter the result on line N. Enter the Cost to replace on Line O. Obtain from the IHS Budget Cost Estimating System. Divide Line N by Line O and enter the result on line P. <p>If the Condition Adjustment Factor (line P) is greater than .75, then change it to 1, otherwise use the value calculated.</p>	Line	Table A, Applicable FEDES Codes and Categories			
		FEDES Code	FEDES Category	Cost	
	A	2	Life Safety Compliance		
	B	3	General Safety		
	C	4	Environmental Compliance		
	D	7	Handicapped Compliance		
	E	8	Energy Conservation		
	F	10	Architectural Maintenance and Repair		
	G	11	Structural Maintenance and Repair		
	H	12	Mechanical Maintenance and Repair		
	I	13	Electrical Maintenance and Repair		
	J	14	Utilities Maintenance and Repair		
	K	17	Roof Maintenance and Repair		
	L	Total FEDES Deficiency			
	M	Existing Facility Size			÷
	N	Cost per m² to Repair			
O	Cost per m² to Replace			÷	
P	Condition Adjustment Factor				

**The Indian Health Service
Health Care Facilities Construction Priority System**

Health Status Criterion Calculations

Figure 10, Calculating the Health Status Criterion Value

<p>The Health Status Criterion is the ¼ the sum of the following four indices from the Federal Employees Health Benefits Disparities Index (FDI) : Birth Disparities, Percent of Population 55 or older, Composite Poverty Index, and Disease Disparities Index. Calculate the Health Status Criterion by Entering the FDI value for each indicator in lines A, B, C, and D.</p> <ul style="list-style-type: none"> • Complete the calculations on lines A, B, C, and D. • Sum health status Column, rows A, B, C, and D. Enter the result in line E 	Line	Health Status Indicators from the FDI	Index Value				Health Status Value
	A	Birth Disparities Index		x	.25	=	
	B	Percent of Population over 55		x	.25	=	
	C	Composite Poverty Index		x	.25	=	
	D	Disease Disparities Index		x	.25	=	
E	Health Status Criterion						Maximum value = 1

Isolation Criterion Calculations

Figure 11, Calculating the Isolation Criterion Value

<p>The isolation of a population is indicated by the average distance most people need to travel for healthcare services.</p>	If the facility is:				Isolation Value
	Less than 40 Km from an ER	Isolation	=	0	= 0
	40-89 Km from an ER	Isolation	=	Km to Alternatives ÷ 90 Kilometers	=
	90 or more Km from an ER	Isolation	=	1	= 1
	Not on a road connecting to Federal or state highway	Isolation	=	1	= 1

Figure 12, Calculating the Barriers to Service Criterion Value

<p>If the barriers to service are documented and the documentation is validated by the Validation Committee, the value is 1, otherwise it is 0.</p>	If the Validation Committee:			Barriers To Service Value
	Does not Verify Barriers to Service	Barriers to Service	=	0
	Does Verify Barriers to Service	Barriers to Service	=	1

**The Indian Health Service
Health Care Facilities Construction Priority System**

Facility Size Criterion Calculations

Figure 13, Facility Size Criterion Value Look up Table

The Facility Size criterion increases the overall score. It is designed so smaller facilities benefit more than large facilities. The look-up table below provides a general estimate the factor used to increase the score.

Facility Required Space In Square Meters (m ²)	Facility Size Value	Facility Required Space In Square Meters (m ²)	Facility Size Value	Facility Required Space In Square Meters (m ²)	Facility Size Value
Up to 1 200	1	9 601 to 10 000	0.541	18 001 to 18 400	0.345
1 201 to 1 600	0.976	10 001 to 10 400	0.524	18 401 to 18 800	0.340
1 601 to 2 000	0.952	10 401 to 10 800	0.507	18 801 to 19 200	0.335
2 001 to 2 400	0.928	10 801 to 11 200	0.489	19 201 to 19 600	0.329
2 401 to 2 800	0.904	11 201 to 11 600	0.472	19 601 to 20 000	0.324
2 801 to 3 200	0.880	11 601 to 12 000	0.455	20 001 to 20 400	0.318
3 201 to 3 600	0.856	12 001 to 12 400	0.438	20 401 to 20 800	0.313
3 601 to 4 000	0.832	12 401 to 12 800	0.421	20 801 to 21 200	0.308
4 001 to 4 400	0.808	12 801 to 13 200	0.416	21 201 to 21 600	0.302
4 401 to 4 800	0.784	13 201 to 13 600	0.410	21 601 to 22 000	0.297
4 801 to 5 200	0.760	13 601 to 14 000	0.405	22 001 to 22 400	0.291
5 201 to 5 600	0.736	14 001 to 14 400	0.399	22 401 to 22 800	0.286
5 601 to 6 000	0.712	14 401 to 14 800	0.394	22 801 to 23 200	0.281
6 001 to 6 400	0.695	14 801 to 15 200	0.389	23 201 to 23 600	0.275
6 401 to 6 800	0.678	15 201 to 15 600	0.383	23 601 to 24 000	0.270
6 801 to 7 200	0.661	15 601 to 16 000	0.378	24 001 to 24 400	0.264
7 201 to 7 600	0.644	16 001 to 16 400	0.372	24 401 to 24 800	0.259
7 601 to 8 000	0.626	16 401 to 16 800	0.367	24 801 to 25 200	0.254
8 001 to 8 400	0.609	16 801 to 17 200	0.362	25 201 to 25 600	0.248
8 401 to 8 800	0.592	17 201 to 17 600	0.356	25 601 to 26 000	0.243
8 801 to 9 200	0.575	17 601 to 18 000	0.351	26 001 to 26 400	0.237
9 201 to 9 600	0.558				
6 801 or more		Calculated using the same formula used for this table. See Table 8, Facility Size Criterion			

**The Indian Health Service
Health Care Facilities Construction Priority System**

Figure 14, Facility Size Criterion Formula

If Required Space is	Use	Facility Size Value
0 to 1 200m ²	1	1
1 200m ² - 6 000m ²	$(1 - [(\text{Required Space} - 1200 \text{ m}^2) \times 0.00006])$	
6 000 m ² than 12 800m ²	$(.712 - [(\text{Required Space} - 6000 \text{ m}^2) \times 0.0000428])$	
More than 12 800 m ²	$(.416 - [(\text{Required Space} - 6000 \text{ m}^2) \times 0.0000135])$	

Innovation Criterion Calculations

Figure 15, Innovation Criterion Value

Evaluation Criteria		Innovation Value
Element 1 Verified by Validation Committee	20% or	.20
Element 2 Verified by Validation Committee	20% or	.20
Element 3 Verified by Validation Committee	20% or	.20
Element 4 Verified by Validation Committee	20% or	.20
Element 5 Verified by Validation Committee	20% or	.20
Total	100 % or	(Maximum of 1)

**The Indian Health Service
Health Care Facilities Construction Priority System**

Figure 16, Facility Condition Factor Lookup Table

Budget Cost																					
Estimating System																					
Cost per M to replace>	\$25- \$49	\$50- \$74	\$75- 99	\$100- \$124	\$125- \$149	\$150- \$174	\$175- \$199	\$200- \$224	\$225- \$249	\$250- \$274	\$275- \$299	\$300- \$324	\$325- \$349	\$350- \$374	\$375- \$399	\$400- \$424	\$425- \$450	\$450- \$474	\$475- \$499	\$500- \$524	\$525
FEDS Cost / M																					
\$0-\$24	1.00	0.50	0.33	0.25	0.20	0.17	0.14	0.13	0.11	0.10	0.09	0.08	0.08	0.07	0.07	0.06	0.06	0.06	0.05	0.05	0.05
\$25-\$49	1.00	1.00	0.67	0.50	0.40	0.33	0.29	0.25	0.22	0.20	0.18	0.17	0.15	0.14	0.13	0.13	0.12	0.11	0.11	0.10	0.10
\$75-\$99	1.00	1.00	1.00	0.75	0.60	0.50	0.43	0.38	0.33	0.30	0.27	0.25	0.23	0.21	0.20	0.19	0.18	0.17	0.16	0.15	0.14
\$100-\$124	1.00	1.00	1.00	1.00	1.00	0.67	0.57	0.50	0.44	0.40	0.36	0.33	0.31	0.29	0.27	0.25	0.24	0.22	0.21	0.20	0.19
\$125-\$149	1.00	1.00	1.00	1.00	1.00	1.00	0.71	0.63	0.56	0.50	0.45	0.42	0.38	0.36	0.33	0.31	0.29	0.28	0.26	0.25	0.24
\$150-\$174	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.75	0.67	0.60	0.55	0.50	0.46	0.43	0.40	0.38	0.35	0.33	0.32	0.30	0.29
\$175-\$199	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.70	0.64	0.58	0.54	0.50	0.47	0.44	0.41	0.39	0.37	0.35	0.33
\$200-\$224	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.73	0.67	0.62	0.57	0.53	0.50	0.47	0.44	0.42	0.40	0.38
\$250-\$274	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.75	0.69	0.64	0.60	0.56	0.53	0.50	0.47	0.45	0.43
\$275-\$299	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.71	0.67	0.63	0.59	0.56	0.53	0.50	0.48
\$300-\$324	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.73	0.69	0.65	0.61	0.58	0.55	0.52
\$325-\$349	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.75	0.71	0.67	0.63	0.60	0.57
\$350-\$374	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.72	0.68	0.65	0.62
\$350-\$374	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.74	0.70	0.67
\$375-\$399	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.75	0.71
\$400-\$424	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
\$425-\$450	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
\$450-\$474	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
\$475-\$499	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
\$500-\$524	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
\$524-\$549	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
\$550-\$574	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
\$575-\$599	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
\$600-\$624	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
\$625-\$649	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

**The Indian Health Service
Health Care Facilities Construction Priority System**

Budget Cost																					
Estimating System	\$25-	\$50-	\$75-	\$100-	\$125-	\$150-	\$175-	\$200-	\$225-	\$250-	\$275-	\$300-	\$325-	\$350-	\$375-	\$400-	\$425-	\$450-	\$475-	\$500-	
Cost per M to replace>	\$49	\$74	99	\$124	\$149	\$174	\$199	\$224	\$249	\$274	\$299	\$324	\$349	\$374	\$399	\$424	\$450	\$474	\$499	\$524	\$525
\$650-\$674	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
\$675-\$699	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
\$700-\$724	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
725	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00